ACCESS TO HEALTHCARE FOR PEOPLE FACING MULTIPLE HEALTH VULNERABILITIES

OBSTACLES IN ACCESS TO CARE FOR CHILDREN AND PREGNANT WOMEN IN EUROPE

Doroftei, aged 10, has not been vaccinated: “I still cannot go to school”
Saint-Denis - France

18th May 2015


EXECUTIVE SUMMARY

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 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/third-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 by MdM in consultations were properly immunised against tetanus (62.5%) or measles, mumps and rubella (34.5%) – although these vaccinations are known to be essential throughout the world and the vaccination coverage for measles at the age of two years is around 90% in the general population in Europe. More than half of the pregnant women had not had access to antenatal care before they came to MdM (54.2%). Of those, the majority came to receive care too late – that is after the 12th week of pregnancy (58.2%). A large majority of pregnant women had no healthcare coverage (81.1%), were living below the poverty line and 30.3% reported poor levels of moral support.

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 as a ‘security issue’, thereby forgetting their duty to protect. An overwhelming majority of patients (84.4%) questioned on their health status reported 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 ensure 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 exhorts all health professionals to provide care to all patients.

BARRIERS TO ACCESSING HEALTHCARE

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

- 8,656 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
- 43.4% were given up trying to access care or treatment in the last 12 months
- 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:
- 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)
- 38.8% of patients did not know where to go to get their children vaccinated

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 Member States
- 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
- 34% had the right to reside in Europe
- 63.4% were or had been involved in an asylum application

OF THE 84.4% 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 patients 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.

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%).

Thus completely isolated
- 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.
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 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/third-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 were properly immunised against tetanus (42.5%) or measles, mumps and rubella (34.5%)—although these vaccinations are known to be essential throughout the world and the vaccination coverage for measles at the age of two years is around 90% in the general population in Europe. More than half of the pregnant women had not had access to antenatal care before they came to MdM (54.2%). 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 exalts all health professionals to provide care to all patients. execute summary

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 exalts all health professionals to provide care to all patients.

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 22,371 patients were seen in the nine European countries

- 8,656 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)
- 81.1% had no health coverage
- 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:

- Only 42.5% had been vaccinated against tetanus (69.7% in Greece)
- Only 34.5% had been vaccinated against mumps, measles and rubella (MMR) (576% in Greece)
- 38.8% of patients did not know where to go to get their children vaccinated

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
  - 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

84.4% 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%)
- Thus completely isolated
- 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.
INTRODUCTION TO THE 2014 SURVEY

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). 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 57.9% 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 28.8% in December 2014¹⁴: 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 2013¹⁴.

¹⁸ Europe, 3, 2014. 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 2013. 

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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.

46. Health problems by organ system

47. Acronyms

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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). 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 57% 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 2014, 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 2013.
The crisis in Greece also had impacts on the number of drug users, the rates of HIV and hepatitis C (HCV) among them, and the type of drugs used. For example, the affordability drug (e.g., methadone mixed with other dangerous substances) is having devastating effects among drug users. A recent study estimated the Greek prevalence for HCV at 1.87%, while almost 80% of chronic HCV patients may not be aware of their infection, and only 58% of diagnosed chronic HCV patients had ever been treated.

**THE IMPACT OF THE CRISIS ON CHILDREN**

An estimated 27 million children in Europe are at risk of poverty or social exclusion, with the economic and social crisis further increasing their vulnerability.19 The national data collected by UNICEF clearly show the harmful impact of the crisis. Some 1.6 million more children were living in severe material deprivation in 2012 than in 2008 (an increase from 9.5% to 11.1%) in 30 European countries. The number of children entering into poverty during the crisis is 2.6 million higher than the number of those who have been able to escape poverty since 2008. Child poverty rates are soaring in Greece (40.5% in 2012 compared with 23% in 2008) and Spain (36.3% in 2012 compared with 26.2% in 2008).20

The latest available OECD data indicate a rise in the number of low-birth-weight babies by more than 16% between 2008 and 2012, 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.

**MIGRANTS IN DANGER AT EUROPE’S BORDERS**

In recent years, there has been a significant rise in the number of international 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 from 262,830 in 2008 to 1,905,354 in 2013.21 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).

The effects of the increase in the number of asylum seekers in Europe were directly observed by UNHCR 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 whereby 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 Syrian refugees who have filed their homes (over half of the total Syrian population), 3.8 million took refuge in neighbouring countries and 76 million were internally displaced.22 Syria was the largest source of asylum seekers centres were opened in 2014. In Munich the number of asylum seekers has almost doubled compared to 2013, temporarily leading to a situation whereby asylum seekers had to sleep in tents or outside, before new reception facilities were opened.

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.

**Migrants In Danger At Europe’s Borders**

In February 2015, Nils Muižnieks, the Council of Europe Commissioner for Human Rights, denounced the fact that “despite advances in legislating against racism and intolerance in the last years, some steps backwards have been observed.”

> **Migrants in Danger At Europe’s Borders**

> _A Syrian child in the migrant reception centre after having just arrived by boat in Lesbos, Greece – 2014_

> _© Philippe Koch_

**Rising intolerance**

Instead of focusing on the needs of vulnerable refugees, the European Council launched a joint police and border guard operation Mos Maiorum that took place over two weeks in October 2014. Although this joint operation was focused on apprehending ‘illegal’ 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 the labour force across OECD countries, the average unemployment rate among foreign-born workers (13%) is significantly higher than that of native-born workers (9%).

> _26. Economist Insight Rights_

> _27. European Commission. Facts and figures on the arrivals of migrants in Europe, Fact Sheet 17/2015._


These differences are most salient in Greece and Spain (respectively 26% and 24% unemployment among native-born compared with 38% and 36% among foreign-born workers).26 During last year’s European Parliamentary elections, the European Network Against Racism (ENAR) and the International Lesbian, Bisexual, Trans and Intersex Association (ILGA Europe) registered 42 hate speech incidents against migrants (LGBTI, Muslims and Roma) by election candidates, five of whom currently sit in the newly elected Parliament.

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> _31. OECD data on migrants for 2013: https://data.oecd.org/migration/foreign-born-participation-rates.htm#indicator-chart, last accessed on 17/02/2015._


> _34. OECD data on migration for 2013: https://data.oecd.org/migration/foreign-born-participation-rates.htm. Last accessed on 17/02/2015._


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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), 3.8 million took refuge in neighbouring countries and 76 million were internally displaced - Syria was the largest group of people out of 10 million. However under 150,000 Syrians have sought asylum in the EU since the war began - less than 4% of the conflict’s total refugee population - and the majority of Syrians were resettled in two countries, Germany and Sweden.

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 on the Mare Nostrum operation. UNHCR estimates that around 3,400 people have died or have gone missing at sea (data as of November 2014).

These differences are most salient in Greece and Spain (respectively 26% and 24%) unemployment among native-born compared with 38% 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 against migrants, LGBTI, Muslims and Roma: by election candidates, five of whom currently sit in the newly elected Parliament.

