Reception of asylum seeking and refugee children in the Nordic countries: The Norwegian report


Lutine de Wal Pastoor - Senior Researcher, NKVTS

Ketil Eide - Senior Researcher, RBUP

Leoul Mekonen - Project Associate, RBUP

Norwegian Centre for Violence and Traumatic Stress Studies

R.BUP

Centre for Child and Adolescent Mental Health
EASTERN and SOUTHERN NORWAY

Nordic Network for Research on Refugee Children

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The Norwegian report (2010)

Lutine de Wal Pastoor, Ketil Eide, Leoul Mekonen

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Inquiries regarding the report may be addressed to:

Lutine de Wal Pastoor, dr. polit.
Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS)
Kirkeveien 166 (building 48), N-0407 Oslo, Norway
Phone: +47 22 59 55 00
E-mail: lutine.pastoor@nkvts.unirand.no

Ketil Eide, dr. polit.
The Centre for Child and Adolescent Mental Health (RBUP), Eastern and Southern Norway
Postboks 4623 Nydalen, N- 0405 Oslo, Norway
Phone: +47 22 58 60 00
E-mail: ketil.eide@r-bup.no

Nordic Network for Research on Refugee Children
http://www.nordicrefugeechildren.org

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Foreword

The Norwegian report is the result of a questionnaire addressing the reception of asylum seeking and refugee children in the Nordic countries. So far, comparable reports are available from Sweden, Denmark and Iceland. The questionnaire has been developed by The Nordic Network for Research on Refugee Children[1], a network initiated by researchers of the Nordic School of Public Health (NHV) in Gothenburg, Sweden. The aim of the network is to promote research on health, welfare and well-being of refugee children in the Nordic countries. The network has received funding from FAS (The Swedish Council for Working Life and Social Research), for the years 2008-2010.

The intention of the Nordic survey is both to identify and to compare the reception of asylum seeking and refugee children in the Nordic countries in relation to issues concerning health, care, accommodation and education. The collected data will make it possible to learn more about reception conditions in each country as well as in the Nordic countries in general from a comparative perspective.

The compilation of the Norwegian report is a product of collaboration between the Norwegian Centre for Violence and Traumatic Stress (NKVTS) and the Centre for Child and Adolescent Mental Health (RBUP), Eastern and Southern Norway. Lutine de Wal Pastoor (NKVTS) has been responsible for completing and editing the final content of the report.

The answers to the questionnaire rely on a review of relevant websites, available literature and public documents (e.g. the Immigration Act and the Education Act) as well as from consulting relevant ministries and directorates (e.g., BLD, UDI) and a number of professionals in the field. Some changes were made to adapt the questionnaire to the Norwegian context. We were not able to answer all the questions, but have extended others by supplying additional information, in order to enable an increased understanding of the Norwegian situation.

The data collection was carried out during autumn 2009 and spring 2010. The report, which was initially completed June 2010, was updated November 2010 with some additional information on recent developments.

We hope this report may contribute to a more comprehensive understanding of reception conditions of asylum seeking and refugee children in Norway as well as may facilitate further comparative research in the Nordic countries.

Oslo, 1 December 2010

Lutine de Wal Pastoor
Senior Researcher, NKVTS

Ketil Eide
Senior Researcher, RBUP

[1] For more information: http://www.nordicrefugeechildren.org

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c. Are health services for asylum services integrated into the national health care system? If not how are they organised and who provides them?
d. Do you have any centres of excellence in terms of providing health care, medical care and psychiatric care for asylums seekers? With a special focus on children? Please attach any available documentation.
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e. Are there any special psychosocial strategies for recently arrived foreign children in your school system?
f. Do you have any centres of excellence in terms of education or psychosocial support to recently arrived foreign children? Please attach documentation, if available.
g. Is there a national body that has the responsibility of supervising and evaluating educational services for asylum seekers? National guidelines/reports? Please attach if available.
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1. Statistics

a. How many asylum seekers between the ages 0-6 and 7-17 years arrived during 2002-2008? Unaccompanied or accompanied?

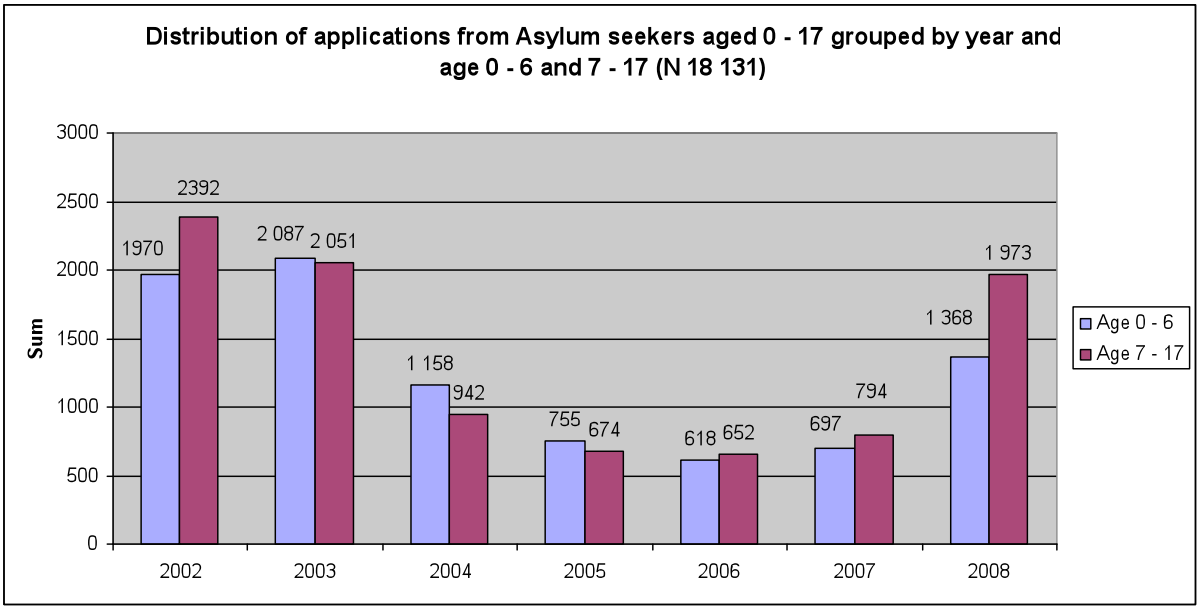
In total 18 131 children applied for asylum in Norway during 2002-2008, of these were 8.653 aged between 0-6 and 9.478 between 7-17 years. The table below shows that the number of asylum seeking children may vary considerably from year to year.

Table 1.1 Asylum seekers aged 0 – 6 and 7 – 17 years during 2002 – 2008.

Year	Age 0 – 6	Age 7 - 17	Total
2002	1 970	2 392	4 362
2003	2 087	2 051	4 138
2004	1 158	942	2 100
2005	755	674	1 429
2006	618	652	1 270
2007	697	794	1 491
2008	1 368	1 973	3 341
Total	**8 653**	**9 478**	**18 131**

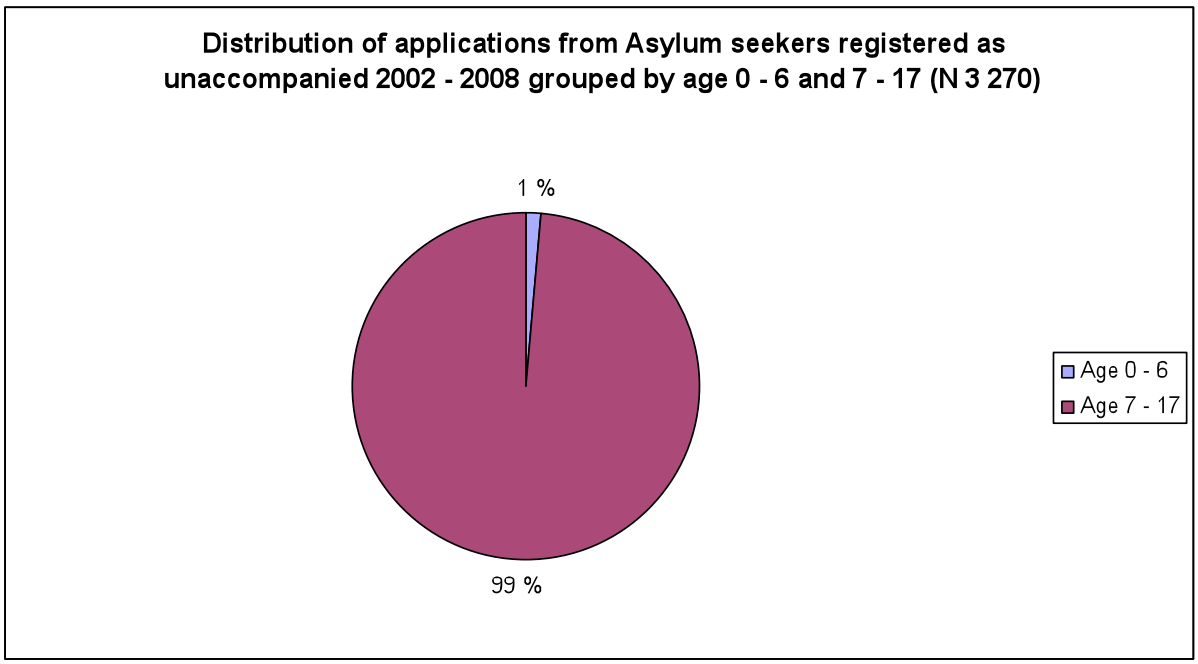
The statistical data concerning age and number of asylum seeking children for the period 2002 – 2008 is obtained from the Norwegian Directorate of Immigration (UDI). Some of the numbers in Table 1.1 differ from previous publications from UDI due to changes in age status of a number of applicants. The ages of asylum seekers used in this report are based on the latest known and confirmed birth dates. For example, an asylum seeker who initially stated to be 15 years of age at the time of application and who later on in the asylum process is confirmed to have been 17 years old at that time, is here registered as 17. When it comes to unaccompanied refugee minors (URM), age and age assessment is a central issue in Norway (see Section 9).

Figure 1.1 Asylum seeking children, age and year of arrival



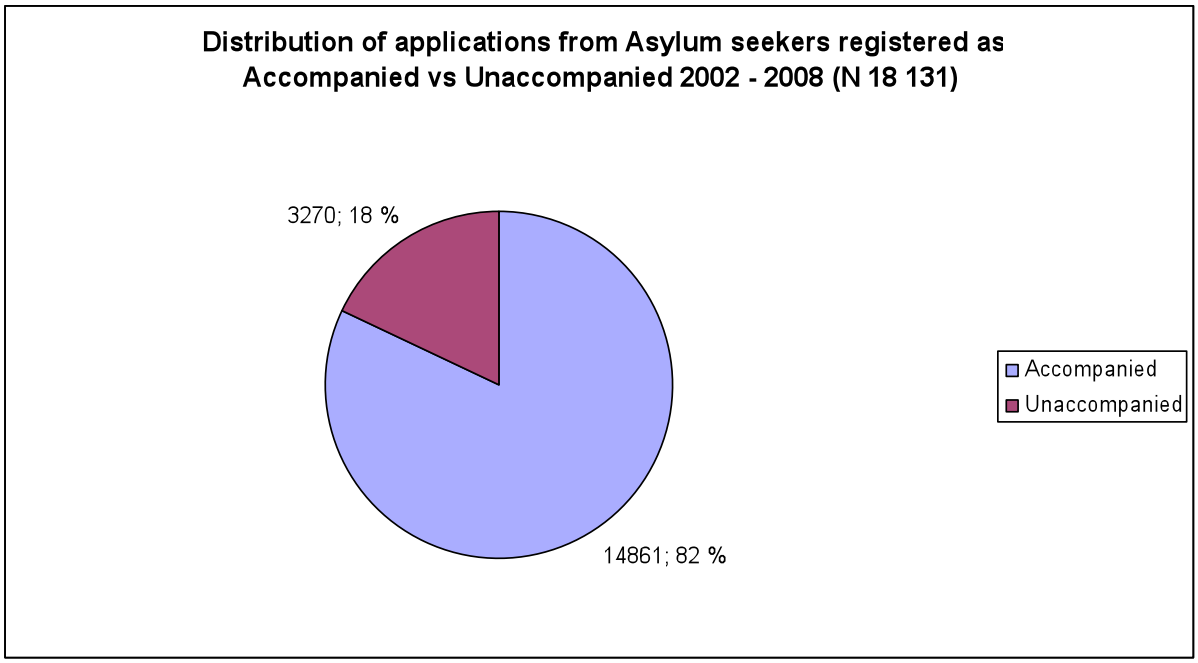
When it comes to unaccompanied asylum seeking children, the age distribution differs significantly from the accompanied children. As the figure below shows, the number of unaccompanied asylum seekers in the age group 0 – 6 years is very low.

Figure 1.2 Unaccompanied asylum seeking children grouped by age



During the period of 2002-2008, the number of unaccompanied minors is 3.270, which is 18 percent of the total number of asylum seeking children.

Figure 1.3 Percentage of accompanied compared to unaccompanied children



UDI operates with different figures concerning the number of unaccompanied children on arrival and the adjusted number after age assessments are completed. As in many other European countries, age assessment of unaccompanied minors is a controversial topic in Norway. This issue will be further discussed under Section 9 (Special concerns regarding unaccompanied minors).

Table 1.2 Numbers of accompanied versus unaccompanied asylum seeking children

Year	Accompanied	Unaccompanied	Total
2002	3 656	706	4 362
2003	3 702	436	4 138
2004	1 904	196	2 100
2005	1 214	215	1 429
2006	1 013	257	1 270
2007	1 167	324	1 491
2008	2 205	1 136	3 341
Total	**14 861**	**3 270**	**18 131**

b. How many of the asylum seekers have been granted asylum - permanent or temporary residence – or rejected?

As there are no temporary residence permits in Norway with reference to 2002-2008, UDI is unable to report on the distinction between permanent and temporary residence permits. However, those who are granted residence receive initially a one-year permit, which is

renewable. The only exception concerns UNHCR-refugees that receive a two-year permit on arrival. When the refugee/asylum seeker has renewed his/her residence permit at least twice and fulfils all other requirements for a permanent residence permit [*bosetningstillatelse*], they are entitled to apply for and will be granted a permanent settlement permit.

In order to be granted a permanent residence permit, you must have stayed in Norway for a continuous period of three years during which you have held temporary permits forming a basis for a permanent residence permit, and have completed tuition in the Norwegian language. A permanent residence permit entitles the holder to live and work in Norway indefinitely. For more information on this matter, see www.udiregelverk.no.
Or: http://www.udi.no/Norwegian-Directorate-of-Immigration/Central-topics/Permanent-Residence-Permit/

A new Immigration Act and Immigration Regulations entered into force on 1 January 2010. An important content-wise change in the new law is that many of those who for the first time are granted protection will receive the status of refugees. In accordance with the law, both the people who today get granted asylum and persons who currently receive protection against their return, receive protection if the UDI makes a decision on their case after 1 January 2010. This means that both groups that previously had different status will receive the status of refugees after the new law, and thus they also the rights this entails. With the new law there are also several conceptual changes. For example, the word 'asylum' is replaced with the word 'protection' to reflect the concept of international refugee law, i.e., protection.

Many unaccompanied minors are not granted residence on protection grounds stated in the UN Refugee Convention[2] but due to strong humanitarian considerations. Unaccompanied minor asylum seekers who neither meet the conditions for protection nor have special grounds for a residence permit on humanitarian grounds, are nevertheless given residence permit if Norwegian immigrant authorities do not manage to trace parents or others who have or may have care responsibility for the child. Clarification of identity and age, along with localization of care persons outside Norway, are time-consuming and may explain the at times long processing time for asylum applications. Because the methods for age testing cannot give definitive answers with reference to age, it is emphasised both in the law and in the preparatory works that the result of the age testing only shall be included as a factor in an overall consideration of the unaccompanied minor's age, and may not alone be decisive (Ministry of Children – The Rights of the Child, 2008, p. 124).

[2] Article 1 of the UN Refugee Convention as amended by the 1967 Protocol provides the definition of a refugee: A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

Table 1.3 Asylum decisions 2000-2008. All aged 0-17.

Year	Rejection	Granted	Total
2002	3147	1226	4373
2003	3001	1308	4309
2004	1389	849	2238
2005	814	684	1498
2006	678	640	1318
2007	727	762	1489
2008	1492	1403	2895
Total	**11248**	**6872**	**18120**

Table 1.4 Asylum decisions 20002-2008. Unaccompanied aged 0-17.

Year	Rejection	Granted	Total
2002	280	445	725
2003	241	221	462
2004	81	119	200
2005	64	147	211
2006	86	182	268
2007	106	215	321
2008	278	668	946
Total	**1136**	**1997**	**3133**

Table 1.5 Asylum decisions 2002-2008. Accompanied aged 0-17

Year	Rejection	Granted	Total
2002	2867	781	3648
2003	2760	1087	3847
2004	1308	730	2038
2005	750	537	1287
2006	592	458	1050
2007	621	547	1168
2008	1214	735	1949
Total	**10112**	**4875**	**14987**

Between the two groups of asylum seeking children there is a substantial difference as to rejection and granting of residence permits. While 36 percent of the asylum applications of unaccompanied children were rejected, as much as 67 percent of the asylum applications of accompanied children were rejected.

Tightening of asylum policy unaccompanied minors

Since October 2009, asylum practice concerning unaccompanied minor asylum seekers has been tightened:

- Temporary acceptance of unaccompanied asylum seeking minors whose only basis for being allowed to stay is that it is impossible to locate their parents or guardians in the country of origin.
- Introduction of the Dublin II regulation affecting unaccompanied asylum seeking minors.

Unaccompanied minor asylum seekers who have completed 16 years at the time of the asylum decision and do not have a need for protection and where there do not exist strong humanitarian considerations that could justify an ordinary residence permit, will be granted a *temporary residence permit* until they reach the age of 18. At the age of 18 the permit no longer applies. However, unaccompanied minor asylum seekers will not be sent back to their home country unless the Norwegian authorities believe their care situation in the country is satisfactory. For more information on this subject: http://www.regjeringen.no/nb/dep/aid/pressesenter/pressemeldinger/2009/innstramming-av-praksis-for-einslege-min.html?id=581712

* Update: The number of unaccompanied minor asylum seekers has dropped by 67% at the end of October 2010 compared to the same period in 2009. This has led to a reduced need for reception places for this group of asylum seekers. Consequently, UDI has closed 30 reception centres/ reception departments for unaccompanied minor asylum seekers.

c. What is the average time from application to final decision?

The statistics regarding waiting time from application to final decision are difficult to analyse as extreme values have a great influence on the average (Mean). Therefore the statistics include also values that are cut off in both ends by 0.2 and 0.8 percentiles as a help to improve analysis of waiting time. Consequently, UDI is usually reluctant to supply researchers with mean values. However, the table below can still provide some indications. It shows, for example, that minimum waiting time in 2006 for all aged 0-17 was 58 days, while maximum was 413 days, median 205 days, and mean 212 days.

