Access to healthcare for people facing multiple health vulnerabilities
Pierre Chauvin, Cécile Vuillermoz, Nathalie Simonnot, Frank Vanbiervliet,
Marie Vicart, Anne-Laure Macherey, Valérie Brunel

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

18TH MAY 2015
Europe is the cradle of human rights. Indeed, the range of international texts and State commitments that ensure people’s basic and universal rights is impressive. With regard to healthcare, European Union institutions recently reaffirmed their adherence to the values of universality, access to good quality care, equity and solidarity. Yet, this report shows how, in practice, these promises too often remain just words rather than effective progress. Doctors of the World – Médecins du monde (MdM) teams are distinctive because they work both on international programmes and at home. Abroad, 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/3rd-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 exerts all health professionals to provide care to all patients.

The reported barriers to healthcare, as well as the analogies of the legal frameworks in the countries surveyed, confirm that restrictive laws and complex administrative processes to obtain access to care actually contribute to making people sicker. As in previous surveys, the barriers to accessing healthcare most often cited were financial inability to pay, administrative problems, lack of knowledge or understanding of the healthcare system and rights to care, and language barriers. It is thus hardly surprising that one patient in five said s/he had given up trying to access care or treatment in the last 12 months. The data collected clearly deconstruct the myth of migration for health reasons, so often used by governments to restrict access to care. The migrants encountered in 2014 had been living in the ‘host country’ for 6.5 years on average before consulting MdM. Only 3% quoted health as one of the reasons for migration. Among the migrants who suffered from chronic diseases, only 9.5% knew they were ill before arriving in Europe. European and national migration policies focus heavily on migration as a ‘security issue,’ thereby forgetting their duty to protect. An overwhelming majority of patients (84.4%) questioned on their experience of violence reported that they had suffered at least one violent experience, whether in their country of origin, during the journey or in the host country. They need extra care and safe surroundings to rebuild their lives, instead of too often living in ditches and slums in fear of expulsion. EU Member States and institutions must offer universal public health systems built on solidarity, equality and equity (and not on profit rationale), open to everyone living in the EU. MdM urges Member States and EU institutions to ensure immediately that all children residing in the EU have full access to national immunisation programmes and to paediatric care. Similarly, all pregnant women must have access to termination of pregnancy, antenatal and postnatal care and safe delivery. In order to respect the ban on the death penalty, seriously ill migrants should never be expelled to a country where effective access to adequate healthcare cannot be guaranteed. They must be protected in Europe and have access to the care they need. As health professionals, we will continue to give appropriate medical care to all people regardless of their administrative or social status and the existing legal barriers. MdM refuses all restrictive legal measures to alter medical ethics and exerts all health professionals to provide care to all patients.
EXECUTIVE SUMMARY

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Increasingly dangerous migration routes due to tightening border controls, sub-standard detention conditions and a life in fear of being expelled await most of the migrants who decide to seek safety and refuge in Europe. They have in common with destitute EU citizens the risk of becoming victims of exploitation, but they also face xenophobia. While the economic crisis and austerity measures have resulted in an overall increase in unmet health needs, women and children seem to be affected disproportionately.

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In 2014, MdM provided care to 23,040 patients seen in face-to-face medical and social consultations in 25 countries (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.

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) (57.6% in Greece)
- 38.8% of patients did not know where to go to get their children vaccinated

BARRIERS TO ACCESSING HEALTHCARE

- 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
- 34% had the right to reside in Europe
- 43% were or had been involved in an asylum application

OF ALL THE PEOPLE SEEN IN THE NINE EUROPEAN COUNTRIES:
- 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 rights (14.1%)
- 54.8% needed an interpreter.
- During the previous 12 months:
  - 20.4% had given up seeking medical care or treatment
  - 15.2% had been denied care on at least one occasion
  - 4.5% had experienced racism in a healthcare setting
  - 52% of patients without permission to reside said they restricted their movement or activity for fear of arrest.
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INTRODUCTION TO THE 2014 SURVEY

THE CONTEXT IN 2014

The context in 2014

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

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

The researchers at the WHO European Observatory on Health Systems and Policies noted that many of the countries at risk of inadequate levels of public funding following the crisis are actually EU countries, further adding that: “the important economic and social benefits of public spending on health have not been sufficiently acknowledged in fiscal policy decisions and EU-IMF Economic Adjustment Programmes”.

The Organisation for Economic Co-operation and Development (OECD) recently warned that the gap between rich and poor is at its highest level in most OECD countries in 30 years: “Not only cash transfers but also increasing access to public services, such as high-quality education, training and healthcare, constitute long-term social investment to create greater equality of opportunities in the long run”.

