Access to healthcare for people facing multiple health vulnerabilities
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Doroftei, aged 10, has not been vaccinated: “I still cannot go to school”
Saint-Denis - France

18TH MAY 2015
Europe is the cradle of human rights. Indeed, the range of international texts and State commitments that ensure people’s basic and universal rights is impressive. With regard to healthcare, European Union institutions recently reaffirmed their adherence to the values of universality, access to good quality care, equity and solidarity. Yet, this report shows how, in practice, these promises too often remain just words rather than effective progress.

Doctors of the World – Médecins du monde (MdM) teams are distinctive because they work both on international programmes and at home. MdM is active in many of the places in the world from which people try and escape to survive. At home, we provide freely accessible frontline medical and social services to anyone who faces barriers to the mainstream healthcare system. This report is based on data collected in 2014 in face-to-face medical and social consultations with 23,040 people in 25 programmes/cities in Belgium, France, Germany, Greece, the Netherlands, Spain, Sweden, Switzerland, the United Kingdom and Turkey. It paints a bleak picture of the ‘cradle of human rights’.

Increasingly dangerous migration routes due to tightening border controls, sub-standard detention conditions and a life in fear of being expelled await most of the migrants who decide to seek safety and refuge in Europe. They have in common with destitute because they work both on international programmes and at home. MdM is active in many of the places in the world from which people try and escape to survive. At home, we provide freely accessible frontline medical and social services to anyone who faces barriers to the mainstream healthcare system. This report is based on data collected in 2014 in face-to-face medical and social consultations with 23,040 people in 25 programmes/cities in Belgium, France, Germany, Greece, the Netherlands, Spain, Sweden, Switzerland, the United Kingdom and Turkey. It paints a bleak picture of the ‘cradle of human rights’.

The reported barriers to healthcare, as well as the analysis of the legal frameworks in the countries surveyed, confirm that restrictive laws and complex administrative processes to obtain access to care actually contribute to making people sicker. As in previous surveys, the barriers to accessing healthcare most often cited were financial inability to pay, administrative problems, lack of knowledge or understanding of the healthcare system and rights to care, and language barriers. It is thus hardly surprising that one patient in five said s/he had given up trying to access care or treatment in the last 12 months. The data collected clearly deconstruct the myth of migration for health reasons, so often used by governments to restrict access to care. The migrants encountered in 2014 had been living in the ‘host country’ for 6.5 years on average before consulting MdM. Only 3% quoted health as one of the reasons for migration. Among the migrants who suffered from chronic diseases, only 9.5% knew they were ill before arriving in Europe. European and national migration policies focus heavily on migration as a ‘security issue’, thereby forgetting their duty to protect. An overwhelming majority of patients (84.4%) questioned on their experience of violence reported that they had suffered at least one violent experience, whether in their country of origin during the journey or in the host country. They need extra care and safe surroundings to rebuild their lives, instead of too often living in ditches and slums in fear of expulsion.

EU Member States and institutions must offer universal public health systems built on solidarity, equality and equity (and not on profit rationale), open to everyone living in the EU. MdM urges Member States and EU institutions to ensure immediately that all children residing in the EU have full access to national immunisation programmes and to paediatric care. Similarly, all pregnant women must have access to termination of pregnancy, antenatal and postnatal care and safe delivery. In order to respect the ban on the death penalty, seriously ill migrants should never be expelled to a country where effective access to adequate healthcare cannot be guaranteed. They must be protected in Europe and have access to the care they need.

As health professionals, we will continue to give appropriate medical care to all people regardless of their administrative or social status and the existing legal barriers. MdM refuses all restrictive legal measures to alter medical ethics and exerts all health professionals to provide care to all patients.

The 2014 in figures

23,040 patients seen in face-to-face medical and social consultations in 25 cities in Belgium, France, Germany, Greece, the Netherlands, Spain, Sweden, Switzerland, the United Kingdom and Turkey, of whom 22,171 patients were seen in the nine European countries:

- 6,856 were women
- 42,534 social and medical consultations, of which 41,238 in the nine European countries
- 23,240 diagnoses in the nine European countries

Of the 310 pregnant women seen in Europe:

- 54.2% had no access to antenatal care
- 58.2% came to receive care too late – after the 12th week of pregnancy (among those who had not accessed antenatal care prior to consulting MdM)
- 89.2% had no health coverage
- 89.2% lived below the poverty line
- 54.2% did not have the right to reside
- 55.3% were living in temporary accommodation and 8.1% were homeless
- 47.9% reported poor levels of moral support
- 30.3% were living apart from one or more of their minor children
- In Istanbul, 98% of the pregnant women seen had no healthcare coverage

Of the 623 children seen in Europe:

- Only 42.5% had been vaccinated against tetanus (63.7% in Greece)
- Only 34.5% had been vaccinated against mumps, measles and rubella (MMR) (57.6% in Greece)
- 38.8% of patients did not know where to go to get their children vaccinated

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Of all the people seen in the nine European countries:

- 43% were women
- The median age was 35.8
- 93.6% were foreign citizens:
  - 15.6% were migrant EU citizens and 78% citizens of non-EU countries
  - 6.4% of the patients seen were nationals (up to 30.7% in Greece and 16.5% in Germany)
- Foreign citizens had been living in the surveyed country for 6.5 years on average before consulting MdM
- 91.3% were living below the poverty line
- 64.7% of patients were living in unstable or temporary accommodation and 9.7% were homeless
- 29.5% declared their accommodation to be harmful to their health or that of their children
- 18.4% never had someone they could rely on and were thus completely isolated
- 50.2% had migrated for economic reasons, 28.2% for political reasons and 22.4% for family reasons: only 3% had migrated for health reasons
- 34% had the right to reside in Europe
- 63.4% were or had been involved in an asylum application

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48.4% of the patients who were questioned on the issue reported that they had suffered at least one violent experience:

- 52.1% had lived in a country at war
- 39.3% reported violence by the police or armed forces
- 37.6% of women reported sexual assault and 24.1% had been raped
- 10% reported violence in the host country

Health status

- 22.9% of patients perceived their physical health as bad or very bad. When it comes to mental health, this goes up to 27.1%
- 70.2% hadn’t received medical attention before going to MdM among patients who suffered from one or more chronic condition(s)
- Only 9.5% of migrants who suffered from chronic diseases knew about them before coming to Europe
- 57.9% had at least one health problem needing treatment that had never been treated before their consultation at MdM

Barriers to accessing healthcare

- 62.9% of the people seen in Europe had no healthcare coverage
- The most often cited barriers to accessing healthcare were financial problems in paying for care (27.9%), administrative problems (21.9%) and lack of knowledge or understanding of the healthcare system and of their rights (14.1%)
- 54.8% needed an interpreter.
- During the previous 12 months:
  - 20.4% had given up seeking medical care or treatment
  - 15.2% had been denied care on at least one occasion
  - 4.5% had experienced racism in a healthcare setting
- 52% of patients without permission to reside said they restricted their movement or activity for fear of arrest.
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Increasingly dangerous migration routes due to tightening border controls, sub-standard detention conditions and a life in fear of being expelled await most of the migrants who decide to seek safety and refuge in Europe. They have in common with destitute EU citizens the risk of becoming victims of exploitation, but they also face xenophobia. While the economic crisis and austerity measures have resulted in an overall increase in unmet health needs in most countries, the most destitute – including an increasing number of nationals – have been hit the hardest. In total, 6.4% of the patients seen in Europe were nationals (up to 30.7% in Greece and 16.5% in Germany), 15.6% were migrant EU citizens (up to 53.3% in Germany) and 78% of all patients seen were from outside the EU/EU country nationals.

 Altogether, 62.9% of the people seen by MdM in Europe had no healthcare coverage. Children’s right to healthcare is one of the most basic, universal and essential human rights. And yet less than half of the children seen in MdM consultations had access to antenatal care before they came to MdM (54.2%).

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The data collected clearly deconstruct the myth of migration for health reasons, so often used by governments to restrict access to care. The migrants encountered in 2014 had been living in the ‘host country’ for 6.5 years on average before consulting MdM. Only 3% quoted health as one of the reasons for migration. Among the migrants who suffered from chronic diseases, only 9.5% knew they were ill before arriving in Europe.

European and national migration policies focus heavily on migration as a ‘security issue’, thereby forgetting their duty to protect.

An overwhelming majority of patients (84.4%) questioned on their health status went up to 91.3% in Greece) had no health coverage, were living below the poverty line (55.3% in Greece). 89.2% lived below the poverty line. 52.4% did not have the right to reside. 55.3% were living in temporary accommodation and 8.1% were homeless. 30.3% reported poor levels of moral support. 47.5% were living apart from one or more of their minor children.

In Istanbul, 98% of the pregnant women seen had no healthcare coverage.

Of the 623 children seen in Europe:

- 54.2% had no access to antenatal care
- 58.2% came to receive care too late – after the 12th week of pregnancy (among those who had not accessed antenatal care prior to consulting MdM)
- 40.1% had no health coverage
- 89.2% lived below the poverty line
- 52.4% did not have the right to reside
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Of the 623 children seen in Europe:

- Only 42.5% had been vaccinated against tetanus (69.7% in Greece)
- Only 34.5% had been vaccinated against mumps, measles and rubella (MMR) (57.6% in Greece)
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Of all the people seen in the nine European countries:

- 43% were women
- The median age was 35.8
- 93.6% were foreign citizens:
  - 15.6% were migrant EU citizens and 78% citizens of non-EU countries
  - 6.4% of patients seen were nationals (up to 30.7% in Greece and 16.5% in Germany)

Foreign children had been living in the surveyed country for 6.5 years on average before consulting MdM

- 9.1% were living below the poverty line
- 64.7% of patients were living in unstable or temporary accommodation and 9.7% were homeless

23,040 patients seen in face-to-face medical and social consultations in 25 cities in Belgium, France, Germany, Greece, the Netherlands, Spain, Sweden, Switzerland, the United Kingdom and Turkey of whom 22,717 patients were seen in the nine European countries

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OF THE 310 PREGNANT WOMEN SEEN IN EUROPE:

- 54.2% had no access to antenatal care
- 58.2% came to receive care too late – after the 12th week of pregnancy (among those who had not accessed antenatal care prior to consulting MdM)
- 40.1% had no health coverage
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- 55.3% were living in temporary accommodation and 8.1% were homeless
- 30.3% reported poor levels of moral support
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OF THE 623 CHILDREN SEEN IN EUROPE:

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HEALTH STATUS

- 22.9% of patients perceived their physical health as bad or very bad. When it comes to mental health, this goes up to 27.1%
- 70.2% hadn’t received medical attention before going to MdM among patients who suffered from one or more chronic condition(s)
- Only 9.5% of migrants who suffered from chronic diseases knew about them before coming to Europe
- 57.9% had at least one health problem needing treatment that had never been treated before their consultation at MdM

BARRIERS TO ACCESSING HEALTHCARE

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- The most often cited barriers to accessing healthcare were financial problems in paying for care (27.9%), administrative problems (21.9%) and lack of knowledge or understanding of the healthcare system and their rights (14.1%),
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- During the previous 12 months:
  - 20.4% had given up seeking medical care or treatment
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  - 4.5% had experienced racism in a healthcare setting
  - 52% of patients without permission to reside said they restricted their movement or activity for fear of arrest.

2014 IN FIGURES
INTRODUCTION TO THE 2014 SURVEY

THE CONTEXT IN 2014

THE CONTINUING EFFECTS OF THE ECONOMIC CRISIS

Health expenditure fell in half of the European Union countries between 2009 and 2012, and significantly slowed in the rest of Europe. The public share of total spending on health globally declined between 2007 and 2012. At the same time, the overall population’s unmet needs for medical examination are on the rise in most European countries and have nearly doubled since the beginning of the crisis in Greece and Spain.

The crisis has led the World Health Organization (WHO) to (re)confirm that “health systems generally need more, not fewer resources in an economic crisis”. In the same document, WHO notes that measuring the impact that the economic crisis has had on healthcare systems remains difficult, because of time lags in the availability of international data and in the effects of both the crisis and policy responses to counter these negative effects. It also continues to be difficult because the adverse effects on population groups already facing vulnerability factors can remain unseen in public health information systems or surveys.

In recent decades, a number of Member States have introduced or increased out-of-pocket payments for health with the objective of making patients ‘more responsible’ – thereby reducing the demand for healthcare and direct public health costs. Yet, co-payment has been proven to be administratively complex. In addition, it does not automatically decrease the overall utilisation of healthcare services, and does not necessarily incite users to make more rational use of healthcare. Furthermore, it has been shown that destitute people or people with greater health needs (such as the chronically ill) are more affected by co-payment schemes. Consequently, WHO warns that user fees should be used with great caution in view of their detrimental effects on vulnerable populations.

The researchers at the WHO European Observatory on Health Systems and Policies noted that many of the countries at risk of inadequate levels of public funding following the crisis are actually EU countries, further adding that “the important economic and social benefits of public spending on health have not been sufficiently acknowledged in fiscal policy decisions and EU-IMF Economic Adjustment Programmes”. The Organisation for Economic Co-operation and Development (OECD) recently warned that the gap between rich and poor is at its highest level in most OECD countries in 30 years: “Not only cash transfers but also increasing access to public services, such as high-quality education, training and healthcare, constitute long-term social investment to create greater equality of opportunities in the long run”.

GREECE: THE SITUATION REMAINS PARTICULARLY WORRYING

Although the aftermath of the financial and economic crisis that started in 2008 is still being felt across healthcare systems throughout Europe, some countries have been hit more severely than others. In Greece, 2.5 million people live below the poverty line (23.1% of the total population)1. Moreover, 27.3% of the total population live in overcrowded households, 29.4% state that they are unable to keep their home adequately warm, and 579% of the destitute population report that they are being confronted with payment areas for electricity, water, gas, etc. Crisis and austerity policies have left almost a third of the population without healthcare coverage. Unemployment stood at 25.8% in December 20142, unemployment benefits were limited to 12 months, after which there was no minimum income guarantee. The percentage of people reporting unmet medical care needs has increased since the beginning of the crisis, rising from around 5.4% of the population in 2008 to 9% in 20133.

2 Eurostat. Self-reported unmet needs for medical examination, by sex, age and reason. 2015.

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INTRODUCTION TO THE 2014 SURVEY

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The effects of the increase in the number of asylum seekers in Europe were directly observed by MDH teams in Switzerland, where two additional asylum seeker centres were opened in 2014. In Munich the number of asylum seekers has almost doubled compared to 2013, temporarily leading to a situation where asylum seekers had to sleep in tents or outside; before new reception facilities were opened.

Since the start of the Syrian crisis, of the total estimated 11.4 million Syrians who have fled their homes (over half of the total Syrian population) – and the majority of Syrians were internally displaced – Syria was the largest group of refugees, with 28.2% in 2008 and 40% compared to 2013 according to UNHCR. The latest available OECD data indicate a rise in the number of low-birthweight babies by more than 16% between 2008 and 2013, which has long-term implications for child health and development. Obstetricians have reported a 32% rise in stillbirths in Greece between 2008 and 2010, while fewer pregnant women have access to antenatal care.

The effects of the increase in the number of asylum seekers in Europe have been hosting the majority of the millions of displaced persons, there has also been a gradual increase in the number of asylum applications in the 28 Member States of the EU to 626,820 in 2014 – an increase of more than 40% compared to 2013 according to UNHCR. The fact that asylum seekers cannot freely choose where to lodge an asylum application (because the Dublin II regulation requires to request asylum in the EU country where asylum seekers arrived first) has serious consequences for their well-being and mental health. It also shows the clear lack of solidarity between Member States when it comes to migration issues.

Due to controls and walls on land migration routes, many migrants try to reach Europe through the Mediterranean Sea. In December 2014, the UNHCR estimated their total annual number at 200,000 (compared to 65,000 in 2013). Among those seeking a better future in Europe are large numbers of unaccompanied minors. In Italy and Malta alone, over 23,800 children had arrived by sea, including at least 12,000 unaccompanied, during the first nine months of 2014. While 150,000 migrants were rescued under the Mare Nostrum operation, UNHCR estimates that around 3,400 people have died or have gone missing at sea (data as of November 2014).

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Since the start of the Syrian crisis, the total estimated 11.4 million Syrians who have fled their homes (over half of the total Syrian population), 3.8 million took refuge in neighbouring countries and 76 million were internally displaced. 

Syrians were also the largest group of asylum seekers temporarily reaching Europe through the Mediterranean Sea. In December 2014, the UNHCR estimated that around 3,400 people had arrived by sea, including at least 12,000 unaccompanied, during the first nine months of 2014. 

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Migrants in danger at Europe’s borders

In recent years, there has been a significant rise in the number of internal armed conflicts and other forms of violent situations leading to mass displacement within or across borders, e.g. in Afghanistan, the Central African Republic, Eritrea, Iraq, Libya, Pakistan, South Sudan and Syria, to name but a few. Besides the direct impact of violence, many other factors endanger the populations in these countries, such as increasing poverty, food insecurity and hunger, as well as increasing risks of public health problems.

Although countries in North Africa, the Middle East and East Africa have been hosting the majority of the millions of displaced persons, there has also been a gradual increase in the number of asylum applications in the 28 Member States of the EU to 626,820 in 2014 – an increase of more than 40% compared to 2013 according to UNHCR.

The fact that asylum seekers cannot freely choose where to lodge an asylum application (because the Dublin II regulation requires to request asylum in the EU country where asylum seekers arrive first) has serious consequences for their well-being and mental health. It also shows the clear lack of solidarity between Member States when it comes to migration issues.

29  UNHCR. So close, yet so far from safety, The Central Mediterranean Sea Initiative. 2014. 30  The national data collected by UNICEF clearly indicate a rise in the number of low-birth-weight babies by more than 16% between 2008 and 2010, which has long-term implications for child health and development. Obstetricians have reported a 32% rise in stillbirths in Greece between 2008 and 2010, while fewer pregnant women have access to antenatal care services.

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22 OECD data: http://www.unhcr.org/551128679.html


Rising intolerance

Instead of focusing on the needs of vulnerable refugees, the European Council launched a joint police and border guard operation Max Maastricht that took place over two weeks in October 2014. Although this joint operation was focused on apprehending ‘irregular’ migrants and their facilitators, a quarter of the people encountered by the authorities were Syrian asylum seekers.

Although migrants contribute more in taxes and social contributions than they receive in benefits – and clearly make positive fiscal contributions – they are often falsely described as ‘benefit-oriented’. Furthermore, the crisis has first and foremost hit foreign-born workers: despite identical participation rates in labour forces across OECD countries, the average unemployment rate among foreign-born workers (13%) is significantly higher than that of native-born workers (9%).

These differences are most salient in Greece and Spain (respectively 26% and 24%) among native-born compared with 31% and 36% among foreign-born workers).

During last year’s European Parliamentary elections, the European Network Against Racism (ENAR) and the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA Europe) registered 42 hate speech incidents (migrants, LGBTI, Muslims and Roma)- by election candidates, five of whom currently sit in the newly elected Parliament.

In February 2015, Nils Muhttrek, the Council of Europe Commissioner for Human Rights, denounced the fact that ‘despite advances in legislation, implementation and measures to combat intolerance and racism, discrimination and hate speech not only persist in France but are on the rise. [...] In recent years, there has been a huge increase in anti-Semitic, anti-Muslim and homophobic acts. In the first half of 2014 alone, the number of anti-Semitic acts virtually doubled. [...] The rising number of anti-Muslim acts, 40% of which are carried out against women, and homophobic acts, which occur since two every day, is also cause for great concern.’


RECENT LEGAL CHANGES, FOR BETTER OR WORSE

2014 saw a number of positive and negative legislative changes that have influenced access to healthcare as summarised below:

BELGIUM: The Law of 19 January 2012 confirmed the practice of most public trusts that had already given full health coverage. The full extent of this measure is expected by the end of 2015.

GERMANY: In March 2015, the German Federal government modified the law on Asylum seekers: the length of time during which their access to healthcare is restricted to «acute medical issues and serious pain» was reduced from 48 to 15 months.

GREECE: According to the Common Ministerial Decree of 5 June 2014, access to healthcare for individuals without healthcare coverage whose legal residence status is granted under certain conditions. People entitled to free medical care in hospitals include uninsured Greek people; EU citizens or people from outside the EU who live permanently and legally in Greece, have no medical coverage through a public or private insurance scheme and do not fulfil the requirements in order to issue a health booklet; and people who previously had health insurance but lost it due to debts to their insurance funds. A three-member committee in all public hospitals is responsible for reviewing all requests, on a case-by-case basis, and granting access to free medical care. This process obviously results in long waiting times. New reforms are expected in the course of 2015.

THE NETHERLANDS: Since 2012, there has been a drastic increase in the amount a patient has to pay to being reimbursed for healthcare costs – from €220 to at least €375 a year in 2015 (up to €4875 depending on the formula and insurance provider the individual has chosen). This has resulted in the difficulties for an increasing number of patients. However, this payment of a contribution does not apply (nor does it apply to their dental care). GP visits, antenatal care or for integrated care schemes for chronic diseases e.g. diabetes.

SWEDEN: Since July 2013, a law has granted undocumented migrants (so-called) and the specific healthcare coverage for undocumented migrants, State Medical Aid (Aide Médicale de l’Etat – AME), the threshold of which is the same as for the CMUs. This measure should enable more than 750,000 additional patients to obtain medical care. However, «not to be deferred», including medical examination and medicine covered by the Pharmacists’ Mutuals and Secondary National Health Services (SNS) services during their stay as someone category «not to be questioned».

The definition of «ordinary residences» will be changed so that all those who do not have access to free medical care will be subject to the charge. Ordinary residence legalising full access to the NHS was already restricted in 2004 (from anyone living in the UK for over one year to only people with a permit to stay). From 2015 onwards, this new restriction to cover only people with indefinite leave to remain will exclude those who have not been living in the UK for more than five years and have not made a successful application for indefinite leave to remain.

The Department of Health has set out its intention to extend charging to some primary care and accident and emergency services but no decision has been made on if or when this will be implemented. GP consultations should remain free.

