Policies on Health Care for Undocumented Migrants in EU27

Country Report

Sweden

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Preface

Undocumented migrants gain increasing attention in the EU as a vulnerable group that is exposed to high health risks and challenges public health. In general, undocumented migrants face considerable barriers in accessing services. Health of undocumented migrants is highly at risk due to difficult living and working conditions often characterised by uncertainty, exploitation, and dependency. In a state-control logic, national regulations often severely restrict access to health care for undocumented migrants. At the same time, right to health care has been recognized as human right by various international instruments ratified by European Countries (PICUM 2007; Pace 2007). This opens a paradox for health care providers: if they give care, they may act against legal and financial regulations, if they don’t give care they violate human rights and exclude the most vulnerable. This paradox cannot be resolved on a practice level but has to be managed in a way neither human rights nor national regulations are violated.

The EU Project “Health Care in NowHereland” works on the issue of improving health care services for undocumented migrants. Experts from research and practice identify and assess contextualised models of good practice of health care for undocumented migrants. It builds upon compilations of

- policies in EU 27 on national level
- practices of health care for undocumented migrants on regional and local level
- experiences from NGOs and other advocacy groups from their work with undocumented migrants

With its title, the project introduces the image of an invisible territory of Nowhere-land that is part of the European presence “here and now”. How health care is organised in NowHereland, what are policy frameworks that influence health care provision and who are the people that live and act in this NowHereland are central question raised.

**Health Care in NowHereland:**
**Improving Services for Undocumented Migrants in the EU**

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*Partners:* Center for Health and Migration at the Danube University Krems (AT) (main coordinator), Platform for International Cooperation on Undocumented Migrants (BE), Azienda Unità Sanitaria Locale di Reggio Emilia (IT), Centre for Research and Studies in Sociology (PT), Malmö Institute for Studies of Migration, Diversity and Welfare (SE), University of Brighton (UK)
Introduction

This report is written within the framework of the research project, NowHereland - Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU, and one of its work packages. The focus of this work package – policy compilation – was to collect data on policy approaches regarding access to health care for undocumented migrants in the EU member states, to deliver 27 Country Reports and to offer a clustering of the states. A descriptive approach has been applied. In order to contextualise health care access, certain other themes are covered, such as the main characteristics of the various health systems, aspects of policies regarding undocumented migrants and the general context of migration.¹

The term used in this project is thus, “undocumented migrants”, which may be defined as third-country nationals without a required permit authorising them to regularly stay in the EU member states. The type of entry (e.g. legal or illegal border crossing) is thus not considered to be relevant. There are many routes to becoming undocumented; the category includes those who have been unsuccessful in the asylum procedures or violated the terms of their visas. The group does not include EU citizens from new member states, nor migrants who are within the asylum seeking process, unless they have exhausted the asylum process and are thus considered to be rejected asylum seekers.

All the reports draw upon various sources, including research reports, official reports and reports from non-governmental organisations. Statistical information was obtained from official websites and from secondary sources identified in the reports. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was information obtained via a questionnaire sent to recognised experts in the member states.²

The General Migration Context

Sweden became a member of the EU in 1995 and a part of the Schengen Agreement in 1996.

Sweden developed from a country of migration to a country of immigration in the 1930s, although most immigrants were returning migrants from North America. Before this decennium, Sweden had a net emigration. The immigration escalated in the 1940s as a

¹ Information regarding the project and all 27 Country Reports can be found at http://www.nowhereland.info/. Here, an Introduction can also be found which outlines the theoretical framework and method as well as a clustering of the states.
² In the case of Sweden the questionnaire was processed by the author.
result of refugees coming from the Baltic Sea and Nordic countries (Bengtsson et al. 2005). The modern era of immigration can be divided into four distinct stages, with each stage representing different types of immigrants and immigration: 1) Refugees from neighbouring countries (1938 to 1948), 2) Labour immigration from Finland and southern Europe (1949 to 1971), 3) Family reunification and refugees from developing countries (1972 to 1989), 4) Asylum seekers from south eastern and eastern Europe (1990 to present) and the free movement of EU citizens within the European Union (Westin 2006).