GREECE: THE SITUATION REMAINS PARTICULARLY WORRYING

Although the aftermath of the financial and economic crisis that started in 2008 is still being felt across healthcare systems throughout Europe, some countries have been hit more severely than others. In Greece, 2.5 million people live below the poverty line (23.1% of the total population). After 2010, 23.1% of the total population live in overcrowded households; 29.4% were unable to keep their home adequately warm, and 57.9% of the destitute population report that they are being confronted with payment arrears for electricity, water, gas, etc. Crisis and austerity policies have left almost a third of the population without healthcare coverage. Unemployment stood at 28.4% 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.

4. European Observatory on Health Systems and Policies, op.cit.
17. In 2012, only 30,000 persons (3% of unemployed) could benefit from the long-term unemployment assistance schemes to cover basic income threshold. Makrigiannakis G et al. Estimating the social impact of the crisis in Greece. OECD Economic Department, 9 January 2014, p.56.
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THE CONTEXT IN 2014

The context in 2014 was shaped by the continuing effects of the economic crisis. The economic crisis that began 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, 23.1% 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 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.

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14 OECD Directorate for Employment, Labour and Social Affairs. op. cit.


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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, the total number of 11.4 million Syrians who have fled their homes (over half of the total Syrian population) has reached 3.8 million. According to UNHCR, 2013; 346: f1061.

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 2012 compared with 23% in 2008 and 36% in 2012 compared with 26.2% in 2008.

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

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.

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 affordable drug diazepam (methylamphetamine 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.

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14 www.unhcr.org/551318479.html

13 © MdM

12 www.eurostat.net


10 2015/366/EU - see www.eurostat/eu28/30418.htm


8 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).

7 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 that had targeted migrants, LGBTI, Muslims and Roma. By-election candidates, five of whom currently sit in the newly elected Parliament.

6 In February 2015, Nils Muiznieks, 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, 40% of which are carried out against women, and homophobic acts, which occur since two every day, is also cause for great concern.”
RECENT LEGAL CHANGES, FOR BETTER OR WORSE

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

BELGIUM: The Law of 19 January 2012 confirmed the practice of most public healthcare services in Belgium to provide healthcare to undocumented migrants who are in the country during the first three months of their stay [1]. Consequently, destitute EU citizens have to prove that they have been living in Belgium for longer than three months, before obtaining the same access to the healthcare scheme as undocumented migrants. However, on 30 June 2014[2], the Constitutional Court of Belgium ruled that this measure created a difference of treatment that is discriminatory to destitute EU citizens and their family members, as destitute undocumented migrants are not integrated in medical care (from 2013, they can benefit from the Urgente – AMU) scheme upon arrival. Thus, with this judgment, EU citizens in Belgium should have access to AMU during the first three months of their stay in Belgium. However, this has not yet been applied in practice by many CPAS.

FRANCE: Following the French President’s political commitments, from 1 July 2013 onwards, the thresholds for the complementary Universal Medical Coverage (Couvercle Mutuelle Universelle complémentaire – CMUC) and the solidarity fund during their stay as someone ordinary resident (services during their stay as someone ordinarily resident) are increased. However, in 2014, the Socialstyrelsen publicly ‘abuse’ to being reimbursed for healthcare costs, among other things. 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.

There is an impressive range of international texts and commitment measures that ensure people’s basic and universal right to health. 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 Convention on Human Rights and the European Social Charter) and the European Union (The Treaty on the European Union, the Treaty on the Function of the European Union and the EU Charter on Fundamental Rights), as well as many resolutions, conclusions and opinions of the European institutions and agencies which are the most recent and relevant expressions of commitment to health protection since MDMS’ previous European report in May 2014.

COUNCIL OF EUROPE

In its 2014 conclusions on Spain concerning health, social security and social protection, the European Committee of Social Rights (ECER) condemns the exclusion of undocumented migrants from healthcare in Spain. In its 2014 conclusions on Greece, the Committee questions whether the right to healthcare for pregnant women, adolescents and the uninsured is sufficiently guaranteed. Concerning Human Rights, WH, Madison, reminded national governments that universal access to healthcare should not be undermined by austerity measures or the economic crisis - and following his visit to France, he denounced the serious and chronic inadequacies in the reception of asylum seekers and unaccompanied minors, as well as the use of bone age tests to determine their care or confinement. Migrants seeking leave to enter the country for more than six months will have to pay an immigration health charge. The amount payable is set at £200 for adults and £150 for children aged up to 18 years.