AN OVERVIEW OF INTERNATIONAL AND EU BODIES’ COMMITMENT TO HEALTH PROTECTION

There is an impressive range of international texts and commitment that ensure people’s basic and universal right to health. This covers the United Nations (UN) Covenant on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights, the Council of Europe (the European Convention on Human Rights and the European Social Charter) and the European Union (the Treaty on the European Union, the Treaty on the Function of the European Union and the EU Charter on Fundamental Rights), as well as many resolutions, conclusions and opinions published by its institutions and agencies. Below there are the most recent and relevant expressions of commitment to health protection since MIDM’s previous European report in May 2014.

COUNCIL OF EUROPE

In its country conclusions on Spain concerning health, social security and social protection, the European Committee of Social Rights (ECRS) condemns the exclusion of undocumented migrants from healthcare in Spain. In its country conclusions on Greece, the Committee questions whether the right to health care for pregnant women, adolescents and the uninsured is sufficiently guaranteed. Concerning Human Rights, Mrs. Malmqvist, reminded national governments that universal access to healthcare should not be undermined by austerity measures or the economic crisis. Following his visit to France, he denounced the serious and chronic inadequacies in the reception of asylum seekers and unaccompanied minors, as well as the use of bone age tests to determine their care or centre of origin. Concerning Children, the Parliamentary Assembly (PACE) noted that, «there is no legal instrument, or even consensus, with regard to protecting the health of asylum seekers’ or ‘anger’ The Assembly stressed the need to apply the benefit of the doubt, bearing in mind the higher interest of the child.»

EUROPEAN UNION INSTITUTIONS

The European Parliament (EP) acknowledged that, “access to the most basic healthcare services, such as emergency care, is severely limited for almost all migrants in the EU. The EP has also asked the Troika – not to cut in fundamental areas such as healthcare as a condition for financial assistance to euro-area countries - The Commission’s EULink Action Plan on HIV/AIDS for 2014-2016 (March 2014) includes access to prevention, treatment and care for undocumented migrants as an indicator. Following the Granada Declaration by public health researchers and professionals, the Council of the EU acknowledged that, “universal access to healthcare is of paramount importance in addressing health inequalities… and notes with concern that extensive cuts in the supply of healthcare can affect access to care and may have long-term health and economic consequences, particularly for those vulnerable groups.” The Special Rapporteur for Health, Vytenis Andriukaitis, former Minister of Health of Lithuania, is committed to the reduction of health inequalities in Europe as he declared to a newly created Interest Group on Access to Healthcare in the European Parliament. “In many countries, very few have already sent a clear message – they would not put up with policies that not only neglect citizens’ right to access healthcare but even push them below poverty line.” The EU Fundamental Rights Agency (FRA) issued a paper on the criminalisation of migrants in an irregular situation and of persons engaging with them – mentioning the fact that undocumented migrants fear of detection deprives them of healthcare. Finally, the European Foundation for the Improvement of Living and Working Conditions (Eurofound) published an extensive report on Access to healthcare in times of crisis, which included a focus on the situation of specific groups in vulnerable situations, such as Roma, undocumented migrants, older people, people with chronic health conditions or disabilities and people with mental health problems.

41 In February 2015, the Ministry of Health recognized the need to improve the quality and affordability of healthcare, «only in a few cases».
42 Please note that MdM and its partners, especially the Platform for International Cooperation on Undocumented Migrants (PICUM), published in February 2015 a report on the effect of the new «WetG» to designate a person. Only the laws describ- ing the work the person is doing while undocumented is not an other against persons possessing a work permit should be valid in order to take into account. It is made in line with legal advice on the subject.
44 The FRA also published a report on fundamental rights at airports and another one on European minimum requirements for asylum seekers and unaccompanied minors, completing earlier work on migrants’ rights at Europe’s southern border areas.
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BELGIUM: The law of 19 January 201238 on undocumented migrants, State Medical Coverage by the specific healthcare coverage for undocumented migrants from outside the EU was covered thanks to this positive political commitments, from 1 July 2014 (last available data), there has been a drastic increase in the amount of costs reimbursed, from €220 to at least €475 a year in 2015 (up to €875 depending on the formula and insurance provider the individual has chosen). This has resulted in payment to be deferred", without further precision. However, in December 2014, the Socialstyrelsen publicly announced that EU citizens should be considered as undocumented (and have the same access to care as asylum seekers and third-country nationals). In practice, undocumented EU citizens still have to pay full fees for receiving healthcare in most hospitals.

Greece: According to the Minister of Health Mr. Vassilis Kipping full fees for receiving healthcare in most hospitals.

FRANCE: Following the French President’s political commitments, from 1 July 2014 onwards, the thresholds for the complementary Universal Medical Coverage (Couvèrtemedio Universelle complémentaire, or CMU) and the social welfare centres (centres sociaux et cultures, or CSC) confirmed the practice of most public hospitals is responsible for reviewing all requests, on a case-by-case basis, and granting access to free medical care. This process obviously results in long waiting times. New reforms are expected in the course of 2015.

The Netherlands: Since 2012, there has been a drastic increase in the amount a patient has to pay to obtain reimbursement for healthcare costs – from €220 to at least €475 a year in 2015 (up to €875 depending on the formula and insurance provider the individual has chosen). This has resulted in payment to be deferred", without further precision. However, in December 2014, the Socialstyrelsen publicly announced that EU citizens should be considered as undocumented (and have the same access to care as asylum seekers and third-country nationals). In practice, undocumented EU citizens still have to pay full fees for receiving healthcare in most hospitals.

United Kingdom: In May 2014, the government passed the new Immigration Act, setting out its intention to make it “more difficult for illegal” immigrants to live in the UK. According to the government, the Act is intended to: - introduce changes to the removals and appeals system, making it easier and quicker to remove those with no right to be in the UK. - end the “right to family reunion”. Article 8 of the European Convention on Human Rights – the right to respect for family life. - Prevent “illegal” immigrants accessing and abusing public services or the labour market - Prevent “illegal” immigrants accessing and abusing public services or the labour market.

Switzerland: Since July 2013, a law has been granted undocumented migrants (not including people covered by the specific healthcare coverage for undocumented migrants, State Medical Aid (Aide Médicale de l’Etat – AME), the threshold of which is the same as for the CMU). This measure should enable more than 750,000 additional people to have full healthcare coverage. The full intent of this measure is expected by the end of 2015.

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THE INTERNATIONAL NETWORK'S DOMESTIC PROGRAMMES

MdM activities can thus lead to social change: amending laws and supporting the creation of self-support groups as a way of strengthening the healthcare system. MdM programs are aimed at empowering people facing numerous vulnerability factors, and MdM believes that the right to health is a fundamental human right. The work of MdM is based on the premise that health is a human right that should be accessible to all. MdM supports the creation of self-support groups as a way of strengthening the healthcare system. MdM's main mission is to provide access to healthcare through a network of accessible frontline social and medical services for people who face barriers to health care.

MdM programs are in place in 44 countries and include a network of over 1000 medical clinics, health centers, and community centers. MdM programs are run by local volunteers and employees consisting of health professionals – nurses, medical doctors, midwives, dentists, specialists etc. – as well as social workers, support workers, psychologists and administrators etc.

To meet the needs of various populations and adapt to the specific needs of each group, MdM programs vary from country to country. Different packages of services and types of interventions are adapted to the specific needs of each group, and the program is developed in close collaboration with local organizations.

THE OBSERVATORY'S OBJECTIVES AND ACTIVITIES

In spite of the growing awareness and literature on health inequalities, the populations encountered through health programs (especially undocumented migrants) often fall through population-wide official surveys and are not capture in the official health information systems – and thus are often referred to as ‘invisible’.

In the light of this observation, in 2004 MdM International Network initiated the Observatory on access to healthcare, documenting the social determinants of health and patient health status with the following objectives:

- Continuously improve the quality of services provided to MdM patients (through the use of questionnaires to guide the social and medical consultations).
- Establish the evidence base necessary to raise awareness among healthcare providers and authorities on how to effectively integrate people facing vulnerabilities into the mainstream healthcare system.
- Support the field teams in monitoring their programs.

The Observatory has developed a quantitative and qualitative information system that includes systematic patient data collection and annual statistical analyses, narrative patient testimonies, and the objective is to improve the standard of care provided to patients and to enhance the quality of services offered.

The Observatory's objectives

- To best meet the multiple needs of populations encountered, different types of interventions exist across the MdM international network. Depending on the locations and specific characteristics of the national health systems, MdM programs offer primary health care (including sometimes including vaccination, care for mental health issues, chronic conditions and sexual and reproductive health), specialist consultations and referrals to other health care providers (e.g. laboratories, hospital care, obstetric and pediatric care).

Examples of interventions include:

- Social and medical consultation
- HIV/AIDS prevention and care
- Reproductive health care
- Mental health care
- Children's health care
- Emergency care
- Community health care
- Palliative care
- Dental care

OPENING OF MdM LUXEMBOURG AND FIRST INFORMATION ON BARRIERS TO HEALTHCARE

For ten months in 2014, MdM Luxembourg provided medical consultations to destitute, homeless or undocumented people in a day shelter in the city of Luxembourg. The same questionnaires as for the 25 other programs were administered to 59 patients in order to provide a picture of the population encountered. The overall majority of patients were men. The main barriers to healthcare were related to the patients' lack of knowledge and access to healthcare. The majority of patients encountered had no medical coverage and only had access to emergency services. More and more hospitals require a deposit from people who don't present a healthcare coverage. For ten months, the clinic in Luxembourg provided free healthcare to people living in the city.

PrOGRAMMES SURVEYED

These programs consist of fixed clinics that offer freely accessible front-line primary healthcare consultations as well as social support and information about the healthcare system and patient rights with regard to accessing healthcare. Ultimately, these programs aim to help patients reintegrate into the mainstream healthcare system, where it is legally possible. MdM programs are run by volunteers and employees consisting of health professionals – nurses, medical doctors, midwives, dentists, specialists etc. as well as social workers, support workers, psychologists and administrators etc.

To meet the needs of various populations and adapt to the specific needs of each group, MdM programs vary from country to country. Different packages of services and types of interventions have been developed over the years, as summarized below:

PrOGRAMMES INVOLVED IN THE SURVEY AND SPECIFIC CHARACTERISTICS

<table>
<thead>
<tr>
<th>Country</th>
<th>Country</th>
<th>Sites Participating in the Survey</th>
<th>Programmes in 2014 (In addition to freely accessible front-line primary healthcare consultations as well as social support and information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BE Belgium</td>
<td>Antwerp</td>
<td>In addition to social and medical services, provision of psychological support.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>CH Switzerland</td>
<td>La Chaux de Fonds</td>
<td>In addition to social and medical services, provision of paediatric, gynaecological, psychological and psychological consultations.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>DE Germany</td>
<td>Munich</td>
<td>In addition to social and medical services, provision of psychological, gynaecological, psychological and psychological consultations.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>EL Greece</td>
<td>Athens</td>
<td>In addition to social and medical services, provision of psychological and specialist consultations.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>ES Spain</td>
<td>Valencia</td>
<td>In addition to social and medical services, the Spanish programs offer awareness-raising and health promotion campaigns, training, intercultural mediation between professionals and programme users and awareness-raising of professionals working in public facilities.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>FR France</td>
<td>Saint-Denis</td>
<td>Tailored social and medical facilities to respond to the needs of groups who cannot access health care.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>NL Netherlands</td>
<td>Amsterdam</td>
<td>Provision of social advice and support to undocumented migrants from outside the EU for their integration into the regular healthcare system.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>SE Sweden</td>
<td>Stockholm</td>
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<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>TR Turkey</td>
<td>Istanbul</td>
<td>The Turkish-West African association ASME (The Association for Sociality and support for migrants) in partnership with MdM runs a social and medical clinic for asylum seekers, refugees, and undocumented migrants in Istanbul.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
<tr>
<td>UK United Kingdom</td>
<td>London</td>
<td>The clinic in East London offers primary healthcare to excluded groups, especially migrants and sex workers. A large part of the work involves helping patients to register with a general practitioner, the entry point to the healthcare system.</td>
<td>Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information)</td>
</tr>
</tbody>
</table>

DIFFERENT TYPES OF INTERVENTIONS ADAPTED TO SUIT THE POPULATIONS ENCOUNTERED BY MdM

To best meet the needs of populations encountered, different types of interventions exist across the MdM international network. Depending on the locations and specific characteristics of the national health systems, MdM programs offer primary health care (including sometimes including vaccination, care for mental health issues, chronic conditions and sexual and reproductive health), specialist consultations and referrals to other health care providers (e.g. laboratories, hospital care, obstetric and pediatric care).

Examples of interventions:

- Free social and medical consultations
- Harm reduction programs with syringes, condoms and outreach medical consultations in slums, squats, on the streets etc.

18 Prior to the creation of the MdM International Network, Observatory on Access to Healthcare MdM France implemented in 2005 a common class collection tool in order to monitor the main social determinants of health, the barriers to access healthcare and the health status of its service users and public the results. This led to the creation in 2005 of the Observatory of Access to Healthcare in France.

60 Throughout this document, countries are cited in alphabetical order by their official international code, according to European recommendations (Interinstitutional Style Guide, EU, Rev. 14 / 1.3.2012).
THE MDM INTERNATIONAL NETWORK’S DOMESTIC PROGRAMMES

Since 1980, the international aid organisation Doctors of the World – Médecins du monde (MdM) has been working for a world where trau- 
mas to health have been overcome and where the right to health is 
recognised and effective – both at home and abroad. The work of MdM 
mainly relies upon the commitment of volunteers. Working on a daily 
basis with people facing numerous vulnerability factors, MdM believes 
in social justice as a vehicle for equal access to healthcare, respect 
for fundamental rights and collective solidarity.

MdM international network currently comprises 15 autonomous 
organisations in Argentina, Belgium, Canada, France, Germany, Greece, 
Japan, Luxembourg, the Netherlands, Portugal, Spain, Sweden, Swit- 
zerland, the UK and the USA. More than half of the MdM International 
Network’s programmes are domestic, including 150 across the Euro- 
pean continent, 12 in the USA, Canada and Argentina and three in Ja- 
pan. 80% of the domestic programmes are run by mobile, outreach 
teams.

MdM’s main mission is to provide access to healthcare through freely 
available social and medical services for people who face 
barriers to the mainstream healthcare system. At home, MdM works 
mainly with people confronted with multiple vulnerabilities affecting 
their access to healthcare including homeless people, drug users, 
destitute nationals as well as European citizens, sex workers, undocu- 
mented migrants, asylum seekers and Roma communities.

MdM programmes are aimed at empowerment through the active partici- 
pation of user groups, as a way of identifying health-related solutions 
and best practices when it comes to working with people facing multiple 
vulnerability factors.

This way the Observatory develops a sound knowledge of the popu- 
lations encountered in MdM’s programmes that complements popula- 
tion-wide official statistics with concrete experience provided direct- 
ly by people confronted with multiple vulnerability factors and by the 
health professionals working with them.

Rather than talking about vulnerable groups, the International Network 
Observatory proposes to use the concept of vulnerability in health. 
Defining vulnerable groups in a static manner ignores the subjective, 
interpersonal and contextual dimensions of vulnerabilities. For instan- 
tce, some population groups are being made vulnerable due to res- 
trictive laws. Furthermore, everyone is likely to be vulnerable at some 
point in his or her life. Vulnerability factors can be accumulated and 
have combined effects. On the other hand, although health is largely 
shaped by social determinants, many members of vulnerable groups are 
actually quite resilient.

Since 2006, the five reports produced by the Observatory have seen a 
gradual expansion in the geographical coverage of the data collec- 
tion, as well as in the focus – from undocumented migrants to all 
patients who attended MdM health centres throughout the MdM Inter- 
national Network. All the survey reports and public reports aimed at 
health professionals and stakeholders that have been produced by the 
MdM International Network Observatory on Access to Healthcare are 
available at: www.mdmobservable.wordpress.com

THE OBSERVATORY’S OBJECTIVES AND ACTIVITIES

In spite of the growing awareness and literature on health inequalities, 
the populations encountered through health programmes (especially 
undocumented migrants) often fall through population-wide official 
surveys and are currently not captured by the official health informa- 
tion systems – and thus are often referred to as ‘invisible’.

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> Continuously improve the quality of services provided to MdM pa- 

tients (through the use of the questionnaires to guide the social 
and medical consultations).

> Establish the evidence basis necessary to raise awareness among 


healthcare providers and authorities on how to effectively inte-


grate people facing vulnerabilities into the mainstream healthcare 
system.

> Support the field teams in monitoring their programmes.

The Observatory has developed a quantitative and qualitative infor- 
mation system that includes systematic patient data collection and 
annual statistical analyses, narrative patient testimonies, de jure and 
de facto analysis of healthcare systems, as well as identification of best 
practices when it comes to working with people facing multiple 
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red, different types of interventions exist across the MdM in-
ternational network. Depending on the location and specific characteristics 
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Examples of interventions: free social and medical consul-
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in the city of Luxembourg. The same questionnaires as for the 25 other programmes were administered to 59 patients in order to provide 
a picture of the population encountered. The overall majority of the patients were 
undocumented migrants from Turkey and Switzerland. The main conditions of all the patients were chronic diseases: 46% declared hypertension, 
41% diabetes mellitus, 37% asthma and 28% anemia. Other conditions were respiratory infections (15%), acute renal failure (13%), fractures 
and connective tissue diseases (12%), etc. To meet the various needs of patients and fit the characteristics of each 
country’s context, different packages of services and types of inter-
ventions have been developed over the years, as summarised below.

PROGRAMMES SURVEYED

These programmes consist of fixed clinics that offer freely accessible front-
line primary healthcare consultations as well as social support and informa-
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healthcare. Ultimately, these programmes aim to help patients reintegrate 
into the mainstream healthcare system, where it is legally possible. MdM 
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PROGRAMMES INVOLVED IN THE SURVEY AND SPECIFIC CHARACTERISTICS

<table>
<thead>
<tr>
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<th>CODE</th>
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<th>SITES PARTICIPATING IN THE SURVEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>BE</td>
<td>BEL</td>
<td></td>
<td>CH</td>
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<td>NZ</td>
<td>NZ</td>
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<td>DK</td>
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<td>ES</td>
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<td>SE</td>
<td>SWE</td>
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<td>SE</td>
<td>SWE</td>
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<td>TR</td>
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<tr>
<td>UK</td>
<td>GBR</td>
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<td>GB</td>
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</tr>
</tbody>
</table>

In addition to social and medical services, provision of psychological support.

Nurse-led consultations in asylum seeker centres (in the canton of Neuchâtel) and nurse consul-
tation and social advice in the city of La Chaux de Fonds - mainly aimed at migrants.

In addition to social and medical services, provision of paediatric, gynaecological, psychiatric and psychological consultations. For all people without healthcare coverage including undocu-
mented migrants.

In addition to social and medical services, provision of psychological support and specialist consultations in Minsk, consultations are provided in reception centres for migrants who ar-
ried by sea.

Tailored social and medical facilities to respond to the needs of groups who cannot access health-
care. Specialised consultations including psychotherapy, referral to mainstream healthcare system.

Provision of social advice and support to undocumented migrants from outside the EU for their int-
egration into the regular health system. Additionally over-the-counter medication (but no ma-
dical consultation), empowerment of migrant groups and awareness-raising of health professio-

tals in the public sector.

Provision of healthcare and patient referral to the public health system after informing them about 
their rights. EU citizens constitute the main group of patients but migrants from outside the EU are also assisted. Psychosocial support and legal consultations regarding asylum are also provided as well as follow-up of patient referrals.

The Turkish-West African organisation ASME (the Association for solidarity and support for mi-
grants in partnerships with MdM), runs a social and medical clinic for asylum seekers, refugees, and undocumented migrants in Istanbul. Patients are also given information on their rights, al-
though they have very few legal avenues for treatment that is free or at little cost. ASME has 
developed a strong link with West African communities.

The clinic in East London offers primary healthcare to excluded groups, especially migrants and 
sew women. A large part of the work involves helping patients to register with a general practi-
tioner, the entry point to the healthcare system. Additionally, social consultations are provided in 
a migrant centre in central London, and with an organisation supporting sea 

OPENING OF MdM LUXEMBOURG AND FIRST INFORMATION ON BARRIERS TO HEALTHCARE

58 In January 2015, the new organisations joined the MdM International Network to form the Eu-

nrpean continent, 12 in the USA, Canada and Argentina and three in Ja-

apan. 80% of the domestic programmes are run by mobile, outreach 
teams.

60 Throughout this document, countries are cited in capitalised order by their official international code, according to European recommendations (Interntational Sigma Guide, E.U. Rev 1/0.1 12/2012).

MdM’s main mission is to provide access to healthcare through freely 
available social and medical services for people who face 
barriers to the mainstream healthcare system. At home, MdM works 
mainly with people confronted with multiple vulnerabilities affecting 
their access to healthcare including homeless people, drug users, 
destitute nationals as well as European citizens, sex workers, undocu-
mented migrants, asylum seekers and Roma communities.

MdM programmes are aimed at empowerment through the active partici- 
pation of user groups, as a way of identifying health-related solutions 
and best practices when it comes to working with people facing multiple 
vulnerability factors.

This way the Observatory develops a sound knowledge of the popu-
lations encountered in MdM’s programmes that complements popu-
lation-wide official statistics with concrete experience provided direct-
ly by people confronted with multiple vulnerability factors and by the 
health professionals working with them.

Rather than talking about vulnerable groups, the International Network 
Observatory proposes to use the concept of vulnerability in health. 
Defining vulnerable groups in a static manner ignores the subjective, 
interpersonal and contextual dimensions of vulnerabilities. For instan-
tce, some population groups are being made vulnerable due to res-
trictive laws. Furthermore, everyone is likely to be vulnerable at some 
point in his or her life. Vulnerability factors can be accumulated and 
have combined effects. On the other hand, although health is largely 
shaped by social determinants, many members of vulnerable groups are 
actually quite resilient.