Table 1.6 All aged 0 – 17:
Min, Max, Median and Mean from application to final decision 2002 – 2008 (days)

Year	Min	Max	Median	Mean
2002	82	364	224	223
2003	60	375	201	208
2004	51	302	126	140
2005	39	369	120	146
2006	58	413	205	212
2007	63	284	154	161
2008	73	273	179	183

Table 1.7 Accompanied aged 0 - 17:
Min, Max, Median and Mean from application to final decision 2002 – 2008 (days)

Year	Min	Max	Median	Mean
2002	69	287	193	184
2003	55	377	162	180
2004	46	308	134	149
2005	38	370	95	132
2006	52	442	148	186
2007	53	295	121	139
2008	55	252	125	134

Table 1.8 Unaccompanied aged 0 - 17:
Min, Max, Median and Mean from application to final decision 2002 – 2008 (days)

Year	Min	Max	Median	Mean
2002	151	415	254	263
2003	137	387	223	236
2004	88	243	137	145
2005	66	351	129	158
2006	119	333	212	220
2007	105	251	167	170
2008	148	287	213	214

The waiting period in the reception centres is another central theme when it comes to unaccompanied asylum seeking children. This group of children is to be given priority in the asylum process and it is a stated objective that the settlement in the municipality shall be made within three months after the child has received a decision on residency. The average waiting time - from the decision of residency until settlement in a municipality - for unaccompanied minors was 3.9 months in 2007 (IMDi 2009).

Previously, it has been an internal goal to process 75 percent of the applications of unaccompanied minors within seven weeks (KRD, 2000). Attainment of this goal depends on many factors, such as uncertainties about the minor's age, identity and tracking of caregivers outside Norway. As a result of increasing number of arrivals, this objective had to be adjusted. More recently, it has been stated that decisions in asylum cases for unaccompanied minors will be taken within six months. Statistics for 2008 show that it usually takes about seven months to make decisions in asylum cases (UDI 2009). This means that for unaccompanied asylum seeking children the average waiting time in the reception centre, from the date of arrival until their settlement in a municipality, is approximately 12 month.

d. What are the asylum seeking children's countries of origin?

The largest groups of all asylum seeking children during the period 2002 – 2008 were from Russia, Serbia and Montenegro, Iraq, Afghanistan, Somalia, Eritrea, Stateless, Bosnia and Herzegovina, Iran and Ethiopia. When it comes to country of origin see the Appendix for details. The Appendix shows the country of origin for all minors, for accompanied minors, and unaccompanied minors respectively.

Depending on the global situation the countries of origin of asylum seekers differ from year to year. In 2008, approximately 14.400 persons sought for asylum in Norway, most of them came from Iraq, Eritrea and Afghanistan. Of these 14.400 asylum seekers, about 3.500 were children. 1374 of these 3.500 asylum seeking children were unaccompanied minors. The majority of the unaccompanied minors came from Afghanistan (80%), Iraq and Somalia.

In 2008, 4.617 asylum seekers were granted asylum in Norway. In addition, 770 UNHCR-refugees were accepted, most of them came from Myanmar (Burma) and Iraq or were stateless Palestinians.

e. Parental educational background and age?

No statistics available regarding educational background and age of the parents.

f. Family structure when families apply (two-parent families, single-parent families, or children accompanied by other caregiver than parent)

No statistics available on family structure.

*** Additional note: The Status of the Asylum-seeking Child in Norway**

In their article, The Status of the Asylum-seeking Child in Norway and Denmark, Lidén & Vitus (2010) discuss how asylum-seeking children are positioned in discourse, politics and practice in Norway and Denmark through a comparative analysis of schooling, the use of hearings in asylum cases, and the grounds for being granted humanitarian residence permits:

> … the article concludes that while in Norway a discourse of national border control competes equally with that of the protection of the child, in Denmark the former discourse has gained hegemony. In Norway asylum-seeking children are positioned as both asylum-seekers and children, with rights to normal schooling, to being heard in the asylum process, and to possible humanitarian residence permits based on attachment to Norway. By contrast, in Denmark these children are primarily positioned as asylum-seekers — with the possibility of a humanitarian residence permit based only on their or their parents' illness, with no separate hearings, and with access primarily limited to schooling without credits. (Lidén & Vitus, 2010, p. 62)

2. Health examinations

a. Are health examinations voluntary or compulsory? Are they accepted by the asylum seekers, by the general public?

Immediately after their arrival in Norway asylum seekers are sent to the *arrival/transit* reception centre at Tanum in Bærum municipality, where they stay for 3-10 days before they get transferred to another *transit* reception centre or an *ordinary* reception centre.

Unaccompanied minors (15 years and older) are first sent to Hvalstad *transit* reception centre for unaccompanied minors (Asker municipality), while unaccompanied minors under 15 years of age are sent to *care centres* (run by Child Welfare authorities). The first centre, Eidsvoll care centre, was opened December 2007.

While still in transit centres, asylum seekers undergo initial health examinations. As the transit phase is rather short, health examinations and services primarily concentrate on matters that require quick clarification and follow-up:
• a brief medical screening in order to detect the need of treatment of diseases as well as health conditions requiring immediate attention
• an obligatory test for tuberculosis
• an optional HIV-test

It has been argued that the first medical screening could be a good opportunity to seek information about a possible history of violent abuse and torture. As the system is now, this identification is left to the ordinary consultations with health personnel after the applicant arrives at the ordinary reception centre. However, special attention and methods are required to detect and document signs of torture and sexual violence. Unfortunately, detecting/documenting serious abuse and torture is not part of the general knowledge of Norwegian health personnel (Brekke & Vevstad, 2007).

Mandatory tuberculosis screening in transit reception centres
In general, health examinations are voluntary for asylum seekers except that all asylum seekers have to undergo a compulsory tuberculosis test that take place at the health station of the arrival reception centre. Tests regarding other diseases such as HIV and hepatitis are voluntary but recommended. Pregnant women are HIV tested.

According to the regulations concerning tuberculosis control § 3-1 and The Norwegian Communicable Disease Prevention Act [*smittevernloven*] § 3-1, tuberculosis screening is mandatory. Other types of health examinations require consent unless The Communicable Diseases Prevention Act in specific case permits compulsory examination. People from countries with high rates of tuberculosis, and who will be staying more than three months in Norway, as well as refugees and asylum seekers, are obliged to undergo tuberculosis screening. The Norwegian Institute of Public Health shall, in accordance with the Regulations concerning Tuberculosis Control specify which countries have high rates of tuberculosis (Brunvatne, 2006).

The screening includes tuberculin skin test also known as mantoux and additional radiographs (commonly chest x-rays) to asylum seekers over 15 years of age. The tuberculosis test usually is completed within fourteen days after entry. The provision in TB Control Regulations § 3-1 applies to asylum seekers and refugees, regardless of where they reside. Mandatory tuberculosis examination is justified in part that the risk of spread of infection is believed to be higher in the reception centres than else where, and partly because asylum seekers and refugees may come from countries where the risk of tuberculosis infection is relatively high.

If the tuberculosis examination reveals symptoms or signs of tuberculosis, asylum seekers will be transferred to a reception centre which will facilitate the necessary follow-up. For example, children will be referred to children's ward in a hospital, pulmonary medicine or

infectious medical outpatient clinic for further assessment, supplementary investigations and treatment (Tuberculosis Control Regulations § 3-3). Specialists in pulmonary medicine or infectious diseases or paediatricians are responsible for initiating treatment and choice of treatment regimen. The specialist shall notify the tuberculosis coordinator who is responsible for the establishment of a treatment plan for the patient for the entire treatment period (Tuberculosis Control Regulations § 3-3). The treatment plan will be established in cooperation with the specialist, the patient and the doctor in the municipal health service.

The purpose of health examinations in the transit centres is to capture the need of treatment for disease and health conditions that require immediate attention/follow up as well as to assess whether the health conditions require special considerations when transferring asylum seekers from transit to ordinary reception centres. Asylum seekers who need frequent medical assistance and examination should be transferred to a reception centre that facilitates such follow-up. The same applies to pregnant women and asylum seekers with chronic disease that require immediate follow-up.

Follow-up of asylum seekers with special medical needs should generally not be initiated in the transit phase, as transfer to an ordinary reception centre may cause a break in the therapeutic program. In case of acute signs of recent history of trauma or torture, medical examination and follow up will be offered. When the asylum seekers are transferred to ordinary reception centres, they are assigned to local medical health services in the municipality the reception centre is located.

The Norwegian Directorate of Health [*Helsedirektoratet*] recommends municipal health services to contact newly arrived asylum seekers as soon as possible, in order to make a first evaluation of their physical and mental health as well as their need for medical services. An example of the recommended evaluation sheet to be completed (Skjema 1 - Helseundersøkelse for flyktninger og asylsøkere/egenmelding) can be found in Appendix 2 (p. 83) of the *Guide. The provision of health services to asylum seekers, refugees and reunited family members* [Veileder - Helsetjenestetilbudet til asylsøkere, flyktninger og familiegjenforente] (2010), a recently revised edition of IS-1022 (2003).

In 2006 an offer for reinforced health examination was developed for asylum seekers who the authorities have received worrying information about their mental health. The project is led by Jim Åge Nøttestad of the Regional Resource Centre for security-prisons and forensic psychiatry at Brøseth in Trondheim. Three teams of experts with special competence in psychiatry, risk assessments and refugee health have been established as a result of the project.

The team of experts have given training to workers at reception centres in risk assessments for asylum seekers as well as training that will give them more knowledge about mental health.

b. Who funds the health examinations? State, municipality or the individual?

The state, i.e., the Directorate of Immigration (UDI), covers all the costs associated with the required health examinations (incl. compulsory tuberculosis screening) and immediate

health care (incl. acute dental treatment) to asylum seekers staying at the transit reception centres.

The host municipality receives grants or compensation from the state for residents in ordinary reception centres in the municipality. The subsidy is determined by The Norwegian Parliament and shall cover the average costs of the municipality to provide health care, child welfare services, interpreting services and administration in connection with the reception.

Asylum seekers, refugees and reunited family members are automatically members of the National Insurance Scheme on arrival. As a member of the National Insurance Scheme patients pay only a certain part of the costs of public health services, so-called "deductible" [*egenandel*] . This includes medical treatment, purchase of certain medicines (in blue prescription), physiotherapy, psychologist and travel to examination and treatment. When the patient has paid deductibles up to a certain amount, the person has the right to an exemption card [*frikort*]. Then the patient does not have to pay deductibles for public health services the rest of the calendar year.

In accordance with the "Monetary Regulations" *[Pengereglementet*], i.e., "Regulations for financial assistance to residents of state reception centres", asylum seekers who can not support themselves receive an economic allowance, called *basisbeløpet* [the basis amount]. This basic allowance has to cover the cost of living expenses, such as food, clothing, health services, medications, activities, etc. Asylum seekers who have jobs or other income will receive less financial benefits. Additional allowances may be given if it is necessary to ensure the safety of a person's life and health.
For more information:
http://www.udiregelverk.no/Default.aspx?path={C7C97936-99F7-4075-B16C-1A73F72EF66E}

According to the "Monetary Regulations" the asylum seekers themselves have to pay part of the consultation costs, when visiting a doctor. Deductibles for treatment by a psychologist, psychiatrist, and physiotherapy after referral from a doctor, which are not covered by the Norwegian National Insurance Scheme's "exemption card" [*Frikort/Egen andel*] are covered in full by UDI, the Norwegian Directorate of Immigration. The deductibles also include necessary medicines. If travel costs are larger than the proportion of which is determined by the Norwegian National Insurance Scheme, the cheapest mode of travel expense will be covered as well.

Children receive free medical care up to the age of twelve. Psychological and dental treatment is free up to the age of eighteen.

Issues concerning financing health services to asylum seekers are stated inAppendix 4, Financial matters related to health care, of *Guide - The provision of health services to asylum seekers, refugees and reunited family members* (Sosial- og helsedirektorat, 2003).

c. Which percentage of all asylum seeking children and refugee children undergo a health examination?

No statistics available with reference to this issue.

d. Which health service has the responsibility of doing these health examinations? Integrated into ordinary primary care? Hospital clinics? Special refugee clinics?

In accordance with Norwegian law, the public health services have the same responsibilities in relation to asylum seekers as to the rest of the population, concerning primary health care as well as specialised health services such as mental health care.

The responsibility for the provision of necessary health services to residents in the reception centres lies with the host municipality. This includes residents in transit reception centres as well as ordinary reception centres where asylum seekers stay while their asylum application is processed. According to The Municipal Health Care Act § 1-1 the municipalities shall provide necessary health care to all who live or stay in the municipality. Accordingly, municipalities have primary responsibility for ensuring that refugees and asylum seekers are given proper and equal services in cooperation with other health institutions/specialised health services.

For the most part, health examinations of asylum seekers are integrated into ordinary primary health care in Norway. However, Oslo Municipality has its own section for Migration Health (*Migrasjonshelse*) at the Centre for International Health (located at Ullevål hospital). *Migrasjonshelse* offers free, voluntary, "first time" health examinations to newly arrived asylum seekers, refugees and other immigrants in Oslo. The centre makes use of professional interpreters. The aim of the section is to provide early assistance to immigrants with physical or mental illnesses, disabilities, as well as offering information about health services in Oslo. The section receives annually about 1000 newly arrived refugees and immigrants.

e. Do national guidelines exist? If so, which national body makes them?

In Norway, the national body that has the responsibility for developing national guidelines for health care services to asylum seekers and refugees is *Helsedirektoratet,* i.e., The Directorate of Health (until April 2008 called The Directorate of Health and Social Affairs). The Directorate of Health is a specialist directorate and an administrative body under the Ministry of Health and Care Services and the Ministry of Labour and Social Inclusion. The Directorate is administered by the Ministry of Health and Care Services.

In 2003, the Directorate of Health and Social Affairs published an updated and revised guide (IS-1022), "Veileder - Helsetjenestetilbudet til asylsøkere og flyktninger" [*Guide - The provision of health services to asylum seekers and refugees*]. The previous guide was from 1993. The guide was developed in collaboration with The Ministry of Local Government and Regional Development, The Norwegian Directorate of Immigration (UDI), The Ministry of Health and The Norwegian Institute of Public Health.
* Update: June 2010, a new and revised Guide - now also including services to reunited family members - was released (only electronically): "Veileder - Helsetjenestetilbudet til asylsøkere, flyktninger og familiegjenforente" [*Guide - The provision of health services to asylum seekers, refugees and reunited family members*] (Helsedirektoratet, 2010).

The purpose of the Guide is to ensure that asylum seekers and refugees are given the necessary somatic and mental health care. In this regard, the municipality is expected to follow the guide as a basis for planning, organizing and provision of health services to asylum seekers and refugees. The guide is primarily intended for healthcare professionals and people in administrative positions in primary and specialised health care. In addition, it is intended for employees in the reception centres and in different decision making organs in municipalities, counties, and regional health authorities (*Helseforetak*). However, despite national norms, local practice seems to vary greatly: "the Guide is often only a guide" (Brekke & Vevstad, 2007).

The Guide provides updated information on health services for asylum seekers and refugees. It includes information about medical examinations in the transit phase, in the ordinary reception centres, and after receiving a settlement in a municipality. The Guide contains a range of issues regarding the health care provider's responsibility in providing qualified interpreters, obligatory tuberculosis examination in transit reception centres, transferring of health-related information and journals (concerning asylum seekers' health) from health services in transit centres to the municipal health services where the ordinary reception centre is located. The Guide also includes prevention, examination and treatment of communicable disease, vaccination, the need for the assessment of psychosocial problems, dental health care, prenatal care, maternal and child health centres, the school health service and environmental health safety in reception centres (Sosial- og helsedirektoratet, 2003).

The current Guide (2003) is under revision again. A revision was necessary due to the increased number of asylum seekers and refugees, more complex disease pictures, challenges when it comes to follow-up of persons who have been subjected to torture, and the need to set psychosocial issues on the agenda. Furthermore, a revision of the guide was necessary as various laws and regulations had been changed since 2003.
Since the study of the reception of asylum seeking children covers the period from 2002 to 2008, the focus is on the guidelines updated in 2003 and used throughout 2008. What is new in the proposed revised version is that the guide includes not only asylum seekers and refugees but also reunited family members who directly settle in Norwegian municipalities and do not stay in reception centres at first. The new guidelines have been "under hearing" (consulting several relevant organizations/experts on the proposal) and a new Guide is expected to be issued soon.

Do the guidelines have any particular section that deals with the situation of children? Are issues regarding children mentioned in the guidelines?

The Guide IS-1022 (2003) addresses health services to asylum seekers in general and there is no particular section that deals with the situation of children. However certain issues related to children's health are briefly mentioned under Section 3.4 which deals with psychosocial problems and Section 3.5 which deals with prenatal care, maternal and child health centres and the schools health services.

Under Section 3.4, the guide informs about the psychosocial situation of children as follows:

> Reactions after arriving in Norway are often characterised by a mixture of relief, exhaustion and uncertainty. There may be considerable variation in how to cope with the situation. Some children have been exposed to great stress and need special attention. Key concepts in the psychosocial work aimed at children are predictability, security and the opportunity to contact an adult. In case of suspicion of serious problems, services from the public sector must be contacted (Psychological Pedagogical Service, PPT, child and adolescent psychiatry, BUP, child protection services, etc). Parents may be affected by traumatic events, and therefore have reduced ability to support their children. Many will need help and support to give their children the necessary care in addition to assistance to participate in the so-called "children's bases" that the reception centres run. Parents should be encouraged to talk to other parents in the same situation.

In the consultation/hearing statement [*Høringssvar*] concerning the proposed revisions of the current Guide, the Children's Ombudsman in Norway calls for a clearer child perspective as well as a greater focus on children's rights and more references to the UN Convention of the Child. The Ombudsman is concerned that children in several contexts are just mentioned in depended clauses [*i en bisetning*]. Consequently they are not sufficiently attended to in the revision of the Guide (Veileder - Helsetjenestetilbudet til asylsøkere, flyktninger og familiegjenforente). For more information on the Norwegian Children's Ombudsman's comments:
http://www.barneombudet.no/horingsutt6/2009/horingssva15/

In 2005, the UN Committee on the Rights of the Child called on Norway to provide satisfactory psychological/psychiatric care for traumatised asylum seeking children

In *The rights of the child. Norway's fourth periodic report to the UN Committee on the Rights of the Child – 2008*), the Norwegian Ministry of Children and Equality and Ministry of Foreign Affairs reports: Children in asylum reception centres have the same right to health care services as other children, and shall be assisted by the ordinary services network with necessary adjustments. The responsibility for essential health care services to residents in reception centres lies with the host municipality, which, inter alia, shall carry out psychosocial measures based on need. The public health clinic is, in this connection, a vital resource in the preventive and health-promoting work and offers measures directed both toward the community and the individual. Furthermore, all children shall, like adults, be referred to specialist health care services – psychiatric as well as somatic – if identification and clinical examinations in primary health care services so dictate (Ch. 16, 670).

* Update: The new Guide IS-1022 (2010) has now an own subsection 3.5.3 (p.35) with the heading "Oppfølging av barn" [Following up children], which emphasizes that children should receive special attention and care. However, the content of this subsection is not very different from the above mentioned Section 3.4 in Guide IS-1022 (2003).

Professional disciplines involved; Paediatrician? Child and psychiatry involved in any way?