In February 2015, Nils Muižnieks, the Council of Europe Commissioner for Human Rights, denounced the fact that “despite advances in legislation 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, 80% of which are carried out against women, and homophobic acts, which occur six times every two days, is also cause for great concern.”
There is an impressive range of international texts and commitments 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 recommendations of the European Parliament (EP) and the Council of the EU. The EP acknowledged that, “universal access to health care 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 vulnerable groups”. The Commissioner for Health, Vytenis Andriukaitis, reminded national governments that universal access to healthcare is still a matter of concern in many EU countries and that “only in a few cases” are the most recent and relevant expressions of commitment to health protection since 2004 (www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&lg=fr&query=Directive+2014+30+EU+sur+la+couverture+maladie+universelle+et+complémentaire – cmuc)

FRANCE: Following the French President’s political commitments, from 1 July 2014 onwards, the thresholds for the complementary Universal Medical Coverage (Couverture Maladie Universelle complémentaire – cmuc) can be accessed by undocumented migrants from outside the EU. The law on asylum seekers: the length of time during which their access to healthcare is restricted to “acute medical emergencies and serious pathologies” 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 while the 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 fulfill 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 health 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 prior to being reimbursed for healthcare costs – from €220 to at least €375 a year in 2015 (up to €487 depending on the formula and insurance provider the individual has chosen). This has resulted in 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 access to the same healthcare as asylum seekers i.e. subsidised healthcare “that cannot be deferred”, including medical examination and medicine covered by the Pharmaceutical Companies Act. Thus, asylum seekers can be granted medical care “that cannot be deferred”, maternity care and abortion, and sexual and reproductive care. All children under 18 of undocumented parents have the same rights to medical and dental care as Swedish children. In February 2014 the Swedish National Board of Health and Welfare (Socialstyrelsen) came to the conclusion that the terms “that cannot be deferred” and “that cannot be deferred for health reasons” are based on ethical principles of the medical profession, are not medically applicable in health and medical care and can lead to “delaying patient safety”. Indeed, it makes it very difficult for an individual to know whether s/he will be accepted for medical care. Furthermore, there is a lack of legal clarity on whether destitute EU citizens who have lost the right to reside are currently able to access healthcare on the same basis as undocumented migrants from outside the EU. The law merely stipulates that this is possible “only in a few cases”, 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. But 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 removal and appeals system, making it easier and quicker to remove those with no right to be in the UK”. Finally, in Article 2 of the European Convention on Human Rights – the right to respect for family life and private life – it states: “Prevent ‘illegal’ immigrants accessing and abusing public services or the labour market.”

Migrants seeking leave to enter the country for more than six months will have to pay an immigration health charge. The government presumed that this measure will cover 50% of the cost of healthcare for international students and €280 for other categories of migrants. The surcharge will be paid as part of the individual’s visa fee, before their arrival in the UK, and would secure the same access to primary and secondary National Health Service (NHS) services during their stay as someone coming to the UK who has been granted leave to remain, subject to the charge. Ordinary residence (giving 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 granted leave to remain for 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

The EU Fundamental Rights Agency (FRA) issued a paper on the criminalisation of migrants in an irregular situation and of persons engaging with them – warranting 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.

42 i.e. the European Commission, International Monetary Fund and the European Central Bank.

43 Based on the Fundamental Rights Agency’s (FRA) report on fundamental rights at airports and another one on European Parliament’s (EP) position on human rights issues in the context of the Schengen area and the European Internal market.

44 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/SpainXX2_en.pdf

45 www.coe.int/en/web/commissioner/-/maintain-universal-access-to-health-care


47 europa.eu/2020/05/pdf/05052020_2540.pdf

48 europa.eu/2020/05/pdf/05052020_2540.pdf

49 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/Greece3462_en_pdf

50 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/Greece4326_en_pdf


52 www.picum.org

53 Council conclusions on the economic crisis and healthcare, Luxembourg, 20 June 2014.


55 The FRA also published a report on fundamental rights at airports and another one on European Parliament’s (EP) position on human rights issues in the context of the Schengen area and the European Internal market.

56 Council conclusions on the economic crisis and healthcare, Luxembourg, 20 June 2014.


58 www.europarl.europa.eu/pa/what_is/141007en.htm

59 i.e. the European Commission, International Monetary Fund and the European Central Bank.

60 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/Luxembourg60_en.pdf

61 No-one on earth is illegal. Bribing people as illegal are illegal. No-one on earth is illegal. “that being undocumented is not an offense against persons, states or international law, and persons engaging in the practice of ‘criminalising’ people as illegal are illegal.” No-one on earth is illegal.

62 Please note that MUP and its partners, especially the Platform for International Cooperation on Undocumented Migrants (PICUM) are not responsible for the content of the site ‘The new ‘Egal’ to design a person. Only the laws describ- ing human rights are effective to this work and it does not mean that the onerous situation is not an other against persons engaged in the practice of ‘criminalising’ people as illegal. In that case it does not matter whether the person who is not willing to pay the fees will be late or not.”


64 Council conclusions on the economic crisis and healthcare, Luxembourg, 20 June 2014.

65 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/Luxembourg60_en.pdf

66 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/Greece3462_en_pdf

67 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/Greece4326_en_pdf


69 “quality of healthcare”

70 “being undocumented is not an offense against persons, states or international law, and persons engaging in the practice of ‘criminalising’ people as illegal are illegal.” No-one on earth is illegal.

71 “being undocumented is not an offense against persons, states or international law, and persons engaging in the practice of ‘criminalising’ people as illegal are illegal.” No-one on earth is illegal.

72 www.coe.int/en/web/commissioner/-/maintain-universal-access-to-health-care

73 europa.eu/2020/05/pdf/05052020_2540.pdf

74 i.e. the European Commission, International Monetary Fund and the European Central Bank.

75 The FRA also published a report on fundamental rights at airports and another one on European Parliament’s (EP) position on human rights issues in the context of the Schengen area and the European Internal market.


77 www.coe.int/en/web/commissioner/-/maintain-universal-access-to-health-care

78 Kinship and the transplant

79 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/Luxembourg60_en.pdf

80 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/Greece3462_en_pdf

81 Consultations should remain free.

82 www.coe.int/t/dghl/monitoring/socialedp/country/States/Greece4326_en_pdf


84 www.coe.int/en/web/commissioner/-/maintain-universal-access-to-health-care

85 AN OVERVIEW OF INTERNATIONAL AND EU BODIES’ COMMITMENT TO HEALTH PROTECTION
BELGIUM: The law of 19 January 2012 modifying the legislation relating to healthcare coverage for asylum seekers: the length of time during which their access to healthcare is restricted to «acute medical cases and serious» was reduced from 48 to 15 months. By May 2014 (last available information) 2013 onwards, the thresholds for the political commitments, from 1 July 2013, on the asylum seekers’ family reunification. Furthermore, there is a lack of legal clarity on whether destitute EU citizens who have lost the right to reside are currently able to access healthcare on the same basis as undocumented migrants from outside the EU. The law merely stipulates that this is possible “only in a few costs”, 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). But 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’ migrants 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 who have no right to be in the UK. • end the right to health under Article 8 of the European Convention on Human Rights – the right to respect for family life and private life. • prevent ‘illegal’ migrants accessing and abusing public services or the healthcare system. Migrants seeking leave to enter the country for more than six months will have to pay an immigration health charge. The fee is £200 for those aged 18 years and older and £400 for children aged 17 years and under. The fee will be deferred, including medical examination and medicine covered by the Pharmaceutical Services Scheme. All claimed asylum seekers will have full health coverage. The full extent of this measure is expected to end 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 cases and serious» was reduced from 48 to 15 months. By May 2014 (last available information) 2013 onwards, the thresholds for the political commitments, from 1 July 2013, on the asylum seekers’ family reunification. Furthermore, there is a lack of legal clarity on whether destitute EU citizens who have lost the right to reside are currently able to access healthcare on the same basis as undocumented migrants from outside the EU. The law merely stipulates that this is possible “only in a few costs”, 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). But in practice, undocumented EU citizens still have to pay full fees for receiving healthcare in most hospitals.

SWEDEN: Since July 2013, a law has granted undocumented migrants (includig the specific healthcare coverage for undocumented migrants, State Medical Aid (Aide Médicale de l’État – AME) the threshold of which is the same as for the CMUC). This measure should enable more than 750,000 additional people to have full health coverage. The full extent of this measure is expected to end by the end of 2015.