Since 2006, the five reports produced by the Observatory have seen a 
gradual expansion in the geographical coverage of the data collect-
ion, as well as in the focus – from undocumented migrants to all 
patients who attended MdM health centres throughout the MdM Inter-
national Network. All the survey reports and public reports aimed at 
health professionals and stakeholders that have been produced by the 
MdM International Network Observatory on Access to Healthcare are 
available at: www.mdmobservable.wordpress.com

15 Prior to the creation of the MdM International Network, observancy on access to 
healthcare MdM France implemented in 1990 a common class collection tool in order to monitor the main social determinants of health, this labourers to access healthcare and the health status of its service users and publicize the results. This led to the creation in 2000 of the Observatory of Access to Healthcare in France.

85 Throughout this document, countries are cited in capitalised order by their official international code, according to European recommendations (Interntational Sigma Guide, E.U. Rev 1/0.1 12/2012).
METHODS

QUESTIONNAIRES AND METHOD OF ADMINISTRATION

The data analysed in this report61 was collected by means of questionnaires administered to patients who visited one of the 25 programmes in the 10 countries associated with the International Network Observatory in 2014. Every patient who attended a consultation with a health professional and support worker was administered at least one of the three standardised, multilingual forms - social questionnaire, medical questionnaire and medical-re-consultation questionnaire(s).

STATISTICS

This report contains data in three different types of proportion: 1) the proportions by country are all crude proportions and include all the survey sites (irrespective of the number of cities or programmes) – 2) the European total proportions were calculated for the nine European countries and are, for most of them and unless otherwise indicated, weighted average proportions (WAP) of all the countries; this allows actual differences between countries to be corrected so they each have the same weight in the overall total; 3) crude average proportions by country are all standard statistical tests were used for some comparisons: mainly the Chi-square test or Fisher’s exact test when the figures were low. It should be noted that a p < 0.05 denotes a statistically significant difference.

NUMBERS SURVEYED

This report is based on the analysis of data from 23,040 individuals (15,648 with details), of whom 8,656 were women. In total 42,534 consultations were analysed (including 29,888 for which the whole questionnaire was administered in the nine European countries and 1,296 in Turkey).

NUMBER OF PATIENTS AND CONSULTATIONS BY COUNTRY

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>NO. OF PATIENTS</th>
<th>%</th>
<th>NO. OF VISITS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>BE</td>
<td>2,365</td>
<td>15</td>
<td>15,648</td>
<td>100</td>
</tr>
<tr>
<td>CH</td>
<td>935</td>
<td>6.8</td>
<td>12,600</td>
<td>30.2</td>
</tr>
<tr>
<td>DE</td>
<td>5,98</td>
<td>3.4</td>
<td>12,929</td>
<td>26.1</td>
</tr>
<tr>
<td>EL</td>
<td>8,834</td>
<td>6.9</td>
<td>12,976 / 1,636</td>
<td>5.2</td>
</tr>
<tr>
<td>ES</td>
<td>263</td>
<td>1.7</td>
<td>255</td>
<td>0.6</td>
</tr>
<tr>
<td>FR</td>
<td>8,839</td>
<td>56.5</td>
<td>17,165</td>
<td>55.0</td>
</tr>
<tr>
<td>NL</td>
<td>123</td>
<td>0.8</td>
<td>123</td>
<td>0.4</td>
</tr>
<tr>
<td>SE</td>
<td>98</td>
<td>0.6</td>
<td>98</td>
<td>0.3</td>
</tr>
<tr>
<td>TR</td>
<td>869</td>
<td>5.6</td>
<td>1,296</td>
<td>4.2</td>
</tr>
<tr>
<td>UN</td>
<td>1,395</td>
<td>8.9</td>
<td>1,454</td>
<td>4.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23,040/15,648</td>
<td>100</td>
<td>42,534/31,194</td>
<td>100</td>
</tr>
</tbody>
</table>

A. Sampling procedures were used in BE, NL and ES to randomly select patients who were administered with the Observatory’s standard questionnaires.

B. In Greece, the data analysed here was collected between 1 June and 31 December. The first figure represents the total of people seen who were asked the six main questions from the social questionnaire, the second figure represents the sample of patients to whom the whole questionnaire was administered (1/10 in Chania, Mytilini, Patras, Perama and Thessaloniki and 1/20 in Athens).

REASONS FOR CONSULTING MDM PROGRAMMES

The vast majority of patients consulted MDM programmes to obtain medical care (91% in Europe and 99.4% in Istanbul). On the other hand, consulting MDM for an administrative, legal or social issue is also common: one third of patients seen in Europe came for one of these reasons (alone, or more often, together with a health problem).

FOCUS ON PREGNANT WOMEN

A total of 371 pregnant women were seen for consultations in 2014 (mainly in Belgium, Germany, France and Turkey) representing 2.4% of patients. The average age of the pregnant women was 27.8 in the European countries (26.1 in Istanbul) and the youngest was 16 years old. Almost all the pregnant women seen (97.0%) were foreign nationals from sub-Saharan Africa (37.1%), the EU (20.2%), Asia (13.9%) and European countries outside the EU (9.9%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

GEOPHYSICAL ORIGIN OF PREGNANT WOMEN IN THE NINE EUROPEAN COUNTRIES AND ISTANBUL (%)

<table>
<thead>
<tr>
<th>GEOGRAPHICAL ORIGIN OF PREGNANT WOMEN</th>
<th>N = 371</th>
<th>N = 371</th>
</tr>
</thead>
<tbody>
<tr>
<td>EUROPEAN UNION</td>
<td>96.7</td>
<td>99.4</td>
</tr>
<tr>
<td>NEAR AND MIDDLE EAST</td>
<td>0.0</td>
<td>0.3</td>
</tr>
<tr>
<td>AMERICAS</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>NATIONALS</td>
<td>7.9</td>
<td>2.4</td>
</tr>
<tr>
<td>MAGhreb</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>EUROPE (NON EU)</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>ASIA</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>SUB-SAHARAN AFRICA</td>
<td>100.0</td>
<td>97.0</td>
</tr>
</tbody>
</table>

Of the pregnant women seen in Europe, 33.3% were in the process of claiming asylum (29.4% in Istanbul). 44.1% were or had at some point been involved in an asylum claim (33.3% in Istanbul) and, of these, 37.5% had been refused asylum. As a result of being undocumented, two thirds of the pregnant women in the nine European countries restricted their movements to varying degrees for fear of arrest. This creates a significant additional obstacle to accessing antenatal care. In Istanbul 79.7% were in this situation.

REASONABLE OF PREGNANT WOMEN IN 2014

In Europe, 52.4% of the pregnant women seen had no right to reside: 2.4% were EU nationals and 50.0% nationals of non-EU countries.

ADMINISTRATIVE STATUS OF THE PREGNANT WOMEN INTERVIEWED

<table>
<thead>
<tr>
<th>ADMINISTRATIVE STATUS</th>
<th>% IN EUROPE (N=371)</th>
<th>% IN ISTANBUL (N=371)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITIZEN OF NON-EU COUNTRY WITHOUT PERMISSION TO RESIDE</td>
<td>50.0</td>
<td>29.4</td>
</tr>
<tr>
<td>EU CITIZEN WITH NO PERMISSION TO RESIDE</td>
<td>2.4</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL WITHOUT PERMISSION TO RESIDE</td>
<td>52.4</td>
<td>29.4</td>
</tr>
<tr>
<td>NO RESIDENCE PERMIT REQUIREMENT (NATIONALS)</td>
<td>4.3</td>
<td>17.6</td>
</tr>
<tr>
<td>ASYLUM SEEKER (APPLICATION OR APPEAL ONGOING)</td>
<td>33.3</td>
<td>23.9</td>
</tr>
<tr>
<td>EU NATIONAL STAYING LESS THAN 3 MONTHS (NO RESIDENCE PERMIT REQUIRED)</td>
<td>27.9</td>
<td>5.9</td>
</tr>
<tr>
<td>VISAS OF ALL TYPES</td>
<td>3.6</td>
<td>11.8</td>
</tr>
<tr>
<td>SPECIFIC SITUATION CONFE apparent RIGHT TO REMAIN</td>
<td>2.4</td>
<td>0.0</td>
</tr>
<tr>
<td>TOTAL WITH PERMISSION TO RESIDE</td>
<td>50.7</td>
<td>71.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>MISSING DATA</td>
<td>1.9%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

A. Without adequate financial resources and/or healthcare coverage
B. Of equivocal situation (recent immigrants <90 days)
C. Teenage minor (aged under 15)
D. Including undocumented/MOHAP protected

The pregnant women surveyed in Europe, 33.3% were in the process of claiming asylum (29.4% in Istanbul). 44.1% were or had at some point been involved in an asylum claim (33.3% in Istanbul) and, of these, 37.5% had been refused asylum. As a result of being undocumented, two thirds of the pregnant women in the nine European countries restricted their movements to varying degrees for fear of arrest. This creates a significant additional obstacle to accessing antenatal care. In Istanbul 79.7% were in this situation.

Of the pregnant women seen in Europe, 55.3% were living in temporary accommodation (24.5% in Istanbul). In total, 62.9% of pregnant women seen in Europe and 55.0% in Istanbul considered their accommodation to be unstable. In Europe 22.9% and in Istanbul 54.2% considered that their housing conditions were harmful to their health or that of their children. The vast majority (99.2%) were living below the poverty line.13

61 The full epidemiological report Access to healthcare for people facing multiple vulnerabilities in the 10 countries associated with the International Network Observatory in 2014. Every patient who attended a consultation with a health professional and support worker was administered at least one of the three standardised, multilingual forms - social questionnaire, medical questionnaire and medical re-consultation questionnaire(s).

62 Within one country, if a programme in one city sees ten times fewer patients than another programme in another city, the former will count for one tenth of the latter.

63 The number of people living or the financial resources of the respondent was not asked if they were included the percentage of people living below the poverty line would be much higher and may actually represent all the patients seen by Mdm.

64 The Fort epidemiological report Access to healthcare for people facing multiple vulnerabilities in health in 20 cities across 9 countries, including data collected in Canada, Mexico and at 25% data cross-analysed, published in May 2015, is available at www.mdmeuroblog.wordpress.com.
METHODS

QUESTIONNAIRES AND METHOD OF ADMINISTRATION

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The data analysed in this report was collected by means of questionnaires and medical re-consultation questionnaires. The second figure represents the sample of patients to whom the whole questionnaire was administered in the nine European countries and 25 cities (2014). This report contains data in three different types of proportion: 1) the proportions by country are all crude proportions and include all the survey sites (irrespective of the number of cities or programmes); 2) the European total proportions were calculated for the nine European countries and are, for most of them and unless otherwise indicated, weighted average proportions (WAP) of all the countries; this allows actual differences between countries to be corrected so they each have the same weight in the overall total; 3) crude average proportions (CAP) - where countries contribute proportionally to their numbers - are also given systematically in the tables and figures. When numbers of respondents were low, or when subgroups of populations were examined, CAP was preferably provided.

Reasons for consulting MDM programmes

The vast majority of patients consulted MDM programmes to obtain medical care (81.1% in Europe and 99.4% in Istanbul). On the other hand, consulting MDM for an administrative, legal or social issue is also common: one third of patients seen in Europe came for one of these reasons (alone, or more often, together with a health problem). A total of 371 pregnant women were seen for consultations in 2014 (mainly in Belgium, Germany, France and Turkey) representing 2.4% of patients. The average age of the pregnant women was 27 in the European countries (29 in Istanbul) and the youngest was 16 years old. Almost all the pregnant women seen (970%) were foreign nationals from sub-Saharan Africa (37%), the EU (20-24%), Asia (13.9%) and European countries outside the EU (9.3%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

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A total of 49.3% of the pregnant women reported having one or more minor children. Nearly half of them (47.5%) were living apart from their children. Women who are separated from their children due to migration report considerable emotional strain, including anxiety, loss, and guilt, and they are at greater risk of depression.

Of those surveyed, 30.3% of pregnant women declared they never or rarely had someone they could rely on in case of need. The figure was even worse in Istanbul where 72.8% pregnant women were in this situation. These figures show how strong the social isolation was for these women, at a time when they were in great need of moral support. It constitutes one more barrier to accessing healthcare.

Regardless of their administrative status, 81.1% of pregnant women seen by MDM in Europe had no healthcare coverage. A total lack of healthcare coverage on the day of their first consultation was specifically recorded for pregnant women in Belgium (95.2%), France (100.0%), London (94.9%) and Istanbul (98.1%). In addition, in Germany 75.3% only had access to emergency care.

Among the pregnant women in the nine European countries, 54.2% had not had access to antenatal care when they came to MDM’s free health centres and, of those, 58.2% received care too late—that is after the 12th week of pregnancy.

**Risks that mothers and children face without access to timely antenatal care**

- Sexually transmitted infections go unnoticed, that can cause abortion, premature ruptures of membranes, pre-term delivery
- No early detection of anemia and diabetes (also leading to increased morbidity and mortality for both mother and child)
- Pre-eclampsia goes unnoticed during the second and third trimester
- No preparation before the delivery leads to increased stress and risks during birth and during first months as well as no future family planning, no explanation about breast feeding, vaccination etc.

Source: WHO Europe/MDM. What is the efficacy/effectiveness of antenatal care and the financial and organizational implications?
A total of 49.3% of the pregnant women reported having one or more minor children. Nearly half of them (45.9%) were living apart from one or more of their minor children. In Istanbul, up to 74% were living without any of their children. Women who are separated from their children due to migration report considerable emotional strain, including anxiety, loss and guilt, and they are at greater risk of depression.

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HEALTH CARE COVERAGE FOR PREGNANT WOMEN

<table>
<thead>
<tr>
<th>% IN EUROPE (N=390)</th>
<th>% IN ISTANBUL (N=61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO COVERAGE / ALL CHARGES MUST BE PAID</td>
<td>58.4</td>
</tr>
<tr>
<td>ACCESS TO EMERGENCY SERVICES ONLY</td>
<td>22.7</td>
</tr>
<tr>
<td>FULL HEALTHCARE COVERAGE</td>
<td>6.3</td>
</tr>
<tr>
<td>OPEN RIGHTS IN ANOTHER EUROPEAN COUNTRY</td>
<td>5.9</td>
</tr>
<tr>
<td>ACCESS TO GP WITH FEES</td>
<td>2.4</td>
</tr>
<tr>
<td>PARTIAL HEALTHCARE COVERAGE</td>
<td>21</td>
</tr>
<tr>
<td>FREE ACCESS TO GENERAL MEDICINE</td>
<td>11</td>
</tr>
<tr>
<td>ACCESS ON A CASE BY CASE BASIS</td>
<td>10</td>
</tr>
</tbody>
</table>

RISKS THAT MOTHERS AND CHILDREN FACE WITHOUT ACCESS TO TIMELY ANTENATAL CARE

- Sexually transmitted infections go unnoticed, that can cause abortion, premature ruptures of membranes, pre-term delivery
- No early detection of anaemia and diabetes (also leading to increased morbidity and mortality for both mother and child)
- Pre-eclampsia goes unnoticed during the second and third trimester
- No preparation before the delivery leads to increased stress and risks during birth and during first months as well as no future family planning, no explanation about breast feeding, vaccination etc.

Source: WHO Europe/MDM. What is the efficacy/effectiveness of antenatal care and the financial and organizational implications?

Jane is from Nigeria and came to the UK four years prior to her pregnancy. She presented to the clinic at 23 weeks gestation. She had become temporarily registered with her GP and was referred to her local hospital for antenatal care but was too scared to go, as she was worried about being found by the UKBA (Home Office).

She was referred to the Accident and Emergency services by the MDM clinician who assessed her, due to concerns about her health. She was admitted to a nearby hospital and then discharged after a few days but sadly went into premature labour and lost her baby girl in the early neonatal period. She received a bill for €3,620.

MDM UK - London - 2014
A LEGAL OVERVIEW OF ACCESS TO CARE FOR PREGNANT WOMEN.

BELGIUM: Undocumented pregnant women have full, free access to antenatal and delivery care if they have obtained the AMU (which can be a long and difficult process and the AMU can also be refused based on very variable and opaque criteria, depending on where the patient lives). However, access to (preventive and psychosocial) antenatal and postnatal care consultations should be free of charge for everyone. Termination of pregnancy can be approved by the AMU, but the procedure is too long to fall within the 12-week limit, in which case women must pay out-of-pocket (at least €250).

FRANCE: Undocumented pregnant women can gain access to AIE but there are many barriers to obtaining it, thus it can be difficult to gain access to antenatal and postnatal care. Nevertheless, a specific provision states that all care for pregnant women must be considered as urgent (antenatal care, delivery and postnatal care), as well as termination of pregnancy. This applies only in hospitals and is free of charge.

GERMANY: Only undocumented pregnant women with a temporary tolerance to residence (duldung) can access antenatal and postnatal care. This status is granted only for a limited time period when women are considered ‘unfit for travel’ – generally three months before and three months after delivery. Women are not covered for the first six months of the pregnancy. With regard to migrant EU citizens, an increasing number of pregnant women do not have any access to antenatal and postnatal care.

Women whose income is below €1,033 per month can have their termination of pregnancy reimbursed by their health insurance. Theoretically, asylum seekers and undocumented women are also entitled to reimbursement. However, access remains very difficult for undocumented women, due to the need for a health insurance voucher from the social welfare office and because of the risk of being reported when requesting it. Civil servants, such as health personnel (with the exception of medical emergency wards) have a duty to report undocumented migrants.

GREECE: The new Migration Code implemented by law in 2014 continues to prohibit Greek public services (article 28), local authorities, and organizations of social security to offer services to foreigners who are “unable to prove that they have entered and are residing in the country legally”. So undocumented pregnant women have no health coverage. However, undocumented pregnant women have now access to free delivery but not to antenatal and postnatal care. New changes might occur in 2015. With regard to termination of pregnancy, they have to pay approximately €340 in public hospitals. Article 79(1) of the same law establishes that undocumented pregnant women may not be expelled from the country during their pregnancy or for six months after giving birth. Undocumented migrants who cannot be expelled for medical reasons may benefit from a temporary residence permit.

NETHERLANDS: Pregnant women who are seeking asylum have access to healthcare free at the point of delivery under a specific scheme for asylum seekers (including antenatal care, delivery and postnatal care). Undocumented migrants cannot get healthcare coverage.

Undocumented pregnant women have access to antenatal, delivery and postnatal care but they are expected to pay themselves, unless it is proven that they cannot pay in the case of pregnancy and childbirth, the authorities reimburse contracted hospitals and pharmacies 100% of the unpaid bills. However, in practice, undocumented women are often urged to pay straight away in cash or it is suggested that they sign to pay by instalments, or receive a bill and reminders at home, and are pursued by debt collectors contracted by healthcare providers. In contrast to maternity care, contraception and termination of pregnancy, no out-of-pocket payment is required.

SWITZERLAND: Undocumented pregnant women who can afford the cheapest health insurance (around €300 per month) are fully covered for termination of pregnancy, antenatal care, delivery and postnatal care. No franchise and no out-of-pocket payment are required. Pregnant women without healthcare coverage have to pay themselves. In case of emergency, practitioners must provide healthcare without asking if patients have healthcare coverage, but patients have to pay the bill or have to leave without giving any contact address.

TURKEY: Undocumented pregnant women have to pay their health expenses for antenatal care, delivery and postnatal care. They are often reported to the police by healthcare staff, either because they are undocumented or because they cannot pay the doctor’s fees.

UK: Maternity care for pregnant undocumented women – including antenatal care, delivery and postnatal care – is not free at the point of use, but considered as secondary care. Thus, women are usually billed for the full course of care through pregnancy, delivery and postnatal care around £2000 without complications.

Regarding termination of pregnancy, while it is considered as primary care by law and thus should be free of charge, it is in practice regarded as secondary care in some parts of the country and undocumented pregnant women have to pay for this service.

MOBILISATION FOR WOMEN’S RIGHT TO DECIDE FOR THEMSELVES IF AND WHEN THEY HAVE A CHILD

At the end of 2013 the Spanish government proposed to repeal the 2000 law on sexual and reproductive health and voluntary interruption of pregnancy, thereby robbing the right of girls and women to decide themselves if and when they want a child. The draft law would only allow termination of pregnancy in the case of rape or if the pregnancy posed a serious physical or mental health risk to women (to be attested by two different doctors not working at abortion facilities).

The proposal required girls and women pregnant as a result of rape to report the crime to the police before they could access a legal abortion. This would have introduced serious barriers for all women who are victims of rape, but especially for undocumented women (fear of and actual risk of being expelled if they contact the authorities).

In reaction to the draft law, women (and men) from a wide range of political parties and social backgrounds, and from all over Europe, took to the streets in great numbers in order to demonstrate against the proposal and to show international solidarity with women in Spain.

At the same time, the MdM International Network ran a campaign for the right of women to decide if and when they want to have children, for access to contraception and for access to safe and legal abortion. The campaign was called Names not Numbers in reference to the 50,000 women who die every year as a result of unsafe abortion, i.e. without medical supervision.

Under this pressure, the Spanish draft law was eventually withdrawn.

At the UN Special Conference on Sexual and Reproductive Health in September 2014, UN General Secretary Ban Ki-moon emphasised in his opening speech the risks associated with illegal abortion: “We must confront the fact that some 800 women still die each day from causes related to pregnancy or childbirth. An estimated 8.7 million young women in developing countries resort to unsafe abortions every year. They urgently need our protection.”

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68 www.youtube.com/watch?v=KTr9RiJ7VlI
69 www.mdmeuroblog.wordpress.com
BELGIUM: Undocumented pregnant women have full, free access to antenatal and postnatal care if they have obtained the AMU (which can be a long and difficult process and the AMU can also be refused based on very variable and opaque criteria, depending on where the patient lives). However, access to (preventive and psychosocial) antenatal and postnatal care consultations should be free of charge for everyone. Termination of pregnancy must be paid for by the AMU, but the procedure is too long to fall within the 12-week limit, in which case women must pay out-of-pocket (at least €250).