Currently, Sweden has only regulated refugee migration (asylum) and family reunion migration, along with controlled labour migration. For non EU citizens, work permits are requested prior to entrance into the country. In 2008, Sweden received 24 875 asylum applications (Eurostat 66/2009). The main countries of origin were Iraq (6 325), Somalia (3 410) and Serbia (2 035) (ibid.). The same year, 31 220 decisions were issued (in the first and second instance) and the rate of recognition was 26.6% (in the first instance) (Eurostat 175/2009). In 2009, there were 24 124 asylum applicants, including 5 874 from Somalia, 2 297 from Iraq and 1 994 from Afghanistan. 3

The numbers in respect of work migration are lower. The number of applicants for work permits was approximately 10 500 in 2007 and 12 800 in 2008. The majority of permits issued consisted of short term work permits. In addition, 542 persons in 2007 and 796 in 2008 were granted permanent residence based on labour market needs. This trend is increasing and in terms of nationalities, citizens from Thailand, India and China accounted for the increment. At the end of 2008, some changes were implemented in the regulations, which brought further increases. During the first six months of 2009, 13 300 work permits were issued. 4

**Total Population and Migrant Population**

By 1 January 2010, the population in Sweden was 9 347 899 (Eurostat). In 2008, the foreign born population was 524 000 (Eurostat 94/2009). The main countries of origin were Finland (80 400), Iraq (40 000) and Denmark (38 400) (ibid.). Sweden does not register religion, ethnicity, or race as categories in its census (this is prohibited in terms of the constitution). The official key categories are country of birth, citizenship and parents' nationalities.

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3 Migrationsverket (National Board of Migration).  
http://www.migrationsverket.se/download/18.78fcf371269cd4cda980001223/Asyls%C3%B6kande+2009.pdf (04-02-2010).

4 See The Government's budgetary proposition 2009/10:1, Section 8, Migration.  
http://www.regeringen.se/content/1/c6/13/17/16/1af93b55.pdf (15-02-2010).

5 Eurostat.  
Estimated Number of Undocumented Migrants

Estimates of the number of undocumented migrants range from 15 000 to 80 000, which equals 0.5 % of the population and represents a comparatively moderate level within the European context (Baldwin-Edwards & Kraler 2009:41). In its periodical report on public health, The Board of Health and Welfare referred to 20 000 undocumented migrants (Socialstyrelsen 2009).

Categories of Undocumented Migrants

In terms of pathways into irregularity, undocumented migrants have received most attention with respect to failed asylum seekers, since the asylum system has a role in “producing” undocumented migrants (Kraler and Reichel 2009:138). Asylum seekers are also assumed to represent the largest share of undocumented migrants, with illegal entry or overstaying considered less common (ibid.).

Policies Regarding Undocumented Migrants

Regularization Practice, its Logic and Target Groups

Regularisation is granted in Sweden primarily on humanitarian grounds and is closely connected with the asylum system (Baldwin-Edwards & Kraler 2009:40). Sweden has implemented one regularisation program, in 2005, which consisted of a temporary amendment of the Aliens Act. The logic of the program followed humanitarian arguments and the main target group was families with children who had established themselves whilst waiting for a decision. Under this programme, 17 000 rejected asylum seekers were regularised and in the majority of cases, received a permit to reside (13 000 permanently and some 4 000 temporarily). 8 000 of the processed cases concerned persons whose asylum applications were discontinued. A total of 31 000 applications were processed. The main countries of origin were Iraq, Somalia, Palestine, Afghanistan and Serbia (Blaschke 2008). In addition, rejected asylum seekers are occasionally regularised on an individual basis and on humanitarian grounds (Kraler and Reichel 2009).