GREECE: According to the Common Ministries Decree of 5 June 2014, access to healthcare for individuals without healthcare coverage where the 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 fulfill 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 prior to being reimbursed for healthcare costs – from €220 to at least €875 a year in 2015 (up to €475 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.

FRANCE: Following the French President’s political commitments, from 1 July 2013 onwards, the thresholds for the complementary Universal Medical Coverage (Couverte Madelîne Universelle complémentaire – CMUC) can benefit from the Urgent Medical Aid (Aide Médicale de l’État – AME). However, this has not yet been applied in practice by many CRAS.

There is an impressive range of international texts and commentaries that ensure people’s basic and universal right to health. This covers the United Nations (UN) Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights, the Council of Europe (the European Conven- tion 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 he declared to a newly created Interest Group on Access to Healthcare in the European Parliament: ‘In many countries, voters have already sent a clear message: they would not up with policies that not only neglect citizens’ right to access healthcare but eventually 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: recognizing the fact that undocumented migrants are deprived of health care. Firstly, 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 specific situations of vulnerable groups, such as Roma, undocumented migrants, people with HIV or cancer patients with health problems.

EUROPEAN UNION INSTITUTIONS

The European Parliament (EP) acknowledged that, “access to the most basic healthcare services, such as emergency care, is severely undermined in many countries. In its country conclusions on Spain concerning health, social security and social protection, the European Committee of Soci- al Rights (ECR) condemns the exclusion of undocumented migrants from healthcare in Spain...” The EP’s rapporteur on Access to Health Care for Asylum Seekers and Unaccompanied Minors, the Parliamentary Assembly (PACE) noted that, “there is no legal instrument, or even consensus, with regard to protection of the health interests of children...” The Assembly stressed the need to apply the benefit of the doubt, bearing in mind the higher interest of the child.

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.
Since 1980, the international aid organisation Doctors of the World – Médecins du monde (MdM) has been working for a world where trai- ners 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 cooperation 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 or- ganisations in Argentina, Belgium, Canada, France, Germany, Greece, Japan, Luxembourg, the Netherlands, Portugal, Spain, Sweden, Swit- zerland, the UK and the USA58. 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 Japan. 80% of the domestic programmes are run by mobile, outreach teams.

MdM’s main mission is to provide access to healthcare through freely accessible front line 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, undocumented 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 of combating the stigmatisation and exclusion of these groups. MdM supports the creation of self-help groups, as a way of stren- ghening civil society and recognising experience-based expertise. MdM activities can thus lead to social change: amending laws and practices as well as reinforcing equity and solidarity.

THE OBSERVATORY’S OBJECTIVES AND ACTIVITIES

In spite of the growing awareness and literature on health inequalities, the populations encountered through local 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’. 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 fol- lowing objectives:

❖ Continuous improvement of 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 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, interactional and contextual dimensions of vulnerabilities. For ex- ample, 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. The re- lation, 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.mdmeuroblog.wordpress.com

PROGRAMMES SURVEYED

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

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

To best meet the multiple needs of populations encounted, different types of interventions exist across the MdM in- ternational network. In the city of Luxembourg, the same questionnaires as for the 25 other programmes were administered to 59 patients in order to provide a 58 Prior to the creation of the MdM International Network, Observatory on access to healthcare, MdM France implemented in 2006 a common class code 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 publish the results. This led to the creation in 2000 of the Observatory of Access to Healthcare in France. 58 In January 2015, 10 new organisations joined the MdM International Network to form the MdM International Network. In order to comply with the requirements for membership, they signed a charter that includes an obligation of an equal commitment to the objectives of the network. The new members are Austria, Bulgaria, the Czech Republic, Hungary, Ireland, Italy, Norway, Poland, Romania -> Slovenia. More on this at www.mdmeuroblog.wordpress.com. 59 Prior to the creation of the MdM International Network, the Observatory on access to healthcare, MdM France implemented in 2006 a common class code 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 publish the results. This led to the creation in 2000 of the Observatory of Access to Healthcare in France.
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matic violence has 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 in 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 accessible frontline 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 nations 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 of combating the stigmatisation and exclusion of these groups.
MdM supports the creation of self-help support groups as a way of stren-
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MdM activities can thus lead to social change: amending laws and
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tions (especially for 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’. In

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

- Continuously improve the quality of services provided to MdM pa-
patients (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 analysis, narrative patient testimonies, de jure and
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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,
interacting and contextual dimensions of vulnerabilities. For ex-
ample, 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
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shaped by social determinants, many members of vulnerable groups are
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Since 2000, the five reports produced by the Observatory have seen a
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THE OBSERVATORY’S OBJECTIVES AND ACTIVITIES

The Observatory on Access to Healthcare in France

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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well as social workers, support workers, psychologists and administrators.

To meet the various needs of patients and 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

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<th>Country</th>
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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 practi-
tioner, the entry point to the healthcare system. Additionally, social communications are provided in a migrant centre in central London, and with an organisation supporting sex workers

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 questionnaire as for the 25 other programmes was
administered to 59 patients in order to provide a survey of the population in question. The overall majority of patients (72%) were men and the vast majority (94%) of the patients were Luxembourg nationals, followed by Romanian and Italian citizens. More than a quarter of patients encountered in 2014 were homeless. In
Luxembourg the main barriers to social welfare in general and to healthcare in particular consist of administrative and financial difficulties.

Even when encountered through day shelters, they are required to pay moderate user fees. Access to healthcare coverage depends upon having work and a residential address. Undocumented migrants have no healthcare cover-
age and only have access to emergency services. More and more hospitals require a deposit from people who don’t present a healthcare insurance
statement, expanding the collaborative partnership to 10

In January 2015, five new organisations joined the MdM International Network to form the Euro- pean Observatory on Access to Healthcare. MdM France implemented in 2010 a common class collection tool in order to monitor the main social determinants of health, the factors in access healthcare and the health status of its service users and publish the results. This led to the creation in 2000 of the Observatory of Access to Healthcare in France.

OPENING OF MdM LUXEMBOURG AND FIRST INFORMATION ON BARRIERS TO HEALTHCARE

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http://www.mdmeuroblog.wordpress.com

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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 (29.1 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 (9.3%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

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>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU Citizen with no permission to reside</td>
<td>2.4%</td>
</tr>
<tr>
<td>Total without permission to reside</td>
<td>22.9%</td>
</tr>
</tbody>
</table>

Geographical Origin of Pregnant Women in the Nine European Countries and Istanbul (%)

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of Patients</th>
<th>No. of Visits</th>
<th>%</th>
<th>No. of Patients</th>
<th>No. of Visits</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU</td>
<td>2,350</td>
<td>15</td>
<td>0.6</td>
<td>2,450</td>
<td>12</td>
<td>0.5</td>
</tr>
<tr>
<td>NL</td>
<td>395</td>
<td>2.2</td>
<td>0.8</td>
<td>400</td>
<td>2.2</td>
<td>0.8</td>
</tr>
<tr>
<td>DE</td>
<td>538</td>
<td>3.4</td>
<td>1.9</td>
<td>543</td>
<td>2.8</td>
<td>1.2</td>
</tr>
<tr>
<td>GR</td>
<td>8,854 / 162</td>
<td>4.9</td>
<td>0.3</td>
<td>8,576 / 163</td>
<td>5.2</td>
<td>0.3</td>
</tr>
<tr>
<td>ES</td>
<td>263</td>
<td>1.7</td>
<td>0.1</td>
<td>265</td>
<td>1.7</td>
<td>0.1</td>
</tr>
<tr>
<td>FR</td>
<td>8,539</td>
<td>56.5</td>
<td>1.2</td>
<td>7,965</td>
<td>55.0</td>
<td>1.2</td>
</tr>
<tr>
<td>NL</td>
<td>123</td>
<td>0.8</td>
<td>0.1</td>
<td>123</td>
<td>0.8</td>
<td>0.1</td>
</tr>
<tr>
<td>SE</td>
<td>98</td>
<td>0.6</td>
<td>0.1</td>
<td>98</td>
<td>0.6</td>
<td>0.1</td>
</tr>
<tr>
<td>TR</td>
<td>869</td>
<td>5.6</td>
<td>0.4</td>
<td>1,295</td>
<td>8.2</td>
<td>0.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,319</td>
<td>6.2</td>
<td>0.2</td>
<td>2,454</td>
<td>14.5</td>
<td>0.2</td>
</tr>
</tbody>
</table>

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).