FRANCE: Undocumented pregnant women can gain access to AME but there are many barriers to obtaining it, thus it can be difficult to gain access to antenatal and postnatal care. Nevertheless, a specific provision states that all care for pregnant women must be considered as urgent (antenatal care, delivery and postnatal care consultations (preventive and psychosocial) antenatal care, pregnancy and childbirth), the authorities will pay for this service.

GERMANY: Only undocumented pregnant women (and minors) who can get a temporary tolerance to (duldung) can access antenatal and postnatal care. This status is granted only for a limited time period when women are considered “unfit for travel” – generally three months before and three months after delivery. Women are not covered for the first six months of the pregnancy. With regard to migrant EU citizens, an increasing number of pregnant women do not have any access to antenatal and postnatal care.

Women whose income is below €1,033 per month can have their termination of pregnancy reimbursed by their health insurance. Theoretically, asylum seekers and undocumented women are also entitled to reimbursement. However, access remains very difficult for undocumented women, due to the need for a health insurance voucher from the social welfare office and because of the risk of being reported when requesting it. Civil servants, such as health personnel (with the exception of medical emergency wards) have a duty to report undocumented migrants.

GREECE: The new Migration Code implemented by law in 2014 continues to prohibit Greek public services (article 26), local authorities, and organizations of social security to offer services to foreigners who are “unable to prove that they have entered and are residing in the country legally”. So undocumented pregnant women have no health coverage. However, undocumented pregnant women have now access to free delivery but not to ante- and postnatal care. New changes might occur in 2015.

NETHERLANDS: Pregnant women who are seeking asylum have access to healthcare free at the point of delivery. Undocumented asylum seekers can get healthcare coverage. Undocumented migrants cannot get healthcare coverage.

SWEDEN: Adult asylum seekers and undocumented migrants from outside the EU have access to healthcare and dental care that “cannot be deferred”. They have access to the maternity care and termination of pregnancy. They have to pay a fee of around €45 for every visit to a doctor. The situation is unclear for pregnant EU nationals who have lost the right to reside in Sweden.

SWITZERLAND: Undocumented pregnant women who can afford the cheapest health insurance (around €300 per month) are fully covered for termination of pregnancy, antenatal care, delivery and postnatal care: no franchise and no out-of-pocket payment are required. Pregnant women without healthcare coverage have to pay themselves. In case of emergency, practitioners must provide healthcare without asking if patients have healthcare coverage, but patients will get the bill or have to leave without giving any contact address.

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UK: Maternity care for undocumented pregnant women as well as antenatal care, delivery and postnatal care is free at the point of service but is not paid for by the doctor’s fees. Women are usually billed for the full course of care throughout pregnancy – around €700 without complications.

Regarding termination of pregnancy, while it is considered as primary care by law and thus should be free of charge, it is in practice regarded as secondary care in some parts of the country and undocumented pregnant women have to pay for this service.
FOCUS ON CHILDREN VACCINATION

The vaccine(s) that protect against tetanus, MMR (measles, mumps and rubella), diphtheria and whooping cough are considered essential throughout the world, and most WHO Europe countries have included the vaccine against Hepatitis B in their national immunisation schedules.

Many vaccines not only protect the individual but also the community, through the mechanism of ‘herd immunity’: vaccinating an individual will also help keep others around them safer in order for this mechanism to work, and to achieve the eradication of these preventable diseases, a sufficiently large part of the population needs to be protected by means of vaccination. Coverage rates need to be above 95% to eradicate measles, above 85% for diphtheria and between 92% and 94% for whooping cough.

Vaccination for groups facing multiple vulnerabilities is even more important than for the general population, as they have fewer opportunities to be vaccinated because of multiple barriers to healthcare (mainly legal and financial). Furthermore, social determinants (e.g. lack of access to adequate food, housing, water and sanitation) have an impact on their likelihood of becoming ill and the risks of developing more serious diseases. Vaccination may help to reduce these risks, since it often lessens the severity or complications of a disease even in the few cases where vaccination does not succeed in preventing it.

A total of 645 minor patients were seen by MdM programmes in 2014. They represent 4.1% of the total population. No minors were seen in Sweden.

In Europe, only 42.5% of minors who responded had been vaccinated against tetanus. In France, only 29.3% of minors had definitely been vaccinated. In Istanbul, this applied to 52.4%.

The rates of vaccination against hepatitis B (HBV) were even lower: the average proportion of vaccinated minors in Europe was 38.7%. The HBV vaccination rate was very low in France (22.1%). In the European countries, following the WHO recommendation to incorporate hepatitis B vaccine as an integral part of national infant immunisation programmes, the immunisation coverage in the general population is averaging 93%.

The rates for mumps, measles and rubella (MMR) and pertussis/whooping cough vaccinations were 34.5% and 39.8% respectively. Yet, in the majority of countries participating in the survey, vaccination coverage for pertussis and measles at the age of two years has reached (and often exceeded) 90% in the general population.

These figures highlight the shocking gap between the general population and the children seen in MdM clinics in terms of access to vaccination. In fact, over half of the children (57.5%) seen by MdM teams had not been vaccinated against tetanus and about 60% to 65% were not protected from whooping cough or MMR.

In total, 38.6% of the people asked about vaccination did not know where to go to have their children vaccinated in the five European countries where the question was asked. In Istanbul, almost nobody knew where to go to have their child vaccinated.

2. Herd immunity applies to measles, rubella, varicella (chickenpox), polio and whooping cough. For infections for which humans do not form a reservoir (e.g. tetanus, rabies), vaccines only offer individual protection.
4. VACCINATION COVERAGE AMONG MINORS (%)
5. KNOWLEDGE OF WHERE TO GO FOR VACCINATIONS FOR MINORS, %
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As vaccination and health cards are requested for registration at state schools, not accessing healthcare can result in being excluded from school as well. Mariela, from Paraguay, has a permit to reside as well as a work permit in Spain, where she lives with her two children, aged 11 and 15. ‘I cannot send one of my children to school because I have to show his health card. In the public health centre, they told me: “I cannot send one of my children to school because I have to show his health card.”’

Indeed, the municipality has recently introduced new legislation limiting undocumented migrant registration. Although her first child was registered and Mariela had a permit to reside, the new local regulation has made the registration with the Municipality of her second child more difficult. This, in turn, impedes obtaining a health card from the health centre.

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A LEGAL OVERVIEW OF ACCESS TO HEALTHCARE FOR CHILDREN

In Belgium, France, Greece, Spain, Sweden and UK, Children of asylum seekers and refugees have the same rights to healthcare as nationals.

BELGIUM: The children of undocumented migrants have free access to vaccinations and preventative care through the Birth and Childhood Office or Child and Family service until the age of six. For all curative care and over the age of six, they need to obtain the AMU like adults.

Unaccompanied minors, if they go to school, have the same access to care as nationals and authorised residents.

FRANCE: Children in France are not considered as undocumented, they do not need a permit to reside. Children of undocumented migrants are entitled to the AME scheme upon arrival in France (without the three-month residence condition), even if their parents are not eligible. The AME is granted for one year.

In France, children can get vaccination for all principal diseases free of charge. Unaccompanied minors are supposed to have the same access to healthcare through the health system as the children of nationals or authorised residents.

GERMANY: Children of asylum seekers and refugees are subject to the same system as adults (48 months of residence in Germany before being integrated into the mainstream system). However, children can receive other care to meet their specific needs (no precision in law). They are entitled to the recommended vaccinations. Children of undocumented migrants also have the same rights as adults, i.e. they need to request a health insurance voucher, which puts them at risk of being reported to the authorities. Therefore, there is no direct access to vaccination and the only way for children of undocumented migrants to be vaccinated is by paying the costs of the medical consultation (around €45) and the costs of the vaccines (around €70 per vaccine). Unaccompanied minors under the protection of the Youth Office have access to healthcare.

Greece: In theory, children of undocumented migrants should have access to healthcare, as they are explicitly not included in the law prohibiting access to care for undocumented adults beyond emergency care.

In practice, they often only have access to emergency care. However, they have free access to vaccination at Mother and Child Protection Centres (those that haven’t closed down due to the crisis). However, they often have to pay for vaccines and medical consultations, just like all other children without healthcare coverage.

Unaccompanied minors, regardless their status, should have access to the same healthcare as children of undocumented migrants or children of asylum seekers and refugees. However, in Greece, until recent political changes, unaccompanied minors could spend months in detention centres – often in the same cell as adults.

NETHERLANDS: All children can access free vaccination in preventative frontline infant consultations (0-4 years). Children of asylum seekers come under the same specific scheme for asylum seekers as their parents. For curative care, the children of undocumented migrants face the same barriers to care as their parents. There are no specific legal provisions for children of destitute EU citizens who have lost their right to reside and have no health insurance. Unaccompanied minors do not have any specific protection, their access to healthcare depends on their residence status.

Spain: Article 3° of Law 16/2003 (added by Article 1° of Royal Decree-Law 16/2022) provides that ‘In any case, foreigners who are less than 18 years old receive healthcare under the same conditions as Spanish citizens’. This provision states clearly that all minors in Spain, regardless of their administrative status, will be granted access to healthcare services, including vaccinations, under the same conditions as Spanish minors (i.e. free of charge). Nonetheless, the acquisition of an individual health card for the children of undocumented migrants is not so easy. Therefore, they are sometimes denied care and/or vaccination. It is clearly a problem of the implementation of the law; public health centres do not know how to deal with these minors and may refuse to take care of them until they have a health card.

Sweden: The July 2013 law grants full access to healthcare to children of undocumented migrants below the age of 18. Consequently, all children of authorised residents, asylum seekers and undocumented third-country nationals now have access to free vaccination. In accordance with the national vaccination programme. The vaccination of young children is performed by the health centre, while children at primary school are vaccinated by the school health system. There is a lack of legal clarity on whether children of undocumented EU citizens can access vaccination – in practice, they have to pay the full fees for vaccination.

Switzerland: Children of asylum seekers and refugees have health insurance (if their parents do) which includes vaccination. Children of undocumented migrants have the same access as their parents. Either their parents can afford private health insurance for them (around €80 per month), so children have access to vaccinations; or they cannot pay the contributions and they have to pay all doctor’s fees. Children’s health insurance is compulsory for school attendance.

Turkey: Asylum seekers must submit a claim to the Social Aid and Solidarity Foundation to obtain access to subsidised healthcare for their children. To this end, they must prove their lack of financial resources and obtain a residence permit giving them a ‘citizen number’. The children of undocumented migrants have no access to prevention or care. Those born in Turkey may have access to free vaccination at a family health centre but they need to be registered in the civil registry. Otherwise, each vaccine costs around €18, added to the €33 medical consultation costs. Unaccompanied minors waiting for a decision on international protection can access healthcare, those who are rejected cannot.

United Kingdom: The children of undocumented migrants have the same entitlement to care as adults. They can register with a GP and receive free vaccinations but they will be charged for secondary healthcare. In practice, children are only accepted in GP practices if at least one of their parents is already registered. Unaccompanied minors seeking asylum or with refugee status enter local authority care, meaning that, like asylum seekers, they are exempt from all charges.
As vaccination and health cards are requested for registration at state schools, not accessing healthcare can result in being excluded from school as well. Maria has a permit to reside and work in Spain, where she lives with her two children, aged 11 and 15. ‘I cannot send one of my children to school because I have to look after her: Mariela, from Paraguay, has a permit to reside as well as a work permit in Spain and the result is being excluded from school as well: Mariela, from Paraguay, has a permit to reside as well as a work permit in Spain. She has a claim to the Social Aid and Solidarity Foundation to obtain access to subsidised healthcare for her children. To do this, they must prove their lack of financial resources and obtain a residence permit giving them a ‘citizen number’. The children of undocumented migrants have no access to prevention or care. Those born in Turkey may have access to free vaccination at a family health centre but they need to be registered in the civil registry. Otherwise, they cannot pay the contributions and they have to pay all the doctor’s fees. Children’s health insurance is compulsory for school attendance.

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**Belgium:** The children of undocumented migrants have free access to vaccinations and preventative care through the Bith and Child Health Office or Child and Family service until the age of six. For all curative care and over the age of six, they need to obtain an AMU like adults. Unaccompanied minors, if they go to school, have the same access to care as nationals and authorised residents.

**France:** Children in France are not considered as undocumented, they do not need a permit to reside. Children of undocumented migrants are entitled to the AMU scheme upon arrival in France (without the three-month residence condition), even if their parents are not eligible. The AMU is granted for one year.

In France, children can get vaccination for all principal diseases free of charge. Unaccompanied minors are supposed to have the same access to healthcare through the health system as the children of nationals or authorised residents.

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**Greece:** In theory, children of undocumented migrants should have access to healthcare, as they are explicitly not included in the law prohibiting access to care for undocumented adults beyond emergency care. In practice, they often only have access to emergency care. However, they have free access to vaccination at Mother and Child Protection Centres (those that haven’t closed down due to the crisis). However, they often have to pay for vaccines and medical consultations, just like all other children without health coverage.

Unaccompanied minors, regardless their status, should have access to the same healthcare as children of undocumented migrants or children of asylum seekers and refugees. However, in Greece, until recent political changes, unaccompanied minors could spend months in detention centres – often in the same cell as adults.

**Netherlands:** All children can access free vaccination in preventative frontline infant consultations (0-4 years). Children of asylum seekers come under the same specific scheme for asylum seekers as their parents. For curative care, the children of undocumented migrants face the same barriers to care as their parents. There are no specific legal provisions for children of destitute EU citizens who have lost their right to reside and have no health insurance. Unaccompanied minors do not have any specific protection, their access to healthcare depends on their residence status.

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Mr. and Mrs. D. are Syrian Christians. They were living in Aleppo with their children, aged two and eight, when they had to escape from war and persecution. They arrived in Paris (France) in September 2014. With the current housing shortage, they were advised to leave the region and decided to try their luck in Nice, where they requested asylum. However, the French Immigration and Integration Office (OFII) failed. Due to a lack of funds, the Departmental social cohesion directorate (DDCS) refused to allocate them housing. The family is homeless, sleeping in the Armenian Church every now and then.

When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM came from an individual who proposed to host the family. More than a month after their arrival, the D. family obtained a place in a Centre for Asylum Seekers in another Department.
Mr and Mrs D. are Syrian Christians. They were living in Aleppo with their children, aged two and eight, when they had to escape from war and persecution. They arrived in Paris (France) in September 2014. With the current housing shortage, they were advised to leave the region and decided to try their luck in Nice, where they requested asylum at the French Immigration and Integration Office (OFII). Their request to be taken into the Centre for Asylum Seekers (CADA) failed. Due to a lack of funds, the Departmental social cohesion directorate (DDCS) refused to allocate them housing. The family is homeless, sleeping in the Armenian Church every now and then.

When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM alerted the DDCS again and received the same answer that there was no budget. MdM then made the exceptional decision to pay for a few nights in a hotel for the family. After alerting its network, the only individual who proposed to host the family. More than a month after their arrival, the D family obtained a place in a Centre for Asylum Seekers in another Department.

Centre for Asylum Seekers in another Department.

While many politicians denounce the humanitarain catastrophe taking place in Syria and talk about hosting Syrian refugees in France, the D. family would have spent a month living on the streets if an individual had not offered to take them in.

MdM France – Nice – October 2014
In the nine European countries, patients mostly originated from sub-Saharan Africa (29.0%), followed by the European Union (15.6%), Asia (11.6%), Maghreb (11.4%), Near East (9.3%) and the Americas (essentially Latin America: 8.9%).

Nationalities represent 6.4% and the total of nationals and foreign EU citizens amounts to 22%.

Among the migrant EU citizens encountered at MdM, 62.3% were from Romania, which corresponds to the significant numbers of Roma people from Romania reached by MdM’s mobile units in the Paris suburb of Saint-Denis, and referred to the clinic (n=1,035 people). People from Bulgaria form the second most significant EU nationality (14.8%), followed by EU migrants from Poland, Portugal, Spain and Italy.

The nationalities most frequently encountered varied from one location to another: (including the Maghreb) remains the top continent of origin for patients seen in Belgium and France, while this is Asia for patients seen in London. In Greece, Greek citizens came first, followed by people from the Near and Middle East. In Germany, EU migrants came first, followed by German citizens.

**Length of Stay in the Country by Foreign Nationals**

On average, in CH, DE, ES, NL and UK, foreign citizens had been living in the country for 6.5 years; half of them had been there for between three and eight years. This illustrates once again that migration for the purposes of seeking healthcare is a myth, as the patients had already been living in Europe for long periods at their first visit to MdM clinics.

In 2013, in the European countries, the reasons most often cited for migration were, overwhelmingly, economic- (50.2%), political (19.3%) in total, including 8.9% to escape from war and family related (whether to join or follow someone: 14.6%), or to escape from family conflict: 7.8%.

As every year, health reasons were extremely rare (3.0% in Europe, which is a similar rate to that reported in 2008, 2012 and 2013: 0.9% in Turkey). There is no correlation between the number of people who migrate for health reasons, among others, and the level of legal restrictions and barriers to accessing healthcare in the host country. This is yet more proof to deconstruct the myth of migration for health.

**Reasons for Migration**

**Reasons for Migration by Country (%)**

**Economic Reasons, Unable to Earning a Living in Home Country**

<table>
<thead>
<tr>
<th>Country</th>
<th>CH</th>
<th>DE</th>
<th>EL</th>
<th>ES</th>
<th>NL</th>
<th>SE</th>
<th>UK</th>
<th>WAP</th>
<th>CAP</th>
<th>TR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>19.7</td>
<td>6.7</td>
<td>7.2</td>
<td>70.5</td>
<td>36.8</td>
<td>52.6</td>
<td>19.6</td>
<td>51.6</td>
<td>50.2</td>
<td>6.0</td>
</tr>
<tr>
<td>DE</td>
<td>50.2</td>
<td>7.6</td>
<td>10.2</td>
<td>36.6</td>
<td>52.6</td>
<td>19.6</td>
<td>51.6</td>
<td>50.2</td>
<td>6.0</td>
<td></td>
</tr>
<tr>
<td>EL</td>
<td>14.6</td>
<td>26.9</td>
<td>5.7</td>
<td>13.2</td>
<td>14.9</td>
<td>5.3</td>
<td>12.8</td>
<td>13.3</td>
<td>14.6</td>
<td>3.3</td>
</tr>
<tr>
<td>FR</td>
<td>5.1</td>
<td>3.5</td>
<td>2.7</td>
<td>6.6</td>
<td>12.3</td>
<td>5.3</td>
<td>10.8</td>
<td>6.6</td>
<td>7.8</td>
<td>2.2</td>
</tr>
<tr>
<td>NL</td>
<td>0.6</td>
<td>6.4</td>
<td>4.2</td>
<td>6.3</td>
<td>0.9</td>
<td>7.0</td>
<td>0.0</td>
<td>2.6</td>
<td>3.1</td>
<td>0.0</td>
</tr>
<tr>
<td>SE</td>
<td>0.6</td>
<td>3.5</td>
<td>1.9</td>
<td>5.8</td>
<td>7.0</td>
<td>0.0</td>
<td>2.6</td>
<td>3.1</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>NO</td>
<td>0.0</td>
<td>3.1</td>
<td>0.4</td>
<td>1.9</td>
<td>0.9</td>
<td>3.5</td>
<td>6.1</td>
<td>2.3</td>
<td>3.8</td>
<td>2.0</td>
</tr>
<tr>
<td>UK (1)</td>
<td>4.5</td>
<td>11.1</td>
<td>9.8</td>
<td>6.7</td>
<td>6.1</td>
<td>10.5</td>
<td>17.9</td>
<td>9.2</td>
<td>12.9</td>
<td>2.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>14.0</td>
<td>12.7</td>
<td>12.1</td>
<td>11.6</td>
<td>10.8</td>
<td>7.5</td>
<td>12.1</td>
<td>12.6</td>
<td>12.6</td>
<td>12.0</td>
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</table>

**Missing Data (%)**

<table>
<thead>
<tr>
<th>Country</th>
<th>CH</th>
<th>DE</th>
<th>EL</th>
<th>ES</th>
<th>NL</th>
<th>SE</th>
<th>UK</th>
<th>WAP</th>
<th>CAP</th>
<th>TR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>60.3</td>
<td>19.6</td>
<td>60.0</td>
<td>1.5</td>
<td>7.3</td>
<td>41.0</td>
<td>14.7</td>
<td>29.6</td>
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<td>7.0</td>
</tr>
<tr>
<td>DE</td>
<td>0.0</td>
<td>3.1</td>
<td>0.4</td>
<td>1.9</td>
<td>0.9</td>
<td>3.5</td>
<td>6.1</td>
<td>2.3</td>
<td>3.8</td>
<td>2.0</td>
</tr>
</tbody>
</table>

A: Multiple responses were possible in France the question was not asked and in Belgium the response rate was too low.

83: In this report, the Middle East comprises Afghanistan, Egypt, Iraq, Israel, Kazakhstan, Kurdistan, Kuwait, Lebanon, Pakistan, Palestine, Syria, the United Arab Emirates and Yemen.
In the nine European countries, patients mostly originated from sub-Saharan Africa (29.0%), followed by the European Union (15.6%), Asia (11.6%), Maghreb (11.4%), Near and Middle East (9.3%) and the Americas (essentially Latin America: 8.9%).

Nationalities represent 6.4% and the total of nationals and foreign EU citizens amounts to 22%.

Among the migrant EU citizens encountered at MdM, 62.3% were from Romania, which corresponds to the significant numbers of Roma people from Romania reached by MdM’s mobile units in the Paris suburb of Saint-Denis, and referred to the clinic (n=0.35 people). People from Bulgaria form the second most significant EU nationality (14.8%), followed by EU migrants from Poland, Portugal, Spain and Italy.

The nationalities most frequently encountered varied from one location to another: (including the Maghreb) remains the top continent of origin for patients seen in Belgium and France, while this is Asia for patients seen in London. In Greece, Greek citizens came first, followed by people from the Near and Middle East. In Germany, EU migrants came first, followed by German citizens.