Internal Control: Accommodation, Labour, Social Security and Education

In Sweden it is not possible for non residents to sign a legally binding contract for accommodation. This relates to the fact that they, having not being registered by the authorities (i.e. tax-authorities), lack a “personal number”, which all residents are issued with. This number is widely used in different contexts (libraries, electricity companies to name a few). Undocumented migrants, as non residents, can neither gain access to employment nor the related social security.

Currently, undocumented children have no right to education as there is no obligation on schools to enrol children who are irregularly resident. However, in February 2010, an
inquiry suggested changes in the legal framework to ensure that all children present in Sweden should be entitled to education (all forms of primary and secondary education), pre-school activities and school-age childcare (SOU 2010:5).

From this it can be concluded that Sweden has a strong internal control of migration.

Main Characteristics of the Health System

Financing, Services and Providers

The health care system in Sweden is considered to be a public responsibility and is regulated by the 1982 Health Care Act (Hälso- och sjukvårdslagen). It has a general universal orientation with a publicly operated health service and is organized on three levels: national, regional and local (Glenngård et al. 2005). Health care is predominantly financed through national and local general taxation (85%). Private health insurance plays a supplementary role (providing faster access to care) and covers 2.5% of the population (Thomson et al. 2009). County councils, which form the basis of the system, are responsible for financing primary care, hospital care and mental health care. Municipalities are responsible for financing home care and nursing home care. Most primary health centres and hospitals are owned and operated by the county councils, although the number of privately contracted primary care providers is growing (up to 60% in some urban counties). Residents are increasingly able to choose their primary care providers. Primary care has no formal gatekeeping function, but financial incentives (higher co-payments) encourage patients to visit primary care providers before visiting specialists (Thomson et al. 2009).

The overall responsibility for development in health care rests with the Ministry of Health and Social Affairs (Socialdepartementet) at a national level. The National Board of Health and Welfare (Socialstyrelsen) is the government’s central advisory and supervisory agency, responsible for follow ups, evaluations and providing guidelines (Glenngård et al. 2005).

All residents are covered for a comprehensive range of health services under the Health and Medical Services Act. However, this is expressed from the providers’ point of view, as the goal is to ensure “the entire population a good health and care on equal terms” and in addition is granted according to needs. There is no defined list of benefits, but guidelines have been put in place (by the Board of Health and Welfare) to establish health care priorities. Co-payments exist for most health services, but children are exempt. The fee for health care ranges from approximately €10 -30 depending on county council and the level of required expertise of care. The cost is €8 per day in hospital. There is a cost ceiling in

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terms of which cost sharing is capped at an annual amount of €90 for health services and €180 for prescription pharmaceuticals. Medical treatment for children and young people up to the age of 19 is free of charge (Glenngård et al. 2005). Dental care is covered by the national dental insurance system, which includes a subsidy for adults. The pricing of dental care has been deregulated, which means that providers set their own fees for each form of treatment and subsidies are more limited. Dental care for children and young people up to the age of 19 is free (ibid.).

The health care delivery system, managed by the county councils, involves primary care, hospital care and public health and preventive care. The county councils are organised in health care districts with responsibility for the health of the population in their areas. The care facilities are organised as regional hospitals and district county hospitals. Primary care is provided in health care centres (vårdcentraler). The county council regulates the private health market. A private provider must have an agreement in order to obtain reimbursements from the social insurance. Accordingly, private health care, with few exceptions, is publicly funded via insurance (Glenngård et al. 2005:23). In April 2009, a change in the Health Care Act was implemented, called “Care choice” (Vårdval) which strengthened the position of private providers and de-coupled the geographical affiliation of patients seeking primary care.7

**Basis of Entitlement**

The basis of entitlement is legal residence. The term used in the Health and Medical Services Act is thus, “the entire population”. Legal residents get a personal number (similar to a social security number) in terms of the Population Registers Act.8 This number is used within the administration of health care and care is, in principle, inaccessible for persons without this number.