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.
METHODS

QUESTIONNAIRES AND METHOD OF ADMINISTRATION

The data analysed in this report was collected by means of questionnaires administered to patients who visited one of the 25 programmes in the 20 countries associated with the International Network Observa-
tory 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).

MAP OF THE SITES SURVEYED IN 2014

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 Euro-
porean countries and are, for most of them and unless otherwise in-
dicated, 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 pro-
portions (CAP) - where countries contribute proportionally to their nu-
mbers - 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.

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 29,898 for which the whole questionnaire was administered in the nine European countries and 1,296 in Turkey).

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).

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 Eu-
ropean countries (29.1 in Istanbul) and the youngest was 14 years old. Almost all the pregnant women seen (9706) were foreign nationals from sub-Saharan Africa (37.1%), the EU (20.2%), Asia (13.9%) and Eu-
ropean countries outside the EU (9.9%). In Istanbul, almost all the pre-
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FOCUS ON PREGNANT WOMEN

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.

In Turkey, 2.8% saw the MDM programmes 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 Eu-
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gnant women (96.7%) were from sub-Saharan Africa.
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 one or more of their minor children. In Istanbul, up to 74.1% 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.

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 (98.7%). 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.

HEALTH CARE COVERAGE FOR PREGNANT WOMEN

<table>
<thead>
<tr>
<th>% IN EUROPE (N=370)</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>24.0</td>
</tr>
<tr>
<td>PARTIAL HEALTHCARE COVERAGE</td>
<td>21.0</td>
</tr>
<tr>
<td>FREE ACCESS TO GENERAL MEDICINE</td>
<td>11.9</td>
</tr>
<tr>
<td>ACCESS ON A CASE BY CASE BASIS</td>
<td>1.0</td>
</tr>
</tbody>
</table>

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

- Sexual 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/EHN. What is the efficiency/effectiveness of antenatal care and the financial and organizational implications?

"Antenatal care is a right for pregnant women. Therefore interventions proved effective in the scientific literature should be provided universally, free of charge." (WHO)

Antenatal care also known as prenatal care is the set of interventions that a pregnant woman receives from organized health care services. Antenatal care is essential to prevent or identify and treat conditions that may threaten the health of the fetus/newborn and/or the mother; to help a woman approach pregnancy and birth as positive experiences and provide a good start for the newborn child. The care for each pregnant woman needs to be individualized based on her own needs and wishes.

Without access to timely, i.e. after 12 weeks of pregnancy – and regular antenatal care throughout the pregnancy, a number of risks can affect mothers and children:
- Mother to child transmission of HIV (and Hepatitis B)
- 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.
- Partial healthcare coverage
- Free access to general medicine
- Access to emergency services only
- No healthcare coverage
- Open rights in another European country
- Access to GP with fees
- Partial healthcare coverage
- Access on a case by case basis

In most countries this means that they have to pay for their care.

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

MdM UK - London - 2014
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—∅.

Regardless of their administrative status, 81.1% of pregnant women see MōM 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 MōM’s free health centres—∅ and, of those, 58.2% received care too late—that is after the 12th week of pregnancy—∅.

Among 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.

During pregnancy, women reported that the lack of healthcare coverage led 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 breastfeeding, no explanation about postnatal care. Women reported higher stress and risks during birth and during first months as well as no future family planning, no explanation about breastfeeding, no explanation about postnatal care.

Among the risks that mothers and children face without access to timely antenatal care are:

- 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)
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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).

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MōM UK — London — 2014
BELGIUM: Undocumented pregnant women can gain access to AMU 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 and delivery 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 residence permit (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 health care, 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 ante- and postnatal care. New changes might occur in 2015.

According to the new law, women who can afford the cheapest health insurance (around €340 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 for the full course of care.

SWITZERLAND: Undocumented 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. However, 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 pregnant 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 must be fully paid for by undocumented women.

SPAIN: According to Article 3ter of the 2012 Royal Decree, undocumented migrants are excluded from the healthcare scheme, except for pregnant women (and minors) who can get a specific “pregnancy individual health card” at the nearest public health centre to where they live. This card is only valid during the pregnancy, delivery and postnatal care periods. It seems that two years after the adoption of this new law, many health centres are still not implementing it, thus lacking of knowledge or will, leaving pregnant women with no health care.

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 antenatal care and termination of pregnancy. They have to pay a fee of around €45 every time they contact the authorities. The situation is unclear for pregnant EU nationals who have lost the right to reside in Sweden.

UK: Maternity care for undocumented pregnant 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 and childbirth. Women pay a fee of around £2,000 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.

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 taking 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 MDN 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 87 million young women in developing countries resort to unsafe abortions every year. They urgently need our protection.”

Mobilisation for women’s right to decide for themselves if and when they have a child

MDM participation in the European mobilisation against the Spanish anti-abortion law – Paris, France – February 2014

MDM

For all details and references to the laws, please consult the full Moham report on access to maternity care in Europe in May 2015 at www.mdmeuroblog.wordpress.com.

68 www.youtube.com/watch?v=KTr9RiJ7VlI
69 www.youtube.com/watch?v=79F6x77T7Q
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 is only available if obtained 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 AMU but there are many barriers to obtaining it, thus it can be difficult to gain access to antenatal care 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 reside (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.

With regard to termination of pregnancy, they have to pay approximately €340 in public hospitals. Article 79(b) 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 must be fully paid for by undocumented women.

SPAIN: According to Article 3ter of the 2012 Royal Decree, undocumented migrants are excluded from the healthcare scheme, except for pregnant women (and minors) who can get a specific “pregnancy individual health card” at the nearest public health centre to where they live. This card is only valid during the pregnancy, delivery and postnatal care periods. It seems that two years after the adoption of this new law, many health centres are still not implementing it, through lack of knowledge or will, leaving pregnant women with no health care.

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 antenatal 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 pregnant women 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 undocumented pregnant 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, which is around €7000 without complications.

At the end of 2013 the Spanish government proposed to repeal the 2001 law on sexual and reproductive health and voluntary interruption of pregnancy, thereby revoking 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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Mobilisation for Women’s Right to Decide for Themselves if and When They Have a Child
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 also 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, as 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 4.4% 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%). 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 (57.6%) 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, 38.8% 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.

KNOwLEDGE OF WHERE TO Go FOR VACCINAtIONS

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A total of 645 minor patients were seen by MdM programmes in 2014. They represent 4% of the total population. No minors were seen in Sweden.

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2. Herd immunity applies to measles, rubella, varicella (chickenpox), whooping cough. For infections for which humans do not form a reservoir (e.g. tetanus, rabies), vaccines only offer individual protection. 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.
3. Knowledge of where to go to have their children vaccinated.

In total, 38.8% 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.

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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 and is registered with the Municipality of her second child. She told me that he is not allowed to get one as he is not registered with the Municipality.

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.

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 are exempt from paying these costs.

UNDOCUMENTED MIGRANTS

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 health care (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 3rd, al. 4 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 price 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 €40 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 €43, added to the €43 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.