Varies greatly.

Somatic content: Infectious disorders, dental health, nutritional, room for individual needs of health and medical care?

Varies greatly.

Psychological content: Are psychological issues regarding children mentioned in the guidelines? Is there a structured interview? Are psychological/psychiatric issues often raised during the examination?

The *Guide - The provision of health services to asylum seekers, refugees and reunited family members*]. (IS-1022), Appendix 2, Examples of forms (of evaluation and consent), includes an inquiry sheet concerning refugees' physical and mental health: Form 1 [*Skjema 1*], an Assessment of reactions/symptoms, is a kind of structured interview concerning traumatic experiences and psychological symptoms. The inquiry sheet may be completed by a nurse in collaboration with the individual asylum seeker. The sheet is based on the Harvard Trauma Questionnaire and PTSS - 10 respectively. The purpose of it is to identify the need for assistance, and it can form the basis for further discussions and follow-up

According to the health personnel in transit reception centres there is no standard or structured interview to assess the psychological condition of asylum seeking children. But during medical examination, if the health personnel are concerned about the mental health of a child, the child will be referred to further medical examinations and psychological or psychiatric assessment.

Children in reception centres are considered a vulnerable group because many of them have experienced situations that affect their mental health and well being. In addition, there are many stress factors associated with the life as an asylum seeker. There has not been carried out a psychological screening of this population. However, according to O'Loughlin at RVTS West (The resource centre for violence and traumatic stress and suicide prevention), between 20 and 35 percent of children in the reception centres suffer from anxiety and depression (Lauritzen 2007).

In the newly established *care centres* for unacompanied refugees under 15 years, which are run by the child welfare authorities [*Bufetat* - Barne-, ungdoms- og familieetaten], there is more focus on children's well-being and mental health. An outpatient team of seven trained psychologists/therapists, who are centrally employed by Bufetat's Eastern region office in Oslo, offer their services to the care centres in the region (where five of the seven care centres in Norway are located). Earlier the care centres cooperated with regional child guidance clinics [*BUP - Barne og ungdoms- psykiatri* Child and Adolescent Mental Health]. As the collaboration did not work out as intended, an alternative model was introduced. However, the other two other care centres still cooperate with regional child guidance clinics.

A recently started research project regarding identification and treatment of traumatized unaccompanied asylum seeking children in the care centres, is carried out in cooperation with the above mentioned team of trained psychologists employed by Bufetat East. The project manager is Tine Jensen, Ph.D. Psychology, senior researcher at the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS). The project aims to map what kind of traumatic experiences and psychological difficulties asylum seeking children in care centres are struggling with (by means of semi-structured interviews and mapping of PTSD-symptoms).To reduce post traumatic stress and depression a short-term intervention of TF-CBT (Trauma-focused cognitive behavioral therapy) is offered (12-15

treatments) and tested. One of the mapping/testing tools used is MultiCASI - Multilingual Computer Assisted Self-Interview.

Furthermore, the Directorate of Health and Social Affairs draws attention to asylum seekers and refugees with mental health problems by means of a special circular [rundskriv] Sosial- og helsedirektoratets Rundskriv IS-22/2004: *Helsetjenester til asylsøkere og flyktninger – faglige råd og en påminning om gjeldende lov - og regelverk – med særlig vekt på psykisk helse* [Healthcare for asylum seekers and refugees - professional advice and a reminder of current laws and regulations - with particular emphasis on mental health].

This circular is a supplement to Guide-Health services offer to asylum seekers and refugees (IS-1022). The circular is intended as an aid in the municipal health services' efforts to identify and follow up of asylum seekers and refugees who need extra efforts and attention because of psychological problems. It is also intended as a reminder to local councils to use the above Guide in order to ensure good quality health service to asylum seekers and refugees.
The Norwegian Board of Health Supervision's nationwide audit of health services to refugees and asylum seekers (2004) indicated that many municipalities do not ensure that asylum seekers with serious mental health problems receive necessary health care.
The booklet "Mental health of refugees - common reactions and prevention of mental health problems" (UDI 2003) focuses on how to understand mental health problems among refugees and asylum seekers and what the employees of reception centres can do to prevent / alleviate the problems. The booklet is available on the website: www.udi.no

When it comes to investigations of persons who have been subjected to torture, one is referred to the brochure: "The refugee patient. The general practitioner's encounter with patients who have experienced extreme strains. Investigation and diagnosis" [Flyktningepasienten. Allmennpraktikerens møte med pasienter som har opplevd ekstreme påkjenninger - Undersøkelse og diagnose]. The brochure has been prepared by the Norwegian Medical Association's committee for human rights and is available at: http://www.legeforeningen.no/asset/22502/1/22502_1.doc

Are the children themselves informed about the purpose and content of the health examination? Are parents? How?

In accordance with the Health Personnel Act and Patient's Rights Act, asylum seekers - both parents and children - will be informed about the purpose of the health examinations carried out in transit and reception centres. According to the information obtained from health care professionals in transit centres, asylum seekers generally accept the compulsory tuberculosis screening. Occasionally, asylum seekers may be somewhat skeptical. However, according to the health professionals involved, the asylum seekers' doubt is overcome by thorough information about the purpose of the screening.

f. Are there any centres that have extensive experience in doing health examinations with children and have documented their experiences?

Competency building regarding refugee health care has been prioritised in Norway's Escalation Plan for Psychiatric Health 1998–2008. As a result, new national and regional centres of knowledge and competence in the area of violence, traumatic stress and refugee health have been established. These centres have direct relevance for health personnel in the municipal and specialist health services as well as for the staff at reception centres in connection with developing competence in relation to refugee health. The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) was established in 2004 with the subsequent establishment of five Regional Resource Centres for Violence, Traumatic Stress and prevention of Suicide (RVTS). NKVTS was established to strengthen knowledge and competence concerning violence and abuse,
refugees and forced migration, catastrophes and traumatic stress. The regional resource centres have dedicated professional teams for refugee health who give guidance and expertise to reception centre staff along with thematic competency building for various municipal bodies and specialist health services (Helsedirektoratet, 2009).

These resource centres have good competence in terms of working with asylum seekers and refugees (adults a well as children), who suffer from trauma and migration related problems. However, currently there are no centres of excellence providing health services, medical care and/or psychiatric care with a special focus on asylums seeking children.

g. Are there any general problems on the organisational level in providing health examinations?

No data available on this issue.

h. Is there a national body that has the responsibility of supervising and evaluating health examinations and to develop the content of this health examination?

The Norwegian Board of Health Supervision [*Statens helsetilsyn*] has supervision authority for child welfare, health and social services in Norway. The board is a national public institution organised under the Ministry of Health and Care Services. The main purpose of the Board is to ensure that health and social services are provided in accordance with national acts and regulations as well as to assess whether the quality of services is adequate and meet requirements laid down in the legislation. The supervision applies to all statutory services, irrespective of whether they are provided by public hospitals, municipalities, private enterprises or health care personnel who run their own practice.

The supervision authorities work independently of political management. To a large extent, they decide themselves which services to give priority to with regard to supervision, and which areas supervision shall include. Among other things, priorities are determined on the basis of information about risk and vulnerability.

In 2004, the county departments of the Board conducted a nationwide audit of municipal health services to newly arrived immigrants, asylum seekers and refugees. The Board examined whether the municipalities had procedures to ensure that asylum seekers, refugees and reunited family members from countries with a high incidence of tuberculosis were screened for the disease in accordance with the tuberculosis control

regulations. Checks were also made of whether all persons in the above-mentioned groups were given information about the Norwegian health service and the health care they required in terms of infectious disease, maternity care and mental health care. The audit was conducted in 55 municipalities, and they found regional differences regarding the health services provided.

The Board revealed that the tuberculosis screening was duly performed. According to The Board's report a quarter of the municipalities did not have a system to ensure that new arrivals received information about the health service, and that the municipalities were not aware of their responsibility to provide information or that it was unclear as to who in the health service had responsibility for providing the information. The municipalities did little to address issues concerning infectious diseases other than tuberculosis. Pregnant asylum seekers, refugees and members of family reunifications were systematically offered maternity care. The Board indicated that while interpreters were used, only limited records of this were made in the patients' medical notes (Helsetilsynet, 2005).

Regarding access to and use of health services at reception centres, the survey indicated that every reception centre in Norway has had residents who received mental health care. At the same time, almost half of the reception centres indicate that they have residents with an unmet need for treatment. The mental health care provisions as a whole are rated as "good" or "middling" by 84 per cent of the reception centres, while 17 percent rate the provisions as "poor" (Helsedirektoratet, 2009).

i. Have any reports been published that deals with or are based on these health examinations? Please, attach if possible.

Reports regarding health examinations are not available.

The Norwegian Centre for Health Service Studies [Nasjonalt kunnskapssenter for helsetjeneste] is a state enterprise that summarizes research in health, measures the quality of health services and helps to develop and improve the quality of healthcare. However, no publications concerning health examinations for refugees/asylum seekers are available.

Migration and health (2009) is the most recent in a series of reports on challenges and trends in the health sector from the Directorate of Health. With this series, the Directorate aims to provide new insights into the health and care domain in order thereby to drive improvements and changes where they are needed. Last year's report was devoted to health and migration.

3. Health services.

a. Are there any restrictions in access to health, medical, psychiatric care, dental care, drugs for asylums seekers in general? For children?

In Norway, the health care system has the same responsibilities for health services to asylum seekers as for the rest of the population. The responsibilities concern primary

health care as well as specialised health services such as mental health care and dental care.

According to the sector responsibility principle, each competent authority has a responsibility for health and dental services offered to all groups of the population. This means that the authorities in different sectors and administrative levels, such as municipal, county and regional health authorities, have the same responsibilities to asylum seekers and refugees like the rest of the population.

The county municipalities shall according to Dental Health Care Act § 1-1 ensure the availability of dental services, including specialist services to a reasonable degree to all who live or stay in the county. The regional health authorities shall, according to Specialist Health Care Act § 2-1 ensure that persons with permanent domicile or residence within the health region is offered specialised health care in and outside institutions, including hospital services, medical laboratory services, radiological services, acute and emergency medical services and ambulance service.

Even though the provision of primary health care lies with the host municipality, there are variations in terms of organisation of health care services to asylum seekers. At some reception centres, the health services have their own offices for residents. In other places, the residents meet at the local health centre or are assigned to a particular doctor *[fastlegen*] just as all others in the Norwegian health system, while some reception centres have their own doctor/nurse who comes to the centre.

b. Are there any restrictions in access to health, medical, psychiatric care, dental care, drugs for undocumented migrants in general? For children?

Estimates put the number of undocumented, illegal, irregular or paperless (im)migrants in Europe at between 5 and 8 million people. Norway is thought to have some 18.000 "paperless immigrants". As a group, paperless immigrants in Norway comprise persons who stay longer than the three months permitted for citizens of EU countries; some perform undeclared work; and may be persons whose application for asylum has been rejected or who are the victims of human trafficking (Helsedirektoratet, 2009).

Under the Human Rights Declaration of 1948, the right to health is a human right: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care…But this Section of the Declaration is not itemised, not quantified and proves difficult to enforce. The right to health care is indisputable. It also transcends the concept of essential health care, as it is used in the Norwegian Municipal Health Service Act.

The question whether the approximately 18 000 people who live illegally in Norway will get health care on equal terms as those with legal residence has been debated for a long time. Until now, paperless only had rights to immediate medical assistance in emergency situations or serious diseases. Already autumn last year, the Church City Mission [*Kirkens Bymisjon*] in cooperation with Oslo Red Cross started to offer free health care to paperless immigrants.

Recently, March 2010, the Minister of Justice and the Minister of Health and Care Services extended the offer for paperless refugees. The Government is committed to provide all paperless "right to health care that can not wait". This implies a formal extension of the current regulations which only ensured paperless immigrants emergency aid such as the right to insulin in diabetic patients. Paperless children will receive approximately the same rights as Norwegian citizens. The same rights apply to pregnant women without legal residence. Mental unstable persons that pose a danger will also have access to psychiatric treatment.

c. Are health services for asylum services integrated into the national health care system? If not how are they organised and who provides them?

As mentioned earlier (Section 2, Health examinations) the responsibility for the provision of necessary health services to residents of the asylum reception centres lies with the host municipality. The municipality health care establishes contact with asylum seekers right after they transferred to ordinary reception to provide information about the municipal health services and information on how and where to get help when needed. Health care professionals make an initial assessment of health status and needs for services. Journals from previous health examination should then be transferred to health services in the municipality where the reception centre is located. Those who want health examination will be ensured easy access to it. The main goal of health examination is to map health problems that require treatment or follow-up. There will be both a somatic examination and a preliminary assessment of mental health. Health examination includes consultation with a nurse and a medical examination for those who are at risk or have identified health problems.

d. Do you have any centres of excellence in terms of providing health care, medical care and psychiatric care for asylums seekers? With a special focus on children? Please attach any available documentation.

Through the project Migrant Friendly Hospitals (2002–2005), twelve hospitals in as many countries have collaborated on identifying best practices in the area. Their experiences are summed up in the Amsterdam Declaration towards Migrant Friendly Hospitals in an ethnoculturally diverse Europe, which besides the summary of evidence presents recommendations for how to develop more satisfactory practices in this area. The project, which was funded by the EU, is being continued as a Task Force on Migrant Friendly and Culturally Competent Health Care in the framework of the WHO Network on Health Promoting Hospitals (www.mfh-eu.net). Norway is represented by the Norwegian Centre for Minority Health Research (NAKMI) in this project.

NAKMI is a governmental unit initiated by the Ministry of Health. The aim of NAKMI is to become a meeting point for minority health issues in Norway, especially for competence concerning somatic and mental health care of immigrants and refugees**.** The existing knowledge of minority health is scattered among several small groups, specialties and interested parties. NAKMI tries to map and coordinate this knowledge. The centre also does research and networking as well as information activities. Main target groups are health personnel, scientists and other groups engaged in health care for minorities.

MIGHEALTHNET, the Information network on good practice in health care for migrants and minorities in Europe (www.mighealth.net/no) is administrated by NAKMI. Mighealthnet aims to stimulate the exchange of knowledge on migrant and minority health through the development of interactive data bases in each of the participating countries. By facilitating the transfer of knowledge and expertise and stimulating network formation within and between European countries, the project hopes to further the development of good practices concerned with the health of migrants and minorities.

e. Are NGO's involved in providing health services for asylums seekers/undocumented migrants in any way?

October 2009, the Church City Mission opened a health clinic for undocumented/ paperless migrants. This health clinic is aimed at all people who do not have legal residence in Norway. The clinic offers a range of health services free of charge that allow illegal migrants to consult a nurse, doctor, psychologist, physiotherapist, etc. The clinic is open every Tuesday from 4pm-8 pm. According to the information obtained from the clinic, there are also children among the people using their services. The health centre operates as a drop-in-service, appointments cannot be booked in advance. The health professionals have taken a pledge of confidentiality that they under no circumstances will share the whereabouts or personal details of their patients with the police or the immigration authorities. For those who don't speak Norwegian the clinic hires a translator and pays the costs.

f. Are there any good examples of strategies for collaboration between medical/psychiatric services and social services, schools, etc regarding asylum-seeking/refugee children/undocumented migrants?

Oslo University Hospital, Ullevål, is one of the contributors to a project that provides nearly 4,500 pupils at certain (upper) secondary schools in Oslo, the ability to seek a psychologist through the school health service. The project "Development-promoting talks" [*Utviklingsfremmende samtaler*] is perceived as a very good and important measure providing early support to pupils who feel they need some extra support/help in connection with certain psychosocial difficulties. The project's objective is to give young people the opportunity to talk with qualified people in the school health service. A decisive element is that young people on their own initiative get in touch with the school health staff. The staff wanted to provide an offer where the pupils/students themselves were involved and made efforts for a change. Therefore, they chose to use the concept of "development-promoting talks".

The project is the result of collaboration between several agencies, and is located at the intersection of the municipal health service and mental health care for children and young people, and is a low-threshold service in the true sense. It aims to reach those young people who usually do not dare or want to seek help when they experience crises in their lives. This low-treshold offer also gets in touch with young people encountering more complex problems and it is important to help them to get appropriate expert help as quickly as possible, according to Kristin Olaisen, the project manager.

On her team, Olaisen has both psychologists, clinical social workers and health

sisters, who each in their own way play important roles in the project. Their experience is that they reach many pupils. Both boys and girls, Norwegian youth as well as youth from different ethnic backgrounds are using the service. Through the continuity and presence at school they hope to reach even more - because they experience that there is a need out there. For more information on the project: Olaisen, K. (2007). *Ungdom og utviklingsfremmende samtaler: utvikling av samtaletilbud i skjæringspunktet mellom skolehelsetjenesten og barne- og ungdomspsykiatrien.* Oslo: Nic Waals institutt, Lovisenberg diakonale sykehus.

g. Is there a national body that has the responsibility of supervising and evaluating health services for asylum seekers? National guidelines/reports? Please attach if available.

The Norwegian Board of Health Supervision (Statens helsetilsyn) has supervision authority for child welfare, health and social services in Norway. The Board's nationwide audit of health services to refugees and asylum seekers (2004), showed that many municipalities did not provide adequate healthcare, when it comes:

- to ensure that asylum seekers with serious mental health problems receive necessary health care
- to ensure the necessary coordination of health services
- to provide the necessary skills for health professionals working with asylum seekers and refugees
- to ensure that health information from the transit reception to the municipality is received and followed up by health professionals
- to have established systems to ensure that refugees, asylum seekers and reunited family members receive information about and access to health services as soon as possible after settling in the municipality
- to ensure that there is supervision of the reception centres to comply with requirements of the regulations on environmental health safety

(Sosial- og helsedirektoratet 2004, Helsetilsynet 2005).

4. Education and child care/day-care facilities

a. Are there any restrictions in access to education for asylum seekers / undocumented migrants?

School-age asylum seeking children have the right as well as the obligation to ten years of compulsory primary and lower secondary school education. Primary education shall normally start the year the child turns 6 years of age and lasts until the pupil has completed the tenth school year. In accordance with the Norwegian Education Act [*Opplæringsloven*] and regulations pursuant to the Act, all children/adolescents (6-16 years) living in Norway are both obliged and have the right to attend primary and lower secondary education [*grunnskoleopplæring*]. As a result, asylum seeking children - whether they are unaccompanied or accompanied by their parents - have the same right to primary and lower secondary education as other children in Norway.

The right to primary and lower secondary education applies when it is probable that the child will reside in Norway for a period of more than three months. The obligation to attend primary and lower secondary school commences as soon as residence has lasted for three months. This rule may have practical importance for children of asylum seekers who are waiting for a decision to be made on their asylum application. If it is likely that the child or the family will be granted a residence permit or that it will take longer than three months to process the application, the children have the right to primary and lower secondary education by the same rules that apply to Norwegian children.

Restrictions in access to education for undocumented migrants
It is acknowledged in Norway that all children have the right to go to school - even if they or their parents do not have a residence permit. According to Norwegian laws on education, schools should no longer require children's passport number or identity number in order to enrol them in school. However, according to the research report issued by the Norwegian Directorate of Immigration "*Learning about illegals: issues and methods*" (Brunovskis & Bjerkan 2008), undocumented migrants in Norway do experience difficulties in getting access to education.