EUROPEAN UNION INSTITUTIONS

The European Parliament (EP) acknowledged that, “access to the most basic healthcare services, such as emergency care, is severely limited for migrants. The identification requirement, the high price of treatment and the fear of being detected and reported to the authorities” – The EP has also asked the Troika[3] not to cut in fundamental areas such as healthcare as a condition for financial assistance to euro area countries. The Commission’s ELAction Plan on HIV/AIDS for 2014-2016[4] (March 2014) includes access to prevention, treatment and care for undocumented migrants as an indicator. Following the Granada Declaration[5] by public health researchers and professionals, the Council of the EU acknowledged that, “universal access to healthcare is of paramount importance in addressing health inequalities” [6]. And following his visit to France, he denounced the serious and chronic inadequacies in the reception of asylum seekers and unaccompanied minors, as well as the use of bone age tests to determine their care or confinement. The Committee of Ministers (PACE) noted that, “there is no legal instrument, or even consensus, with regard to protecting the rights of asylum seekers and unaccompanied children”. The Assembly stressed the need to apply the benefit of the doubt, bearing in mind the higher interest of the child.

EU institutions have long-term health and economic consequences, particularly for Roma, undocumented migrants and people with chronic health conditions or disabilities and people with mental health problems.

41 www.cmu.fr

42 Please note that the NHS and its partners, especially the Platform for International Cooperation on Undocumented Migrants (PICUM) and the NHS, offers a package of services at the site of the new ‘Wego’ designed to support migrants. Only the legal documents issued by the local health authority is valid work is difficult. Being undocumented is not an окончательный признак joined to the list of services to be taken into account. It can make the role of General Practitioner

43 The full legislative report on access to healthcare in 12 countries published in May 2015, is available at www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr

44 www.mdmeuroblog.wordpress.com

46 The FRA also published a report on fundamental rights at airports and another one on migrants’ rights at Europe’s sea borders.

48 EP resolution on undocumented women migrants in the EU (2013/2115(INI)).

54 http://ec.europa.eu/commission/2014-2019/andriukaitis/announcements/inaugura-

55 The FRA also published a report on fundamental rights at airports and another one on migrants’ rights at Europe’s sea borders.

RECENT LEGAL CHANGES, FOR BETTER OR WORSE

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

BELGIUM: The law of 19 January 2012 (38) granted additional people full healthcare coverage. The full extent of this measure is expected by the end of 2015.

GERMANY: In March 2015, the German Federal government modified the law on Asylum seekers: the length of time during which their access to healthcare is restricted to ‘acute medical emergencies’ and ‘safety’ 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 but without 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 fulfil the requirements in order to issue a health booklet; and people who previously had health insurance but lost it due to debts to their insurance funds.

Thus, with this judgment, EU citizens in Belgium should have access to AMU (Assistance Médicale Urgente – AMU) scheme upon arrival.

FRANCE: Following the French President’s political commitments, from 1 July 2013 onwards, the thresholds for the complementary Universal Medical Coverage (Couvre Maladie Universelle complémentaire – CMUc) will be calculated on the basis of income (not including parents) for the specific healthcare coverage for undocumented migrants, State Medical Aid (Aide Médicale de l’Etat – AME), the threshold of which is the same as for the CMUc. This measure should enable more than 750,000 additional people to have full health care coverage. The full extent of this measure is expected by the end 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 €1,375 a year in 2015 (up to €4,875 depending on the formula and insurance provider the individual has chosen). This has resulted in the difficulties for an increasing number of patients. However, this payment of a contribution does not apply (nor does it apply to their dental care), GP visits, antenatal care or for integrated care schemes for chronic diseases e.g. diabetes.

SWEDEN: Since July 2013, a law has granted undocumented migrants and the same access to healthcare as asylum seekers i.e. subsidised healthcare ‘that cannot be deferred’, including medical examination and medicine covered by the Pharmaceutical Benefits Act. All children and undocumented parents have the same rights to medical and dental care as Swedish children. In February 2014, a law was introduced, which states that undocumented children ‘not yet been identified’ will remain to the charge of ordinary residence, ordinary residence (living full access to the NHS) was already restricted in 2014 (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 identified in the UK for more than five years and have not made a successful application for indefinite leave to remain.

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

An overview of international and EU bodies ‘commitment to health protection

There is an impressive range of international texts and commitment measures 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 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 and agencies that are the most recent and relevant expressions of commitment to health protection since 1945.

COUNCIL OF Europe

In its country conclusions on Spain concerning health, social security and social protection, the European Commission of Social Rights (ECR) condemns the exclusion of undocumented migrants from healthcare in Spain. In its country conclusions on Greece, the Committee questions whether the right to health for pregnant women, adolescents and the uninsured is sufficiently guaranteed. Concerning Human Rights, the European Parliament, the Council of Europe (PACE) noted that, ‘there is no legal instrument, or even consensus, with regard to providing sufficient protection for the ‘illegals’…’

EUROPEAN UNION INSTITUTIONS

The European Parliament (EP) acknowledged that, ‘access to the most basic healthcare services, such as emergency care, is severely limited for irregular migrants and illegal workers’. The EP has also asked the Troika (41) not to cut in fundamental areas such as healthcare as a condition for financial assistance to euro area countries. The Commission’s EELA Action Plan on HIV/AIDS for 2014-2016 (42) (March 2014) includes access to prevention, treatment and care for undocumented migrants as an indicator. Following the Granada Declaration (43) by public health researchers and professionals, the Council of the EU acknowledged that, ‘universal access to healthcare is of paramount importance in addressing health inequalities…’ and notes with concern that extensive cuts in the supply of healthcare can affect access to care and may have long-term health and economic consequences, particularly for the most vulnerable groups in the society’.