77 Royal Decree-Act 14/2002
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 that he is not allowed to get one as he is not registered with the municipality.’

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MdM Spain – Tenerife – December 2004

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96 The full legislative report on access to healthcare in 12 countries published in May 2015 is available at www.mdmeuroblog.wordpress.com


98 Royal Decree Act 16/2002
have applied for asylum related to unaccompanied children who arrived in Europe since 2008 (the most reliable statistics are those presented in the EU annual report: Brussels, 2014).

Although there are few comprehensive data on the total number of unaccompanied minors present in Europe or arriving each year, significant numbers of unaccompanied children not having any healthcare coverage and half being homeless at their first encounter with MDM. Psychological issues were very common for most of these children, indicating the need for adequate psychosocial and medical support.

In France, the number of unaccompanied migrant minors also increased, with the majority converging towards the Parisian area (Paris and Saint-Denis). Indeed the number of unaccompanied minors visiting MDM in and around Paris tripled in 2014, with most children not having any healthcare coverage and half being homeless at their first encounter with MDM. Psychological issues were very common for most of these children, indicating the need for adequate psychosocial and medical support.

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. 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 had not 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 ‘alternative’ 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.

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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. Africa (including the Maghreb) remains the top continent of origin for patients seen in Belgium and France, while Asia is more significant 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**

| Country | EU No. | CH No. | DE No. | ES No. | NL No. | SE No.
|---------|--------|--------|--------|--------|--------|--------
| Morocco | 473    | 93     | 156    | 51     |
| DR Congo | 189    | 36     | 90     | 24     |
| Georgia | 152    | 22     | 53     | 17     |
| Cameroon | 110    | 21     | 12     | 12     |
| Romania | 86     | 17     | 9      | 10     |
| Algeria | 85     | 17     | 9      | 9      |
| Nigeria | 64     | 16     | 9      | 9      |
| Senegal | 51     | 14     | 9      | 8      |
| Mongolia | 45     | 10     | 9      | 7      |
| Bulgaria | 43     | 10     | 9      | 7      |
| EL No. |    |
| Greece | 251    | 25     | 24     |
| Afghanistan | 149    | 14     | 6     |
| Albania | 88     | 57     | 9      |
| Syria | 64     | 39      | 7      |
| Nigeria | 24     | 9      | 7      |
| Georgia | 25     | 4      | 3      |
| Senegal | 18     | 9      | 3      |
| Bangladesh | 17     | 3      |
| Pakistan | 12     | 9      | 3      |
| UK (1) | 169    | 37      | 32     |
| Philippines | 178    | 50     | 14     |
| India | 164    | 46     | 15     |
| Bangladesh | 140    | 37      | 10    |
| Uganda | 129    | 33     | 13     |
| China | 115    | 38     | 53     |

**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 (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.

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

9.3% in this report, the Middle East comprises Afghanistan, Egypt, Iraq, Israel, Kazakhstan, Kurdistan, Kuwait, Lebanon, Pakistan, Palestine-Syria, the United Arab Emirates and Yemen.

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.

84 In 2008, 2012 and 2013, 6.0%, 1.6% and 2.3% of the people cited health as one of their reasons for migration respectively.

85 In 2008, 2012 and 2013, 6.0%, 1.6% and 2.3% of the people cited health as one of their reasons for migration respectively.
In the nine European countries, patients mostly originated from sub-Saharan Africa (29.0%), Asia (15.6%), 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%.

TOP TEN MOST FREQUENTLY RECORDED NATIONALITIES, BY COUNTRY

<table>
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<tr>
<th>DE NO</th>
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<tr>
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<tr>
<td>Nigeria 64</td>
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<td>Bulgaria 43</td>
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<td>NL NO</td>
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<td>Afghanistan 1497</td>
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<td>Syria 629</td>
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<td>Mali 457</td>
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</tr>
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<td>UK (1) 960</td>
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<td>Gambia 29</td>
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<td>Uganda 138</td>
<td>Sri Lanka 33</td>
<td>Cameroon 103</td>
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<tr>
<td>China 115</td>
<td>Brazil 39</td>
<td>Ivory Coast 53</td>
<td>Ghana 24</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.

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.

REASONS FOR MIGRATION

As in 2013, in the European countries, the reasons most often cited for migration were, overwhelmingly, economic: (50.2%) and 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.

<table>
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<tr>
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ECONOMIC REASONS, UNABLE TO EARN A LIVING IN HOME COUNTRY

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POLITICAL, RELIGIOUS, ETHNIC, SEXUAL ORIENTATION

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<td>26.3</td>
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TO ESCAPE FROM WAR

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TO JOIN OR FOLLOW SOMEONE

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FAMILY CONFLICTS

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TO ENSURE YOUR CHILDREN'S FUTURE

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PERSONAL HEALTH REASONS

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TO STUDY

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OTHER

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<td>0.0</td>
<td>0.0</td>
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</tbody>
</table>

TOTAL

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<th>ES</th>
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<tbody>
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<td>12.0</td>
<td>7.0</td>
<td>12.0</td>
<td>7.0</td>
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</table>

MISSING DATA (%)

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<th>ES</th>
<th>NL</th>
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<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

83 In this report, the Middle East comprises Afghanistan, Egypt, Iraq, Iran, Jordan, Kurdistan, Lebanon, Pakistan, Palestine, Syria, the United Arab Emirates and Yemen.

84 Economic reasons correspond to the question: ‘Why did you leave your country? For economic reasons, to earn a living, because had no perspectives/no way to earn a living in home country’.

85 In 2008, 2012 and 2013: 0.9% to 14.6%, or to escape from family conflict: 7.8%.

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“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

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

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 (81.8%) and family reasons (to join or follow someone: 22.2%) and the others had done it for the four main reasons mentioned above.

<table>
<thead>
<tr>
<th>REASONS FOR MIGRATION: COMPARISON BETWEEN EU CITIZENS (EXCEPT NATIONALS) AND OTHER MIGRANTS (%)</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>
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<tr>
<td>Political, religious, ethnic, sexual orientation</td>
<td>1.2</td>
<td>24.9</td>
<td>&lt;0.001</td>
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<tr>
<td>To escape from war</td>
<td>0.5</td>
<td>10.6</td>
<td>&lt;0.001</td>
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<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>
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<tr>
<td>To ensure your children’s future</td>
<td>0.0</td>
<td>2.5</td>
<td>&lt;0.001</td>
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<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>
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<tr>
<td>Others</td>
<td>5.0</td>
<td>9.5</td>
<td>0.001</td>
</tr>
<tr>
<td>Total</td>
<td>125.3</td>
<td>122.8</td>
<td></td>
</tr>
</tbody>
</table>

@SArAh AL cALAy

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

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<tr>
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MdM France – Calais – 2014
The majority (66.0%) of all people seen at the MDG 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) 63.2% 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, 66% of the 16.8% 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) have permission to reside. 63.2% 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).

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 without permission to reside. As undocumented migrants, EU citizens who have lost their permit to reside can also be subject to expulsion procedures (stricter than for citizens of non-EU countries).

The average proportion of people without a residence permit covers wide disparities. The average proportion of people without a residence permit covers wide disparities. The average proportion of people without a residence permit covers wide disparities. The average proportion of people without a residence permit covers wide disparities. The average proportion of people without a residence permit covers wide disparities.

The majority (66.0%) of all people seen at the MDG 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) have permission to reside. 63.2% 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).
ADMINISTRATIVE SITUATION

The majority (66.0%) of all people seen at the MDM centres in the 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) 63.2% 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 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 without permission to reside. As undocumented migrants, EU citizens who have lost their system of medical coverage for undocumented migrants to include EU nationals (83.9%) of those seen in Belgium and 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 (374/14), the number of foreign citizens with permission to reside (20/39) 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 (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 currently funded by the European Union. Copenhagen accounted for a majority of the patients.