Also the media have reported on cases where migrants have tried to register their children at schools but have been rejected because they did not have a residence permit. Furthermore, many parents without residence permit or legal status seem to be afraid of having their children registered in school and do not dare having contact with official institutions. Children who seek refuge in a church [*kirkeasyl*] have to attend regular school, the municipality will not offer them education in the church.

Restrictions in access to education for asylum seeking adolescents aged 16-18
While access to education is guaranteed for asylum seekers of compulsory school age (6-16), adolescent asylum seekers aged 16 – 18 have no equal access to education. In accordance with the Education Act, children over 16 years of age must have a residence permit to attend lower and upper secondary school education. Consequently, asylum seeking adolescents who are waiting for a decision on their asylum application have no right to secondary education. However, the county municipality [*fylkeskommunen*] can still decide to allow asylum seeking minors to attend secondary schools under the pending decision on the residence permit, but they won't have the right to complete the school year if their asylum application is rejected. Yet, even without the corresponding statutory right in the Education Act, the state gives subsidies to municipalities who provide education to young asylum seekers aged between 16 and 18 years. Asylum seeking adolescents (16 years and older) who do not have education equivalent to Norwegian primary school may be offered training within the system of examination-oriented primary education [*grunnskoleopplæring for voksne*] while they wait for a response on their asylum application. Yet, as long as there are no national laws and regulations concerning asylum seeking adolescents' right to education, educational practices in the various municipalities may differ a great deal.

It has been stated that the Norwegian regulations regarding asylum seeking minors are stricter than the EU regulations when it comes to asylum seekers minors over 16 years of age. In a comparative analysis of different European asylum regimes, Brekke and Vevstad (2007) conclude:

> The Norwegian practice and legislation on access to schooling for asylum seeking children and adolescents is similar to the requirements of the EU Directive and the practice in the Member States. There is however one exception; the right to schooling for the age group 16–18. The access to schooling for this group is not guaranteed in Norwegian legislation. In the Operations Regulations (Driftsreglementet) from the Norwegian Directorate of Immigration, the employees at the reception centres are encouraged to facilitate access to local schooling for this group. This is insufficient compared to the EU Directive. Article 2 and 10 of the Directive, which states that adolescents aged 17 or younger are to be considered minors and therefore are entitled to special rights. The access to schooling for asylum seekers aged 16-18 is better secured in the EU Directive than in Norwegian legislation (Brekke & Vevstad 2007, p.76).

In the study about asylum seeking children's right to education, Valenta (2009) has identified hindrances that exclude adolescent asylum seekers from upper secondary school. The hindrances are primarily located in the Education Act § 6-9 which requires a residence permit and specific requirements stated in § 6-10 such as a proof that the pupil has completed Norwegian primary and lower secondary education, or has a document from abroad which proves that he/she has completed at least 9 years of schooling in his/her country. A requirement to document 9 years of education from asylum seekers' countries of origin is very difficult and often impossible when it comes to war-torn countries with no infrastructure. The language barrier is also mentioned in the report as an obstacle to take part in upper secondary education.

Access to day-care / kindergarten facilities

Studies have shown that children living in reception centres, often experience a difficult time. The everyday experiences of small children's in reception centres are limited by poor economy, unstable networks (because people move in and out) and venues that are not suitable for children's play. Separation anxiety and behavioral disorders seem to be rather common among asylum seeking children. It has been recommended that children in reception centres get access to areas where they can experience mastery, meet peers and get the opportunity to develop as children. School, kindergarten and day-care facilities have been highlighted as important arenas in this context, provided that the offer is adapted to children's situations and conditions (Neumayer et al., 2006; Seeberg, 2009, Østbergutvalget, 2009).

The lack of available living areas contribute to that children have very little space to play, and often are referred to the hallways/corridors of the reception centre. The "Children's bases" [*barnebaser*], i.e. play rooms, in the reception centres usually have limited opening hours and are primarily used as a place to "deposit" children, i.e., keeping them in a safe place, but not as a place that promotes children's development as well as allows to express themselves as children.

Both in terms of language development, social attachment and long-term integration, ordinary kindergarten is recommended for pre-school age children in reception centres. Not only as an educational provision that can promote integration, linguistic and social development, but also as a safe haven, a "time-out" from a difficult situation. Besides, it gives parents respite from their parental role, which may give them more room to be good parents under challenging conditions. Concurrently, parents will get knowledge of an important institution in Norwegian society, which may also facilitate their own integration (Østbergutvalget, 2009).

From 1 January 2008, the Norwegian Directorate of Immigration's specification of Operation Regulations for reception centres states: Children from two years of age to school age should be offered appropriate day-care facilities for a minimum of 3 hours per day from Monday to Friday. This may be provided through separate day-care facilities at the reception centre or by means of acquiring a place in a municipal kindergarten or the like. This applies both if the child has parents or is an unaccompanied minor. For children aged 0-2 years, the reception centre has to ensure a relief opportunity for parents to ensure they are able to participate in the information program as well as in Norwegian instruction (Østbergutvalget, 2009, p.199).

b. Are educational services for asylum seeking children integrated into the national educational system? If not how are they organised and who provides them?

The Norwegian Education Act guarantees the right to differentiated and adapted education. As a result, educational services for language minority pupils, including asylum seeking pupils, are integrated into the national educational system. The purpose of adapted education is that language minority pupils will become sufficiently proficient in Norwegian as soon as possible so that the pupil eventually can follow the ordinary teaching. This provision requires an individual assessment of each pupil's needs. The training will be offered at the school the pupil attends.

If necessary, pupils with mother tongue other than Norwegian and Sami have the right to mother tongue (native language) instruction, bilingual subject training, or both. Each pupil must be assessed individually in relation to whether such training is considered necessary. The deciding factor for this assessment will be whether the pupil has a need for such training to be able to follow the training at the school. Native language training may be offered at a different school other than that normally attended by the pupil, see the Education Act § 2-8 second paragraph.

Bilingual subject training will be offered at the school where the pupils normally attend primary education. The decision regarding the pupil's entitlement to special language education is made by the municipality in accordance to Education Act § 2-8. The decision can be appealed to the County, see § 2 and the Education Act § 15-2.

The municipality in which the reception centre is situated has the responsibility to execute asylum seeking children's right to primary education, see Education Act § 13-1. Municipalities with reception centres receive special state grants to fund the education of children living in the reception centres. The purpose of the grant scheme is to provide primary education to school age children living in reception centres as soon as possible after their arrival in Norway. Asylum seeking children are supposed to attend local schools in the municipality the reception centre is located.

c. Are asylum seekers often educated in their mother tongue?

Minority language students' right to mother tongue education is linked to their right to specially adapted Norwegian education until they are able to follow the ordinary school

education. The Education Act § 2-8, which deals with special language education for pupils from language minorities states:

> Pupils attending primary and lower secondary school with a mother tongue other than Norwegian and Sami have the right to specially adapted education in Norwegian until they are sufficiently proficient in Norwegian to follow the ordinary education. If necessary, pupils with mother tongue other than Norwegian and Sami have the right to mother tongue education, bilingual subject training, or both. Mother tongue education may be given at a different school other than that normally attended by the pupil. When the mother tongue education and/or bilingual education can not be given by the teaching staff, the municipality as far as possible has to facilitate other adapted training in line with the pupil's ability.

According to Valenta (2009), mother tongue instruction is defined as an extra support (in order to learn Norwegian) that does not have a value in itself. Tuition in the mother tongue is only given to pupils who are not sufficiently proficient in Norwegian (Rambøll, 2006). In Valenta's study only four percent of the schools reported that they do not offer adapted Norwegian education but more than half of the schools responded that they do not provide mother tongue education to asylum seeking pupils. The same study shows that 62% of the selected schools do not have bilingual education and 55% of the schools provide neither mother tongue nor bilingual education. Among those schools who provide mother tongue education, many have limitations in terms of providing mother tongue education in many of the languages required. It seems that many Norwegian schools prioritize specially adapted Norwegian language education while mother tongue instruction often is neglected.

The most important obstacle to the organization of mother tongue education is precisely the lack of qualified teachers. Lack of qualified mother-tongue teachers is one of the most common explanations used by the schools. It is not easy to find mother-tongue teachers for some language groups. It is especially difficult to find mother-tongue teachers in small municipalities.

The other reason mentioned by Valenta (2009) is that reception centres for asylum seekers establish and closed continuously in line with fluctuations in arrival numbers of asylum seekers to Norway. Many municipalities and schools have experienced that an asylum reception centre has been closed a few years after its establishment. Moreover, the language composition of the groups of asylum seekers that live in the reception also changes. In addition, municipalities that receive a significant number of asylum seekers experience that many of them move to other places after being granted residence (Djuve & Kavli, 2000). This creates uncertainty as to whether the schools need the competence of mother-tongue teachers in the future.

d. Are there any special educational strategies for recently arrived foreign children in your school system?

According to "Østbergutvalget" [the Østberg Committee] (2009) there are different educational strategies to introduce newly arrived children into Norwegian schools. In general, the introductory models are organised in the following ways:
a) Newly arrived pupils are given training in mainstream classes at their respective local schools

b) Newly arrived pupils are given training in special introductory classes at one or more selected primary schools [*innføringsklasser*]. Within a municipality, there may be one or more introductory classes.
c) Newly arrived pupils are given education in the introductory class(es) where a particular school is in charge of a certain grade level. For example, within the municipality one school will be responsible for grades 1 to 7 and another school will be responsible for grades 8 to 10.
d) Newly arrived pupils are given training in introductory classes organised as an independent unit or school. Within the municipality there will be established a special introductory unit or a special introduction school.

Today, many schools practice inclusion of newly arrived pupils in mainstream classes from day one (model a), and provide special language instruction to all pupils in need of it. This seems to be very common in many smaller municipalities. Special Norwegian tuition is done by taking the pupils out of the classroom during Norwegian lessons or by providing adapted instruction in the classroom. Bilingual subject training and/or mother tongue education may come in addition to Norwegian education.

Furthermore, the Østberg Committee (2009) noted that many pupils are placed in mainstream classes without getting a satisfactory offer of special language training and without being able to make use of the instruction in different subjects in a satisfactory manner. Consequently, newly arrived pupils are then put in a very difficult situation.

The idea behind immediately including newly arrived pupils included in mainstream classes is inclusion. Many believe that a separate introductory offer is not in line with the Norwegian school's values and goals. However, there is a risk that pupils do not benefit of the education provided. Model "a" requires a lot of the involved teachers to provide adapted education and can easily lead to that pupils do not get the monitoring they need. Inclusion from day one may be an illusion, in reality the pupil may be sitting in a class without the prerequisites to be included and participate in the classroom community. The Østberg committee recommends that there in a shorter period should be a special, separate introduction for newly arrived pupils before they proceed to ordinary classes.

e. Are there any special psychosocial strategies for recently arrived foreign children in your school system?

No data available on this issue.

f. Do you have any centres of excellence in terms of education or psychosocial support to recently arrived foreign children?

To our knowledge, there is no centre of excellence in terms of education or psychosocial support to recently arrived asylum seeking and immigrant children.

g. Is there a national body that has the responsibility of supervising and evaluating educational services for asylum seekers? National guidelines/reports? Please attach if available.

The Norwegian Directorate for Education and Training [*Utdanningsdirektoratet*] is responsible for the development of primary and secondary education. The Directorate is the executive agency for the Ministry of Education and Research. In this capacity the Directorate has the overall responsibility for supervising education and the governance of the education sector, as well as the implementation of Acts of Parliament and regulations. The Directorate is responsible for supervision of Norway's school owners: municipalities, county authorities and private schools. The purpose of this supervision is to ensure fulfilment of the right of children and young people to equivalent high-quality education The Directorate is also responsible for managing the Norwegian Support System for Special Education [*Statped*], state-owned schools and the educational direction of the National Education Centres. The Directorate is also responsible for all national statistics concerning primary and secondary education; on the basis of these statistics it initiates, develops and monitors research and development.

Østbergutvalget: the Østberg Committee

October 2008 the Norwegian government appointed a committee, a.k.a. the Østberg Committeee, which has been mandated to undertake a comprehensive review and evaluation of education of language minorities in kindergarten, school and higher education. The committee is chaired by Sissel Østberg, chancellor [*rektor*] of Oslo University College.

The Østberg committee was given a broad mandate to evaluate current responsibilities, means and measures taken in terms of education to ethnic and language minorities. It means that the committee will conduct both a review of the organization and the content of education, as well as the legal and financial framework. On this basis, the committee will propose measures that can improve the learning outcomes and learning environment for ethnic and language minority pupils. The committee will use existing research and data, but will also try to obtain new knowledge and data when needed. The committee will assess the regulations, finance, administrative responsibilities and organization; in addition it will also consider how this works in practice. Moreover, the committee is asked to consider in what ways the multicultural perspective can be integrated into educational institutions.

The committee would provide a final report 1 June 2010, i.e., NOU 2010:7. However, in December 2009 the committee issued a first-part-report *[delrapport*] with preliminary assessments and proposals concerning education for language minorities in nursery and primary schools.

In their first-part-report the committee emphasizes the following points:
• Good and relevant expertise in all parts and at all levels of the educational sector is a critical variable in order to ensure a good and stable education for various minority language groups.
• It is of decisive importance to continue working actively on increasing minority-language children's participation in kindergarten.
• Special Norwegian education, mother tongue tuition and bilingual subject training are instruments that should be used more often and more varied.
• The rights of children of asylum seekers and unaccompanied minors must be strengthened.

For more information:
http://www.regjeringen.no/nb/dep/kd/aktuelt/nyheter/2010/delrapport-om-opplaringstilbudet-til-min.html?id=590248

* Update: 1. June 2010 The Østberg Committee submitted the NOU 2010:7 Mangfold og mestring (Diversity and achievement) to the Ministry of Education. The NOU is now sent out for consultation (hearing).

In the NOU, the Østberg Committee emphasizes implementation challenges as many of the laws and regulations adopted in recent years are followed poorly in practice. It may be due to lack of knowledge, lack of prioritization of these student groups, the poor economy and / or lack of teachers. The committee proposes greater cooperation between municipalities in order to better exploit the expertise developed in some places, increased cooperation between counties and municipalities in particular with respect to the transition between primary and secondary education and the relationship between basic/primary education and adult education (NOU 2010:7).

h. Are there any good examples of strategies for collaboration between medical/psychiatric services and schools, etc. regarding asylum-seeking/refugee children/undocumented migrants?

For an example of "good practice" concerning collaboration between municipal medical and mental health services and a selection of secondary schools in Oslo , see subsection 3.f: The project "Development-promoting talks" [*Utviklingsfremmende samtaler*].

i. What proportion of asylum seekers are cared for in child psychiatric services? More or less often than in the general population?

Currently there are no available data regarding asylum seeking children in child psychiatric services.

5. Housing of asylum seekers

a. Is the housing of asylum seekers integrated in municipalities? Or are they provided with special housing in camps, etc?

The Directorate of Immigration (UDI) has to ensure that Norway has a robust and flexible receiving apparatus with a capacity depending on how many asylum seekers come to the country. The receiving system must attend to the composition of the various groups of asylum seekers as well as to their individual needs. Living in the reception is voluntary, but the vast majority chooses to make use of this offer. UDI determines in which reception centre asylum seekers will stay during the asylum process.

UDI does not operate reception centres themselves, but enters into agreements with municipalities, NGOs or private companies. However, UDI has made regulations for the

operation of reception centres and is responsible for the ongoing monitoring of the centres.

Operators of reception facilities provide various kinds of accommodation for asylum seekers. Decentralised reception is different from centralised reception centres where many asylum seekers live in one particular place or area. In decentralised reception centres the residents are placed in ordinary apartments or houses scattered throughout the municipality. Decentralised housing for asylum seekers gives residents a more normal living situation. It specially gives children's families a better chance to be a family. By living in a house or apartment, residents get more privacy than in a reception centre. In various asylum and immigration policy documents, it is strongly recommended to provide asylum seekers decentralised reception to a greater extent because such housing may promote both their quality of life and contact with the local community. Experience also shows that the local community responds more positively to a family in the neighbourhood than many people in a larger centralised reception centre. Decentralised housing helps to have a more natural and everyday contact between asylum seekers and residents in the area. This will have a profound effect on asylum seekers' integration and participation in society.

However, the challenge of decentralised reception is to give good follow up and assistance to the new residents as those who live in a centralised reception centre. For single residents, centralised housing may be better as it ensures a larger network and it helps to avoid isolation and loneliness. Another challenge with decentralised housing is that it may be difficult to provide accommodation when there are many new arrivals. In addition, decentralised housing is often a more expensive option. From the immigration authorities' perspective it is thus desirable to have a combination of decentralised and centralised reception options.

Reinforced reception centres [*forsterkede mottak*] or reinforced units at ordinary reception centres are part of UDI's efforts to raise the standard of assistance offered to asylum seekers with special needs. Reinforced reception also helps to create a better situation for other residents and employees in ordinary reception centres. People with mental health problems are the primary target group for the reinforced reception units. This applies to persons who are not so sick that they are admitted to a psychiatric institution, but which, for example, are under medication and go get outpatient treatment.

Unaccompanied minor asylum seekers (UM) aged 15 – 18 years stay in special reception centres for UM [*EM-mottak*] or in special units for UM at ordinary reception centres.

From December 2007, the Norwegian government transferred the responsibility for the care of unaccompanied asylum seekers under the age of 15 from the immigration authorities (UDI) to regional child welfare services under state authority. The child welfare services are supposed to offer UM under the age of 15 the opportunity to reside at a care centre upon their arrival in the country and until they are granted residency or possibly returned to their home country. Alternative care arrangements may be considered, for instance if the unaccompanied minor has relatives living in Norway. The accommodation of unaccompanied minors will be discussed in more detail under Section 9.

b. Are any special concerns regarding the needs of children considered when housing for asylum seekers is planned and provided?

UDI has outlined a special set of regulations concerning how to take care of children in reception centres, i.e., "Requirements to working with children and young people in the reception centres" [*Krav til arbeid med barn og unge i statlige mottak*]: http://www.udiregelverk.no/default.aspx?path=%7BB2D09DBE-B1F9-4AE1-8CED-81429C54D8BD%7D

The requirements and procedures stated in the document emphasize the rights and needs of children and young people, and they aim at contributing to a safe, predictable and meaningful live for children and young people in reception centres.

The UDI-document emphasizes that reception centres should have internal procedures that take into consideration the developmental needs of children and young people. Furthermore, it recommends good cooperation with local government and relevant agencies in the municipality the reception centre is located. It also has written procedures for how to deal with anticipated or actual neglect, violence and abuse and contact with local child welfare authorities. There are also requirements regarding measures related to the children's education and day care.