### TOP TEN MOST FREQUENTLY RECORDED NATIONALITIES, BY COUNTRY

<table>
<thead>
<tr>
<th>Country</th>
<th>DE</th>
<th>NO</th>
<th>CH</th>
<th>NL</th>
<th>SE</th>
<th>UK</th>
<th>FR</th>
<th>TR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morocco</td>
<td>673</td>
<td>49</td>
<td>193</td>
<td>217</td>
<td>116</td>
<td>61</td>
<td>29</td>
<td>3</td>
</tr>
<tr>
<td>DR Congo</td>
<td>189</td>
<td>26</td>
<td>36</td>
<td>90</td>
<td>49</td>
<td>24</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Gambia</td>
<td>152</td>
<td>53</td>
<td>22</td>
<td>9</td>
<td>17</td>
<td>11</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Cameroon</td>
<td>136</td>
<td>21</td>
<td>15</td>
<td>12</td>
<td>12</td>
<td>9</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Romania</td>
<td>94</td>
<td>17</td>
<td>9</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Algeria</td>
<td>85</td>
<td>17</td>
<td>16</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Nigeria</td>
<td>64</td>
<td>9</td>
<td>16</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Senegal</td>
<td>51</td>
<td>14</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>45</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>43</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

### LENGTH OF STAY IN THE COUNTRY BY FOREIGN NATIONALS

On average, in CH, DE, ES, NL and UK, foreign citizens had been living in the country for 6.5 years; half of them had been there for between three and eight years. This illustrates once again that migration for the purposes of seeking healthcare is a myth, as the patients had already been living in Europe for long periods at their first visit to MdM clinics.

### REASONS FOR MIGRATION

As in 2013, in the European countries, the reasons most often cited for migration were, overwhelmingly, economic—(52.0%), political (19.3%) in total, including 8.9% to escape from war—and family related (whether to join or follow someone: 14.6%, or to escape from family conflict: 7.8%).

As every year, health reasons were extremely rare (3.0 % in Europe, which is a similar rate to that reported in 2008, 2012 and 2013); 0.9% in Turkey). There is no correlation between the number of people who migrate for health reasons, among others, and the level of legal restrictions and barriers to accessing healthcare in the host country. This is yet more proof to deconstruct the myth of migration for health.

### ECONOMIC REASONS, UNABLE TO EARN A LIVING IN HOME COUNTRY

<table>
<thead>
<tr>
<th>Country</th>
<th>CH</th>
<th>DE</th>
<th>NL</th>
<th>SE</th>
<th>UK</th>
<th>FR</th>
<th>TR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macedonia</td>
<td>19.7</td>
<td>14.7</td>
<td>0.9</td>
<td>5.2</td>
<td>25.6</td>
<td>21.2</td>
<td>10.3</td>
</tr>
<tr>
<td>Romania</td>
<td>13.3</td>
<td>14.6</td>
<td>5.3</td>
<td>12.8</td>
<td>13.3</td>
<td>14.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Portugal</td>
<td>7.8</td>
<td>3.3</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Greece</td>
<td>7.8</td>
<td>3.3</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>7.8</td>
<td>3.3</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Pakistan</td>
<td>7.8</td>
<td>3.3</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>7.8</td>
<td>3.3</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>7.8</td>
<td>3.3</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Nigeria</td>
<td>7.8</td>
<td>3.3</td>
<td>3.8</td>
<td>3.8</td>
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<tr>
<td>Afghanistan</td>
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<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
</tr>
</tbody>
</table>

### OTHER REASONS FOR MIGRATION

- Economic reasons correspond to the question ‘why did you leave your country? Economic reasons, to earn a living, because had no perspectives’/no way to earn a living in home country’.
- Personal health reasons, for migration respectively.
- For health reasons were extremely rare (3.0 % in Europe, which is a similar rate to that reported in 2008, 2012 and 2013; 0.9% in Turkey). There is no correlation between the number of people who migrate for health reasons, among others, and the level of legal restrictions and barriers to accessing healthcare in the host country. This is yet more proof to deconstruct the myth of migration for health.

A. Multiple responses were possible in France the question was not asked and in Belgium the response rate was too low.
We had to drive far out into the countryside to a place near St Omer to visit the last, and most shocking, settlement where a group of 20 to 30 Syrians were living in a ditch. As we squelched down the remote muddy lane in the rain, it was hard to believe anyone could be living there. To our left were tilled fields, now just mud, and to our right were bushes, leading down into a long ditch. I had turned up my trousers to the knees to avoid getting muddied and I thought I looked silly. When we got closer a group of boys appeared from the bushes, with an adult. Recognising our logo (MdM) they huddled beneath our umbrella. Only the adult spoke, he was from Aleppo, as were all the boys, who stood with bare feet on the tops of their wet and mud-caked shoes. I stopped thinking about my trousers.

The boys were aged between 10 and 15 and were muddied and unwashed, all there without their families. The ten-year-old was scratching because of scabies. They took me down into the ditch beneath the tarpaulins to a small fire. They camped in this far-flung location because there was a service station nearby where they could try to board trucks.

“There is so much we don’t have here, still it is better than Aleppo. But we will not be here long,” the adult told me. My French colleague later told me this was a common delusion, perhaps a necessary one, and that it usually took many months to cross the channel. So how could children be living for long periods of time in muddy ditches in a rich, supposedly civilised country such as France?”

Testimony written by MdM UK in France – Calais – Saint Omer – November 2014

Lastly, no significant difference was observed in the frequency of health reasons for migration between EU citizens and other migrants: both being very low (2.9% and 2.5% respectively, p=0.68). Of course, the most frequent other reasons for migration were very different between the two groups: EU citizens had migrated mostly for economic (88.8%) and family reasons (to join or follow someone: 22.2%) and the others had done it for the four main reasons mentioned above.

John, aged 25, from Eritrea, keeps smiling as he talks. It is a grin that seems to mask the fatigue and exhaustion of a long journey and all that he does not want to say...

“I was born in Eritrea, I left for Sudan and Uganda. I moved a lot. In 2008, I got a diploma in Statistics. In Uganda, I have worked and earned about $6,000 to leave. I knew that it was tough in France, but not as much as it is. In England, I would like to resume my studies and open my own survey company.”

MdM France – Calais – 2014

<table>
<thead>
<tr>
<th>Reasons for Migration</th>
<th>EU Citizens (n=418)</th>
<th>Others (n=3082)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic reasons, unable to earn a living in home country</td>
<td>81.8</td>
<td>48.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Political, religious, ethnic, sexual orientation</td>
<td>1.2</td>
<td>24.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>To escape from war</td>
<td>0.5</td>
<td>10.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>To join or follow someone</td>
<td>22.2</td>
<td>9.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Family conflicts</td>
<td>3.5</td>
<td>7.0</td>
<td>0.004</td>
</tr>
<tr>
<td>To ensure your children’s future</td>
<td>0.0</td>
<td>2.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Personal health reasons</td>
<td>2.9</td>
<td>2.5</td>
<td>0.68</td>
</tr>
<tr>
<td>To study</td>
<td>2.4</td>
<td>3.9</td>
<td>0.14</td>
</tr>
<tr>
<td>Others</td>
<td>5.0</td>
<td>9.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total</td>
<td>125.3</td>
<td>122.8</td>
<td></td>
</tr>
</tbody>
</table>
“We had to drive far out into the countryside to a place near St Omer to visit the last, and most shocking, settlement where a group of 20 to 30 Syrians were living in a ditch. As we squeaked down the remote muddy lane in the rain, it was hard to believe anyone could be living there. To our left were tilled fields, now just mud, and to our right were bushes, leading down into a long ditch. I had turned up my trousers to the knees to avoid getting muddied and I thought I looked silly. When we got closer a group of boys appeared from the bushes, with an adult. Recognising our logo (MdM) they huddled beneath our umbrella. Only the adult spoke, he was from Aleppo, as were all the boys, who stood with bare feet on the tops of their wet and mud-caked shoes. I stopped thinking about my trousers.

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Testimony written by MdM UK in France – Calais – Saint Omer – November 2014

Lastly, no significant difference was observed in the frequency of health reasons for migration between EU citizens and other migrants: both being very low (2.9% and 2.5% respectively, p=0.68). Of course, the most frequent other reasons for migration were very different between the two groups: EU citizens had migrated mostly for economic (88.8%) and family reasons (to join or follow someone: 22.9%) and the others had done it for the four main reasons mentioned above.

John, aged 25, from Eritrea, keeps smiling as he talks. It is a grin that seems to mask the fatigue and exhaustion of a long journey and all that he does not want to say...

“I was born in Eritrea, I left for Sudan and Uganda. In 2008, I got a diploma in Statistics. In Uganda, I have worked and earned about $6,000 to leave. I knew that it was tough in France, but not as much as it is. In England, I would like to resume my studies and open my own survey company.”

MdM France – Calais – 2014

### Reasons for Migration: Comparison Between EU Citizens (Except Nationals) and Other Migrants (%)

<table>
<thead>
<tr>
<th>Reason</th>
<th>EU Citizens</th>
<th>Others</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic reasons, unable to earn a living in home country</td>
<td>81.8</td>
<td>48.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Political, religious, ethnic, sexual orientation</td>
<td>1.2</td>
<td>24.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>To escape from war</td>
<td>0.5</td>
<td>10.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>To join or follow someone</td>
<td>22.2</td>
<td>9.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Family conflicts</td>
<td>3.3</td>
<td>7.0</td>
<td>0.004</td>
</tr>
<tr>
<td>To ensure your children’s future</td>
<td>0.0</td>
<td>2.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Personal health reasons</td>
<td>2.9</td>
<td>2.5</td>
<td>0.68</td>
</tr>
<tr>
<td>To study</td>
<td>2.4</td>
<td>3.9</td>
<td>0.14</td>
</tr>
<tr>
<td>Others</td>
<td>5.0</td>
<td>9.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total</td>
<td>125.3</td>
<td>122.8</td>
<td></td>
</tr>
</tbody>
</table>
The majority (66.0%) of all people seen at the MDM centres in the nine European countries do not have permission to reside: 56.7% of citizens from non-EU countries and 9.3% of EU citizens (who have been in the country for over three months and do not have adequate financial resources and/or valid healthcare coverage) are undocumented migrants, EU citizens who have lost their right to reside without permission to reside. As undocumented migrants, EU citizens who have lost their right to reside in an EU country other than their own, Article 7 of the Directive, states clearly, “All Union citizens shall have the right of residence on the territory of another Member State for a period of longer than three months if they have sufficient resources for themselves and their family members not to become a burden on the social assistance system of the host Member State during their period of residence and have comprehensive sickness insurance cover in the host Member State.”

As a consequence of Directive 2004/38/CE, EU citizens staying for more than three months in a host Member State without sufficient resources or healthcare coverage find themselves in a situation as undocumented migrants from outside the EU. Belgium, France, and Switzerland have expanded their system of medical coverage for undocumented migrants to include EU nationals without permission to reside. As undocumented migrants, EU citizens who have lost their permit to reside can also subject to expulsion procedures (stricter than for citizens of non-EU countries).

The average proportion of people without a residence permit covers wide disparities from one country to the other: Switzerland (18.6%), Greece (19%) and Germany (33.9%) had the lowest figures. In contrast, 94.2% of patients seen in the Netherlands; 83.9% of those seen in Belgium; 67.9% of those seen in France7 and 63.9% of those seen in Spain4 were without permission to reside.

In Germany, 29.1% of patients were EU nationals who had lost their permission to reside (compared with an average rate of 8% in the other countries). Additionally, 18.2% of patients were EU nationals who had arrived in the country less than three months ago (compared with fewer than 3% in the other countries except Sweden) and 5.0% were EU nationals with permission to reside. Germany was the country with the largest share of EU citizens (excluding German nationals), which may reflect its economic attractiveness in a Europe in crisis.

In Greece, the overwhelming majority of patients have the right to reside in Greece (83%). This is due to the large numbers of Greek and foreign citizens who do not need a permit (374%), the number of foreign citizens with permission to reside (20.9%) and asylum seekers (1%).

In Spain, 25.9% of patients were non-EU nationals with a valid residence permit (compared with fewer than 6% in most other countries). This is due to mass unemployment and economic problems in the country (which have primarily affected immigrants). In Switzerland, a significant majority of patients were asylum seekers (77.5%); in contrast to the other countries surveyed (asylum seekers represented 15.3% of the total in London and 13.4% in France). The main programme in Switzerland is actually aimed at asylum seekers housed in three reception facilities in the canton of Neuchâtel and accounted for a majority of the patients.

In Sweden, 47.3% of patients had no permission to reside; a quarter were EU nationals staying for less than three months and 4.3% had a residence permit in another EU country.

In London, 57.5% of those coming to the centre were foreign nationals who did not have permission to reside and 15.3% were asylum seekers; 11.8% had a visa (the highest proportion observed in the European countries of the survey).

In Istanbul, 63.2% of patients had no permission to reside; 16.0% were seeking asylum and 12.4% were recent immigrants (less than 30 days). Overall, in the nine European countries, 45.4% of citizens from non-EU countries were or had been involved in an asylum application (N=4,440). Only a very small minority of asylum seekers were granted refugee status (5.6%) while four out of ten had already been rejected (39.6%). Finally, those affected by the Dublin II/Eurodac regulation were relatively few (between 1% and 3% except in Stockholm and Munich where they respectively represented 10.5% and 10.3% of the total.

Administrative Status by Country (%)

<table>
<thead>
<tr>
<th>Country</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>DE</td>
<td>70.5</td>
<td>15.4</td>
<td>9.0</td>
<td>14.3</td>
<td>54.9</td>
<td>9.91</td>
</tr>
<tr>
<td>CH</td>
<td>13.4</td>
<td>4.1</td>
<td>29.1</td>
<td>2.7</td>
<td>8.6</td>
<td>8.8</td>
</tr>
<tr>
<td>EL</td>
<td>0.0</td>
<td>0.0</td>
<td>20.9</td>
<td>0.5</td>
<td>5.5</td>
<td>9.9</td>
</tr>
<tr>
<td>FR</td>
<td>0.3</td>
<td>18.6</td>
<td>38.1</td>
<td>17.0</td>
<td>63.5</td>
<td>87.9</td>
</tr>
<tr>
<td>SE</td>
<td>0.0</td>
<td>0.0</td>
<td>22.2</td>
<td>0.0</td>
<td>2.2</td>
<td>11.8</td>
</tr>
<tr>
<td>UK</td>
<td>0.3</td>
<td>0.0</td>
<td>14.3</td>
<td>0.4</td>
<td>14.3</td>
<td>0.3</td>
</tr>
<tr>
<td>NL</td>
<td>1.0</td>
<td>0.3</td>
<td>7.1</td>
<td>0.0</td>
<td>0.0</td>
<td>9.6</td>
</tr>
<tr>
<td>GR</td>
<td>0.6</td>
<td>0.0</td>
<td>17.7</td>
<td>0.0</td>
<td>0.0</td>
<td>2.9</td>
</tr>
<tr>
<td>AT</td>
<td>0.6</td>
<td>0.0</td>
<td>19.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.3</td>
</tr>
<tr>
<td>ES</td>
<td>0.3</td>
<td>0.0</td>
<td>18.5</td>
<td>0.0</td>
<td>0.0</td>
<td>1.9</td>
</tr>
<tr>
<td>SE</td>
<td>0.5</td>
<td>0.0</td>
<td>28.2</td>
<td>0.0</td>
<td>0.0</td>
<td>2.2</td>
</tr>
<tr>
<td>UK</td>
<td>0.3</td>
<td>0.0</td>
<td>34.5</td>
<td>0.0</td>
<td>0.0</td>
<td>2.0</td>
</tr>
<tr>
<td>NL</td>
<td>0.3</td>
<td>0.0</td>
<td>44.6</td>
<td>0.0</td>
<td>0.0</td>
<td>3.2</td>
</tr>
</tbody>
</table>

A. Without adequate financial resources and/or healthcare coverage
B. In France, children do not require a residence permit and are therefore included in this category
C. Or equivalent situation (recent immigrants <90 days)
D. Adequate financial resources and valid healthcare coverage
E. Including subsidiary/humanitarian protection
The majority (66.0%) of all people seen at the FMM centres in the nine European countries do not have permission to reside: 56.7% of citizens from non-EU countries and 9.3% of EU citizens (who have been in the country for over three months and do not have adequate financial resources and/or valid healthcare coverage) are not covered by the treaty of residence. 36.3% of the EU citizens and 66.2% of the citizens from non-EU countries had no permission to reside in the country where they were interviewed (p<0.001).

Since the adoption of European Directive 2004/38/EC on the right of citizens of the EU and their family members to move and reside freely, EU nationals who do not have adequate financial resources or health insurance have lost their right to reside in an EU country other than their own. Article 7 of the Directive, states clearly: “All Union citizens shall have the right of residence on the territory of another Member State for a period of longer than three months if they... have sufficient resources for themselves and their family members not to become a burden on the social assistance system of the host Member State during their period of residence and have comprehensive sickness insurance cover in the host Member State.”

As a consequence of Directive 2004/38/EC, EU citizens staying for more than three months in a host Member State without sufficient resources or healthcare coverage find themselves in the same situation as undocumented migrants from outside the EU. Belgium and France have expanded their system of medical coverage for undocumented migrants to include EU nationals who do not have permission to reside. As undocumented migrants, EU citizens have lost their right to reside and can also be subject to expulsion procedures. (stricter than that for citizens of non-EU countries). The average proportion of people without a residence permit covers wide disparities from one country to the other: Switzerland (16.6%), Greece (17%) and Germany (38.1%) had the lowest figures. In contrast, 94.2% of patients seen in the Netherlands; 83.9% of those seen in Belgium, 67.9% of those seen in France and 63.5% of those seen in Spain were in this situation. In Germany, 29.1% of patients were EU nationals who had lost their permission to reside (compared with an average rate of 8% in the other countries). Additionally, 18.2% of patients were EU nationals who had arrived in the country less than three months ago (compared with fewer than 3% in the other countries except Sweden) and 5.0% were EU nationals with permission to reside. Germany was the country with the largest share of EU citizens (excluding German nationals), which may reflect its economic attractiveness in a Europe in crisis.

In Greece, the overwhelming majority of patients have the right to reside in Greece (83%). This is due to the large numbers of Greek and foreign citizens who do not need a permit (374/4, the number of foreign citizens with permission to reside (20.9%) and asylum seekers (11%).

In Spain, 25.9% of patients were non-EU nationals with a valid residence permit (compared with fewer than 6% in most other countries). This is due to mass unemployment and economic problems in the country (which have primarily affected immigrants).

In Switzerland, a significant majority of patients were asylum seekers (75.5%), in contrast to the other countries surveyed (asylum seekers represented 15.3% of the total in London and 13.4% in France). The main programme in Switzerland is actually aimed at asylum seekers housed in three reception facilities in the canton of Neuchâtel and accounted for a majority of the patients.

In Sweden, 47.3% of patients had no permission to reside; a quarter were EU nationals staying for less than three months and 14.3% had a residence permit in another EU country.

In London, 57.5% of those coming to the centre were foreign nationals who did not have permission to reside and 15.3% were asylum seekers; 11.8% had a visa (the highest proportion observed in the European countries of the survey). In Istanbul, 63.2% of patients had no permission to reside; 16.0% were seeking asylum and 12.4% were recent immigrants (less than 90 days).

Overall, in the nine European countries, 43.4% of citizens from non-EU countries were or had been involved in an asylum application (N=4,440). Only a very small minority of asylum seekers were granted refugee status (5.6%) while four out of ten had already been rejected (39.6%). Finally, those affected by the Dublin III/Eurodac regulation were relatively few (between 1% and 3%) except in Stockholm and Munich where they respectively represented 10.5% and 10.3% of the total.

The FRENCH STATE MEDICAL ASSISTANCE IS A FULL HEALTHCARE COVERAGE MEASURE FOR UNDOCUMENTED MIGRANTS, UNDER SPECIFIC CONDITIONS AND ADMINISTRATIVE CONSTRAINTS. ASSISTANCE FROM SUPPORT VIGNETTES IS AVAILABLE TO ALL NATIONALS. EUROPEAN DIRECTIVE 2004/38/EC

ADMINISTRATIVE SITUATION

<table>
<thead>
<tr>
<th>Country</th>
<th>BE</th>
<th>CH</th>
<th>DE</th>
<th>EL</th>
<th>ES</th>
<th>FR</th>
<th>AT</th>
<th>SE</th>
<th>UK</th>
<th>NL</th>
<th>DEU</th>
<th>TR</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU CITIZEN</td>
<td>70.5</td>
<td>15.6</td>
<td>9.7</td>
<td>14.3</td>
<td>54.9</td>
<td>59.1</td>
<td>94.3</td>
<td>26.4</td>
<td>57.9</td>
<td>44.6</td>
<td>56.7</td>
<td>61.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>13.4</td>
<td>1.6</td>
<td>29.1</td>
<td>2.7</td>
<td>8.6</td>
<td>8.8</td>
<td>0.0</td>
<td>20.9</td>
<td>0.5</td>
<td>9.5</td>
<td>9.9</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Total without permission to reside: 8.3% in Belgium, 68.8% in Spain, 17.0% in France, 70.5% in the Netherlands, 57.9% in the UK and 44.6% in Germany. The Directive was effectively transposed into the legislation of all the countries except Sweden.

EUROPEAN DIRECTIVE 2004/38/EC

Source: The data presented here are from a survey of the European Commission on EU citizens without permission to reside. The survey was conducted in the nine countries of the survey: Austria, Belgium, Denmark, France, Germany, Greece, Italy, the Netherlands and the UK. The survey was conducted in 2014.
It must be noted, as every year that the vast majority of people who presented at the MDM clinics had a range of social vulnerability factors that were determinant in their poor health status.

HOUSING CONDITIONS

Overall, in the seven European countries where the question was asked, 64.7% of patients were living in unstable or temporary accommodation (this was particularly common in Switzerland, Sweden and the Netherlands). This proportion stood at 63.0% in Istanbul.