In Sweden, 43.7% of patients had no permission to reside; a quarter were EU nationals staying for less than three months and 44.3% had a residence permit in another EU country.

In London, 57.5% of those coming to the centre were foreigners who did not have permission to reside and 15.3% were asylum seekers; 18.1% 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).

The French health care system is based on a full health care coverage framework for undocumented migrants, under specific conditions and administrative constraints: assistance from support workers is a full healthcare coverage for undocumented migrants, under specific conditions and administrative constraints: assistance from support workers is (HELPFUL) PARIS, FRANCE – 2014.

**Administrative Status by Country (%)**

<table>
<thead>
<tr>
<th>Country</th>
<th>DE</th>
<th>CH</th>
<th>BE</th>
<th>IT</th>
<th>ES</th>
<th>FR</th>
<th>NL</th>
<th>SE</th>
<th>UK</th>
<th>IE</th>
<th>RO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen of Non-EU Country without permission to reside</td>
<td>70.5</td>
<td>15.4</td>
<td>9.0</td>
<td>14.3</td>
<td>54.9</td>
<td>59.1</td>
<td>54.3</td>
<td>20.4</td>
<td>57.0</td>
<td>44.6</td>
<td>56.7</td>
</tr>
<tr>
<td>EU citizen with no permission to reside</td>
<td>13.4</td>
<td>1.4</td>
<td>2.9</td>
<td>1.7</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>8.3</td>
</tr>
<tr>
<td>Total without permission to reside</td>
<td>83.9</td>
<td>16.8</td>
<td>38.1</td>
<td>11.7</td>
<td>63.5</td>
<td>67.9</td>
<td>54.2</td>
<td>47.3</td>
<td>58.0</td>
<td>54.7</td>
<td>66.0</td>
</tr>
<tr>
<td>No residence permit requirement (nationals)</td>
<td>1.8</td>
<td>0.8</td>
<td>1.7</td>
<td>37.4</td>
<td>0.8</td>
<td>5.0</td>
<td>0.0</td>
<td>2.2</td>
<td>1.0</td>
<td>7.3</td>
<td>4.7</td>
</tr>
<tr>
<td>Asylum seeker (application or appeal ongoing)</td>
<td>3.9</td>
<td>71.5</td>
<td>3.2</td>
<td>11.0</td>
<td>2.4</td>
<td>13.4</td>
<td>2.5</td>
<td>3.3</td>
<td>12.3</td>
<td>14.1</td>
<td>12.7</td>
</tr>
<tr>
<td>Valid residence permit</td>
<td>1.8</td>
<td>6.1</td>
<td>4.4</td>
<td>20.9</td>
<td>2.9</td>
<td>2.5</td>
<td>0.0</td>
<td>11.1</td>
<td>0.0</td>
<td>7.5</td>
<td>4.0</td>
</tr>
<tr>
<td>EU national staying for less than three months (no residence permit required)</td>
<td>2.4</td>
<td>31</td>
<td>18.2</td>
<td>3.8</td>
<td>12</td>
<td>21</td>
<td>0.0</td>
<td>24.2</td>
<td>1.3</td>
<td>6.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Visas of all types</td>
<td>1.6</td>
<td>0.6</td>
<td>7.6</td>
<td>0.5</td>
<td>2.8</td>
<td>2.8</td>
<td>0.0</td>
<td>2.2</td>
<td>11.8</td>
<td>3.3</td>
<td>3.6</td>
</tr>
<tr>
<td>EU national with permission to reside</td>
<td>2.8</td>
<td>3.0</td>
<td>5.0</td>
<td>2.7</td>
<td>2</td>
<td>15</td>
<td>0.0</td>
<td>2.2</td>
<td>0.3</td>
<td>1.9</td>
<td>17</td>
</tr>
<tr>
<td>Residence permit from another EU country</td>
<td>1.0</td>
<td>0.3</td>
<td>3.4</td>
<td>1.6</td>
<td>0.4</td>
<td>14</td>
<td>0.0</td>
<td>14.3</td>
<td>0.4</td>
<td>2.5</td>
<td>16</td>
</tr>
<tr>
<td>Specific situation concerning right to remain</td>
<td>0.4</td>
<td>0.6</td>
<td>1.8</td>
<td>0.5</td>
<td>1.2</td>
<td>2.0</td>
<td>0.0</td>
<td>0.0</td>
<td>3.3</td>
<td>11</td>
<td>1.7</td>
</tr>
<tr>
<td>Total with permission to reside</td>
<td>15.5</td>
<td>83.1</td>
<td>60.8</td>
<td>83.0</td>
<td>36.7</td>
<td>32.1</td>
<td>5.0</td>
<td>49.5</td>
<td>34.6</td>
<td>42.9</td>
<td>34.0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0.5</td>
<td>0.3</td>
<td>1.2</td>
<td>4.4</td>
<td>0.0</td>
<td>0.0</td>
<td>0.8</td>
<td>3.3</td>
<td>7.6</td>
<td>2.0</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Missing data (%)</td>
<td>7.1</td>
<td>9.4</td>
<td>4.8</td>
<td>23.0</td>
<td>2.7</td>
<td>32.6</td>
<td>1.6</td>
<td>7.1</td>
<td>8.8</td>
<td>16.3</td>
<td>21.6</td>
</tr>
</tbody>
</table>

A. With 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. With adequate financial resources and valid healthcare coverage
E. Including subsidiary/humanitarian protection

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 (39.5%).

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.

88 In Belgium and France, access for undocumented migrants to personal healthcare coverage if they are destitute (through MDD in France and AMU in Belgium) remains very constrained. Authorized residents are referred to the mainstream system without attending a social or medical consultation in MDD.
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\(^1\) (this was particularly common in Switzerland, Sweden and the Netherlands). This proportion stood at 63.0% in Istanbul.\(^2\)

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 62.0% 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.\(^3\)

29.5% of those questioned in Europe\(^4\) deemed their accommodation to be harmful to their health or that of their children. In Istanbul, this proportion reached 57.9%.\(^5\)

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\(^1\) The notion of unstable accommodation was given by patients if they were not sure they would be able to stay where they were living – it is their own perception of the instability of their housing which is of significance.

\(^2\) The question was not asked in Belgium and in Greece in the other countries, the missing values accounted for 9.2% in CH, 6.2% in DE, 13.6% in EL, 30.0% in IT, 12.0% in NL, 6.1% in SE and 56.0% in UK.

\(^3\) Response rate at 95.0%.

\(^4\) The question was not asked in Belgium and in Greece.

\(^5\) Missing values: 46.0% in CH, 40.8% in DE, 20.0% in EL, 15.0% in IT, 25.0% in NL, 6.3% in SE and 56.0% in UK.

\(^6\) Response rate at 96.8%.

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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, 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).\(^6\)

Almost all the people 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)\(^7\).

SOCIAL ISOLATION

When asked about moral support\(^8\), one in two people said they could rarely or never rely on support if they needed it. 16.4% 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).

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\(^6\) Missing values: 6.1% in CH, 13.6% in DE, 19.0% in EL, 11.6% in IT, 50.0% in NL, 49.5% in SE, 71.0% in UK, 36.7% in UK, 6.6% in TR.

\(^7\) The notion of isolation is characterized by the fact that patients have no social links and feel isolated. It is therefore unsurprising that 46.6% in NL, 26.7% in DE, 21.9% in CH, 12.5% in se, 6.4% in TR.

\(^8\) The notion of support is defined as the help that people would be able to expect if they were faced with the problem of illness or injury. It would be much higher and may actually represent all the patients seen by MDM.