All reception centres need to have activity programs for their residents. Reception centres also cooperate with NGOs, such as the Norwegian Red Cross and Save the Children [Redd Barna], to facilitate recreational activities that can provide good and positive experiences for the children living at the centres. For example, Save the Children runs four activity groups (for pre-school children, school children, adolescents and women, respectively) three times a week on Løren transit reception centre in Oslo.
For more information: http://www.reddbarna.no/default.asp?V_ITEM_ID=14144

c. Is there any documentation about the housing situation of undocumented migrants?
Most undocumented migrants in Norway only have temporary housing arrangements, although this depends on several circumstances: e.g., how long they have been in Norway, how much money they "make", as well as their social network. Friends or extended networks are crucial for the migrants in finding a place to live. It is quite common among undocumented migrants to move frequently from place to place and many of them live under very poor housing conditions. In 2008, Oslo Church City Mission reported on undocumented migrants' situation in Norway (Ottesen, 2008). For more information (including references) on undocumented migrants in Norway see Mighealth's website: http://mighealth.net/no/index.php/Udokumenterte_migranters_rett_til_tjenester

6. Municipal reception of refugees

a. Do national plans for municipal reception of refugees consider/mention the special needs of children? Please provide documents if available.

Refugees who have been granted residence in Norway will be resettled in a Norwegian municipality. The agreement to settle refugees is done in collaboration between the state,

represented by the Directorate of Integration and Diversity (IMDi), reception centres, the Directorate of Immigration, and municipalities. IMDi is responsible for finding the municipality to those who wish to be settled by public assistance. The practical implementation of the settlement work is done by IMDi's six regional units.

According to IMDi's settlement objective, asylum seekers/refugees who live in reception centres shall be settled within six months from the time a residence permit is granted (three months for unaccompanied minor refugees). Most refugees settle in a municipality with the help of IMDi. Yet, it is possible for persons with a work/residence permit, who can provide for themselves and their family to settle in the municipality of their choice without the authorities being involved.

In a White Paper issued by the parliament [*Stortingsmelding* nr. 17, 2000-2001] - Asylum and refugee policy in Norway, it is stated that the settlement of refugees in Norway shall be a voluntary task for municipalities. In this document, it is further stated that the age of asylum seekers, family and kinship ties in Norway, and particular needs of care and assistance must be taken into consideration in relation to the settlement process. All these aspects will be taken into consideration when selecting a municipality for the people to be settled. Generally, the health situation, special needs, family and kinship ties, schooling and work opportunities are considered when the settlement of refugees – adults as well as children - is planned and provided. However, the national guidelines for settling refugees primarily focus on adult family members.

The goal of Norwegian integration policy is rapid settlement of refugees in areas with opportunities for employment and education. The settlement program for adult refugees settling in a municipality assures them rights in terms of receiving economic assistance, and the right to participate in the Introductory programme [*Introduksjons-programmet*] (including Norwegian language instruction and social studies) organised by the municipality of residence. From September 2005 it is compulsory for newly arrived adult refugees/immigrants to participate in 300 lessons of instruction in the Norwegian language and social studies. Those who have further needs for instruction will have the opportunity to take more classes (up to 3,000 lessons, depending on the needs of the individual). The goal of the instruction is to learn enough Norwegian to enable refugees/immigrants to participate in the employment market and in society at large.

Norwegian municipalities are responsible for implementing the Norwegian national integration policy into practice. Drawing on the Norwegian context of the settlement of refugee families who have been granted a residence permit after applying for asylum, Josée Archambault (forthcoming, 2010) looks at how the incorporation of children's rights into domestic immigration policies appears to offer asylum-seeking children a better entry as 'active citizens' than is offered to their parents in the early stages of asylum. Later on during the asylum process, once families obtain a residence permit along with the right to settle, the focus of welfare policies shifts toward the emancipation of adults' integration as active new citizens. Archambault explores the reasons for that shift and identifies how the special status of refugee children seems to go off at a tangent when their whole family officially settles in the country. This transitional process highlights the duality between the state's recognition of the responsibility of parents, and the recognition of the rights of children as individuals.

b. Do municipalities generally consider the needs of children in their plans for refugee reception? Are they mentioned in guidelines, etc?

There are huge variations in how Norwegian municipalities attempt to integrate refugee children in the settlement phase, according to a new study of Norwegian municipalities' integration of refugee children after settlement (Bjerkan, 2009). The main purpose of this study has been to give an account of the municipalities' approach to integration of refugee children and explore to which extent Norwegian municipalities employ special arrangements in integrating refugee children after settlement in the municipalities.

Norwegian municipalities are responsible for implementing national integration policy. In regard to children, this involves maintaining the prosperity of refugee children within general welfare arrangements, but the municipalities may also formulate integration efforts in addition to these arrangements.

The survey shows that 72 % of Norwegian municipalities and urban districts employ special arrangements in the integration of refugee children. Large municipalities report such measures more often than smaller municipalities. Arrangements aimed at increasing social participation and arrangements in kindergarten and after-school programs dominate. Respectively 74 % and 83 % of the municipalities which settle refugees employ such measures. Arrangements directed towards the youngest children are most widespread: kindergarten measures are more common than measures in after-school.

58 % of the municipalities report of private actors, special interest organizations or voluntary organizations that provide special arrangements for refugee children after settlement within the municipality. These are to a certain extent concentrated within municipalities that provide such measures themselves. The involvement of non-governmental organizations (NGOs) seems to correlate with the size of both the refugee population and the total population of the municipality. NGOs mainly provide the same arrangements as the local authorities (Bjerkan, 2009).

c. Are the situation and the needs of the children often in focus in the work of local social workers in municipal reception? How is this achieved? Structured interviews regarding the children?

The various municipalities have chosen different organizational solutions concerning the settlement of accompanied and unaccompanied minor refugees. When children are accompanied by their parents, the focus is often on the family, that is to say, primarily on the parents (cf. Archambault, 2010).

Nonetheless, municipalities have responsibility for all children living in the municipality and there are clear requirements and expectations to them when refugee children are to to be resettled. Children should have access to varied services in the settlement municipality or in neighbouring municipalities, such as education, health care (including children and youth psychiatric outpatient), leisure activities and other activities/organisation, such as immigrant organizations (Bufetat, 2009).

Municipalities that settle unaccompanied minors organise their work in different ways. Some municipalities have found it most convenient to anchor the work in child welfare

services and residential care measures are taken as resolutions under the child welfare law. Other municipalities have chosen a different organizational foundation, and have conveyed responsibilities and the work to the refugee office, social services or other service units.

However, in order to make the settlement of refugees, both adults and children – accompanied or unaccompanied, in the various municipalities as successful as possible, the Directorate of Integration and Diversity (IMDi) had made a 'manual' which serves as a guide for the settlement work (Rutiner for bosettingsarbeid i IMDi, 28.05.2009): http://www.imdi.no/Documents/Retningslinjer/Bosettingsrutiner20versjon20282005.pdf

While IMDi –in cooperation with UDI, the actual reception centre, and the settlement municipality - is responsible for the settlement of unaccompanied minor refugees over 15 years, the child welfare authorities [*Bufetat* - Barne-, ungdoms- og familieetaten] are responsible for the settlement of unaccompanied minors under 15 years.

The preparatory settlement work concerning unaccompanied minor refugees (15-18 years) is carried out by the reception centre, which is responsible to make the "Individual assessment and action plan" [*IKTP, i.e., Individuell Kartlegging og TiltaksPlan*] for each unaccompanied minor. The IKTP is prepared in cooperation with the unaccompanied minors and their guardians. The reception centre will then send the IKTP to IMDi within two weeks after the permit to stay is granted. The IKTP will be used as a basis for selection of the municipality and facilitation of settlement in accordance with the needs of unaccompanied minors. The IKTP-form with the questions to be completed: http://www.tolkeportalen.no/upload/3085/Kartlegging%20og%20tiltak%20skjema%20august%202004.doc

Also the needs of the youngest asylum seekers minors (under the age of 15) in the care centres are assessed as a part of preparatory settlement work. The information of the assessment and the required follow-up will be recorded in the unaccompanied minor's follow-up plan [*OP, i.e., Oppfølgingsplan*]. Like the information in the IKTP, the OP is of decisive importance to facilitate successful settlement s well as appropriate housing and care facilities for minor asylum seekers.

On the basis of the individual survey, IKTP or OP, made in the asylum seeker period the municipality will determine what kind of accommodation and care the unaccompanied minor is best served with. For supplementary information concerning accommodation and care solutions for the unaccompanied minors: see Section 9 b (Special concerns concerning regarding unaccompanied minors).

d. Are there any good examples of strategies for collaboration between medical/ psychiatric services and municipal services/local authorities regarding asylum-seeking and refugee children.

No information available.

e. Do you have any municipalities of excellence in terms of reception of refugee children?

The Directorate of Integration and Diversity (IMDi) was established on 1 January 2006 to act as a competence centre and a driving force for integration and diversity. IMDi works to achieve a speedy, satisfactory and stable settlement of refugees in municipalities. IMDi's six local offices are responsible for the practical work in connection with settlement, and they cooperate closely with the reception centres and municipalities involved. For the municipalities, settling refugees is a voluntary task.

The goal of the IMDi is that refugees settle in well and quickly become integrated into the local community. As far as possible, IMDi tries to take the wishes of the refugees into consideration and to organise their settlement in a way that allows them to realise their plans for the future with respect to work and education.

*** IMDi's Settlement Prize**
There are municipalities of excellence in relation to reception of refugees. IMDi's settlement prize *[Bosettingsprisen]* is awarded to a municipality that has made a special good effort to settle and integrate refugees. In 2008, twelve municipalities were nominated. Finally, it was Vadsø municipality who received the Settlement Prize 2008. The press release on the website below tells us why [see: Press Release - winner of the Settlement Prize 2008]:
2008http://www.imdi.no/no/Stottemeny/Pressesenter/Pressemeldinger/20081/Pressemelding---vinner-av-Bosettingsprisen-2008/

The jury's justification to award the Settlement prize to Vadsø municipality is as follows:

• The municipality has been welcoming a high number of refugees in relation to needs and in relation to the population of the municipality.

• More than 4 out of 5 participants in the introduction programme proceeds to work or education after having completed the programme.

• Norwegian training in the municipality achieves good results as measured by percentage of the students who passed oral and written examinations.

• Refugees are offered work for private housing, a project with support from the NAV (The Norwegian Labour and Welfare Administration) and the municipality.

• The municipality goes actively in for meaningful leisure time. The municipality has a partnership with Red Cross for homework help and women's cafe on Saturdays.

• The municipality has good documentation on their professional work and has demonstrated the ability to follow up their new inhabitants.

• The municipality has accepted more refugees than IMDi had requested. The municipality has on its own initiative, decided to triple the number of refugees to be settled in the municipality in 2008.

7. Social services and child welfare

a. Are there any restrictions in terms of the support and service provided for asylum seekers and undocumented refugees compared with residents?

Municipalities are obliged to provide support and relief to all their residents. However, in practice this obligation does not always apply to rejected asylum seekers and undocumented migrants living in the municipality. Municipalities' practices seem to vary rather much.

The financial support given by the government to asylum seekers in reception centres has been explained under Section 2b: In accordance with the "Monetary Regulations" *[Pengereglementet*], i.e., "Regulations for financial assistance to residents of state reception centres", asylum seekers who can not support themselves receive an economic allowance, called *basisbeløpet* [the basis amount]. This basic allowance has to cover the cost of living expenses, such as food, clothing, health services, medications, activities, etc. Asylum seekers who have jobs or other income will receive less financial benefits. Additional allowances may be given if it is necessary to ensure the safety of a person's life and health. For more information: http://www.udiregelverk.no/Default.aspx?path={C7C97936-99F7-4075-B16C-1A73F72EF66E}

At the end of 2003/2004, the Norwegian government decided that from 1. January 2004, asylum seekers who have received a final rejection to their asylum application would no longer be allowed to stay at reception centres, nor receive public benefits:

> Asylum seekers whose applications have been rejected as being unfounded should no longer be given free board and lodging, according to Trygve Nordby, head of the Immigration Directorate. Mr Nordby believes that this would scare off other bogus asylum seekers. Norway is Europe's most popular country for asylum seekers per head of population. Never before have so many asylum seekers been housed at Norwegian refugee reception centres, and there is no room for more …
> (*www.noas.org* , website of NOAS - the Norwegian Organization for Asylum Seekers).

Some of the asylum seekers affected by this were the so-called "not –returnable" asylum seekers, who due to various reasons not can return to their country of origin. Many of them go in hiding and stay in Norway as illegal or undocumented refugees/migrants.

During 2005 it has become clear that asylum seekers with final rejections that no longer are allowed to stay at the reception centres, can receive emergency aid from social welfare services. However, this has been practiced in very different ways in different municipalities. What "emergency aid" means is also interpreted in different ways. The Organization against Public Discrimination (OMOD) has been engaged in several cases concerning asylum seekers who have not received aid from social welfare services.

b. When there is a suspicion of abuse or neglect is this processed in any different manner for asylum seekers and undocumented migrants compared with residents?

Just like other health professionals and social workers, the laws and regulations in the Child Welfare Act require that the staff at the reception centres do report suspected child abuse and neglect to the Child Welfare Services. It is also important to emphasize that the municipal child welfare services have a responsibility for children and adolescents when the reception centres or others send reports of concern about their situation, on the same level as other youths in Norway.

However employees in reception centres and child welfare services encounter many challenges and dilemmas in relation to refugee children. Several aspects may complicate the cooperation between reception centres and child welfare services. There seems to be a considerable variation in terms of the follow-up by child welfare services in the various municipalities. Some reception centres report they cooperate well with local child welfare authorities, who show great willingness to provide preventative support to families, such as home visits, parental guidance, coverage of expenses for day care, after-school or leisure activities. In other places, the cooperation is more problematic.

Child welfare employees may find it difficult to go into families where the long asylum application process, mental problems and difficulties in accepting a final rejection weakens parents' ability to offer the children appropriate care. In some cases, child and adolescent psychiatric services are reluctant to accept children living in reception centres for treatment because the therapists do not know whether the treatment can be completed while the children live in reception centres. Lack of multicultural competence among employees in reception centres and child welfare services and problems related to the use of interpreters seem to hinder successful cooperation between reception centres and local health and child welfare services. The employees at reception centres are often left with the responsibility to deal with families and children having (mental health and other) problems and to implement measures that they do not have expertise or capacity to.

Reception staff tries to observe, inform and help parents and children, and they report to other municipal services if the family situation is considered to be acute. Their role is thus primarily defined as advisors and facilitators.

There are no reports available on abuse and neglect of children in undocumented migrant families or those who are undocumented minors them selves. However as a response to the growing international and national focus on combating human trafficking [*menneskehandel*], Norway developed its first action plan on trafficking for the period 2003-2005, succeeded by another one to cover the period of 2005-2008 which was replaced by yet another for 2006-2009. A number of ministries and governmental agencies are involved in the implementation of the Action Plan, and the Ministry of Foreign Affairs (MFA) is responsible for supporting initiatives and efforts taken internationally and within the framework of development cooperation. The MFA's main responsibility is to support prevention, protection and reintegration of victims; support the development of knowledge and evidence; promote interdisciplinary cooperation; and strengthen international frameworks and cooperation. Children are considered a priority group and should receive special attention in supported programs and activities (NORAD, Norwegian Agency for Development Cooperation).

Several asylum seeking minors have escaped from the reception centres. They may be unwittingly bought by people who are waiting for them in Norway or in other European countries. After leaving the centre and with the Norwegian authorities "out of the picture",

criminals are free to put them in income-generating activities, such as prostitution or other sexual purposes, but also outright slave labour, as so-called house boys and house girls. Many are placed in street teams to beg or sell drugs (Ekspedisjonssjef Oddbjørn Hauge, The Ministry of Children, Equality and Social Inclusion, available from http://www.frifagbevegelse.no/nyhetsbrev/article4980590.ece).

In 2007, a working group was established to study children's disappearances from reception centres and propose measures which can be implemented to prevent and shed light on such disappearances. The working group is led by the Ministry of Justice and the Police. Representatives from the Norwegian Directorate of Immigration participate from the immigration authorities' side.

8. Family reunification

a. Is children's access to their intermediate family in any way restricted in national policy?
b. Is children's access to their intermediate family in any way restricted in practice?

As family reunification is an issue, which is most relevant for unaccompanied minors, this issue will be discussed in the section below, i.e., Section 9.

9. Special concerns regarding unaccompanied minors

a. Age assessment. Is the age of asylum seeking children often questioned? What methods are used when it is questioned and who does the examination? Is the medical personnel advisory or decisive? Is there a possibility of appeal?

In 2003, the Directorate of Immigration (UDI) introduced age assessment of unaccompanied minor asylum seekers, when there was a doubt about the applicant's age. The purpose of age assessment was to reduce the number of adults who tried to come and stay in Norway as unaccompanied minors.

As in many other European countries, also in Norway age assessment of unaccompanied minors is a very controversial issue. There are disagreements between the governmental, medical and other interest groups concerning physically testing the children. It is claimed that age assessments are based on inaccurate methods and that the margin of error can be up to + / - 5 years (Watters, 2005). The registered age of the individual minor has great significance both in relation to reception facilities, receiving residence permits, and rights related to asylum and resettlement.

Unaccompanied asylum seeking minors under the age of 15 are a group with few arrivals, i.e., usually accounting for approximately 10 percent of unaccompanied minors' arrivals. Minors classified in this group have more rights, including to be taken care of by child welfare services. This means that the age category "under 15" requires more resources. However, the largest group of unaccompanied minors consist of adolescents aged 16-17 years. These children have fewer rights as far as child welfare and access to education

concerns. Asylum seekers who are classified as over 18 years of age are considered adults and lose their right to free legal aid, guardian and have reduced prospect to be granted residency.

Age assessment of unaccompanied refugee children is controversial as the methods used for age testing cannot give definitive answers concerning their age, and may threaten the rights of children who are in vulnerable situation (Gaarder & Krogh, 2005).

In 2006, NOAS (Norwegian Organisation for Asylum Seekers) published a survey and a review regarding the age testing of unaccompanied refugee minors, funded by Save the Children in Norway. The pilot study consisted of interviews with professionals of Oslo University Hospital (i.e., Ullevål Sykehus and Rikshospitalet) and the Faculty of Dentistry at the University of Oslo. Also experts from Retsmedicinsk Institutt in Denmark and Rättsmedicinalverket in Sweden were contacted. In order to assess the immigration authorities' method of age testing, 50 individual cases were reviewed.

Furthermore, the NOAS-report refers to Yosofzay (2005) the University of Oslo's Faculty of Dentistry, who had evaluated 485 asylum-seeking cases involving age assessment by a dental check[3]. Yosofzay observed that two of the unaccompanied minors had stated to be aged between 6-10 years, while only one x-ray of the wrist proved that age. Seven children had stated to be aged between 11-13 years, but only one dental examination and one x-ray of the wrist confirmed the reported age. 196 applicants told that their age was between 14-16, though only 17 dental examinations and 11 x-rays of the wrist supported their information. The researcher wondered why unaccompanied refugee minors would state these ages when their age - with relatively good margin - is under 18. Yosofzay concludes that the unaccompanied minors either report incorrectly regarding their age or the age assessments are not good enough. The report suggests that the latter explanation is more likely than the former.

However, age assessment is important as age provides basic information concerning children's needs and rights. Thus UDI decided to proceed with age testing, and new regulations (e.g., extend the assessment with a clinical test) should become operative from October 2009. Several professionals have questioned the proposed methods of age testing. Especially, many have had objections regarding the proposal to extend the currently used physiological tests (dental examination and x-ray of the wrist) with a "clinical check" of the genitals and breasts.