**Special Requirements for Migrants**

Legally resident migrants are fully entitled to care. In addition, emergency coverage is provided to all patients from EU/European Economic Area countries and countries with which Sweden has bilateral agreements (Glenngård et al. 2005:26). A prerequisite is that they possess a European health card or certificate. If not, they are required to pay the full cost in cash.9

Care for asylum seekers is regulated by The Act on Health Care for Asylum Seekers, *inter alia* (Lagen om Hälso- och sjukvård åt asylsökande m.fl.). Asylum seekers are entitled to “care that can not wait”, maternity care, care in relation to abortion and family planning.

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7 Governments’ information, [http://www.sweden.gov.se/sb/d/11264](http://www.sweden.gov.se/sb/d/11264) (15-02-2010)


9 Article 34, Förordningen (EEG) nr 574/72.
Asylum seeking children (under 18 years) are however fully entitled to care. Asylum seekers are entitled (i.e. the county council shall offer) a screening free of charge. Screening for HIV and other contagious diseases is included. As regards HIV/AIDS treatment, this is covered in terms of The Communicable Disease Act (Smittskyddslagen).

In relation to undocumented migrants, it is relevant that asylum seekers are, by the migration authorities (the National Board of Migration), provided with a personal card, which is valid for a certain period (LMA card). This card is required to be presented when seeking care.

**Difference Sensitivity**

In Sweden, some adaptive structures to migrants in health care can be found, including mediation/translation services, translated informational material, the promotion of multicultural staff in the health sector (understood in a general framework), health services adapted to specific migrant needs (for example, meals in hospitals) as well as in the integration of education for healthcare providers.

Due to the integration approach (in terms of policy and tradition), which is officially interpreted as being non-stigmatising, the measures applied are mainly “mainstreamed”. There is also a broad consensus to mainstream health in the area of integration (Björngren Cuadra 2009). As regards initiatives which have been developed, a major item is to be found in The Administration Act (Förvaltningslagen para. 8). This law provides for the right to an interpreter, or to be more specific, it provides that whenever a public authority communicates with a person who does not understand Swedish, the authority should provide an interpreter and pay for the cost thereof. This also includes persons with hearing difficulties. Interpreting services are most often organised at municipal level and in practice this is executed by a certain bureau holding contracts with authorized interpreters. Another mainstreaming approach involves initiatives at university level to integrate perspectives on migration in the curricula for health workers (ibid.). However, in line with the integration approach, there are also initiatives explicitly targeting migrants, which aim at migrants’ needs during their first 2 years in Sweden. This includes asylum seekers and persons with new residence permits. This involves screening (at national level) and initiatives at regional and local level, such as “health communicators”, which focus on peer-education and function as cultural mediators. Furthermore, some county councils have developed Medical Centres targeting refugees and persons with war and torture trauma. In some cases, this is

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10 Lagen om Hälso- och sjukvård åt asylsökande m.fl., SFS 2008:344 para. 4
11 Smittskyddslagen, SFS 2004:168, chapter 4, para. 6 regarding care and chapter 7, para 1 and 2 regarding no free services.
12 LMA refers to the law in terms of which this card is issued, the Law on Reception of Asylum seekers, LMA, lagen om mottagande av asylsökande m.fl. (SFS 1994:137).
organised in cooperation with the Red Cross. There are also initiatives to be found in the civil society, organised by non-governmental organisations (ibid).  

**Health Care for Undocumented Migrants**

**Relevant Laws and Regulations**

There is no specific legislation regarding access to health care for undocumented migrants. Due to a lack of legislation, current access is implied by the general legal framework. The following acts are relevant:

The **Health and Medical Services Act (Hälso- och sjukvårdslagen)**, which regulates the targets for the care providers in terms of ensuring “the entire population a good health and care on equal terms” (para. 1) and “offering care to those resident in the country” (para 3). Furthermore, it also regulates the right to hold the patient accountable for fees (para. 26).

Paragraph 4 refers to persons not living (resident) in the county and provides that if a person is present, but not resident, in the county and in need of immediate care, the county council shall offer such care.  

The **Dental Care Act (Tandvårdslagen)** outlines the obligation to provide dental care under the same premises as the Health and Medical Services Act.