In its country conclusions in Spain concerning health, the European Commission of Social Rights (ECR) condemned the exclusion of undocumented migrants from healthcare in Spain. In its country conclusions on Greece, the Committee questions whether the right to health for pregnant women, adolescents and the uninsured is sufficiently guaranteed. Concerning Human Rights, the European Parliament, the Council of Europe (PACE) noted that, ‘there is no legal instrument, or even consensus, with regard to providing sufficient protection for the ‘illegals’…’ The Assembly stressed the need to apply the benefit, bearing in mind the higher interest of the child:

41. Resolution on undocumented migrants in Euro area countries: The Troika’s negative legislative changes that have influenced access to healthcare as summarised below:

42. ‘Prevent ‘illegal’ immigrants accessing and abusing public services or the labour market’.

43. ‘Prevent “illegal” immigrants accessing and abusing public services or the labour market’.

44. ‘Prevent illegal’ immigrants accessing and abusing public services or the labour market’.

The new Commission, European Commission (2014/2019(INI)) on the Function of the European Union and the EU Charter on Fundamental Rights, following the Granada Declaration (43) by public health researchers and professionals, the Council of the EU acknowledged that, ‘universal access to healthcare is of paramount importance in addressing health inequalities…’ and notes with concern that extensive cuts in the supply of healthcare can affect access to care and may have long-term health and economic consequences, particularly for the most vulnerable groups in the society’.

The Assembly stressed the need to apply the benefit, bearing in mind the higher interest of the child:

45. ‘Prevent ‘illegal’ immigrants accessing and abusing public services or the labour market’.

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MdM activities can thus lead to social change: amending laws and then gathering civil society and recognising experience-based expertise. MdM supports the creation of self-support groups as a way of strengthening user groups, as a way of identifying health-related solutions in the access to healthcare including homeless people, drug users, and undocumented migrants. More than half of the MdM International Network’s programmes are domestic, including 150 across the European 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 participation 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-support groups as a way of strengthening 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 health programmes (especially undocumented migrants) often fall through population-wide official surveys and are currently not captured by the official health information systems – and thus are often referred to as ‘invisible’.

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

- Continuously improve the quality of services provided to MdM patients (through the use of 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 integrate people facing vulnerabilities into the mainstream healthcare system.
- Support the field teams in monitoring their programmes.

The Observatory has developed a quantitative and qualitative information 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 populations encountered in MdM programmes that complements population-wide official statistics with concrete experience provided directly 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, interactive and contextual dimensions of vulnerabilities. For instance, some population groups are being made vulnerable due to restrictive 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 dependent on the social context, factors such as health insurance can be accumulated and have combined effects. Moreover, social vulnerability often translates into social vulnerability.

Since 2006, the five reports produced by the Observatory have seen a gradual expansion in the geographical coverage of the data collection, as well as in the focus – from undocumented migrants to all patients who attended MdM health centres throughout the MdM International 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 information about the healthcare system and patient rights with regard to accessing healthcare. Ultimately, these programmes aim to help patients reiterate into the mainstream healthcare system, where it is legally possible. MdM programmes are run by volunteers and employees consisting of health professionals – nurses, medical doctors, midwives, dentists, specialists etc. – as well as social workers, support workers, psychologists and administrators etc. To meet the various needs of patients and the characteristics of each country’s context, different packages of services and types of interventions 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 encountered, different types of interventions exist across the MdM International Network, depending on the location and specific characteristics of the national health systems. MdM programmes may offer primary healthcare (child healthcare sometimes including vaccinations, care for mental health issues, chronic conditions and sexual and reproductive health), specialist consultations and referrals to other health care providers (e.g. laboratories, hospital care, obstetric and pediatric care).

Examples of interventions: free social and medical consultations, harm reduction programmes with syringes, condoms and outreach medical consultations in slums, squats, on the streets etc.

OPENING OF MdM LUXEMBOURG AND FIRST INFORMATION ON BARRIERS TO HEALTHCARE

For ten months in 2014, MdM Luxembourg provided medical consultations to destitute, homeless or undocumented people in a day shelter in the city of Luxembourg. The same questionnaires as for the 25 other programmes were administered to 59 patients in order to provide a picture of the population encountered. The overall majority of the medical consultations were provided to patients who were recognised as vulnerable. Among the medical consultations, 60% were conducted by nurses and 40% by doctors. 25% were conducted by doctors and nurses.