The Norwegian Antiracist Centre [*Antirasistisk Senter*] has launched a campaign against the proposal to use the checking of the genitals as part of the age testing of unaccompanied minors:

> Norwegian authorities will examine the asylum children's breasts and testicles to determine age. This is humiliating and contrary to human rights. Children should not be forced to strip naked. Anti-Racist Centre has launched a protest campaign. If the

[3] The dental age check consists of a clinical examination of the teeth (whether the applicant has fillings, caries, plaque, dental stone or colour coating as well as the degree of tooth wear) and a radiological investigation in the form of an OPG-X-ray (checking e.g. how far the tooth roots have reached and whether wisdom teeth are missing or fully developed). The results are then compared with different tables (by some people regarded as rather arbitrary tables).

> Norwegian authorities will examine children's genitals, we will make sure to give them access to adults instead … (*ww.antirasistisk-senter.no)*

Consequentially, UDI decided to further investigate the proposed methods of age assessment, and will get help of an expert group to do this.

* Update: At a press conference in June 2010, Minister of Justice Knut Storberget said that he now puts the clinical age testing of unaccompanied minors on ice. Furthermore, 1. September 2010, Norsk Barnelegeforening (The Norwegian Pædiatrician Association) writes in a submission to the Central Board of the Medical Association (Den norske lægeforeningen) that physicians should not participate in the X-ray studies of wrist to determine the age of unaccompanied child asylum seekers (Norsk Barnelegeforening, NBF).

UDI has asked the staff of the care centres for unaccompanied asylum seeking children (under 15 of age) to make an assessment of the children's age based on their daily observations of the children. In general, the people working at the care centres have been reluctant to do age assessments, as it is such a critical and sensitive issue (Eide & Broch, 2010). They justify their decision by saying that their biggest challenge and most important task is to win the children's trust, an assignment which cannot be combined with giving information that may jeopardize children's chances in the asylum seeking process. The only exception would be if a child in the care centre should be a problem to themselves or other children.

b. How are unaccompanied minors housed? Foster care? Residential care run by municipalities? By migrational authorities?

From December 2007, the government transferred the responsibility for care of unaccompanied minor asylum-seekers under the age of 15 from the immigration authorities to child welfare services. These children stay in care centres run by regional child welfare authorities. Currently there are 7 care centres for unaccompanied minor asylum seekers under the age of 15 and the purpose of these care centres is to provide residence and care during the asylum application process, until settlement or until they have to leave the country following rejection. The care centres for unaccompanied minors are supposed to provide services which are just as good as the services provided to other children under the care of child welfare services (Ot.prp. nr 28, 2007-2008).

The largest group of unaccompanied minors, i.e., minors from 15 – 18 years, stay either in special reception centres for unaccompanied minors (UM) or in ordinary reception centres with a separated section for unaccompanied minors. In total, there are currently 47 reception centres for unaccompanied minors. However, because of the declining number of arrivals as regards unaccompanied minors during the first two months of 2010, two UM-reception centres will be closed in the near future.

When the minors have been granted a residence permit, they are resettled in a municipality, which then is responsible for their accommodation and care. The type of housing /care offered dependents on the age and needs of the unaccompanied minor

involved. Family/foster care or institution is more common for the youngest minors. The elder minors are more often placed in independent accommodation on their own.

The most common accommodation and care solutions for the unaccompanied minors when resettled in municipalities (ECON, 2007):

1. Resettled with relatives or foster home (usually unaccompanied minors under 15 years)
2. Institution for unaccompanied minors with special needs
3. Shared-housing communities [*bofellesskap*]: 3-5 unaccompanied minors living together, full-time staffing / shift arrangement if required (usually minors over 15 years)
4. Independent housing solutions, single room/lodging with follow-up, not full-time staffed, follow up if needed (usually unaccompanied minors over 15 years)

When it comes to the provided accommodation/care there are several differences between unaccompanied minors and Norwegian children in general. According to Statistics Norway (SSB), it is more common to provide foster care for majority children (74 percent) than for unaccompanied minors (41 percent). Another special feature of accommodating unaccompanied minors is the use of family placement: 33 percent of foster care placements for unaccompanied minors are with family/relatives, while for other children this was 21 percent (Statistics Norway). This difference may be due to unaccompanied minors' ethnic background and the concern for the preservation of cultural norms and values, but may also be caused by the difficulties in recruiting foster homes for this group of children. The statistics of SSB are confirmed by a survey of 40 Norwegian settlement municipalities carried out in 2005 by ECON (2007) concerning the provision of care and accommodation to unaccompanied minors.

The ECON-report shows that about 40 percent of the unaccompanied minors lived in single rooms/lodgings [*hybler*]. This may be related to the age distribution of the unaccompanied minors, i.e., 50 percent were over 16 year old. The second largest accommodation option, shared-housing communities [*bofellesskap*], included 22 percent of the unaccompanied minors. Family/foster care placement was also a rather common solution, 19 percent of the minors lived with relatives.

c. Policy of family reunification for unaccompanied minors. Is there a possibility?

When it comes to applying for family reunification, it is important to take in to consideration the legal status of unaccompanied minors. Children and young asylum seekers who have been granted asylum have the right to family reunification in Norway if their family can be traced. Parents and unmarried siblings under 18 who live with their parents can get a residence permit and be reunited with the unaccompanied minor living in Norway. However, according to the information from Statistics Norway (Pettersen, 2007), relatively few unaccompanied minor asylum seekers are granted asylum.

Most unaccompanied minor asylum seekers attain a residence permit on humanitarian grounds. The primary humanitarian consideration is that they are separated from their parents and that their parents or other caregivers could not be traced. Unaccompanied minors who have been granted residence permit on humanitarian grounds are not entitled to family reunification, but they can apply. However, if their families/caregivers are found, reunification is likely to take place in the country of origin or in a third country.

Residence permit for family members is only given when strong humanitarian considerations warrant it.

Practices regarding family reunification for unaccompanied minors, who stay in Norway on humanitarian grounds, have notably changed over the past decade. Until 2000, the common practice was that unaccompanied minor children under 12 years were granted family reunification in Norway, if the parents could be traced. When unaccompanied minors aged between 12 and 15 applied for family reunification, their application used to be thoroughly assessed by immigration authorities, though relatively many were granted reunification in Norway. However, it was very rare that children over 15 years were granted family reunification. Until 2000, the child's age was thus of decisive importance for the outcome of the application for family reunification. After the year 2000, the child's age is no longer given weight in the assessment of family reunification (Pettersen, 2007). In addition, it is now regarded to be in the best interest of children to live with their parents in their home country. Consequently, family reunification is not granted when reunification can find place in the child's country of origin or a third country.

Of the 2.181 unaccompanied minors who were granted residence during 1996-2005, only four percent of them have been reunited with their parents in Norway. In 89 cases the mother and / or father immigrated to Norway. Most of the parents coming to Norway as a result of family reunification were mothers. Only in six cases, the children were only reunited with their fathers. Altogether 28 unaccompanied minor asylum seekers have been reunited with both parents in Norway. The analysis from Statistics Norway (2007) shows that the number of unaccompanied minors who were reunited with parents is higher among minors who have been granted asylum (8 percent) compared with those who have been granted residence on humanitarian grounds (3 percent).

In general, the likelihood of reunification with parents is highest among girls, and especially girls who were under 12 years old during settlement. In conclusion, common practice shows that family reunification in Norway between unaccompanied minors and their parents is a very limited phenomenon. Even before tightening the possibility for family reunification, there were relatively few minors who were reunited with parents in Norway. Consequently, most unaccompanied minors in Norway are lonely in the sense that they live separated from their most immediate family (Pettersen, 2007).

10. Leisure activities

a. Are there limitations in access to leisure activities sponsored by the municipality? Like libraries? Sports? Swimming schools?

In Norway, reception centres vary a great deal in terms of size, composition of staff, geographical location, the distance from the reception centre to the centre of the municipality, as well as the leisure activities, sports installations, swimming pools, etc. available in the municipality the reception centre is located. All these aspects may affect asylumseekers' opportunities of getting access to leisure activities. In addition the economy of the residents in the reception centres may limit their possibilities of getting involved in leisure activities. Assylum seeker children and their families do often have little money to cover expenses for leisure activities.

b. Good examples of NGO sponsored leisure activities?

NGOs such as Save the Children Norway, the Norwegian Red Cross, the Church City Mission, sponsor different types of activities for asylum seekers. Save the Children and Redd Cross are NGOs that organise recreational activities for children and adolescents in various reception centres across the country. These kind of activities may also include children and young people with refugee background who have been granted residence in Norway and are settled in a municipality. They organise for example, sports activities, excursions, arts and crafts, cultural events, tutoring homework, cafés for women and others.

11. Economic support

a. What kind of economic support from the society can asylum seeking families receive? Housing? Food? Medicine? Travel? Child-specific expenses?

In accordance with the "Regulations for financial assistance to persons in the state reception centres" (Monetary Regulations), asylum seekers who can not support themselves, receive financial allowances, called the "basic amount", from the government. This basic amount will have to cover the cost of living expenses, such as food, clothing, health services, medications, activities, etc. Those who have jobs or other earnings receive less financial support. If necessary, asylum seekers can receive additional benefits in order to ensure their life, health and well-being.

b. Do NGO's give economic support to asylum seeking families? Undocumented migrants?

To our knowledge, there are no NGOs that give economic support to asylum seekers and undocumented migrants.

12. Other comments

NOAS -The Norwegian Organization for Asylum Seekers
The Norwegian Organization for Asylum Seekers (Norsk Organisasjon for Asylsøkere) aims to advance the interests of asylum seekers in Norway. According to NOAS' principle the organization provides legal aid or general welfare to persons who seek and/or have been granted asylum status and protection in Norway. NOAS shall also be engaged with refugee policy matters as well as work to oppose perceptions that promote racism and xenophobia.

NOAS has currently 12 staff. The main office is located at Torggata in Oslo and another office is situated at the asylum reception centre in Bærum. The operations of NOAS, includes legal aid, information activity, academic and political efforts aimed at ensuring that asylum seekers get the appropriate justice and welfare assistance. NOAS is a membership organization with about 500 members. NOAS is mainly financed through state grant (from NOAS webside: http://www.noas.org/?p=news&news_id=66).

Association of guardians: Vergeforening 'Følgesvennen'

Vergeforening *Følgesvennen* is an Association of guardians representing unaccompanied minor asylum seekers: http://www.vergeforeningen.no/

Minor asylum seekers are considered as' unaccompanied' when they come to Norway without parents nor others with parental responsibility. A guardian (verge) or an 'assistant guardian' (hjelpeverge) is a person who represents the child on behalf of their parents and will ensure that the minor's needs and rights are taken care of.

Guardians need to ensure that:
• the minor is prepared for the asylum interview and to ensure that the interview is conducted correctly
• the minor gets appropriate follow-up by her/his lawyer
• the minor gets the financial aid he /she is entitled to
• the minor receives appropriate education
• the minor gets necessary health care
• the ressettling in a municipality takes into account the minor's needs and desires
• the minor receives the required care and accommodation

Folkehjelpen (Norwegian People's Aid) holds courses for guardians.

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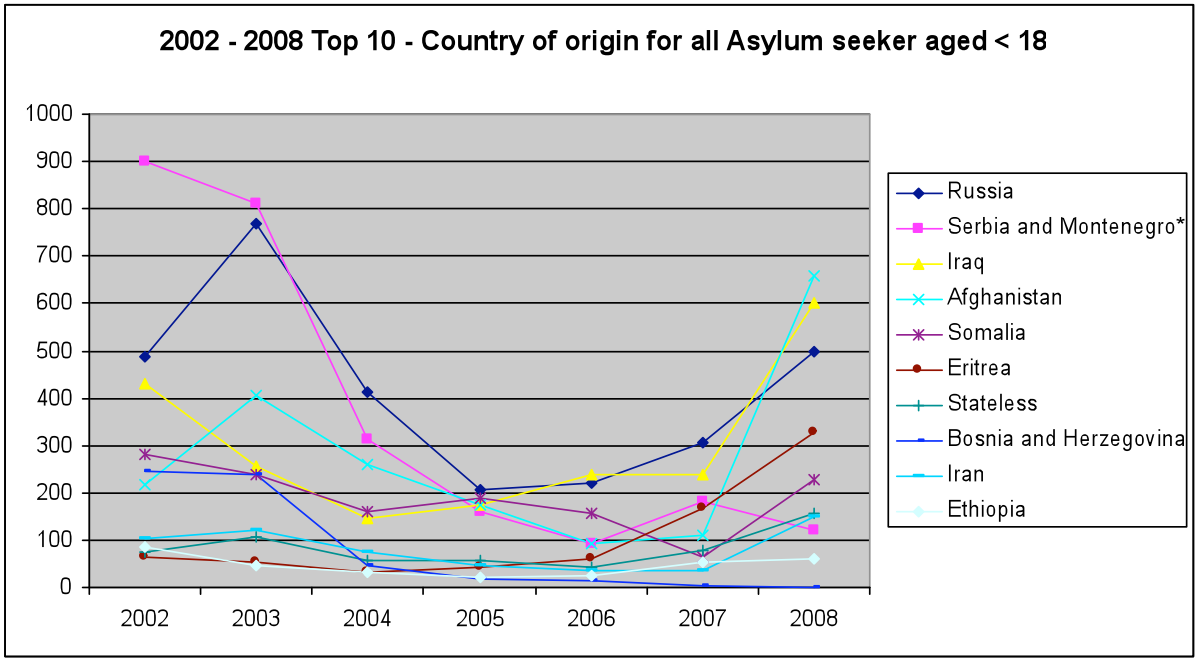
Appendix

Countries of origin and numbers of asylum seeking minors 2002-2008

2002-2008: Country of origin for <u>all</u> asylum applications by minors aged < 18



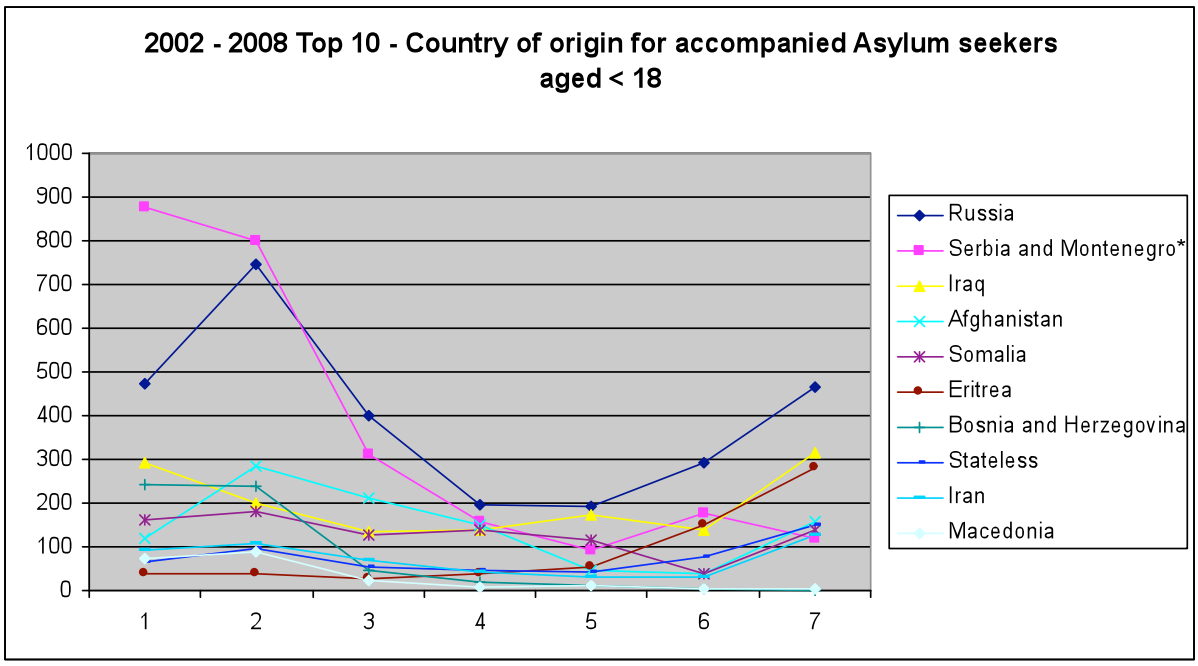
* The figures for 2007 and 2008 are solely valid for Serbia.