Of the patients seen in eight European countries (all but Greece where the question was not asked), 9.7% were homeless (up to 20.0% in Stockholm) and 16.4% had been provided with accommodation for more than 19 days by an organisation (up to 83.0% in Switzerland where most patients are met at asylum seeker centres).

The most frequent housing condition was to be living with family members or friends (38.9%, up to 62.6% in France) or to have his/her own home (29.5%), which by no means always represented stable accommodation and furthermore could also be overcrowded. In Istanbul 75.2% lived in their own flat or house; as in 2013, homeless people were extremely rare.

29.5% of those questioned in Europe deemed their accommodation to be harmful to their health or that of their children. In Istanbul, this proportion reached 57.9%.

WORK AND INCOME

A slim majority of people attending MDM centres in Europe had no permission to reside and therefore did not have permission to work. It is therefore unsurprising that only 21.9% of them reported an activity to earn a living in the eight European countries (question not asked in Belgium).

Almost all the patients surveyed in the eight European countries (91.3%) were living below the poverty line: (on average, over the past three months, taking into account all sources of income).

SOCIAL ISOLATION

When asked about moral support, one in two people said they could rarely or never rely on support if they needed it. 18.4% of patients seen in seven European countries replied that they never had anyone they could rely on or turn to if the need arose and one third (32.6%) said they could rely on such support only sometimes. In Istanbul, 86.1% of patients were isolated: 29.4% said they could never rely on anyone for moral support and 56.7% said they could do so only occasionally. Altogether men more often reported being isolated and without support than women (p≤0.01).

Bilal, aged 38, from Sudan, is undocumented and cannot get healthcare coverage or work. After a year of procedures his asylum application was rejected and he had to leave the centre for asylum seekers.

After living on the streets, he joined a group of around 100 homeless ex-asylum seekers who subsequently squatted a church and office buildings. He is now living in a derelict office building with small, cramped spaces. The windows in the building cannot be opened and there is no heating. There is only one shower, with no warm water. The group is dependent on charity from the neighbourhood and volunteers for food and other basic necessities.

Bilal has been an insulin-dependent diabetic since he was 10 years old. When Bilal was still an asylum seeker, he had access to medication. When MDM met Bilal, he was very sick, with extremely high blood sugar levels. With MDM’s intervention, Bilal now sees a general practitioner and has a small refrigerator and volunteers for food and other basic necessities.

After work, Bilal used to work there as a security guard. The problem is that they tell you you will earn €400 a month, but in reality you do not. I earned only €180 a month; I had health insurance there, through my work, which was a good thing. But when I lost my job I lost my insurance as well. My cousin told me that he had a job for me here, but when I came it was not available anymore. Now that I am here I want to give it a chance. But it is a vicious circle. I need to have a registered address at the municipality to get a job, but to have an address you need money to pay for housing. I have to apply each time for a place to sleep and this way it is very hard to find a job.

I found out about your organisation through another clinic for homeless people in Munich. They said I need an X-ray, but they do not have doctors that do this for free. They said you could help. I’ve had headaches for a couple of days. I’ve never had this before. I stay in a place with 16 men for one hour, which is never very healthy. I think my living situation is now affecting my health.

MGM Germany – Munich – December 2014
LIVING CONDITIONS

It must be noted, as every year, that the vast majority of people who presented at the MDM clinics had a range of social vulnerability factors that were determinant in their poor health status.

HOUSING CONDITIONS

Overall, in the seven European countries where the question was asked, 64.7% of patients were living in unstable or temporary accommodation 60 (this was particularly common in Switzerland, Sweden and the Netherlands). This proportion stood at 63.0% in Istanbul. 61

Of the patients seen in eight European countries (all but Greece where the question was not asked), 9.7% were homeless (up to 20.0% in Stockholm) and 16.4% had been provided with accommodation for more than 19 days by an organisation (up to 83.0% in Switzerland where most patients are met at asylum seeker centres).

The most frequent housing condition was to be living with family members or friends (39.8%, up to 62.6% in France) or to have his/her own home (29.5%), which by no means always represented stable accommodation and furthermore could also be overcrowded. In Istanbul 75.2% lived in their own flat or house; as in 2013, homeless people were extremely rare.

29.5% of those questioned in Europe 62 deemed their accommodation to be harmful to their health or that of their children. In Istanbul, this proportion reached 57.9%.

25

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After living on the streets, he joined a group of around 100 homeless ex-asylum seekers who subsequently squatted a church and office buildings. He is now living in a derelict office building with small, cramped spaces. The windows in the building cannot be opened and there is no heating. There is only one shower, with no warm water. The group is dependent on charity from the neighbourhood and volunteers for food and other basic necessities.

Bilal has been an insulin-dependent diabetic since he was 10 years old. When Bilal was still an asylum seeker, he had access to medication. When MDM met Bilal, he was very sick with extremely high blood sugar levels. With MDM’s intervention, Bilal now sees a general practitioner and has a small refrigerator with insulin and syringes. He also has regular check-ups by a diabetes specialist in hospital.

MDM Netherlands – Amsterdam – November 2014

WORK AND INCOME

A slim majority of people attending MDM centres in Europe had no permission to reside and therefore did not have permission to work. It is therefore unsurprising that only 21.9% of them reported an activity to earn a living in the eight European countries (question not asked in Belgium). 63

Almost all the people surveyed in the eight European countries (91.3%) were living below the poverty line 96. The number of people living on the financial resources of their community (80.0%). In the other countries, missing values were: 24.1% in CH, 33.1% in DE, 19.7% in El, 11.1% in ES, 64.8% in FR, 4.9% in NL, 9.2% in SE, 13.3% in UK, 8.4% in TR.

95 Missing data: 63.5% in CH, 33.1% in DE, 19.7% in El, 11.1% in ES, 50.6% in FR, 4.9% in NL, 9.2% in SE, 64.8% in UK, 4.9% in TR.

96 The number of people living on the financial resources of their community (80.0%).

97 The percentage of people living below the poverty line of all but Greece where the question was not asked.

98 Unfortunately, the question was not asked in Belgium.

SOCIAL ISOLATION

When asked about moral support 65, one in two people said they could rarely or never rely on support if they needed it: 18.4% of patients seen in seven European countries (80.0%) said they never had anyone for moral support and 56.7% said they could do so only occasionally. Altogether men more often reported being isolated and without support than women (p<0.01).

MDM Germany – Munich – December 2014

Karl, aged 40, is from a German minority in Romania. ‘I came from Romania about one month ago. I came to work there as a security guard. The problem is that they tell you you will earn €400 a month, but in reality you do not. I earned only €180 a month. I had health insurance there, through my work, which was a good thing. But when I lost my job I lost my insurance as well. My cousin told me that he had a job for me here, but when I came, it was not available anymore. Now that I am here I want to give it a chance. But it is a vicious circle. I need to have a registered address at the municipality to get a job, but to have an address you need money to pay for housing. I have to apply each time for a place to sleep and this way it is very hard to find a job.’

I found out about your organisation through another clinic for homeless people in Munich. They said I need an X-ray, but they do not have doctors that do this for free. They said you could help. I’ve had headaches for a couple of days. I’ve never had this before. I stay in a place with 16 men in one room. I think my living situation isn’t very healthy. I think my living situation is now affecting my health.

92 Response rate at 96.8%.

93 deering et al. (2015).

94 Response rate at 95.0%.

95 Missing data: 63.5% in CH, 33.1% in DE, 19.7% in El, 11.1% in ES, 64.8% in FR, 4.9% in NL, 9.2% in SE, 13.3% in UK, 8.4% in TR.

96 The number of people living on the financial resources of their community (80.0%).

97 The percentage of people living below the poverty line of all but Greece where the question was not asked.

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99 Missing data: 63.5% in CH, 33.1% in DE, 19.7% in El, 11.1% in ES, 50.6% in FR, 4.9% in NL, 9.2% in SE, 64.8% in UK, 4.9% in TR.

100 The percentage of people living below the poverty line of all but Greece where the question was not asked.

101 The percentage of people living below the poverty line of all but Greece where the question was not asked.
In London, almost all patients (82.7%) had no access to the NHS at all in the period, which varies from one day to six months. Since the national law does not specify the validity period of the MML, each CPAS defines the period, which varies from one day to six months.

Zoe, a 60-year-old Moroccan woman, is undocumented. She lives at her sister’s home. Zoe visits MMD for a regular consultation and anticipates possible problems due to her age. She explains how difficult it is to stand for hours outside in the cold with many other patients who do not have access to the healthcare system. Nevertheless, she doesn’t want to postpone the visit and wait too long until it is too late. Zoe had urgent medical coverage (AMU specifically for undocumented migrants) for a while, but she had to renew it too often. Besides, it was hard to get to the CPAS each time. Zoe sums up the absurdity of the situation: “Why don’t they offer at least one-year medical cards? These cards cover only 15 days and, if you are not sick within this period, it’s useless. When you are sick, it is an emergency, while getting the card takes time, what is an emergency for them?”

Zoe would like to work in order to contribute to her family’s needs. “It is possible to work undetected but you can’t contribute to anything. You are nobody when working undetected. You make a bit of money, but you have no rights to healthcare. I don’t know much about the Belgian system, but it is unfair sometimes.” Since the national law does not specify the validity period of the MML, each CPAS defines the period, which varies from one day to six months.

In Germany, 73.6% of patients only had access to emergency healthcare. 15.5% were entitled to healthcare coverage in another European country (which is in line with the high number of Europeans in Belgium among the patients received, as noted above). In Munich, asylum seekers, refugees and undocumented migrants are required to request a health voucher from the municipal social welfare office in order to access free healthcare. However, civil servants including health personnel have a duty to report undocumented migrants to the police, which creates a huge barrier to healthcare. As undocumented migrants fear being arrested. For emergency care, a recommendation was issued by the government stating that health personnel are not obliged to report undocumented migrants. However, this recommendation is not binding and has not been widely disseminated. As a result, the MMD team has been confronted with an undocumented patient being reported to the police at an emergency unit and has held a meeting with hospital staff from the five MDD public hospitals to inform them about the option not to report undocumented migrants in the case of emergencies – which would be a duty not to report.

In Greece, 84.9% of patients had no healthcare coverage at all. Foreign nationals without permission to reside have no rights to any healthcare coverage. As the social crisis in Greece worsened, more and more Greek nationals and foreign citizens with permission to reside also lost their healthcare coverage due to the lack of contributions through their employment or their inability to pay for it.

In the Netherlands, 82.5% of patients seen in Amsterdam and The Hague could access general practitioners, albeit with a financial contribution, and 14% had no access at all.

In Spain, 61.6% of patients seen only had access to emergency care. While undocumented migrants are supposed to have access to free emergency care in practice cases where they are not referred for the emergency care they received were witnessed by MMD as well as being reported by the Ombudsman in Spain.

In Sweden, half of the patients (47.5%) had no access to healthcare at all, a quarter (28.7%) had access to some subsidised healthcare – i.e. by paying a reduced fee for a defined package of care – and 15.0% were EU citizens with coverage in another country.

In Switzerland, 74.5% of patients seen had full healthcare coverage. They were mainly asylum seekers, who have the right to healthcare during their application process (although the procedures involved can be complex and the context rather restrictive). The other patients seen either did not have or no longer had any (adequate or effective) form of healthcare coverage.

In Turkey, the vast majority of those consulting had no coverage at all for their health expenses (98.7%).

The absence of any coverage concerned 70.4% of migrant EU citizens in Europe. And 15.1% had access to emergency services only. They were even less frequently fully covered than nationals of non-EU countries (3.7% versus 8.3%, p<0.001), although 81% of them had healthcare rights in another EU country.

Scarlett, a 45-year-old Moroccan woman, is undocumented. She lives in her mother’s home. Her son is living in France and visits her occasionally. Scarlett receives help from the Red Cross in emergencies and was referred to MMD by the Red Cross.

In Switzerland, 94.7% of people had full healthcare coverage. They were mainly asylum seekers, who have the right to healthcare during their application process (although the procedures involved can be complex and the context rather restrictive). The other patients seen either did not have or no longer had any (adequate or effective) form of healthcare coverage.

In Italy, 99% of patients seen only had access to emergency care. While undocumented migrants are supposed to have access to free emergency care in practice, cases where they are not referred for the emergency care they received were witnessed by MMD as well as being reported by the Ombudsman in Italy.
ACCESS TO HEALTHCARE

Two thirds (62.9%) of patients seen in the MDM European centres had no healthcare coverage when they first came to MDM programmes.

<table>
<thead>
<tr>
<th>Coverage of Healthcare Charges by Country (%)</th>
<th>BE</th>
<th>CH</th>
<th>DE</th>
<th>EL</th>
<th>ES</th>
<th>FR</th>
<th>AL</th>
<th>SE</th>
<th>UK</th>
<th>WAP</th>
<th>CAP</th>
<th>TR</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Coverage / All Charges Must Be Paid</td>
<td>51.8</td>
<td>15.9</td>
<td>73.6</td>
<td>85.3</td>
<td>62.0</td>
<td>52.3</td>
<td>40.7</td>
<td>66.7</td>
<td>52.7</td>
<td>62.9</td>
<td>85.5</td>
<td>98.7</td>
</tr>
<tr>
<td>Full Healthcare Coverage</td>
<td>5.1</td>
<td>74.8</td>
<td>4.7</td>
<td>5.6</td>
<td>32.8</td>
<td>4.1</td>
<td>3.5</td>
<td>5.7</td>
<td>15.7</td>
<td>7.6</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Partial Healthcare Coverage</td>
<td>0.3</td>
<td>79.3</td>
<td>3.1</td>
<td>9.1</td>
<td>31.2</td>
<td>2.2</td>
<td>5.2</td>
<td>20.7</td>
<td>0.0</td>
<td>15.2</td>
<td>3.2</td>
<td>0.8</td>
</tr>
<tr>
<td>Healthcare Rights in Another EU Country</td>
<td>1.5</td>
<td>1.3</td>
<td>15.5</td>
<td>0.2</td>
<td>0.0</td>
<td>1.4</td>
<td>0.0</td>
<td>15.0</td>
<td>0.0</td>
<td>3.9</td>
<td>1.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Access on a Case-By-Case Basis</td>
<td>11.1</td>
<td>0.0</td>
<td>3.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.2</td>
<td>0.0</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Free Access to GP Services</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>9.0</td>
<td>1.0</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Chargeable Access to Secondary Healthcare</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.2</td>
<td>3.6</td>
<td>0.6</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In Greece, 84.9% of patients had no healthcare coverage at all. For many patients, access to healthcare was determined by their ability to pay for it. In Spain, 82.5% of patients seen in Madrid and The Hague could access free emergency care, in practice access to emergency care is charged at €5.

In Spain, 16.1% of patients seen only had access to emergency care. While undocumented migrants are supposed to have access to free emergency care, in practice cases where they are referred for the emergency care they received were witnessed by MDM as well as reported by the Ombudsman in Spain.

In Sweden, half of the patients (47.5%) had no access to healthcare at all, a quarter (28.7%) had access to some subsidised healthcare – in paying a reduced fee for a defined package of care – and 15.0% were EU citizens with coverage in another country.

In Germany, 73.6% of patients only had access to emergency healthcare. 15.5% were entitled to healthcare coverage in another European country (which is in line with the high number of Europeans among the patients seen, as noted above). In Munich, asylum seekers, refugees and undocumented migrants are redirected to facilities within the mainstream healthcare system. In theory, undocumented migrants in both countries have the right to healthcare during their application process (although the procedures involved can be complex and the context rather restrictive). The other patients seen either did not have or no longer had any (adequate or effective) form of healthcare coverage.

In Turkey, the vast majority of those consulting had no coverage at all for their health expenses (98.7%). The absence of any coverage concerned 70.4% of migrant EU citizens in Europe, and 15.1% had access to emergency services only. They were even less frequently fully covered than nationals of non-EU countries (3.7% versus 8.3%, p<0.001), although 8% of them had healthcare rights in another EU country.

The availability of drugs is irregular at the hospital. In addition, administrative procedures for requesting a yearly social welfare booklet takes two to six months, during which the family has no free access to treatment. MDM guaranteed their continuous access to the prescribed medication.

In Amsterdam and The Hague could access general practitioners, albeit with a financial contribution, and 14.9% had no access at all.

In Greece, 52.3% and Belgium (91.9%). These rates can mostly be explained by the fact that the concerns centred (Nice, Saint-Denis, Brussels and Amwerf) only accept patients with no effective healthcare coverage, while people who do have healthcare coverage are redirected to facilities within the mainstream healthcare system. In theory, undocumented migrants in both countries have relatively favourable conditions of access to healthcare; in practice, however, administrative barriers and the time taken to process files and applications for periodic renewal of access increase the frequency of situations and interim periods when they have no effective healthcare coverage.

In Sweden, half of the patients (47.5%) had no access to healthcare at all, a quarter (28.7%) had access to some subsidised healthcare – i.e. by paying a reduced fee for a defined package of care – and 15.0% were EU citizens with coverage in another country.

In Spain, 74.9% of patients seen had full healthcare coverage. They were mainly asylum seekers, who had the right to healthcare during their application process (although the procedures involved can be complex and the context rather restrictive). The other patients seen either did not have or no longer had any (adequate or effective) form of healthcare coverage.

In Turkey, the vast majority of those consulting had no coverage at all for their health expenses (98.7%). The absence of any coverage concerned 70.4% of migrant EU citizens in Europe, and 15.1% had access to emergency services only. They were even less frequently fully covered than nationals of non-EU countries (3.7% versus 8.3%, p<0.001), although 8% of them had healthcare rights in another EU country.
One patient in five (20.4%) said that they had given up trying to access healthcare or medical treatment in the course of the previous 12 months106 and up to 63.2% reported the same thing in Istanbul.

The frequency of people giving up seeking healthcare has significantly decreased in Spain since 2012: it was 52.0% in 2002, 22.0% in 2013 and 15.0% in 2014. The interpretation of this decrease is difficult since, unfortunately, the surveyed sites have changed over time (as well as the sample procedure from one year to another). However, it is useful to note that these figures do not represent the general situation of migrants in Spain, but should be taken as an indicator of those migrants who contact MDM. Since the Royal Decree 16/2002, the MDM Spain teams have explored different channels for integrating migrants into the mainstream health services107. Even though some regions are providing special programmes that enable certain rights for some undocumented migrants under certain circumstances, most health professionals and migrants coming to MDM do not know about them, as there has been no communication about these specific measures (such as in Valencia and the Canary Islands). Some of the patients interviewed in 2014 had already been to MDM before answering the questionnaire (and had thus already been informed about their care), which explains the decreasing number of patients giving up seeking care.

DENIAL OF ACCESS TO HEALTHCARE

Denial of access to healthcare refers to any behaviour adopted voluntarily by a health professional that results, directly or indirectly, in failure to provide healthcare or medical treatment appropriate to the patients’s situation. Denial of access to healthcare (over the previous 12 months) was reported by 15.2% of patients seen by MDM in Europe in Istanbul, 37.1% of the patients experienced this situation and a quarter in Spain.

Maria is a 39-year-old unemployed Greek nurse. She had healthcare coverage until 2009. Earning about €400 per month, she has an undeclared job as a care worker for an elderly woman. “My income covers accommodation and food. I was pregnant and without healthcare coverage. I could afford neither the costs of required examinations nor the medications”.

In Greece, thanks to the new presidential decree of 5 June 2014, anyone living legally in Greece and without healthcare coverage can receive a free examination at a hospital. Nonetheless, this decree is not well known or not applied. There are some fears of enforcement. MDM workers provide printed versions of the law and explain it to health professionals. They explain each patient’s case and then follow it up. Maria was able to have free examinations and delivery at the hospital in safe conditions. Nevertheless, as vaccines or drugs are sometimes not available at the hospital, her baby is still medically monitored and vaccinated by MDM services.

MDD Greece – Chania – September 2014

The story of Said, a 23-year-old from Turkey, demonstrates the misunderstanding by the medical staff of the new 2013 law giving access for undocumented migrants to healthcare “that cannot be deferred”. I tried to get an appointment for a doctor’s consultation but was given the information that a social security number is needed to book an appointment and that I needed to pay €85 for the visit. Then they told me that I could only get treatment if I was an asylum seeker and referred me to a hospital. Instead I told them what doctors the World Swden had told me: that the documentation only cost €5. “I then asked if they knew about the new law and they did not.”

MDD Sweden – Stockholm – October 2014

In 2014, in severe pain, Miriam visited MDD Belgium, which referred her to a hospital. She had these pairs for a while but did not dare to go the hospital because of the bill left from her daughter’s surgery: Miram was operated on for an abscess in the groin, but the infection could not be controlled. In addition, the medical staff discovered that Miram had diabetes, which she was not aware of. Miriam died in hospital a few weeks later. Her daughter was 26 months old.

After his wife’s death, Ahmed could not work and take care of his daughter on his own and Sonia was placed in a foster family. As they had rights to care. As they had left Spain four years before, the response from the CPAS was legally unsatisfactory, as rights to healthcare coverage only last for one year. The child needed a second operation, but the parents still had no financial means. A second healthcare coverage request was rejected, as the CPAS stated that the father was financially responsible for his daughter’s operation costs. The surgery was delayed. The father worked hard but still could not cover the bill. Three requests were rejected.

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Ahmed, a 34-year-old Egyptian man, explains: “When my partner died, I lost the house. I do not have my own place anymore. I sleep at my daughter’s mostly. I don’t want to go to the social services because my daughter went bankrupt, did all sorts of jobs, such as car washer, looking after horses and working as a hair dresser. But I am old now and I can’t work. My money is not enough. I was once diagnosed with diabetes. I haven’t had health insurance for a couple of years now. I started to have heart problems and last week I had swollen legs. I told the doctor...” I don’t feel well. I gave them all the money I could and then left immediately, with the urological catheter still in me. I hope you can remove it. I’m not going back to that hospital”.