To meet the various needs of patients and the characteristics of each country’s context, different packages of services and types of interventions have been developed over the years, as summarised below.

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60 Throughout this document, countries are cited alphabetically order by their official international code, according to European recommendations (Interinstitutional Style Guide, EU, Rev. 14 / 1.3.2012).

58 In January 2015, 10 new organisations joined the MdM International Network to form the MdM International Network’s Global Programmes in 2014 (in addition to freely accessible front-line primary healthcare consultations as well as social support and information about the healthcare system and patient rights with regard to accessing healthcare. Ultimately, these programmes aim to help patients reiterate into the mainstream healthcare system, where it is legally possible. MdM programmes are run by volunteers and employees consisting of health professionals – nurses, medical doctors, midwives, dentists, specialists etc. – as well as social workers, support workers, psychologists and administrators etc. To meet the various needs of patients and the characteristics of each country’s context, different packages of services and types of interventions have been developed over the years, as summarised below.

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Since 1980, the international aid organisation Doctors of the World – Medecins du mond (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 commitment of volunteers. Working on a daily
basis with people facing numerous vulnerability factors, MdM believes
in social justice as a vehicle for equal access to healthcare, respect
for fundamental rights and collective solidarity.

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

MdM’s main mission is to provide access to healthcare through free-
ly accessible frontline social and medical services for people who face
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their access to healthcare including homeless people, drug users,
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pation of user groups, as a way of identifying health-related solutions
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MdM supports the creation of self-support groups as a way of stren-
thening user groups, as a way of identifying health-related solutions
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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 qualitative and quantitative infor-
mation system that includes systematic patient data collection and
annual statistical analysis, narrative patient testimonies, de jure and
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practices when it comes to working with people facing multiple
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health. Defining vulnerable groups in a static manner ignores the subjective,
interactional and contextual dimensions of vulnerabilities. For ins-
tance, some population groups are being made vulnerable due to re-
strictive laws. Furthermore, everyone is likely to be vulnerable at some
point in his or her life. Fixed and mobile interventions (and 80% of the
programmes) provide parts of or the entire range of preventive and curative
services as well as social advice.

Depending on the locations and specific characteristics of the
national health systems, MdM programmes may offer pri-
mary healthcare (unpaid consultations sometimes including vac-
cination, care for mental health issues, chronic conditions and
sexual and reproductive health); specialist consultations
(de jure), as well as social workers, support workers, psychologists and administrators
– nurses, medical doctors, midwives, dentists, specialists etc. – as
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Examples of interventions: free social and medical consul-
tations, harm reduction programmes with syringes, condoms
and outreach medical consultations in slums, squats, on the
streets etc.

i50 In January 2015, five organisations joined the MdM international network to form the Cara-
ibbean Network in charge of fundraising in Latin America, including the collaboration groups in 50
countries. Argentina, Bolivia, the Czech Republic, Hungary, Italy, Norway, Poland, Romania and Slovene. More on this at www.mdmeuroblog.wordpress.com

OPENING OF MDM LUXEMBOURG AND FIRST INFORMATION ON BARRIERS TO HEALTHCARE

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age and only have access to emergency services. More and more hospitals require a deposit from people who don’t present a healthcare card. To get healthcare, they have to pay a so-called revenue cover only emergency consultations, the medication prescribed (by a doctor in Luxembourg) and emergency dental care.
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

<table>
<thead>
<tr>
<th>Administrative Status</th>
<th>% in Europe (n=135)</th>
<th>% in Istanbul (n=43)</th>
</tr>
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<tbody>
<tr>
<td>Citizen of non-EU country without permission to reside</td>
<td>50.0</td>
<td>29.4</td>
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<tr>
<td>EU Citizen with no permission to reside</td>
<td>2.4</td>
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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 14-years old. Almost all the pregnant women seen (97.0%) were foreign nationals from sub-Saharan Africa (31.9%), the EU (20.2%), Asia (13.9%) and European countries outside the EU (9.9%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

| Geographical Origin of Pregnant Women in the Nine European Countries and Istanbul (%) |
|----------------------------------|------------------|
| Total | 100.0 |
| European Union | 15.3 |
| Near and Middle East | 37.1 |
| Americas | 0.0 |
| Asia | 0.0 |
| Sub-Saharan Africa | 0.0 |

**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 10 countries associated with the International Network Observatory in 2014. Every patient who attended a consultation with a health professional and support worker was administered at least one of the three standardised, multilingual forms - social questionnaire, medical questionnaire and medical re-consultation questionnaire(s).

**Statistics**

This report contains data in three different types of proportion: 1) the crude proportions by country are all 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) the European total proportions were calculated for the nine European countries and are, for most of them and unless otherwise indicated, weighted average proportions (WAP) of all the countries; this allows actual differences between countries to be corrected so they each have the same weight in the overall total; 3) the crude proportions (CAP) - where countries contribute proportionally to their numbers - are also given systematically in the tables and figures. When numbers of respondents were low, or when subgroups of populations were examined, CAP was preferably provided.