Country	2002	2003	2004	2005	2006	2007	2008	(tom)	Totalt
Russia	486	767	412	207	219	306	499		2896
Serbia and Montenegro	901	813	314	160	94				2282
Iraq	430	257	147	174	239	239	601		2087
Afghanistan	216	404	260	176	92	109	660		1917
Somalia	282	239	160	187	156	64	228		1316
Eritrea	64	52	33	43	60	169	327		748
Stateless	74	105	57	56	43	79	158		572
Bosnia and Herzegovina	246	240	46	19	14	5	1		571
Iran	104	120	74	48	37	37	149		569
Ethiopia	85	48	32	22	24	53	59		323
Serbia						181	121		302
Sri Lanka	38	28	28	17	22	50	104		287
Macedonia	78	92	22	8	11	4	6		221
Turkey	41	69	46	21	20	7	4		208
Slovakia	147	41	7			9			204
Azerbaijan	37	39	34	27	12	10	7		166
Burundi	14	24	27	28	36	11	22		162
Bulgaria	111	36	8	4					159
Czech Republic	87	53	10		1		2		153
Romania	66	74	8	3	1	1			153

Albania	40	48	26	9	6	4	9	142
Ukraine	83	26	12	5	2	1	4	133
Pakistan	72	24	5	9	7	9	1	127
Angola	8	57	11	9	17	10	8	120
China	20	28	20	17	10	7	17	119
Uzbekistan	45	30	13	7	3	4	17	119
Syrian Arab Republic	22	29	16	16	5	7	22	117
Belarus	39	40	13	6	9	1	3	111
Nigeria	8	21	20	12	9	10	30	110
Kosovo							99	99
Libya	7	37	25	7	4	5	12	97
Congo	5	15	9	16	10	12	29	96
Lebanon	8	26	11	4	18	15	12	94
Algeria	44	14	12	4	2	3	7	86
Georgia	39	21	18	3	2		3	86
Rwanda	13	17	12	17	9	6	7	81
Croatia	48	14	5	3	4		1	75
Armenia	43	9	12		6	1	2	73
Kyrgyzstan	40	12	6	7	1	4		70
Kazakhstan	36	14	6	7	3		2	68
Mongolia	32	20		2	4	1	2	61
Yemen	1	7	12	2	1	2	25	50
Moldova	10	14	10	4		3	3	44
Israel	13	13	6	6	4		1	43
Poland	17	14	2	1				34
Sudan	8	6	5		5	4	6	34
Hungary	22	2	2	1	2	1	1	31
Cameroon	7	7	3	2	2	2	5	28
India	6	4	3	3		1	10	27
Lithuania	6	8	4	3				21
Vietnam	4		6	6	2		3	21
Montenegro		7	5	5		2	1	20
Republic of Korea						10	10	20
Morocco	4		4	5	3	1	2	19
Niger	13		2		3		1	19
Tajikistan	7	4	4	1	1	1	1	19
Liberia	2	3	6	1	1		3	16
North Korea	1				6	5	3	15
Uganda	3			1	5	1	4	14
Jordan	4	2	2		1	1	3	13
Kenya	2	1	4		2	3	1	13
Bangladesh	2	6	1		1	1	1	12
Colombia	2		6	1			3	12
Guinea	4	3	2		1	1	1	12
Nepal	6	2	1	2				11
Sierra Leone	1	3	3	1	2	1		11
Egypt	3		1	5	1			10
Netherlands	3			1	2	3	1	10
Côte d'Ivoire	1	3	2		2		1	9
El Salvador	5	3						8
Estonia	5		3					8
Tanzania			7			1		8
Congo, Brazzaville	4	2					1	7
Latvia	5	1	1					7

Myanmar	4	1		1			1	7
Tunisia	2			1			4	7
Zimbabwe				1	3	2	1	7
Chile	1		3	1		1		6
Western Sahara	1	2	1		2			6
Ghana	1		1		1	1	1	5
Kuwait				5				5
United States	1	2				2		5
Djibouti	1		3					4
Slovenia	3	1						4
Benin	2						1	3
Bolivia	3							3
Cape Verde		3						3
France	1				2			3
Gambia						2	1	3
Guatemala						2	1	3
Indonesia	2		1					3
Malta				3				3
Mauritania		2			1			3
Mosambique		2	1					3
Togo	3							3
Turkmenistan			1		1		1	3
Venezuela				3				3
Argentina	2							2
Burkina Faso	1						1	2
Denmark			1	1				2
Germany	1		1					2
Nicaragua							2	2
Philippines		1				1		2
Suriname		1	1					2
United Kingdom						2		2
Bhutan		1						1
Brazil		1						1
Cambodia	1							1
Canada			1					1
Ecuador		1						1
French Guiana	1							1
Guinea-Bissau			1					1
Malaysia				1				1
Mali	1							1
Panama				1				1
South Africa							1	1
Soviet Union		1						1
Spain		1						1
Sweden					1			1
(tom)								
Totalt	4362	4138	2100	1429	1270	1491	3341	18131

2002-2008[1]: Country of origin for accompanied asylum seeking minors



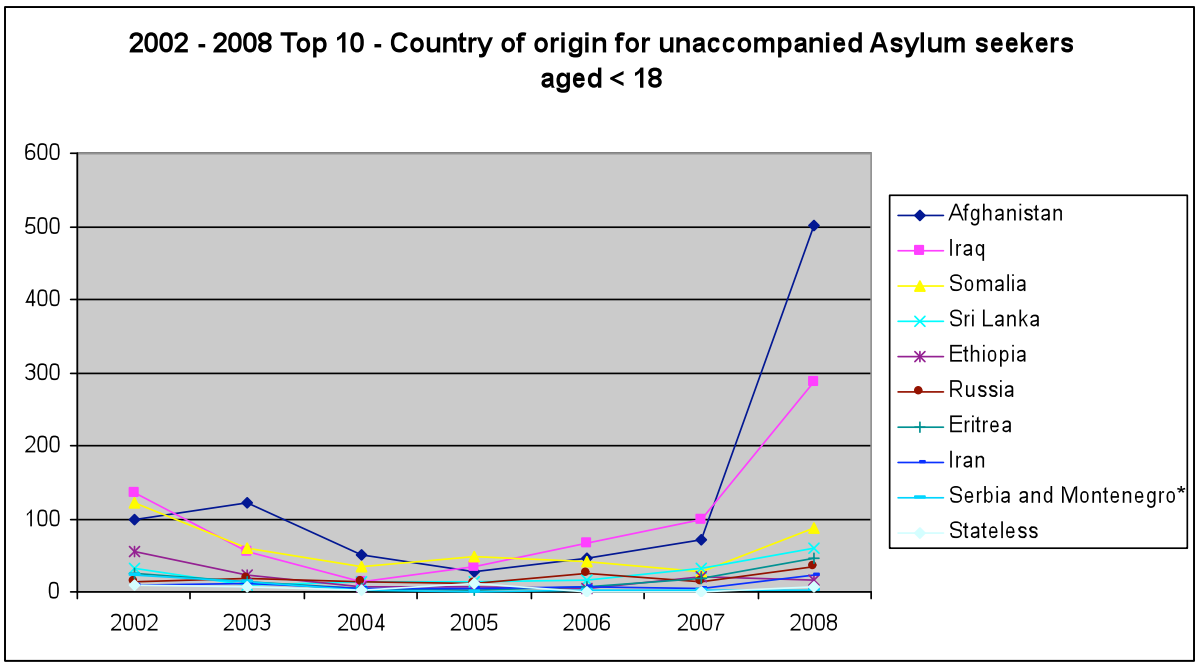
* The figures for 2007 and 2008 are valid for Serbia solely.

Country	2002	2003	2004	2005	2006	2007	2008	Totalt
Russia	472	748	399	195	194	293	465	2766
Serbia and Montenegro	877	799	312	159	91			2238
Iraq	294	201	133	139	173	139	314	1393
Afghanistan	118	283	210	149	45	38	159	1002
Somalia	161	179	126	138	114	37	140	895
Eritrea	39	38	28	40	52	151	282	630
Stateless	64	98	55	45	42	78	150	532
Bosnia and Herzegovina	243	239	46	18	13	5	1	565
Iran	94	109	70	43	31	32	127	506
Ethiopia	30	24	26	15	20	33	42	190
Serbia						178	118	296
Sri Lanka	5	19	14	4	6	18	45	111
Macedonia	74	90	22	8	10	4	5	213
Turkey	38	69	43	21	19	5	4	199
Slovakia	143	41	7			9		200
Azerbaijan	37	37	34	27	11	5	6	157
Burundi	9	17	25	23	28	8	19	129
Bulgaria	110	36	8	4				158
Czech Republic	86	52	10		1		2	151
Romania	60	73	8	3	1	1		146
Albania	38	43	24	9	6	3	7	130
Ukraine	82	25	12	5	2	1	4	131
Pakistan	65	24	4	6	6	9	1	115
Angola	5	49	8	6	15	8	4	95
China	16	22	19	5	8	5	6	81
Uzbekistan	41	28	12	7		4	14	106
Syrian Arab Republic	19	27	14	13	5	7	21	106
Belarus	32	33	12	6	9	1	3	96

Nigeria	1	15	19	11	7	8	25	86
Kosovo							98	98
Libya	1	35	25	6	4	4	11	86
Congo	4	13	9	13	9	10	28	86
Lebanon	8	26	11	3	18	15	10	91
Algeria	30	7	7	3	1	3	6	57
Georgia	30	21	18	2	2		1	74
Rwanda	7	16	12	15	8	6	5	69
Croatia	48	14	3	3	4		1	73
Armenia	40	7	11		6	1	2	67
Kyrgyzstan	37	10	6	7	1	4		65
Kazakhstan	34	12	6	7	3		2	64
Mongolia	25	17		2	4	1	2	51
Yemen	1	7	7	2	1	2	19	39
Moldova	7	9	8	4			3	31
Israel	13	13	6	6	4		1	43
Poland	17	14	2	1				34
Sudan	1	5	5		4	2	4	21
Hungary	22	2	2		2	1	1	30
Cameroon	2	3	3	1	1	2	5	17
India	6	4	3	3				16
Lithuania	2	2	2					6
Vietnam	2		2	2	1		1	8
Montenegro		7	5	5		2	1	20
Republic of Korea						10	8	18
Morocco	2		4	2	1	1	2	12
Niger	3		2		3			8
Tajikistan	5	2	3		1			11
Liberia	1	3	3		1		3	11
North Korea					5	3	3	11
Uganda	2			1	2	1	4	10
Jordan	4	1	2		1	1	3	12
Kenya	1		4		2	2		9
Bangladesh	1	5	1		1	1	1	10
Colombia	2		5	1			3	11
Guinea	2	2	2		1		1	8
Nepal		2	1	2				5
Sierra Leone		2	3		2	1		8
Egypt	2		1	5	1			9
Netherlands	3			1	2	3	1	10
Côte d'Ivoire		1	2		1		1	5
El Salvador	2	3						5
Estonia	5		3					8
Tanzania			2			1		3
Congo, Brazzaville	3	2						5
Latvia	4	1	1					6
Myanmar	3	1		1			1	6
Tunisia	2			1			2	5
Zimbabwe				1	2	2	1	6
Chile	1		3	1		1		6
Western Sahara		1						1
Ghana	1		1		1	1		4
Kuwait				5				5
United States	1	2				1		4

Djibouti	1		3					4
Slovenia	3	1						4
Benin							1	1
Bolivia	3							3
Cape Verde		2						2
France	1				2			3
Gambia							1	1
Guatemala						2	1	3
Indonesia	2							2
Malta				3				3
Mauritania		2						2
Mosambique		2	1					3
Togo	2							2
Turkmenistan					1		1	2
Venezuela				3				3
Argentina	2							2
Burkina Faso							1	1
Denmark			1	1				2
Germany	1		1					2
Philippines						1		1
Suriname		1	1					2
United Kingdom						2		2
Brazil		1						1
Cambodia	1							1
Canada			1					1
Ecuador		1						1
Malaysia				1				1
Panama				1				1
South Africa							1	1
Soviet Union		1						1
Spain		1						1
Sweden					1			1
Totalt	3656	3702	1904	1214	1013	1167	2205	14861

2002 – 2008: Country of origin for unaccompanied asylum seeking minors



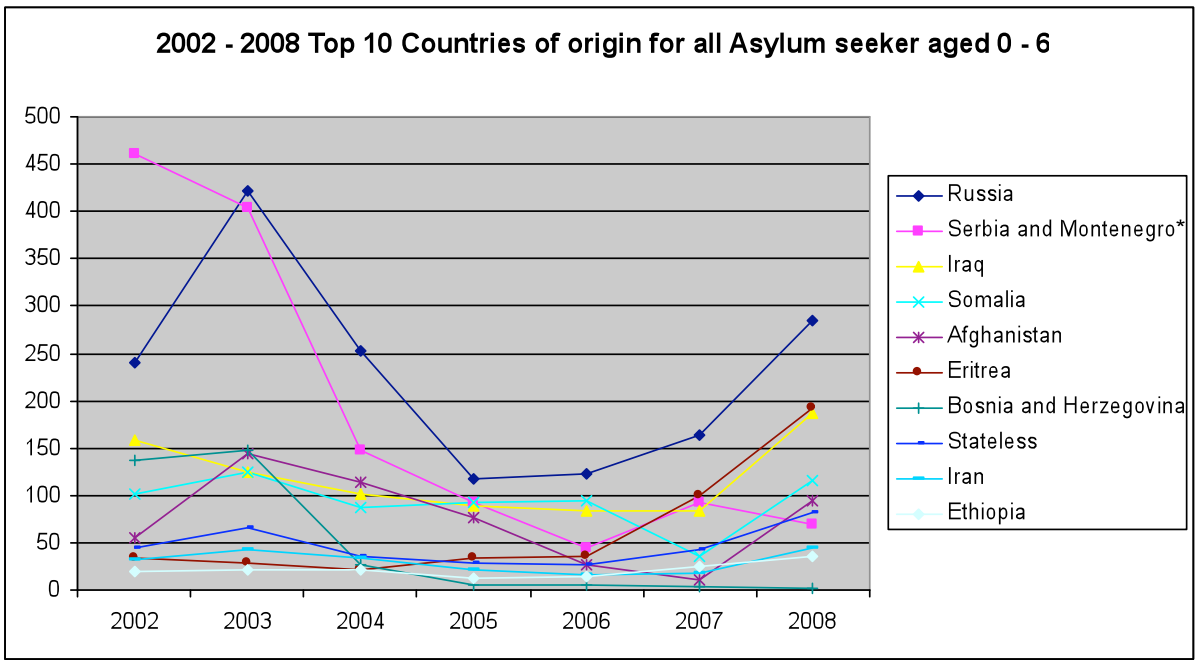
* The figures for 2007 and 2008 are valid for Serbia solely.

Country	2002	2003	2004	2005	2006	2007	2008	Totalt
Afghanistan	98	121	50	27	47	71	501	915
Iraq	136	56	14	35	66	100	287	694
Somalia	121	60	34	49	42	27	88	421
Sri Lanka	33	9	14	13	16	32	59	176
Ethiopia	55	24	6	7	4	20	17	133
Russia	14	19	13	12	25	13	34	130
Eritrea	25	14	5	3	8	18	45	118
Iran	10	11	4	5	6	5	22	63
Serbia and Montenegro	24	14	2	1	3			44
Stateless	10	7	2	11	1	1	8	40
China	4	6	1	12	2	2	11	38
Burundi	5	7	2	5	8	3	3	33
Algeria	14	7	5	1	1		1	29
Angola	3	8	3	3	2	2	4	25
Nigeria	7	6	1	1	2	2	5	24
Belarus	7	7	1					15
Lithuania	4	6	2	3				15
Uzbekistan	4	2	1		3		3	13
Moldova	3	5	2			3		13
Sudan	7	1			1	2	2	13
Vietnam	2		4	4	1		2	13
Albania	2	5	2			1	2	12
Pakistan	7		1	3	1			12
Georgia	9			1			2	12
Rwanda	6	1		2	1		2	12
Syrian Arab Republic	3	2	2	3			1	11

Libya	6	2		1		1	1	11
Yemen			5				6	11
Cameroon	5	4		1	1			11
India						1	10	11
Niger	10						1	11
Congo	1	2		3	1	2	1	10
Mongolia	7	3						10
Turkey	3		3		1	2		9
Azerbaijan		2			1	5	1	9
Macedonia	4	2			1		1	8
Tajikistan	2	2	1	1		1	1	8
Romania	6	1						7
Morocco	2			3	2			7
Bosnia and Herzegovina	3	1		1	1			6
Serbia						3	3	6
Armenia	3	2	1					6
Nepal	6							6
Kyrgyzstan	3	2						5
Liberia	1		3	1				5
Tanzania			5					5
Western Sahara	1	1	1		2			5
Slovakia	4							4
Kazakhstan	2	2						4
North Korea	1				1	2		4
Uganda	1				3			4
Kenya	1	1				1	1	4
Guinea	2	1				1		4
Côte d'Ivoire	1	2			1			4
Lebanon				1			2	3
Sierra Leone	1	1		1				3
El Salvador	3							3
Czech Republic	1	1						2
Ukraine	1	1						2
Croatia			2					2
Republic of Korea							2	2
Bangladesh	1	1						2
Congo, Brazzaville	1						1	2
Tunisia							2	2
Benin	2							2
Gambia						2		2
Nicaragua							2	2
Bulgaria	1							1
Kosovo							1	1
Hungary				1				1
Jordan		1						1
Colombia			1					1
Egypt	1							1
Latvia	1							1
Myanmar	1							1
Zimbabwe					1			1
Ghana							1	1
United States						1		1
Cape Verde		1						1
Indonesia			1					1

Mauritania					1			1
Togo	1							1
Turkmenistan			1					1
Burkina Faso	1							1
Philippines		1						1
Bhutan		1						1
French Guiana	1							1
Guinea-Bissau			1					1
Mali	1							1
Totalt	706	436	196	215	257	324	1136	3270

2002 – 2008: Country of origin for <u>all</u> asylum seeking minors aged 0 – 6



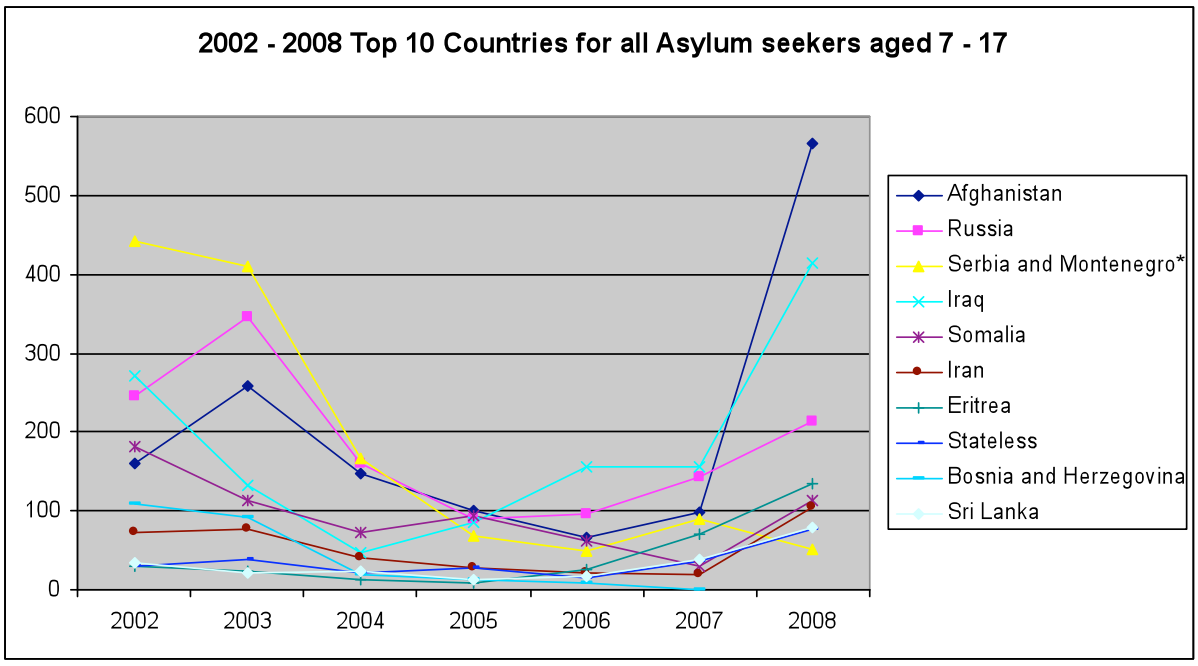
* The figures for 2007 and 2008 are valid for Serbia solely.