The **Act on Health Care for Asylum Seekers, inter alia (Lagen om Hälso- och sjukvård åt asylsökande m.fl.)** is relevant in the sense that it does not apply to foreigners who remain in the country illegally (i.e. rejected asylum seekers) if they are over 18 years of age. This act also establishes a reference for providers developing regional policies contrary to this law (see below). Before this Act went into force in July 2008, the entitlement of asylum seekers and undocumented migrants was regulated by an agreement between the state and the county councils.

The **Communicable Disease Act (Smittskyddslagen)** chapter 4, para. 6, in respect of care and chapter 7, para. 1 and 2, which relates to the fact that services are to be provided free of

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13 For examples, see [http://mighealth.net/se/index.php/Huvudsida](http://mighealth.net/se/index.php/Huvudsida)


16 Lagen om Hälso- och sjukvård åt asylsökande m.fl., SFS 2008:344 para. 4.
charge, is also relevant with respect to contagious diseases and HIV/Aids, and implies an entitlement to testing and treatment.\textsuperscript{17} A right to testing for HIV anonymously is also legislated for.\textsuperscript{18}

With respect to confidentiality, two Acts are relevant: The Health and Medical Services Professional Activity Act (Lag om yrkesverksamhet på hälso- och sjukvårdens område (LYHS))\textsuperscript{19} and The Public and Confidentiality Act (Offentlighets- och sekretesslagen).\textsuperscript{20}

**Access to Different Types of Health Care**

Undocumented migrants are formally excluded from entitlement to health care over and above what follows from the provider's obligation to offer immediate care (in practice interpreted as emergency care), to persons present but not resident in the country. The patient is charged the full cost.\textsuperscript{21} From this follows that undocumented migrants do not access primary and secondary care via the legal framework.

There are currently 13 county councils (out of 21) that have launched regional policies or guidelines regarding entitlements to care. In some cases (7), the policy involves giving care corresponding to the level of entitlement of asylum seekers, which also involves primary care. However, in 3 of these cases, the policy involves only rejected asylum seekers. In other county councils (6), the chosen policy involves enlarging the concept of “emergency care” to also include “immediate necessary care”. In terms of these policies, some of the county councils have launched corresponding guidelines to the front line staff providing that they are not to deny care due to an inability to pay. The guidelines also deal with how to circumvent the administrative obstacles where a patient lacks a personal number (Sigvardsdotter 2009).

Access to care is also provided by non governmental organisations and informal networks of health professionals (see below, see also HUMA Network 2009).

\textsuperscript{17} Smittskyddslagen, SFS 2004:168, chapter 4, para. 6 regarding care and chapter 7, para 1 and 2.
\textsuperscript{18} Förordning (2008:363) om provtagnings för hivinfektion (SFS 2008:363 para. 1).
\textsuperscript{19} Lag (1998;531) om yrkesverksamhet på hälso- och sjukvårdens område (LYHS).
\textsuperscript{20} Offentlighets- och sekretesslagen (2009:400).
\textsuperscript{21} Hälso- och sjukvårdslagen (1982:763) para. 4 on immediate care and para. 26 on charge.
Costs of Care

Undocumented migrants are required to pay the full cost of health care services unless the regional policy provides otherwise (for example, asylum seekers qualifying for subsidised fees).

Specific Entitlements

Undocumented children are, if they are rejected asylum seekers, entitled to the same care as residents. This follows from The Act on Health Care for Asylum Seekers, *inter alia*, which provides that persons who remain in the country clandestinely (i.e. rejected asylum seekers) are not covered if they are over 18 years of age. From this follows that children whose pathway into an irregular stay is not via the asylum system, are left without any entitlement to care beyond what can be accessed via payment of the full charge.