**Reasons for Consulting MDM Programmes**

The vast majority of patients consulted MDM programmes to obtain medical care (81.1% in Europe and 99.4% in Istanbul). On the other hand, consulting MDM for an administrative, legal or social issue is also common: one third of patients seen in Europe came for one of these reasons (alone, or more often, together with a health problem).

**Focus on Pregnant Women**

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<td>-</td>
</tr>
</tbody>
</table>

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 14-years old. Almost all the pregnant women seen (97.0%) were foreign nationals from sub-Saharan Africa (31.9%), the EU (20.2%), Asia (13.9%) and European countries outside the EU (9.9%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

| Geographical Origin of Pregnant Women in the Nine European Countries and Istanbul (%) |
|----------------------------------|------------------|
| Total | 100.0 |
| European Union | 15.3 |
| Near and Middle East | 37.1 |
| Americas | 0.0 |
| Asia | 0.0 |
| Sub-Saharan Africa | 0.0 |

**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

<table>
<thead>
<tr>
<th>Administrative Status</th>
<th>% in Europe (n=135)</th>
<th>% in Istanbul (n=43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen of non-EU country without permission to reside</td>
<td>50.0</td>
<td>29.4</td>
</tr>
<tr>
<td>EU Citizen with no permission to reside</td>
<td>2.4</td>
<td>-</td>
</tr>
</tbody>
</table>

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 14-years old. Almost all the pregnant women seen (97.0%) were foreign nationals from sub-Saharan Africa (31.9%), the EU (20.2%), Asia (13.9%) and European countries outside the EU (9.9%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

| Geographical Origin of Pregnant Women in the Nine European Countries and Istanbul (%) |
|----------------------------------|------------------|
| Total | 100.0 |
| European Union | 15.3 |
| Near and Middle East | 37.1 |
| Americas | 0.0 |
| Asia | 0.0 |
| Sub-Saharan Africa | 0.0 |
FOCUS ON PREGNANT WOMEN

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>Country</th>
<th>% in Europe</th>
<th>% in Istanbul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen of non-EU country with no permission to reside</td>
<td>26.0</td>
<td>30.1</td>
</tr>
<tr>
<td>EU citizen with no permission to reside</td>
<td>2.4</td>
<td>-</td>
</tr>
<tr>
<td>Total without permission to reside</td>
<td>28.4</td>
<td>33.1</td>
</tr>
<tr>
<td>No residence permit requirement (Nationals)</td>
<td>4.3</td>
<td>17.6</td>
</tr>
<tr>
<td>Asylum seeker (application or appeal ongoing)</td>
<td>33.3</td>
<td>29.4</td>
</tr>
<tr>
<td>Valid residence permit</td>
<td>71</td>
<td>5.9</td>
</tr>
<tr>
<td>EU national staying for less than three months (no residence permit required)</td>
<td>0.0</td>
<td>5.9</td>
</tr>
<tr>
<td>Visas of all types</td>
<td>3.6</td>
<td>11.8</td>
</tr>
<tr>
<td>Specific situation concerning right to remain</td>
<td>2.4</td>
<td>0.0</td>
</tr>
<tr>
<td>TOTAL WITH PERMISSION TO RESIDE</td>
<td>50.7</td>
<td>70.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing data</td>
<td>1.9%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

A 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 (970%) were foreign nationals from sub-Saharan Africa (37%), the EU (20-24%), Asia (13-9%) and European countries outside the EU (9%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

**Reasons for Consulting MDM Programmes**

The vast majority of patients consulted MDM programmes to obtain medical care (81% 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).

**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 European countries and are, for most of them and unless otherwise indicated, weighted average proportions (WAP) of all the countries; this allows actual differences between countries to be corrected so they each have the same weight in the overall total; 3) crude average proportions (CAP) - where countries contribute proportionally to their numbers - are also given systematically in the tables and figures. When numbers of respondents were low, or when subgroups of populations were examined, CAP was preferably provided.

**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 10 countries associated with the International Network Observatory in 2014. Every patient who attended a consultation with a health professional and support worker was administered at least one of the three standardised, multilingual forms - social questionnaire, medical questionnaire and medical re-consultation questionnaire(s).