Country	2002	2003	2004	2005	2006	2007	2008	Totalt
Russia	241	421	252	117	122	164	285	1602
Serbia and Montenegro	460	404	147	92	45			1148
Iraq	158	124	101	89	84	84	187	827
Somalia	101	125	88	92	95	35	115	651
Afghanistan	56	145	113	76	26	10	95	521
Eritrea	34	28	21	34	35	99	193	444
Bosnia and Herzegovina	137	148	27	6	6	4	1	329
Stateless	45	66	36	29	27	42	81	326
Iran	32	43	34	21	16	18	45	209
Serbia						92	70	162

Ethiopia	20	21	21	12	15	25	36	150
Turkey	26	33	28	16	9	5	2	119
Macedonia	34	55	9	6	6		2	112
Slovakia	82	15	3			8		108
Burundi	7	12	23	16	17	6	13	94
Azerbaijan	19	14	24	15	5	4	6	87
Albania	25	26	15	5	3	1	4	79
Nigeria	1	13	18	11	5	8	23	79
Bulgaria	46	22	6	2				76
Angola	3	43	8	5	7	5	4	75
Czech Republic	42	26	4		1		2	75
Romania	24	40	6	3	1	1		75
Pakistan	38	17	4	3	5	4	1	72
Syrian Arab Republic	14	16	7	7	5	5	16	70
Ukraine	40	15	7	4	2		2	70
Belarus	18	19	10	5	5	1	3	61
Congo	3	9	7	9	8	6	18	60
Libya	1	24	19	4	2	4	6	60
Sri Lanka	3	7	5	4	4	11	24	58
Lebanon	5	7	5	3	12	11	7	50
Rwanda	7	8	9	12	5	5	2	48
Georgia	19	13	11	2	1		1	47
Uzbekistan	17	13	6	2			9	47
Kosovo							46	46
China	7	10	13	3	5	2	2	42
Croatia	30	8		1	1		1	41
Algeria	21	6	4	3	1	1	3	39
Mongolia	20	9		2	3	1	2	37
Armenia	22	4	4		3	1	2	36
Kazakhstan	16	6	3	3	2		1	31
Yemen	1	6	3	2		2	15	29
Kyrgyzstan	11	5	2	3		2		23
Poland	12	8	2	1				23
Israel	5	5	4	2	2		1	19
Moldova	4	6	2	4			1	17
Hungary	13	1	1				1	16
Montenegro		6	2	5		2	1	16
Sudan	1	4	5			2	4	16
Cameroon	1	3	3	1	1	2	4	15
Republic of Korea						6	6	12
India	4	2	2	2				10
Uganda	2			1	2	1	4	10
Jordan	3		1		1	1	3	9
Guinea	2	2	2		1		1	8
Liberia	1	2	2		1		2	8
Morocco	1		2	1	1	1	2	8
North Korea					4	2	2	8
Bangladesh	1	2	1		1	1	1	7
Estonia	4		3					7
Sierra Leone		1	3		2	1		7
Tajikistan	3	1	2		1			7
Vietnam	2		1	2	1		1	7
Myanmar	3	1		1			1	6
Netherlands	2			1	2	1		6

Côte d'Ivoire		1	2		1		1	5
Egypt			1	3	1			5
United States	1	2				2		5
Colombia	1		2	1				4
El Salvador	1	3						4
Kenya			2			2		4
Latvia	3		1					4
Nepal		1	1	2				4
Niger			1		3			4
Zimbabwe				1		2	1	4
Chile	1		1			1		3
France	1				2			3
Slovenia	2	1						3
Bolivia	2							2
Cape Verde		2						2
Congo, Brazzaville		2						2
Denmark			1	1				2
Djibouti	1		1					2
Ghana					1	1		2
Indonesia	2							2
Kuwait				2				2
Malta				2				2
Philippines		1				1		2
Suriname		1	1					2
Tanzania			1			1		2
Togo	2							2
Tunisia	1			1				2
Turkmenistan					1		1	2
Benin							1	1
Brazil		1						1
Burkina Faso							1	1
Canada			1					1
Ecuador		1						1
Gambia							1	1
Germany	1							1
Lithuania	1							1
Malaysia				1				1
Mosambique			1					1
Nicaragua							1	1
South Africa							1	1
Spain		1						1
Venezuela				1				1
Totalt	1970	2087	1158	755	618	697	1368	8653

2002 – 2008: Country of origin for <u>all</u> asylum seeking minors aged 7 - 17



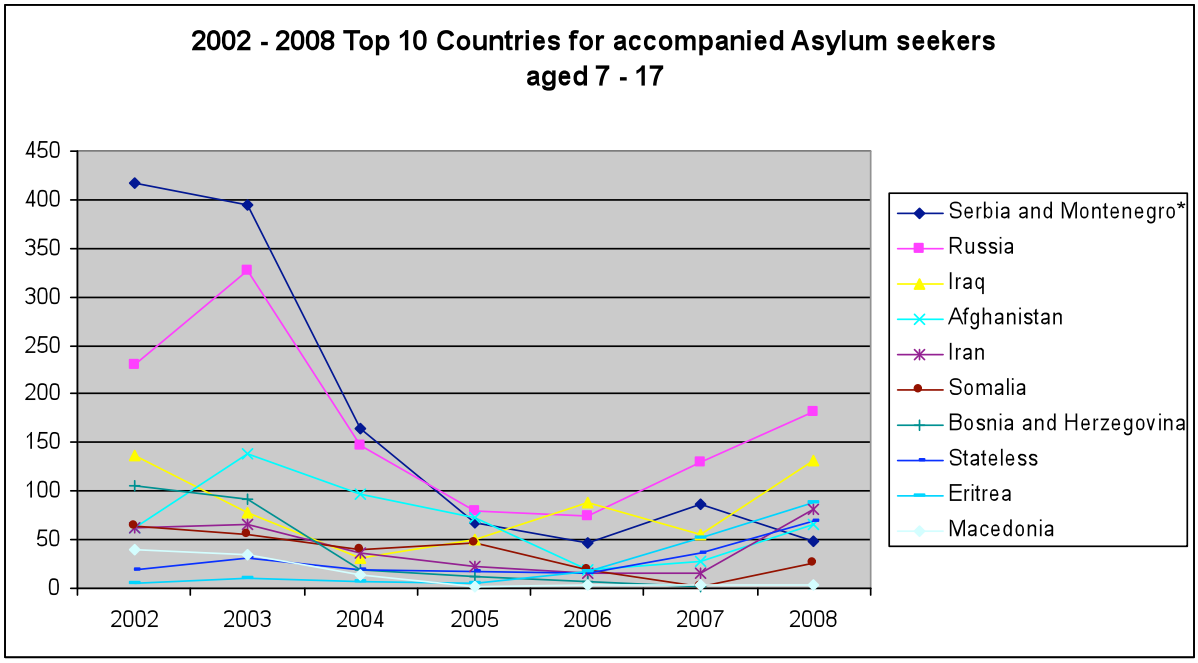
* The figures for 2007 and 2008 are valid for Serbia solely.

Country	2002	2003	2004	2005	2006	2007	2008	Totalt
Afghanistan	160	259	147	100	66	99	565	1396
Russia	245	346	160	90	97	142	214	1294
Iraq	272	133	46	85	155	155	414	1260
Serbia and Montenegro	441	409	167	68	49			1134
Somalia	181	114	72	95	61	29	113	665
Iran	72	77	40	27	21	19	104	360
Eritrea	30	24	12	9	25	70	134	304
Stateless	29	39	21	27	16	37	77	246
Bosnia and Herzegovina	109	92	19	13	8	1		242
Sri Lanka	35	21	23	13	18	39	80	229
Ethiopia	65	27	11	10	9	28	23	173
Serbia						89	51	140
Macedonia	44	37	13	2	5	4	4	109
Slovakia	65	26	4			1		96
Turkey	15	36	18	5	11	2	2	89
Bulgaria	65	14	2	2				83
Azerbaijan	18	25	10	12	7	6	1	79
Romania	42	34	2					78
Czech Republic	45	27	6					78
China	13	18	7	14	5	5	15	77
Uzbekistan	28	17	7	5	3	4	8	72
Burundi	7	12	4	12	19	5	9	68
Albania	15	22	11	4	3	3	5	63
Ukraine	43	11	5	1		1	2	63
Pakistan	34	7	1	6	2	5		55
Kosovo							53	53
Belarus	21	21	3	1	4			50

Algeria	23	8	8	1	1	2	4	47
Syrian Arab Republic	8	13	9	9		2	6	47
Kyrgyzstan	29	7	4	4	1	2		47
Angola	5	14	3	4	10	5	4	45
Lebanon	3	19	6	1	6	4	5	44
Georgia	20	8	7	1	1		2	39
Libya	6	13	6	3	2	1	6	37
Armenia	21	5	8		3			37
Kazakhstan	20	8	3	4	1		1	37
Congo	2	6	2	7	2	6	11	36
Croatia	18	6	5	2	3			34
Rwanda	6	9	3	5	4	1	5	33
Nigeria	7	8	2	1	4	2	7	31
Moldova	6	8	8			3	2	27
Mongolia	12	11			1			24
Israel	8	8	2	4	2			24
Yemen		1	9		1		10	21
Lithuania	5	8	4	3				20
Sudan	7	2			5	2	2	18
India	2	2	1	1		1	10	17
Niger	13		1				1	15
Hungary	9	1	1	1	2	1		15
Vietnam	2		5	4	1		2	14
Cameroon	6	4		1	1		1	13
Tajikistan	4	3	2	1		1	1	12
Morocco	3		2	4	2			11
Poland	5	6						11
Kenya	2	1	2		2	1	1	9
Liberia	1	1	4	1			1	8
Republic of Korea						4	4	8
Colombia	1		4				3	8
Nepal	6	1						7
North Korea	1				2	3	1	7
Western Sahara	1	2	1		2			6
Tanzania			6					6
Bangladesh	1	4						5
Congo, Brazzaville	4						1	5
Tunisia	1						4	5
Egypt	3			2				5
Côte d'Ivoire	1	2			1			4
Guinea	2	1				1		4
Uganda	1				3			4
El Salvador	4							4
Sierra Leone	1	2		1				4
Jordan	1	2	1					4
Montenegro		1	3					4
Netherlands	1					2	1	4
Ghana	1		1				1	3
Latvia	2	1						3
Mauritania		2			1			3
Zimbabwe					3			3
Chile			2	1				3
Guatemala						2	1	3
Kuwait				3				3

Benin	2							2
Gambia						2		2
Argentina	2							2
Djibouti			2					2
Mosambique		2						2
United Kingdom						2		2
Venezuela				2				2
Bhutan		1						1
Burkina Faso	1							1
Cape Verde		1						1
French Guiana	1							1
Guinea-Bissau			1					1
Indonesia			1					1
Mali	1							1
Myanmar	1							1
Nicaragua							1	1
Togo	1							1
Turkmenistan			1					1
Bolivia	1							1
Cambodia	1							1
Estonia	1							1
Germany			1					1
Malta				1				1
Panama				1				1
Slovenia	1							1
Soviet Union		1						1
Sweden					1			1
Totalt	2392	2051	942	674	652	794	1973	9478

2002 –2008: Country of origin for <u>accompanied</u> asylum seeking minors 7-17

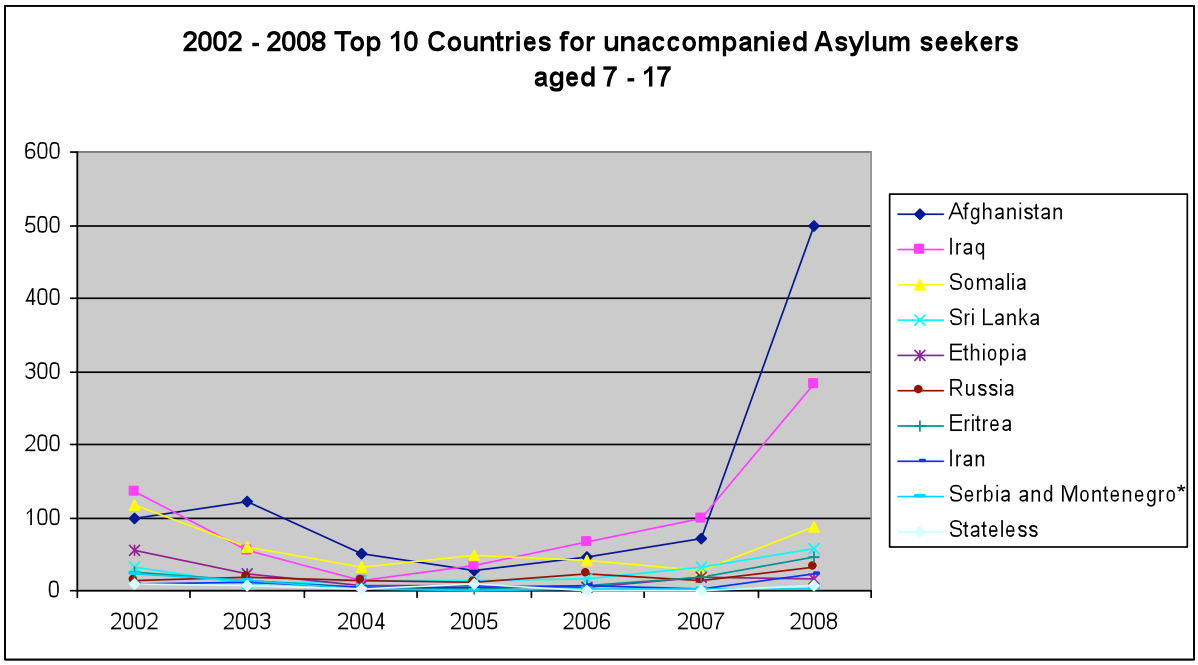


* The figures for 2007 and 2008 are valid for Serbia solely.

Country	2002	2003	2004	2005	2006	2007	2008	Totalt
Russia	231	327	147	79	74	129	182	1169
Serbia and Montenegro	417	395	165	67	46			1090
Iraq	136	78	32	51	89	55	131	572
Afghanistan	62	138	97	73	19	28	65	482
Iran	62	66	36	22	15	16	82	299
Somalia	64	55	40	47	19	2	26	253
Bosnia and Herzegovina	106	91	19	12	7	1		236
Stateless	19	32	19	17	15	36	69	207
Eritrea	5	10	7	6	17	52	89	186
Serbia						87	48	135
Macedonia	40	35	13	2	4	4	3	101
Slovakia	61	26	4			1		92
Bulgaria	64	14	2	2				82
Turkey	12	36	15	5	10		2	80
Czech Republic	44	26	6					76
Romania	36	33	2					71
Azerbaijan	18	23	10	12	6	1		70
Ukraine	42	10	5	1		1	2	61
Uzbekistan	24	15	6	5		4	5	59
Sri Lanka	2	12	9		2	7	23	55
Kosovo							52	52
Albania	13	17	9	4	3	2	3	51
Pakistan	29	7		3	1	5		45
Ethiopia	10	3	5	4	5	9	6	42
Kyrgyzstan	26	5	4	4	1	2		42
Lebanon	3	19	6		6	4	3	41
China	9	12	6	2	3	3	4	39
Burundi	2	5	2	7	12	3	6	37
Syrian Arab Republic	5	11	7	6		2	5	36
Belarus	14	14	2	1	4			35
Kazakhstan	18	6	3	4	1		1	33
Croatia	18	6	3	2	3			32
Armenia	18	3	7		3			31
Georgia	11	8	7	1	1			28
Libya		11	6	2	2		5	26
Congo	1	4	2	4	1	4	10	26
Israel	8	8	2	4	2			24
Angola	2	7		1	8	3	1	22
Rwanda		8	3	3	3	1	3	21
Algeria	9	1	3			2	3	18
Moldova	3	3	6				2	14
Mongolia	5	8			1			14
Hungary	9	1	1		2	1		14
Poland	5	6						11
Yemen		1	4		1		4	10
Nigeria		2	2		2		2	8
Colombia	1		3				3	7
Sudan		1			4		1	6

India	2	2	1	1				6
Republic of Korea						4	2	6
Lithuania	1	2	2					5
Kenya	1		2		2			5
Niger	3		1					4
Tajikistan	2	1	1					4
Morocco	1		2	1				4
Egypt	2			2				4
Montenegro		1	3					4
Netherlands	1					2	1	4
Liberia		1	1				1	3
North Korea					1	1	1	3
Bangladesh		3						3
Congo, Brazzaville	3							3
Tunisia	1						2	3
Jordan	1	1	1					3
Chile			2	1				3
Guatemala						2	1	3
Kuwait				3				3
Cameroon	1						1	2
Tanzania			2					2
Ghana	1		1					2
Latvia	1	1						2
Mauritania		2						2
Zimbabwe					2			2
Argentina	2							2
Djibouti			2					2
Mosambique		2						2
United Kingdom						2		2
Venezuela				2				2
Vietnam			1					1
Nepal		1						1
Western Sahara		1						1
El Salvador	1							1
Sierra Leone		1						1
Bolivia	1							1
Cambodia	1							1
Estonia	1							1
Germany			1					1
Malta				1				1
Panama				1				1
Slovenia	1							1
Soviet Union		1						1
Sweden					1			1
Totalt	1692	1619	750	465	398	476	850	6250

2002-2008: Country of origin for unaccompanied asylum seeking minors aged 7-17



* The figures for 2007 and 2008 is valid for Serbia solely.

Country	2002	2003	2004	2005	2006	2007	2008	Totalt
Afghanistan	98	121	50	27	47	71	500	914
Iraq	136	55	14	34	66	100	283	688
Somalia	117	59	32	48	42	27	87	412
Sri Lanka	33	9	14	13	16	32	57	174
Ethiopia	55	24	6	6	4	19	17	131
Russia	14	19	13	11	23	13	32	125
Eritrea	25	14	5	3	8	18	45	118
Iran	10	11	4	5	6	3	22	61
Serbia and Montenegro	24	14	2	1	3			44
Stateless	10	7	2	10	1	1	8	39
China	4	6	1	12	2	2	11	38
Burundi	5	7	2	5	7	2	3	31
Algeria	14	7	5	1	1		1	29
Angola	3	7	3	3	2	2	3	23
Nigeria	7	6		1	2	2	5	23
Belarus	7	7	1					15
Lithuania	4	6	2	3				15
Uzbekistan	4	2	1		3		3	13
Moldova	3	5	2			3		13
Vietnam	2		4	4	1		2	13
Albania	2	5	2			1	2	12
Rwanda	6	1		2	1		2	12
Sudan	7	1			1	2	1	12
Syrian Arab Republic	3	2	2	3			1	11
Georgia	9						2	11
Libya	6	2		1		1	1	11
Yemen			5				6	11
India						1	10	11

Niger	10						1	11
Cameroon	5	4		1	1			11
Pakistan	5		1	3	1			10
Congo	1	2		3	1	2	1	10
Mongolia	7	3						10
Turkey	3		3		1	2		9
Azerbaijan		2			1	5	1	9
Macedonia	4	2			1		1	8
Tajikistan	2	2	1	1		1	1	8
Romania	6	1						7
Morocco	2			3	2			7
Bosnia and Herzegovina	3	1		1	1			6
Armenia	3	2	1					6
Nepal	6							6
Serbia						2	3	5
Kyrgyzstan	3	2						5
Liberia	1		3	1				5
Western Sahara	1	1	1		2			5
Slovakia	4							4
Kazakhstan	2	2						4
Kenya	1	1				1	1	4
North Korea	1				1	2		4
Tanzania			4					4
Côte d'Ivoire	1	2			1			4
Guinea	2	1				1		4
Uganda	1				3			4
Lebanon				1			2	3
El Salvador	3							3
Sierra Leone	1	1		1				3
Czech Republic	1	1						2
Ukraine	1	1						2
Croatia			2					2
Republic of Korea							2	2
Bangladesh	1	1						2
Congo, Brazzaville	1						1	2
Tunisia							2	2
Benin	2							2
Gambia						2		2
Bulgaria	1							1
Kosovo							1	1
Hungary				1				1
Colombia			1					1
Egypt	1							1
Jordan		1						1
Ghana							1	1
Latvia	1							1
Mauritania					1			1
Zimbabwe					1			1
Bhutan		1						1
Burkina Faso	1							1
Cape Verde		1						1
French Guiana	1							1
Guinea-Bissau			1					1
Indonesia			1					1

Mali	1							1
Myanmar	1							1
Nicaragua							1	1
Togo	1							1
Turkmenistan			1					1
Totalt	700	432	192	209	254	318	1123	3228