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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).\(^6\)

Almost all the people 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).\(^7\)

AVAILABILITY OF SUPPORT WHEN NEEDED BY COUNTRY (%)
LIVING CONDITIONS

It must be noted, as every year, that the vast majority of people who presented at the Médecins du Monde (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 proportion stood at 83.0% in Switzerland, Sweden and the Netherlands.

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 live with family members or friends (38.9%, up to 62.6% in France) or to have their 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%.

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When asked about moral support, one in two people said they could rarely or never 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).

AVAILABILITY OF SUPPORT WHEN NEEDED BY 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 seeking employment 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 MDM team has been confronted with an undocumented patient being reported to the police at an emergency unit and has had a meeting with hospital staff from the Mu- nicipal public hospitals to inform them about the option not to report undocumented migrants in the case of emergencies – which should be a duty not to report.

In Greece, 84.9% of patients had no healthcare coverage at all. For emergency care, a recommendation creates a huge barrier to healthcare, especially for undocumented migrants. The proportion of patients with no healthcare coverage was particularly high in France (52.3%) and Belgium (91.9%). These rates can mostly be explained by the fact that the centres concerned (Nice, Saint-Denis, Brussels and Antwerp) 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 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 8.1% of them had healthcare rights in another EU country.

In Sweden, half of the patients (47.6%) 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, 74.9% 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.

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Table 1 shows that, since September 2012, between 750,000 and 875,000 migrants in Greece lost their healthcare coverage through the suspension in emergency care for undocumented migrants, which should be provided in emergency situations and interim periods where they have no effective healthcare coverage:
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 who obtained citizenship 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 MDM team has been confronted with undocumented patient being reported to the police at an emergency unit and has held a meeting with hospital staff from the five Munich public hospitals to inform them about the option not to report undocumented migrants in the case of emergencies – which should be a duty not to report.

In Greece, 84.9% of patients had no healthcare coverage. In 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 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 when they were denied for the emergency care they received were witnessed by MDM as well as being reported by the Ombudsman in Spain.

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In London, almost all patients (82.7%) had no access to the NHS at all when they came to the MDM clinic, they had not been able to register yet with a GP; the entry point to the healthcare system. This was in a political context where the government was (and still is) increasingly questioning access to healthcare for immigrants. Only 9.0% already had free access to a GP.

The proportion of patients with no healthcare coverage was particularly high in France (92.3%) and Belgium (91.9%). These rates can be mostly explained by the fact that the concerns centred (Nice, Saint-Denis, Brussels and Amsterdam) 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 where they have no effective healthcare coverage.

Zoe, a 60-year-old Moroccan woman, is undocumented. She lives at her sister’s home. Zoe visits MDM 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 AMU 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 undeclared but you can’t contribute to anything. You are nobody when working undeclared. 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 valid period of the AMU, each AMU defines the period, which varies from one day to six months.

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In London, almost all patients (82.7%) had no access to the NHS at all when they came to the MDM clinic, they had not been able to register yet with a GP; the entry point to the healthcare system. This was in a political context where the government was (and still is) increasingly questioning access to healthcare for immigrants. Only 9.0% already had free access to a GP.

The proportion of patients with no healthcare coverage was particularly high in France (92.3%) and Belgium (91.9%). These rates can be mostly explained by the fact that the concerns centred (Nice, Saint-Denis, Brussels and Amsterdam) 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 where they have no effective healthcare coverage.

Zoe, a 60-year-old Moroccan woman, is undocumented. She lives at her sister’s home. Zoe visits MDM 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 AMU 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 undeclared but you can’t contribute to anything. You are nobody when working undeclared. 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 valid period of the AMU, each AMU defines the period, which varies from one day to six months.

MIDM Belgium – Brussels – December 2014
Only 23.0% of all patients surveyed in second European countries reported that they had given up trying to access healthcare for migrants (particularly those undocumented) in Turkey.

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. Therefore, for its enforcement, MdM workers provide points of contact of the law and explain it to health professionals. They explain each patient’s case and then follow it up. Mária 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.

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”. 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 language barrier is just a cost €5. ‘Then I asked the staff if they knew about the new law and they did not.

Mária is a 39-year-old unemployed Greek nurse. She had healthcare coverage until 2009. Earning about €400 per month, she has an undisclosed job as a care worker for an elderly woman. “My income covers accommodation and food. I must work to take care of my mother who is ill.”

In Spain, teams have explored different channels for integrating migrants 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 rights), which explains the decreasing number of patients giving up seeking care.

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 (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.

GIVING UP SEEKING HEALTHCARE

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 months and up to 61.2% 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 2012, 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 16/2012, the MdM Spain teams have explored different channels for integrating migrants into the mainstream health services – 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).

Only 1% of patients said that they had no difficulties when seeking care (versus 23% in Turkey). While some of these people may not have needed healthcare, it is not clear that others have internalised the various barriers to accessing healthcare to such an extent that they did not even try to seek it.

The frequency of patients giving up seeking healthcare has significant decreases in Spain since 2012:

- In 2014, proportions are not valid in Belgium and Switzerland (where less than 10% of people have healthcare coverage)
- In 2012, 52.0% of patients gave up their treatment in Turkey, 22.0% in Spain, 15.0% in 2013 and 10.0% 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 16/2012, the MdM Spain teams have explored different channels for integrating migrants into the mainstream health services.

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They also may have perceived more significant barriers to healthcare before going to an MdM clinic.102. Another third (33.9%) had not tried to access healthcare; with huge differences between France (83.9%), the Netherlands (78.7%) and Sweden (42.0%) and the UK (52.2%) at the top. While some of these people may not have needed healthcare, it is clear that others have internalised the various barriers to accessing healthcare to such an extent that they did not even try to seek care.

In Europe, 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 applied. Therefore, for its enforcement, MdM social 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 for kids are sometimes not available at the hospital, her baby is still medically monitored and vaccinated by MdM services.

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”.103 He 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 of the World Sweden had told me: that the law had guaranteed only cost €85. Then I asked the staff if they knew about the new law and they did not.

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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 (88.4%) and Istanbul (85.0%), whereas, as mentioned before, the fear of being reported or arrested was a frequently cited barrier in Mali (69.4%) and Istanbul (85.0%).

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). Risk of diagnostic errors 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.

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

It is estimated that 34% of women and 22% of men have experienced some form of violence (35.0% among all patients, p<0.001). 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).

Geographical origins of victims of violence surveyed in six European countries.

It is estimated that 34% of women and 22% of men have experienced some form of violence (35.0% among all patients, p<0.001).

Experiences of violence were most frequent among asylum seekers and refugee status holders in Europe, accounting for 64.7% of all victims. Experiences of violence were less common among family members of asylum seekers and refugee status holders (46.7%), followed by those of family members of European nationals (37.6%). Experiences of violence were less common among family members of European nationals (37.6%). Experiences of violence were least common among family members of European nationals (37.6%).

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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 her 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 attend an examination. Two weeks later 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 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

EXPERIENCES OF VIOLENCE

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) or, in diagnostic errors 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 and with interest to accounts of previous experiences of violence, in the country of origin, during the migratory journey and in the host country. Unfortunately, stigmatization of ‘foreigners’ remains one of the main obstacles to better patient care for people fleeing torture and political violence.

In 2014, 1,809 patients were interviewed about violence. Among them, 84.4% reported at least one violent experience in their lifetimes. Experiences of violence affected both sexes and all ages. Asylum seekers were disproportionately highly represented among victims of violence (57.0%) 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 (57.0%) compared with 34.4% among all patients, p<0.001.

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 MdM. MdM 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 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.