**Number of Patients and Consultations by Country**

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of Patients</th>
<th>%</th>
<th>No. of Visits</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>BE</td>
<td>2,365</td>
<td>15</td>
<td>6,065</td>
<td>19.6</td>
</tr>
<tr>
<td>CH</td>
<td>335</td>
<td>2.3</td>
<td>1,200</td>
<td>3.8</td>
</tr>
<tr>
<td>DE</td>
<td>5,38</td>
<td>3.4</td>
<td>12,92</td>
<td>4.1</td>
</tr>
<tr>
<td>ES</td>
<td>8,554/162</td>
<td>4.9</td>
<td>12,976/1,636</td>
<td>5.2</td>
</tr>
<tr>
<td>TN</td>
<td>263</td>
<td>1.7</td>
<td>265</td>
<td>0.8</td>
</tr>
<tr>
<td>FR</td>
<td>8,039</td>
<td>56.5</td>
<td>77,65</td>
<td>55.0</td>
</tr>
<tr>
<td>NL</td>
<td>123</td>
<td>0.8</td>
<td>123</td>
<td>0.4</td>
</tr>
<tr>
<td>SE</td>
<td>96</td>
<td>0.6</td>
<td>96</td>
<td>0.3</td>
</tr>
<tr>
<td>TR</td>
<td>869</td>
<td>5.6</td>
<td>1,296</td>
<td>4.2</td>
</tr>
<tr>
<td>Total (25 cities)</td>
<td>23,040/15,648</td>
<td>100</td>
<td>42,534/31,194</td>
<td>100</td>
</tr>
</tbody>
</table>

**European Union**

<table>
<thead>
<tr>
<th>Country</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU</td>
<td>6.4</td>
</tr>
<tr>
<td>NEA</td>
<td>4.0</td>
</tr>
<tr>
<td>MIDEAST</td>
<td>1.6</td>
</tr>
<tr>
<td>AMERICAS</td>
<td>0.4</td>
</tr>
<tr>
<td>NATIONALS</td>
<td>0.4</td>
</tr>
<tr>
<td>MAGHREB</td>
<td>0.3</td>
</tr>
<tr>
<td>EUROPE (NON EU)</td>
<td>0.3</td>
</tr>
<tr>
<td>ASIA</td>
<td>0.2</td>
</tr>
<tr>
<td>SUB-SAHARIAN AFRICA</td>
<td>0.2</td>
</tr>
</tbody>
</table>

**Country Numbers Surveyed**

Europe, 53% were in the process of claiming asylum (29.4% in Istanbul). 44.1% were or had at some point been involved in an asylum claim (33.3% in Istanbul) and, of these, 37% had been refused asylum. As a result of being undocumented, two thirds of the pregnant women (67%) in the nine European countries restricted their movements to varying degrees for fear of arrest. This creates a significant additional obstacle to accessing antenatal care. In Istanbul 79.7% were in this situation.

Of the pregnant women surveyed in Europe, 33.3% were in the process of claiming asylum (29.4% in Istanbul). 44.1% were or had at some point been involved in an asylum claim (33.3% in Istanbul) and, of these, 37% had been refused asylum. As a result of being undocumented, two thirds of the pregnant women (67%) in the nine European countries restricted their movements to varying degrees for fear of arrest. This creates a significant additional obstacle to accessing antenatal care. In Istanbul 79.7% were in this situation.

Of the pregnant women seen in Europe, 55.3% were living in temporary accommodation (24.6% in Istanbul). In total, 62.9% of pregnant women seen in Europe and 55.0% in Istanbul considered their accommodation to be unstable. In Europe 22.9% and in Istanbul 54.2% considered that their housing conditions were harmful to their health or that of their children. The vast majority (89.2%) were living below the poverty line.

**Focus on Pregnant Women**

Samira was a 22-year-old Congolese woman who lived in Turkey for three years. When she arrived at Eskişehir public health hospital, she was six months pregnant and felt unwell. She was referred to Osmangazi hospital, where £3,000 was requested from her, as her residence permit and health insurance had expired the day before. As she was not able to pay, she went back home.

Three days later, she managed to have her residence permit renewed and immediately went back to Osmangazi hospital. In the meantime her baby had died in the womb and she died the same day, leaving two daughters with their father.

ASfM Turkey- İstanbul- January 2015


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

63 The number of people being on the financial resources of the respondent was not asked. If they were included, the percentage of people living below the poverty line would be much higher and may actually represent all the patients seen by MDM.
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: 2

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: 3 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 nine European countries, 54.2% had not had access to antenatal care when they came to MDM’s free health centers- 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></th>
<th>% in Europe (N=310)</th>
<th>% in Istanbul (N=61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No coverage / all charges must be paid</td>
<td>58.4</td>
<td>98.1</td>
</tr>
<tr>
<td>Access to emergency services only</td>
<td>22.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Full healthcare coverage</td>
<td>6.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Open rights in another European country</td>
<td>5.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Access to GP with fees</td>
<td>2.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Partial healthcare coverage</td>
<td>21</td>
<td>0.0</td>
</tr>
<tr>
<td>Free access to general medicine</td>
<td>11.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Access on a case by case basis</td>
<td>1.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

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

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

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

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

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

MDM UK - London - 2014
A 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 74.1% 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 47.5% were living apart from one or more of their minor children.