MDD Germany – Munich – December
The story of Said, a 22-year-old from Turkey, demonstrates the misunderstanding by the medical staff of the new 2013 law giving access for undocumented migrants to healthcare “that cannot be deferred”.110 I tried to get an appointment for a doctor’s consultation but was given the information that a social security number is needed to book an appointment and that I needed to pay €185 for the visit. Then they told me that I could only get treatment if I was an asylum seeker and referred me to a hospital instead. I told them what doctors of the World Sweden had told me: that the undocumented can only cost €5 and that I would, by now, have taught them about the new law and they did not.

Maria is a 38-year-old unemployed Greek nurse. She had healthcare coverage until 2009. Earning about €400 per month, she has an undeclared job as a car worker for an elderly woman. “My income covers accommodation and food. I have no troubles with the social security system. I could afford neither the costs of required examinations nor the medications”.

In Greece, thanks to the new presidential decree of 5 June 2004, anyone living legally in Greece and without healthcare coverage can receive a free examination at a hospital. Nonetheless, this decree is not well known or not applied. Therefore, if an undocumented migrant in need of healthcare coverage, they explain each patient’s case and then follow it up. Maria was able to have free examinations and delivery at the hospital in safe conditions. Nevertheless, as vaccines or drugs are sometimes not available at the hospital, her baby is still medically monitored and vaccinated by MdM services.

DENIAL OF ACCESS TO HEALTHCARE

Denial of access to healthcare refers to any behaviour adopted voluntarily by a health professional that results, directly or indirectly, in failure to provide healthcare or medical treatment appropriate to the patient’s situation. Denial of access to healthcare in the previous 12 months) was reported by 15.2 % of patients seen by MdM in Europe111 in Istanbul, 37.1% of the patients experienced this situation and a quarter in Spain.

BARRIERS TO ACCESS IN SEVEN EU COUNTRIES AND IN TURKEY (%)
**RACISM IN HEALTHCARE SERVICES**

Fortunately, only a few patients reported having been victims of racism in a healthcare facility. In Europe at least, approximately 4.5% of patients reported such an experience in the six countries where the question was asked. This proportion was the highest in Istanbul (38.7% with a response rate of 77.5%).

**FEAR OF BEING ARRESTED**

Undocumented migrants and migrants with precarious residence status were asked if they limited their movements for fear of being arrested (at the time of the survey) as this also constitutes a well-known barrier in seeking access to healthcare. In Europe, half of the interviewed patients (52.0%) reported such a limitation (either sometimes, frequently or very frequently). This proportion was particularly high in London (83.9%), the Netherlands (69.4%) and Istanbul (85.0%), whereas, as mentioned before, the fear of being reported or arrested was a frequently cited barrier in the United States (62.3%).

In Spain, this proportion was lower (57.5%). Due to either low numbers of respondents or high proportions of missing values, only Spanish, Dutch, UK and Turkish data may be considered separately.

**Experiences of Violence**

In 2014, 1,809 patients were interviewed about violence. Among them, 84.4% reported at least one violent experience in the previous month (57.6% compared with 34.4% among all patients, p < 0.001). Patients from Sub-Saharan Africa and Latin America were over-represented among the victims of violence but no origin was exempt from violence, including (obviously) EU citizens and nationals.

Experiences of violence affected both sexes and all ages. Asylum seekers were disproportionately highly represented among victims of violence (57.6% compared with 34.4% among all patients, p < 0.001). It is crucial to identify previous experiences of violence among migrant populations, in view of their frequency and impact on the mental and physical health of the victims even many years after the original episode (such as depression or post-traumatic stress disorder). Risk factors (co-morbidities) may be apparent when faced with unexplained physical disorders and the need for detection of sexually transmitted infections arising from sexual violence). This is why it is so important to listen attentively to accounts of previous experiences of violence in the country of origin, during the migratory journey and in the host country. Unfortunately, stigmatisation of ‘foreigners’ remains one of the main obstacles to better patient care for people fleeing torture and political violence.

**Geographical Origins of Victims of Violence in the Eight European Countries Surveyed in N (%):**

- **Sub-Saharan Africa:** 43.5
- **Asia:** 8.8
- **Europe (Non EU):** 10.2
- **Maghreb:** 2.5
- **National:** 4.9
- **Americans:** 5.0
- **Near and Middle East:** 0.7
- **European Union:** 17.4

**The Case of Sofia**

Sofia, a 45-year-old woman from Morocco, was pregnant. Her husband was about to obtain the Spanish nationality, but she could not register under his husband’s healthcare coverage as they did not yet have a residence permit. Suffering from pain and bleeding, Sofia went to the emergency department of the maternity hospital in Malaga. According to her and the friend who accompanied her, the doctor said that without healthcare coverage she could not be attended. After two weeks her pain increased and she went back to the health centre. She was denied care “until her administrative situation gets solved.”

She went to MD&M a week later. With the intervention of MD&M, the health centre “solved the case” and provided her with a health card. During the consultation, her general practitioner immediately referred her to the emergency department at the maternity hospital, which diagnosed her as having had a miscarriage that “should have been attended to a month earlier.” Sofia and her husband have filed a complaint in court. Although highly restrictive, the Royal decree provides access to care for pregnant women and children. Even this limited access is not always guaranteed.

MD&M Spain – Malaga – January 2014

**The Case of Fadel**

Fadel is a 17-year-old Cameroonian who left his country, while his sick mother, brothers and sisters stayed. He arrived in France three years after a violent migration journey. Fadel explains that he lived for over a year in the north of Morocco “hiding in the forest.” With other people seeking to make the Strait of Gibraltar crossing, he built a makeshift shelter. He was repeatedly “arrested and beaten up by the Moroccan police.” Fadel said that his “companions were not coming back after being arrested.” One day, Fadel was arrested and badly beaten. He was sent to hospital where he was in a coma for a week. “When I woke up, I couldn’t remember anything; only the beatings by the police.” He tried again to cross the Strait and eventually managed to reach Spain, then France in June 2014.

MD&M FR – Saint-Denis – August 2014

**The Case of Sally**

Sally, a 27-year-old Ugandan woman, was imprisoned in Uganda for being homosexual. She explained that she was tortured and sexually assaulted in jail. When she was released, she lived on the streets. She was trafficked to the UK by some people who found her on the streets in Uganda. The person who brought her to the UK had taken away all her documents and valuables and had also beaten her. They left her outside a church and someone in the church offered to look after her.

Suspecting she was pregnant, Sally was looking for a doctor and therefore contacted MD&M. MD&M referred her to the National Referral Mechanism (the national government process for identifying victims of human trafficking and ensuring they receive the appropriate protection and support) and got her access to medical care and counselling. Sally is now registered with a GP who she is seeing regularly, has had full sexual health screening, is accessing counselling and has antenatal care for her pregnancy. She is receiving some financial support whilst her claim is assessed.

MD&M UK – London – 2014
FEAR OF BEING ARRESTED

Undocumented migrants and migrants with precarious residence status were asked if they limited their movements for fear of being arrested (at the time of the survey) as this also constitutes a well-known barrier in seeking access to healthcare.

In Europe, half of the interviewed patients (52.0%) reported such a limitation (either sometimes, frequently or very frequently) – This proportion was particularly high in London (83.9%), the Netherlands (88.4%) and Istanbul (85.0%), whereas, as mentioned before, the fear of being reported or arrested was a frequently cited barrier in accessing healthcare. In Spain, this proportion was lower (57.5%).

It is crucial to identify previous experiences of violence among migrant populations, in view of their frequency and impact on the mental and physical health of the victims even many years after the original episode (such as depression or post-traumatic stress disorders) (such as depression or post-traumatic stress disorders). The need for detection of sexually transmitted infections arising from sexual violence). This is why it is so important to listen attentively to accounts of previous experiences of violence, in the country of origin, during the migratory journey and in the host country. Unfortunately, stigmatisation of ‘foreigners’ remains one of the main obstacles to better patient care for people fleeing torture and political violence.

Sofia, a 45-year-old woman from Morocco, was pregnant. Her husband was about to obtain the Spanish nationality, but she could not register under his husband’s healthcare coverage as they did not yet have a residence permit. Suffering from pain and bleeding, Sofia went to the emergency department at the maternity hospital in Malaga. According to her and the friend who accompanied her, the doctor said that without healthcare coverage she could not be attended. After two weeks her pain increased and she went back to the health centre. She was denied care “until her administrative situation gets solved.”

She went to MdM a week later. With the intervention of MdM, the health centre “solved the case” and provided her with a health card. During the consultation, her general practitioner immediately referred her to the emergency department at the maternity hospital, which diagnosed her as having had a miscarriage that “should have been attended to a month earlier.” Sofia and her husband have filed a complaint in court. Although highly restrictive, the Royal decree provides access to care for pregnant women and children. Even this limited access is not always guaranteed.

MdM Spain – Malaga – January 2014

In 2014, 1,809 patients were interviewed about violence. Among them, 84.4% reported at least one violent experience in EU, CH, DE, ES, FR, NL and UK (93.5% of women and 85.8% of men).

Patients from Sub-Saharan Africa and Latin America were over-represented among the victims of violence but no origin was exempt from violence, including (obviously) EU citizens and nationals.

Experiences of violence affected both sexes and all ages. Asylum seekers were disproportionately highly represented among victims of violence (57.6%) compared with 34.4% among all patients, p<0.001.

EXPERIENCES OF VIOLENCE

GEOPOLITICAL ORIGINS OF VICTIMS OF VIOLENCE IN THE EIGHT EUROPEAN COUNTRIES SURVEYED IN 16

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>43.5%</td>
</tr>
<tr>
<td>Asia</td>
<td>10.2%</td>
</tr>
<tr>
<td>Europe (Non EU)</td>
<td>8.8%</td>
</tr>
<tr>
<td>Middle East</td>
<td>6.8%</td>
</tr>
<tr>
<td>European Union</td>
<td>17.4%</td>
</tr>
</tbody>
</table>

Source: Eurostat, 2016

It is crucial to identify previous experiences of violence among migrant populations, in view of their frequency and impact on the mental and physical health of the victims even many years after the original episode (such as depression or post-traumatic stress disorders). The need for detection of sexually transmitted infections arising from sexual violence). This is why it is so important to listen attentively to accounts of previous experiences of violence, in the country of origin, during the migratory journey and in the host country. Unfortunately, stigmatisation of ‘foreigners’ remains one of the main obstacles to better patient care for people fleeing torture and political violence.

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MdM UK – London – 2014

Fadel is a 17-year-old Cameroonian who left his country, while his sick mother, brothers and sisters stayed. He arrived in France three years after a violent migration journey. Fadel explains that he lived for over a year in the north of Morocco “hidden in the forest.” With other people seeking to make the Strait of Gibraltar crossing, he built a makeshift shelter. He was repeatedly questioned by Spanish and Moroccan authorities, it is possible that many undocumented migrants are not aware of this and still fear being arrested, thus explaining the high number of people having reported such a limitation.

EurActiv.com ©jerôme Sessini – Magnum Photos for MdM
The types of violence most frequently reported in the eight European countries were:

- Living in a country at war (52.1%), physical threats, imprisonment or torture for one's ideas (43.3%) and violence perpetrated by the police or armed forces (39.1%).
- Beating or injury as a result of domestic or non-domestic violence (45.9%).
- Psychological violence (42.7%).
- Hunger (35.7%).
- Sexual assault (27.6%), reported by 37.6% of women (compared with 73% of men) and rape (14.9%), reported by 24.1% women and 5.4% of men. A quarter of the total numbers of sexual assaults reported were reported by male patients.
- Confiscation of money or documents (23.8%).

Among the respondents, 9.8% reported having experienced violence after having arrived in the countries surveyed. 21% of the reported rapes took place after the victim's arrival in the host country, as did 37% of sexual assaults, 37% of incidents of documents or money being confiscated, 19% of psychological violence and 40.8% of experiences of hunger.

The perceived health status of patients who reported at least one experience of violence was significantly worse in terms of general, mental and physical health (p < 0.001) than the perceived health of patients who did not report an episode of violence. Of these, 71.4% perceived their mental health to be very good or good versus only 33.5% among the people who reported an experience of violence.

12.4% of those who had experienced violence perceived their general health to be very bad versus 17% of the people who did not report an episode of violence. This confirms the major impact of the experience of violence on health and the medical duty to systematically ask patients about their past history of violence, in order to detect and provide adequate care and referrals.

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Among the respondents, 9.8% reported having experienced violence after having arrived in the countries surveyed. 21% of the reported rapes took place after the victim's arrival in the host country, as did 37% of sexual assaults, 37% of incidents of documents or money being confiscated, 19% of psychological violence and 40.8% of experiences of hunger.

The perceived health status of patients who reported at least one experience of violence was significantly worse in terms of general, mental and physical health (p < 0.001) than the perceived health of patients who did not report an episode of violence. Of these, 71.4% perceived their mental health to be very good or good versus only 33.5% among the people who reported an experience of violence.

12.4% of those who had experienced violence perceived their general health to be very bad versus 17% of the people who did not report an episode of violence. This confirms the major impact of the experience of violence on health and the medical duty to systematically ask patients about their past history of violence, in order to detect and provide adequate care and referrals.
The types of violence most frequently reported in the eight European countries were:

- living in a country at war (52.1%), physical threats, imprisonment or torture for one's ideas (43.3%) and violence perpetrated by the police or armed forces (39.1%);
- beating or injury as a result of domestic or non-domestic violence (45.9%);
- psychological violence (42.7%);
- hunger (35.7%);
- sexual assault (27.6%), reported by 37.6% of women (compared with 73% of men) and rape (14.9%), reported by 24% women and 5.4% of men. A quarter of the total numbers of sexual assaults reported were reported by male patients;
- confiscation of money or documents (23.8%).

Among the respondents, 9.8% reported having experienced violence after having arrived in the countries surveyed. 21.1% of the reported rapes took place after the victim’s arrival in the host country, as did 157% of sexual assaults, 37% of incidents of documents or money being confiscated, 19% of psychological violence and 40.8% of experiences of hunger.

The perceived health status of patients who reported at least one experience of violence was significantly worse in terms of general, mental and physical health (p <0.001) than the perceived health of patients who did not report an episode of violence. Of these, 71.4% perceived their mental health to be very good or good versus only 33.5% among the people who reported an experience of violence.

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A majority (58.2%) of patients seen by MdM in Europe perceived their general health status as poor. However, 22.9% of patients perceived their physical health as bad or very bad, and this goes up to 27.9% for their mental health.

In Istanbul (and in this city alone), there was a very significant gap between physical and mental health status; physically only 5.8% of patients felt their health was bad (and none of them very bad) but 41.4% described their mental health as bad (and 2.0% very bad).

Comparing these data with those in the general population of the host countries – obtained from the EU Statistics on Income and Living Conditions survey in 2013 (latest year available) – MdM patients’ health status was worse than that of the general population in all countries, regardless of the age group considered, as well as in comparison with the 25-44 age group (close to the age distribution of the MdM patients). While these figures concern people going to MdM or ASEM clinics, most of whom, by definition, have a health issue, it is, however, not sufficient to explain the scale of the difference with the general population. Among MdM patients, 16.9% and 4.7% reported bad or very bad health respectively, compared with 2.2% and 0.5% of the 25-44 year-old adults in the general populations of these seven countries (in 2013).

More than half of the patients (55.3%) who consulted a doctor in the eight European centres were diagnosed with at least one chronic health condition. In Istanbul, 36.7% of patients seen had at least one chronic health condition.

Health professionals indicated, for each health problem (at each visit), whether it was a chronic or non-chronic health condition. Whether they thought treatment (or medical care) was necessary or only precautionary; whether the problem had been treated or monitored before the patient came to MdM; and whether, in their opinion, this problem should have been treated earlier.

More than half of the patients (55.3%) who consulted a doctor in the eight European centres were diagnosed with at least one chronic health condition; this figure was 100% for Istanbul.

In the nine European countries surveyed, 73.3% of patients had at least one health problem that had never been monitored or treated before coming to MdM. This percentage was significantly higher in Switzerland (93.9% of patients needed at least one necessary treatment), Germany (84.3%), Spain (81.6%) and France (79.5%). In Istanbul, 100% of patients were in this situation.

In the seven European countries surveyed, 79.7% of patients had at least one chronic health condition that had never been checked or treated before. This concerned half of the patients seen in the other seven European countries – and this figure was 100% for Istanbul.

In Istanbul, almost all patients with a chronic condition had not received care before coming to ASEM (93.7%).

Natalia is a 54-year-old Greek woman. She has been the owner of a shoe shop for six years. For the last three years, due to the economic crisis, she has been unable to pay the cost of her healthcare coverage. Natalia was diagnosed with hypertension two years ago, which requires adherence to a specific drug treatment routine. “I was able to cover the cost of the drugs for the first six months… as I couldn’t afford it anymore, I had to stop.”

Since she could not regularly take the medication, she had an episode of high blood pressure which took her to the emergency department. From there she was directed to the social services of the local hospital to MdM’s Polyclinic in Patras. Since then, she had the benefit of free treatment. Now, since she could not regularly take the medication, she had an episode of high blood pressure. "I was able to cover the cost of the drugs for the first six months… as I couldn’t afford it anymore, I had to stop.”

Since she could not regularly take the medication, she had an episode of high blood pressure which took her to the emergency department. From there she was directed to the social services of the local hospital to MdM’s Polyclinic in Patras. Since then, Natalia has been treated at the MdM Polyclinic which covers the costs of the medical tests and medication.

MdM Greece – Patras – October 2014

**HEALTH STATUS**

**SELF-PERCEIVED HEALTH STATUS**

A majority (58.2%) of patients seen by MdM in Europe perceived their general health status as poor. However, 22.9% of patients perceived their physical health as bad or very bad, and this goes up to 27.9% for their mental health.

In Istanbul (and in this city alone), there was a very significant gap between physical and mental health status; physically only 5.8% of patients felt their health was bad (and none of them very bad) but 41.4% described their mental health as bad (and 2.0% very bad).

Comparing these data with those in the general population of the host countries – obtained from the EU Statistics on Income and Living Conditions survey in 2013 (latest year available) – MdM patients’ health status was worse than that of the general population in all countries, regardless of the age group considered, as well as in comparison with the 25-44 age group (close to the age distribution of the MdM patients). While these figures concern people going to MdM or ASEM clinics, most of whom, by definition, have a health issue, it is, however, not sufficient to explain the scale of the difference with the general population. Among MdM patients, 16.9% and 4.7% reported bad or very bad health respectively, compared with 2.2% and 0.5% of the 25-44 year-old adults in the general populations of these seven countries (in 2013).

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In total, three out of four patients (74.5%) in the European programmes needed treatment that was deemed necessary by the doctor. This percentage was significantly higher in Switzerland (74.8%), Germany (72.6%) and France (61.2%) and, above all, in Istanbul (98.9%).

In other words, among the patients who suffered from one or several chronic conditions (70.2%) hadn’t received any medical follow-up before going to MdM (for at least one of their chronic health conditions). Except in Greece, where this situation was uncommon (92.0%), it affected at least one third of patients with a chronic health condition in Spain, 60% in the Netherlands, 68% in London and around three out of four patients in the four other countries.

Nearly half of the patients seen by a doctor at MdM (46.2%) had at least one chronic condition that had never been checked or monitored by a doctor before. This concerned half of the patients seen by a doctor in France. In five patients seen in Spain, one third of patients seen in Istanbul and less than 10% of patients seen in Greece.

In Istanbul, almost all patients with a chronic condition had not received care before coming to ASEM (93.7%).

Health professionals indicated, for each health problem (at each visit), whether it was a chronic or acute health condition; whether they thought treatment (or medical care) was necessary or only precautionary; whether the problem had been treated or monitored before the patient came to MdM, and whether, in their opinion, this problem should have been treated earlier.

More than half of the patients (55.3%) who consulted a doctor in the eight European centres were diagnosed with at least one chronic health condition. In Istanbul, 36.7% of patients seen had at least one chronic health condition.

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HEALTH STATUS

SELF-PERCEIVED HEALTH STATUS

A majority (58.2%) of patients seen by MdM in Europe perceived their general health status as poor. However, 22.9% of patients perceived their physical health as bad or very bad, and this goes up to 27.9% for their mental health.

In Istanbul (and in this city alone), there was a very significant gap between physical and mental health status: physically, only 5.8% of patients felt their health was bad (and none of them very bad) but 44.4% described their mental health as bad (and 2.0% very bad).

Comparing these data with those in the general population of the host countries – obtained from the EU Statistics on Income and Living Conditions survey in 2013 (latest year available) – MdM patients’ health status was worse than that of the general population in all countries, regardless of the age group considered, as well as in comparison with the 25-44 age group (close to the age distribution of the MdM patients). While these figures concern people going to MdM or ASEM clinics, most of whom, by definition, have a health issue, it is, however, not sufficient to explain the scale of the differences from the general population. Among MdM patients, 16.9% and 4.7% reported bad or very bad health respectively, compared with 2.2% and 0.5% of the 25-44-year-old adults in the general population of these seven countries (in 2013).

CHRONIC HEALTH CONDITIONS

Health professionals indicated, for each health problem (at each visit), whether it was a chronic or acute health condition; whether they thought treatment (or medical care) was necessary or only precautionary; whether the problem had been treated or monitored before the patient came to MdM; and whether, in their opinion, this problem should have been treated earlier.

More than half of the patients (55.3%) who consulted a doctor in the eight European centres were diagnosed with at least one chronic health condition. In Istanbul, 36.7% of patients seen had at least one chronic health condition.

Natalia is a 54-year-old Greek woman. She has been the owner of a shoe shop for six years. For the last three years, due to the economic crisis, she has been unable to pay the cost of her healthcare coverage. Natalia was diagnosed with hypertension two years ago, which requires adherence to a specific drug treatment routine. “I was able to cover the cost of the drugs for the first six months... as I couldn’t afford it anymore. I had to stop.”

Since she could not regularly take the medication, she had an episode of high blood pressure which took to the emergency department. From there she was directed by the social services of the local hospital to MdM’s Polyclinic in Patras. Since then, Natalia has been treated at the MdM Polyclinic which covers the cost of drugs and medication.