MdM UK – London – 2014
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 (34.9%), reported by 24.4% of 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 1% 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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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 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 populations of these seven countries (in 2013).

Self–Perceived Health Status

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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.

Chronic Health Conditions

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Urgent Care and Necessary Treatment

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

In total, three out of four patients (74.6%) 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% 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.

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 (72.6%) and France (69.2%) and, above all, in Istanbul (98.9%).

Most of the patients (59%) 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 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 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 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 (92.2%), 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%).

Looking at the diagnoses in detail, very few of the patients may have migrated due to these chronic conditions, as the majority of the reported diagnoses are not life threatening. In Istanbul, 31.7% of the patients were in this situation. Only 9.5% of migratory patients had at least one chronic health problem which they had known about before they came to Europe (in CH, DE, ES, NL and UK).

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 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 medical tests and medication.


Self–Perceived Health Status by Country (%)
### 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 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 populations 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.

#### 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—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% 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 percentage was significantly higher in Switzerland (79.7%), Germany (82.9%), France (76.9%), the Netherlands (65.3%) and London (63.7%). 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 (49.4%), Germany (72.7%) and France (60.2%) and, above all, in Istanbul (98.9%).

#### HEALTH PROBLEMS LARGELY UNKNOWN PRIOR TO ARRIVAL IN EUROPE

Only 9.5% of migrant patients had at least one chronic health problem which they had known about before they came to Europe (in CH, DE, ES, NL and UK).

Looking at the diagnoses in detail, very few of the patients may have migrated due to these chronic conditions, as the majority of the reported diagnoses are not life threatening. In Istanbul, 37.1% of the patients were in this situation. This shows again how the idea of migration for health reasons is false: in Istanbul, foreign citizens must pay 100% of health costs.

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**Self-perceived health status by country (%)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Good</th>
<th>Very Good</th>
<th>Fair</th>
<th>Bad</th>
<th>Very Bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>17.7</td>
<td>9.1</td>
<td>12.1</td>
<td>5.4</td>
<td>7.7</td>
</tr>
<tr>
<td>DE</td>
<td>20.6</td>
<td>25.7</td>
<td>18.5</td>
<td>36.2</td>
<td>29.5</td>
</tr>
<tr>
<td>ES</td>
<td>26.6</td>
<td>24.1</td>
<td>12.2</td>
<td>20</td>
<td>24.6</td>
</tr>
<tr>
<td>NL</td>
<td>36.2</td>
<td>29.5</td>
<td>15.9</td>
<td>16.3</td>
<td>36.3</td>
</tr>
<tr>
<td>SE</td>
<td>42.5</td>
<td>42.5</td>
<td>36.6</td>
<td>36.6</td>
<td>36.6</td>
</tr>
<tr>
<td>UK</td>
<td>37.0</td>
<td>24.8</td>
<td>36.9</td>
<td>24.9</td>
<td>36.6</td>
</tr>
<tr>
<td>total</td>
<td>40.6</td>
<td>24.8</td>
<td>36.9</td>
<td>24.9</td>
<td>36.6</td>
</tr>
</tbody>
</table>

**General health status comparison between MDM patients and the general population (including the 25-44 age group) in the host country (%)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Total pop</th>
<th>MDM pop</th>
<th>Total pop</th>
<th>MDM pop</th>
<th>Total pop</th>
<th>MDM pop</th>
<th>Total pop</th>
<th>MDM pop</th>
<th>Total pop</th>
<th>MDM pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>23.9</td>
<td>45.2</td>
<td>63.6</td>
<td>37.6</td>
<td>64.8</td>
<td>45.2</td>
<td>63.6</td>
<td>37.6</td>
<td>64.8</td>
<td>45.2</td>
</tr>
<tr>
<td>DE</td>
<td>12.2</td>
<td>5.8</td>
<td>27.0</td>
<td>12.9</td>
<td>27.0</td>
<td>12.9</td>
<td>27.0</td>
<td>12.9</td>
<td>27.0</td>
<td>12.9</td>
</tr>
<tr>
<td>ES</td>
<td>26.2</td>
<td>43.7</td>
<td>54.9</td>
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<td>54.9</td>
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<td>54.9</td>
<td>31.6</td>
<td>54.9</td>
<td>31.6</td>
</tr>
<tr>
<td>NL</td>
<td>114.0</td>
<td>4.8</td>
<td>26.8</td>
<td>115.0</td>
<td>26.8</td>
<td>115.0</td>
<td>26.8</td>
<td>115.0</td>
<td>26.8</td>
<td>115.0</td>
</tr>
<tr>
<td>SE</td>
<td>48.8</td>
<td>12.9</td>
<td>24.6</td>
<td>48.8</td>
<td>24.6</td>
<td>48.8</td>
<td>24.6</td>
<td>48.8</td>
<td>24.6</td>
<td>48.8</td>
</tr>
<tr>
<td>UK</td>
<td>69.5</td>
<td>41.5</td>
<td>21.9</td>
<td>69.5</td>
<td>21.9</td>
<td>69.5</td>
<td>21.9</td>
<td>69.5</td>
<td>21.9</td>
<td>69.5</td>
</tr>
</tbody>
</table>

**Missing values:** respectively 19.5% in CH, 32.0% in DE, 21.2% in EL, 1.0% in ES, 24.4% in FR, 8.4% in NL, 59.7% in SE, 5% in UK, 0.1% in TR.

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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 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 a local hospital to MDM’s Polyclinic in Patras. Since then, Natalia has been treated at the MDM Polyclinic which covers the costs of medical tests and medication.

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115 Missing values. In CH, 17.9% in DE, 60.5% in ES, 65.8% in NL, 35.8% in SE, 64.3% in UK, 3% in TR. Question not asked in Belgium.

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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 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 (9.2%), 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%).

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1 For information purposes. Missing values: 25.6% in CH, 35.6% in DE, 66.2% in ES, 61.0% in NL, 65.8% in SE, 62.2% in UK, 62.2% in TR. Question not asked in Belgium.

2 Treatments were regarded as essential by doctors to provide them what they judged to be necessary. The table includes also referrals to primary care physicians. In other cases they were regarded as precautionary. There is no index of unnecessary treatments or of simple complaints.

3 In Switzerland, patients are seen by nurses.

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In the seven European countries surveyed, the questions were not asked in France and only the questions about general health status were asked. Missing values: 75% in CH, 9.8% in DE, 20.0% in ES, 26.8% in NL, 75.9% in SE, 21.3% in UK, 5.0% in TR.
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%), consultations for consultation and depressive 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%).

Overall, 10% of medical consultations for women patients dealt with gynaecological problems: normal pregnancy and postnatal issues (11.0% and 0.3%) were most frequent—at 1.7%.

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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 reduced and he became a more sociable man, made some friends in a church in a city nearby 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 had a ticket. He was nearly arrested because the policeman 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.

Mdm Netherlands – Amsterdam – November 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 but I was brought up by the community. The community members used to talk to each other. They told me: ‘you are 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 that I’d never ever experienced in my life. They took good care of me and I was fortunate as me.”

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’d 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 we all need 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. 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 Cogdon. 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 place takes toughness, 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.”

MdM UK – London – September 2014

Medische Consultatie in Azehm – Istanbul – Turkey – 2014

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

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MdM Netherlands – Amsterdam – November 2014

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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.

- 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 an 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. However, while it holds its Fundamental Rights Charter and its European Social Charter so dearly, at the same time 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 im-presiveness of 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 about it?

- 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.

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.

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127. www.eupha-migranthealthconference.com/?page_id=1766

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mdm.org www.ebcog.org/index.php?option=com_content&view=category&id=44&Itemid=177


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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.

- 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.

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ACRONYMS

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The right of children to health and care is one of the most basic, universal and essential human rights. Athens, Greece 2014

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