As regards HIV/AIDS and communicable diseases, undocumented migrants are entitled to testing in terms of The Communicable Disease Act, which provides that such persons are entitled to remain anonymous. With respect to treatment, the Act provides that a person with a contagious disease shall be offered, free of charge, the required care and treatment in order to prevent and decrease the risk of infection (chapter 4, para. 6 and chapter 7, para. 1 and 2). However, the responsible doctor is obliged to report the person diagnosed with an HIV infection (which involves using the person’s personal number) to the regional doctor (Smittskyddsläkare) who then reports the patient to The Swedish Institute for Infectious Disease Control (Smittskyddsinstitutet). In praxis this mean that non resident patients are not implied to be actualised in the health care system.

Regional and Local Variations

There are clear variations with respect to the entitlement to health care due to the fact that some county councils have their own regional policy. There are also variations due to differing routines and gatekeepers’ discretion. All but two county councils (out of 21) have approached the issue on the right to health care for undocumented migrants and of those 19, all but two have formulated some kind of policy regarding access to health care. These policies can be divided into three groups: those which clarify the national policy, those which enlarge the concept of “emergency” to be understood as “immediate necessary care”, and those which incorporate undocumented migrants in the group of asylum seekers (in terms of the same entitlements), however some county councils differentiate between rejected asylum seekers and “other” undocumented migrants (Sigvardsdotter 2009).

Obstacles to Implementation

Obstacles in implementation can be found at regional level and include the provincial policies (Björngren Cuadra and Staaf 2010).

Obligation to Report

There is no obligation on health care staff to report an undocumented migrant to the relevant migration authorities. However, in terms of the LYHS Act, chapter 12, para. 11, staff are obliged, if asked by police or certain other authorities, to provide information (i.e. answer a direct question) as to whether a specific person is in the facility. In all other cases, in terms of The Confidentiality Act, staff are obliged to keep information regarding their patients confidential.

Providers and Actors

Providers of Health Care

Given the limited entitlement to care, providers are thus the general emergency wards as well as those for children and women (maternity care). However, in the regions with a more generous policy, primary care centres, prenatal clinics and other providers are also included. Nevertheless, the non governmental providers and medical clinics run by health professionals outside office hours during their spare time have been found to be the most important providers (Médecins du Monde 2005; PICUM 2007; Médicins du Monde 2009).

The providers in the mainstream system can be found all over the country. The medical clinics run by non governmental organisations are active in the three main cities, but there are also networks situated at other localities. In Stockholm there are two clinics, one run by Médecins du Monde and one by the Red Cross. In Gothenburg, Rosengrenska (which was the first provider, started in 1995) and in Malmö, Delta Stiftelsen are active.

Advocacy Groups and Campaigns on Rights

Since 2005, a network of advocacy groups has developed to champion the right to health care for undocumented migrants. In 2007, a unified statement was formulated by health profession unions and associations and actors in the civil society, such as Amnesty International, Médecins du Monde, Médecins sans Frontiers, Red Cross, Save the Children and Caritas. It was called, “Right to Health Care-Initiative”. Furthermore, in 2009, 17 health profession unions and associations launched the “Right to Health Care-Initiative”, which provides for a common standpoint on asylum seekers and other undocumented persons, the right to the same health care, on the same basis, as for other residents (Sjögren 2010). Since then, more associations have joined (40 in April 2010). In 2007, Paul Hunt, the former

http://www.vardforpapperslosa.se/english.asp (17-02-2010).
UN Special Rapporteur on the Right to Health, formulated a report criticising the Swedish system.24

**Political Agenda**

In the wake of the critical UN report, the political debate has been focused on the access to health care (Kraler and Reichel 2009:138). On 29 January 2010, an inquiry was started in regard to the entitlement to health care for undocumented migrants (rejected asylum seekers and persons without the required permits).25 In terms of its directives, the inquiry will consider and make suggestions on how the providers’ current obligation to give care at a subsidised fee can be increased. The deadline for the inquiry’s findings is May 2011. The debate has also targeted the right to education and the incongruence in relation to the Convention on the Rights of Children.

**International Contacts**

The professional networks and advocacy groups have international contacts and international organisations are active in Sweden.

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