MdM Greece – Patras – October 2014

URGENT CARE AND NECESSARY TREATMENT

More than one third (36.5%) of patients needed urgent or fairly urgent care when they visited the seven European centres – and this figure was 100% for Istanbul.

In total, three out of four patients (74.5%) in the European programmes needed treatment that was deemed necessary by the doctor. This percentage was significantly higher in Switzerland (93.9% of patients needed at least one necessary treatment), Germany (84.3%), Spain (81.6%) and France (79.5%). In Istanbul, 100.0% of patients were in this situation.

PATIENTS HAD RECEIVED LITTLE HEALTHCARE BEFORE COMING TO MdM

In the nine European countries surveyed, 73.3% of patients had at least one health problem that had never been monitored or treated before coming to MdM. This concerned half of the patients seen in Istanbul, almost all the patients seen in Greece and less than 10% of patients seen in Switzerland (79.7%), Germany (82.9%), France (76.9%), the Netherlands (65.3%) and London (63.3%). In Istanbul, almost all the patients were in this situation.

Altogether, 57.9% of the patients requiring treatment had not received care before coming to MdM. Thus for these patients MdM represents their first point of contact with a primary healthcare provider. This figure was also particularly high in Switzerland (74.4%), Germany (72.7%) and France (69.2%) and, above all, in Istanbul (98.9%).

HEALTH PROBLEMS LARGELY UNKNOWN PRIOR TO ARRIVAL IN EUROPE

Nearly half of the patients seen by a doctor at MdM (46.2%) had at least one chronic condition that had never been checked or monitored by a doctor before. This concerned half of the patients seen in a doctor in France, one in five seen in Spain, one in three patients seen in Istanbul and less than 10% of patients seen in Greece.

In other words, among the patients who suffered from one or several chronic conditions, 70.2% hadn’t received any medical follow-up before going to MdM (for at least one of their chronic health conditions). Except in Greece, where this situation was uncommon (92.0%), it affected at least one third of patients with a chronic health condition in Spain, 60% in the Netherlands, 68% in London and around three out of four patients in the four other countries.

In Istanbul, almost all patients with a chronic condition had not received care before coming to ASEM (93.7%).

For information purposes, missing values: 25.6% in CH, 34.6% in DE, 69.2% in EL, 21.6% in ES, 65.0% in FR, 25.8% in NL, 62.3% in SE, 4.7% in TR. Question not asked in Belgium.

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Treatments were regarded as essential if failure to provide them would almost certainly mean deterioration in the patient’s health or a significantly poorer prognosis; in other cases they were classed as precautionary. There is no consensus of ameliorating treatments or of simple comfort.

In Switzerland, patients are seen by nurses.
HEALTH PROBLEMS BY ORGAN SYSTEM

Half of the health issues encountered correspond to four of the body’s organ systems: the digestive system accounted for 14.4% of all diagnoses, musculoskeletal 13.3%, respiratory 10.0% and cardiovascular 9.5%.

When health problems were grouped under broad disease categories, psychological problems were identified in 10.6% of medical consultations. The most frequently reported mental health problems were anxiety, stress and psychosomatic syndromes (2.9% of consultations). Obviously psychiatric disorders were much rarer (0.5%). Problems related to using psychoactive substances were almost non-existent (0.4%).

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Overall, 10% of medical consultations for women patients dealt with gynaecological problems: normal pregnancy and postnatal issues (10.0% and 0.3%) were most frequently reported, followed by other unspecified gynaecological problems (5.2%), menstruation problems (4.2%) and contraception issues (1.7%).

Peter, a 25-year-old Nigerian man, was temporarily housed in an asylum seeker centre after a period of detention as a result of being undocumented. During his period in detention, his psychiatric problems had worsened dramatically, which resulted in a long period of isolation. A court decision released him and housed him in the asylum seeker centre. As there was a lack of appropriate care, after a month MDM Netherlands became involved to oversee Peter’s admission to a psychiatric ward, which specialised in treating patients from different cultural backgrounds. His psychosis was diagnosed and Peter was treated for more than a year as an inpatient at the psychiatric hospital, which is located in a small village in the countryside, surrounded by fresh air and very quiet.

Gerd, an MDM Netherlands volunteer doctor testifies: “I saw a big man fearing for his life because of his visual and auditory hallucinations. Only after several months of treatment did his condition improve. After a year, Peter had recovered well, he had some relapses, but his delusions retracted and he became a more sociable man, made some friends in a church in a city near by and travelled there by train, with the permission of his doctors. However, the threat of being expelled remained. One day he called me in fear from his room in the hospital. He had been apprehended in the train, for no reason as he said he had a ticket. He was nearly arrested because the policemen thought they recognised him from a "list of people with illegal status who had to be arrested". While Peter was more or less cured of his phobias, he was still taking strong medication and now, suddenly, the reality of the fear of being harassed and arrested by the police entered his life. This event occurred when Peter was still a patient at the psychiatric hospital and he had a permit to stay. Even though they apologised, the attitude of the police was harmful for Peter who now has a new fear that inhibits him from socialising.

MEdIcAL coNSULTATIoN AT ASEM – ISTANbUL – TURKEy – 2014

The testimony shared by Trenton, a 26-year-old Ugandan man, illustrates how violence, discrimination and social isolation can build up into a vicious circle of vulnerabilities, with a serious impact on health and particularly mental health. “I was born in Uganda. I grew up in a tough situation. I didn’t have parents to look after me, no one to care for me while I was growing. I was in the streets, I didn’t have anyone to talk to. Uganda is a society where people of my sexual orientation are not accepted. The homophobia in the country is extreme and it’s tough growing up in such an environment. I managed to get out of the country and come to the UK.”

“When I first came to the UK I thought life would be so easy. I thought I would be free. But it turned out that wasn’t the case. In the UK I had to live with a person close to my family and so it wasn’t easy for me to express myself. I had to hide who I was and I had to pretend that I was happy and this was hurting me on the inside. As a human being, if you continue hiding who you are and hide in what is dear to you, most of the time it will affect you. I didn’t know what was happening to me, what was going on around me. I started developing illnesses. I started having headaches and unusual pains. I had no one to talk to. When I started feeling sick and felt pain inside me there was nothing I could do about it. I had to continuously hide my feelings. I was so down and confused and just worried all the time. I had no interest in anything, no interest in life as a whole.”

Trenton was directed to the MDM UK clinic by a friend. He relates his first contact: “That was a life-changing moment for me. I wrote my name down and I sat down and I waited patiently. The kind of care and service I got when the doctor attended to me is something I’d never ever experienced in my life. They took good care of me and we were so lovely and kind. I was so grateful. I immediately connected with them and connected with the doctor.”

On his arrival Trenton had had a GP. “But I had been told that without visa status you are not allowed to access a GP. I was scared to even visit my GP again. But MDM-UK assured me and said, ‘Everyone is entitled to medical care no matter what their visa status is.’ The MDM volunteer immediately started searching for all the GPs in the area. She asked whether I had been registered at their practices. I never forget that day. They arranged an appointment for me and everything was sorted out for me before I left the clinic. I was referred to two different social groups as well as counselling. I walked out of the clinic that day a very happy person. For once I was excited because I knew that at least I had someone to talk to. Sometimes all we need is someone who we can confide in and talk to.”

Trenton was diagnosed with severe depression. “The doctor also ensured that I had a social group to attend to it helped me to have a safe place where I could meet people like me to talk about our experiences and open up to each other. Little by little I was healing because I was receiving medication that I was taking on a daily basis. The social groups helped me build my confidence and I was even referred to an immigration solicitor. My solicitor booked me an appointment at the Immigration Office in Croydon. I was detained there because I didn’t have valid documents. Although I had taken my medication in the morning, the following day I wasn’t able to take it and didn’t know who to talk to in the detention centre. I kept mentioning it to the officers and I kept telling them, ‘I need my medication’. It is a 30-day treatment and you cannot skip a day.”

Trenton explains that he kept in contact with MDM UK and the GP so that he could get medication on a daily basis. “Staying in the detention centre was tough. It is hard to live in an environment where you see so many people who are stressed, so many people who are down. People are crying, people are ill and in such a place it takes loneliness, courage and support – a lot of support. The medication I was taking in the detention centre was strong and would make me drowsy. But I was also strong because I knew I had the support. Not everyone in the detention centre was as fortunate as me.” (Trenton means the support from MDM-UK GP)

“Not everyone was able to get information about what was happening around them. Some people didn’t even know where they were. Some were so sick that even going to see someone crying, day in, day out, I believe more has got to be done about healthcare within the detention centre. After leaving the detention centre I was granted refugee status. I’m now free to live. I have the freedom to be who I am without any fear because I’m in a free land now. It gives me some sort of peace on the inside to know I can walk around the streets without caring about who is around me and without a constant fear that someone is painting a finger at me. I’m totally free and I’m so grateful for the clinic and the work it does with so many people. There are so many people in the country with no GP. Now that I’m a free man I have plans for the future. I had always dreamt of an IT career but when your health is not good it affects everything that you aspire to. But I believe that now is my time to shine. I’m looking forward to starting work and I’m looking forward to having a place of my own.”

MDM UK – London – September 2014

A MORE EFFECTIVE HEPATITIS C TREATMENT. BUT UNAFFORDABLE!

It is estimated that 85 million people worldwide are infected with hepatitis C, a liver infection that often causes potentially life-threatening cirrhosis and cancer. There is currently no vaccine against hepatitis C. Treatments available came with serious side effects and with low cure rates (50% to 70%). A new generation of drugs now brings great hope: ‘direct-acting antivirals’ are better tolerated by patients and the cure rate exceeds 90%!

However the first drug of 85 kind, sofosbuvir, is sold at exorbitant prices (e.g. €41 000 in France for the full course of treatment).

This means that social security systems in many countries have started to select the most seriously ill patients out of the new treatments. This goes against the public health benefits of treating all patients in order to stop the spread of infection, on top of which comes the public health benefits of treating all patients in order to stop the spread of infection. This goes against the public health benefits of treating all patients in order to stop the spread of infection.

MDM welcomes real medical innovation, but affordable prices put at risk the very existence of our public health model, which is based on solidarity and equity. This is why in February 2015, MDM-opposed the patent for sofosbuvir at the European Patent Office. MDM wants affordable medicines for hepatitis C for all.

51 See Dr. French. https://harvestingblog.wordpress.com/2015/03/26/hepati-
tis-c-affordable-patent-for-sofosbuvir/
HEALTH PROBLEMS BY ORGAN SYSTEM

Half of the health issues encountered correspond to four of the body’s organ systems: the digestive system accounted for 14.4% of all diagnoses, musculoskeletal 13.3%, respiratory 10.0% and cardiovascular 9.6%.

When health problems were grouped under broad disease categories, psychological problems were identified in 10.6% of medical consultations. The most frequently reported mental health problems were anxiety, stress and psychosomatic problems (5.8%), followed by psychotic disorders (5.8% of consultations) and depressive syndromes (2.9% of consultations). Obviously, psychotic disorders were much rarer (5.8% of consultations) and depressive anxiety, stress and psychosomatic problems accounted for 13.3%, respiratory 10.0% and cardiovascular 9.6%.

Overall, 10% of medical consultations for women patients dealt with gynaecological problems: normal pregnancy and postnatal problems (10.0%) and contraception (3.6%) and menopausal problems (1.7%).

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This means that social security systems in many countries have started to select the most seriously ill patients or those most in need from the new treatments. This goes against the public health benefits of treating all patients in order to stop the spread of infection, on top of being highly unethical.

Médecins du Monde welcomes real medical innovation, but affordable prices put at risk the very existence of our public health model, which is based on solidarity and equity. This is why in February 2014 Médecins du Monde opposed the patent for sofosbuvir at the European Patent Office. Médecins du Monde wants affordable medicines for hepatitis C for all.

The testimony shared by Trenton, a 26-year-old Ugandan man, illustrates how violence, discrimination and social isolation can build up into a vicious circle of vulnerabilities, with a serious impact on health and particularly mental health. “I was born in Uganda. I grew up in a tough situation. I didn’t have parent’s love and I didn’t have the guidance of the right people. I was afraid to talk to Uganda. Uganda is a society where people of my sexual orientation are not accepted. The homophobia in the country is extreme and it’s tough growing up in such an environment. I managed to get out of the country and come to the UK.”

“When I first came to the UK I thought life would be so easy. I thought I would be free. But it turned out that wasn’t the case. In the UK I had to live with a person close to my family and it so wasn’t easy for me to express myself. I had to hide who I was and I had to pretend that I was happy and this was hurting me on the inside. As a human being, if you continue hiding who you are and hide in what is dear to you, most of the time it will affect you. I didn’t know what was happening to me, what was going on around me. I started developing illnesses. I started having headaches and unusual pains. I had no one to talk. When I started feeling sick and felt pain inside me there was nothing I could do about it. I had to continuously hide my feelings. I was so down and confused and just worried all the time. I had no interest in anything, no interest in life as a whole.”

Trenton was directed to the MDM UK clinic by a friend. He relates his first contact: “That was a life-changing moment for me. I wrote my name down and I sat down and I waited patiently. The kind of care and service I got when the doctor attended to me is something that I’d never experienced in my life. They took good care of me and we were so lovely and kind. I was so grateful. I immediately connected with them and connected with the doctor.”

On his arrival Trenton had had a GP: “But I had been told that without visa status you are not allowed to access a GP. I was scared to even visit my GP again. But MDM UK assured me and said, everyone is entitled to medical care no matter what their visa status is. The MDM volunteer immediately started searching for all the GPs in the area. She asked whether I had been registered at their practices. I never forget that day. They arranged an appointment for me and everything was sorted out for me before I left the clinic. I was referred to two different social groups as well as counselling. I walked out of the clinic that day a very happy person. For once I was excited because I knew that at least I had someone to talk to. Sometimes all we need is someone who we can confide in and talk to.”

Trenton was diagnosed with severe depression. “The doctor also ensured that I had a social group to attend it helped me to have a safe place where I could meet people like me to talk about our experiences and open up to each other. I felt a little less lonely because I was receiving medication that I was taking on a daily basis. The social groups helped me build my confidence and I was even referred to an immigration solicitor. My solicitor booked me an appointment at the immigration office in Cogdall. I was detained there because I didn’t have valid documents. Although I’d taken my medication in the morning, the following day I wasn’t able to take it and didn’t know who to talk to in the detention centre. I kept mentioning it to the officers and I kept telling them, ‘I need my medication’ it is a 30-day treatment and you cannot skip a day.”

Trenton explains that he kept in contact with MDM UK and the GP so that he could get medication on a daily basis. “Staying in the detention centre was tough. It is hard to live in an environment where you see so many people who are stressed, so many people who are down. People are crying, people are ill and to be in such a place takes loneliness, courage and support – a lot of support. The medication I was taking in the detention centre was strong and would make me drowsy. But I was also strong because I knew I had the support. Not everyone in the detention centre was as fortunate as me.” (Trenton means the support from MDM UK GP).

“Not everyone was able to get information about what was happening around them. Some people didn’t even know what was going on because they were so sick that when people were crying, day in, day out. I believe more has got to be done about healthcare within the detention centre. After leaving the detention centre I was granted refugee status. I’m now free to live. I have the freedom to be who I am without any fear because I’m in a free land now. It gives me some sort of peace on the inside to know I can walk around the streets without caring about who is around me and without a constant fear that someone is painting a finger at me. I’m totally free and I’m so grateful for the clinic and the work it does with so many people. There are so many people in the country with no GP. Now that I’m a free man I have plans for the future. I had always dreamt of an IT career but when your health is not good it affects everything that you aspire to. But I believe that now is my time to shine. I’m looking forward to starting work and I’m looking forward to having a place of my own.”

MDM UK – London – September 2014
CONCLUSION

European stakeholders increasingly recognise the impacts that the economic crisis and austerity measures have had on the accessibility of national healthcare services. In 2014, following repeated calls by NGO’s and the European Parliament, both the Commission and the Council have reaffirmed their adherence to the values of universality, access to good quality care, equity and solidarity.

- MDM urges Member States and EU institutions to ensure universal public health systems built on solidarity, equality and equity, open to everyone living in an EU Member State.

The international and European institutions that have asked national governments to ensure protection for people and groups facing multiple vulnerabilities are legion. The data collected by MDM over the past year clearly show that the crisis and austerity policies are still having negative consequences on people’s health. In addition, as the Council notes, “the scale of effects on health of the economic crisis and the reduction in public health expenditures may only become apparent in the following years”.

The data in this report also show how the declarations of intent that Member States formulated at the level of the Council of the European Union ("The Council acknowledges that universal access to healthcare is of paramount importance in addressing health inequalities") have not been accompanied by any real improvements in access to healthcare for groups which already face multiple vulnerabilities, such as undocumented third-country nationals, destitute EU citizens and groups facing social stigma.

The right of children to health and care is one of the most basic, most universal and most essential human rights. The right of children to health and care is one of the most basic, most universal and most essential human rights.

European Parliament, resolution of 6 July 2010 on access to care for undocumented residents (2009/2010). European Commission Communication on effective, accessible and resilient health systems: COM(2014) 215 final. The Council of the European Union ("the Council acknowledges that universal access to healthcare is of paramount importance in addressing health inequalities") has not been accompanied by any real improvements in access to healthcare for groups which already face multiple vulnerabilities, such as undocumented third-country nationals, destitute EU citizens and groups facing social stigma.

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DECONSTRUCTING THE MYTHS...

Institutions such as the European Centre for Disease Prevention and Control (ECDC) play a key role in deconstructing the myths some policy-makers may still spread against migrants or ethnic minorities as an excuse for not putting equitable public health first. In their assessment, report of how infectious diseases affect migrant populations in Europe, the ECDC warns that, “poor access to healthcare is an important proximal risk factor for poorer health outcomes” and that more needs to be done to ensure equal access to healthcare for migrants, especially for asylum seekers and undocumented migrants. National governments should ensure that coherent and inclusive infectious disease policies are in place that allow access to prevention, care and treatment for anyone residing in Europe.

A small number of migrants become seriously ill after arriving in Europe (e.g. living with HIV, having mental health problems or suffering from renal failure, cancer, hepatitis, etc.) and for them going back to their home country is not an option because they are not able to effectively access healthcare there. European national governments could achieve a quick win in terms of human rights by protecting this small group. The Member States who have done so have not seen any significant rise in the number of seriously ill migrants seeking protection. In doing so, these States are following the Parliamentary Assembly of the Council of Europe, which considered that a migrant living, for example, with HIV, “should never be expelled when it is clear that he or she will not receive adequate healthcare and assistance in the country to which he or she is being sent back”. Expulsions with no assurance of adequate healthcare may be tantamount to a death penalty, which goes against the position of the EU and all EU Member States on “strong and unequivocal opposition to the death penalty in all times and in all circumstances”. When seriously ill migrants are expelled to a country where they will not get adequate healthcare, they face extremely serious consequences for their health, including the possibility of death. This must be avoided at all costs by protecting them in Europe and by giving them access to care.

- Seriously ill migrants must be protected from expulsion when effective access to adequate healthcare cannot be ensured in the country to which they are expelled.

HEALTH PROFESSIONALS CAN MAKE A DIFFERENCE

In 2014, the European Board and College of Obstetrics and Gynaecology (EBCOG) presented the Standards of Care developed by its members from 36 European countries, regarding obstetric, neonatal and gynaecology services. The Board highlights that, “there is still an evident disparity in accessibility to sexual and reproductive health services, in the quality of care and in clinical outcomes across the countries and even in regions within the same country”. The economic and societal impact of such inequitable access shows the “compelling need to improve delivery of care”. EBCOG recommends that “local protocols should be developed to support equal access to healthcare needs for all vulnerable groups including the migrant population and those who do not speak the host country’s language”. In April 2014, the European Public Health Association (EUPHA), the Andalusian School of Public Health and the Consortium for Healthcare and Social Services of Catalonia launched the Granada Declaration. It states that, “when many European countries are implementing austerity policies, it is especially important that the public health community should speak out on behalf of the poor and marginalized. Among them are many migrants, who for various reasons are especially vulnerable at this time.” The declaration calls for better protection of migrants’ health and healthcare, specifically including that of undocumented migrants. Almost 100 European and national institutions, professional associations and civil society organisations have endorsed the document. This shows how many health professionals are demanding to be able to work according to their medical ethics.

- In accordance with the World Medical Association’s Declaration on the Rights of the Patient, MDM will continue to provide appropriate medical care to all people without discrimination. MDM refuses all restrictive legal measures to alter medical ethics and exhorts all health professionals to take care of all patients regardless of their administrative status and the existing legal barriers.
CONCLUSION

European stakeholders increasingly recognise the impacts that the economic crisis and austerity measures have had on the accessibility of national healthcare services. In 2014, following repeated calls by NGOs and the European Parliament, both the Commission and the Council have reaffirmed their adherence to the values of universality, access to good quality care, equity and solidarity.

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The right of children to health and care is one of the most basic, most universal and most essential human rights. However, while it holds its Fundamental Rights Charter, the Council of Europe tolerates national laws that hinder vaccination coverage or antenatal and postnatal care from being universal and available to all children and women residing on its territory.

MDM urges the European Union to develop the necessary mechanisms to transform its impressive body of soft recommendations into hard facts when it comes to the most basic human rights of children and pregnant women. If the EU is not about making its Member States respect human rights, what is it about?

- All children residing in Europe must have full access to national immunisation schemes and to paediatric care. All pregnant women must have access to termination of pregnancy, antenatal and postnatal care and safe delivery.

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REFERENCES FOR QUOTATIONS:


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**ACRONYMS**

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AME</td>
<td>STATE MEDICAL AID (AIDE MÉDICALE DE L’ÉTAT)</td>
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<td>COMPLEMENTARY UNIVERSAL MEDICAL COVERAGE (COUVERTURE MALADE UNIVERSELLE COMPLÉMENTAIRE)</td>
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<td>WAPT</td>
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HOW LONG WILL THEY REMAIN WITH NO OTHER PROSPECT BUT WALLS? CALAIS – FRANCE – 2014

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