Regardless of their administrative status, 81.1% of pregnant women seen by MDM in Europe had no healthcare coverage.

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.

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.

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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 covered by the AMU, but the procedure is too long to fall within the 12-week limit, in which case women must pay out-of-pocket (at least €250).

FRANCE: Undocumented pregnant women can gain access to AME but there are many barriers to obtaining it, thus it can be difficult to gain access to antenatal and postnatal care. Nevertheless, a specific provision states that all care for pregnant women must be considered as urgent (antenatal care, delivery and postnatal care), 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 undocumented pregnant women do not have any access to antenatal and postnatal care.

Women whose income is below €3,033 per month can have their termination of pregnancy reimbursed by their health insurance. Theoretically, asylum seekers and undocumented women are also entitled to reimbursement. However, access remains very difficult for undocumented women, due to the need for a health insurance voucher from the social welfare office and because of the risk of being reported when requesting it. Civil servants, such as health personnel (with the exception of medical emergency wards) have a duty to report undocumented migrants.

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

NETHERLANDS: Pregnant women 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.

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

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

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, antenatal care and postnatal care around €2,700 without complications.

REGARDING TERMINATION OF PREGNANCY, WHILE IT IS CONSIDERED AS PRIMARY CARE BY LAW AND THEREFORE 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.
A LEGAL OVERVIEW OF ACCESS TO CARE FOR PREGNANT WOMEN

BELGIUM: Undocumented pregnant women have full, free access to antenatal and postnatal care if they have obtained the AMU (which can be a long and difficult process and the AMU can also be refused based on very variable and opaque criteria, depending on where the patient lives). However, access to (preventive and psychosocial) antenatal and postnatal care consultations should be free of charge for everyone. Termination of pregnancy is covered 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).

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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 antenatal and postnatal care. New changes might occur in 2015.

With regard to termination of pregnancy, they have to pay approximately €340 in public hospitals. Article 79(1) of the same law establishes that undocumented pregnant women may not be expelled from the country during their pregnancy or for six months after giving birth. Undocumented migrants who cannot be expelled for medical reasons may benefit from a temporary residence permit.

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

Undocumented pregnant women have access to antenatal, delivery and postnatal care but they are expected to pay themselves, unless it is proven that they cannot pay in the case of pregnancy and childbirth, the authorities reimburse contracted hospitals and pharmacies 100% of the unpaid bills. However, in practice, undocumented women are often urged to pay straight away in cash or it is suggested that they sign to pay by instalments, or receive a bill and reminders at home, and are pursued by debt collectors contracted by healthcare providers. In contrast to maternity care, contraception and termination of pregnancy 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 maternity care and termination of pregnancy. They have to pay a fee of around €45 for every visit to a doctor. The situation is unclear for pregnant EU nationals who have lost the right to reside in Sweden.

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

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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 can cost 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 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.

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

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 to 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.”
FOCUS ON CHILDREN VACCINATION

The vaccine(s) that protect against tetanus, MMR (measles, mumps and rubella), diphtheria and whooping cough are considered essential throughout the world, and most WHO Europe countries have included the vaccine against Hepatitis B in their national immunisation schedules.25

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.25

Vaccination for groups facing multiple vulnerabilities is even more important than for the general population, as they have fewer opportunities to be vaccinated because of multiple barriers to healthcare (mainly legal and financial). Furthermore, social determinants (e.g. lack of access to adequate food, housing, water and sanitation) have an impact on their likelihood of becoming ill and the risks of developing more serious diseases. Vaccination may help to reduce these risks, since it often lessens the severity or complications of a disease even in the few cases where vaccination does not succeed in preventing it.25

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.25

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.25 In Istanbul, this applied to 52.4%.

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.25

The rates of vaccination against hepatitis B (HBV) were even lower: the average proportion of vaccinated minors in Europe was 38.7%. The HBV vaccination rate was very low in France (22.1%). In the European countries, following the WHO recommendation to incorporate hepatitis B vaccine as an integral part of national infant immunisation programmes, the immunisation coverage in the general population is averaging 53%.25

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.25

These figures highlight the shocking gap between the general population and the children seen in MDM clinics in terms of access to vaccination. In fact, over half of the children (57.5%) seen by MDM teams had not been vaccinated against tetanus and about 60% to 65% were not protected from whooping cough or MMR.25

2. Herd immunity applies to measles, rubella virus (Rubivirus), polio and whooping cough. For infections for which humans do not form a reservoir (e.g. tetanus, rabies), vaccines only offer individual protection.
3. The rate of children seen in MDM clinics for whom vaccination status was not documented is much too high. All children’s vaccination status should be checked, even if they may subsequently be referred to specific vaccination centres.
5. This means that MDM doctors or nurses had seen the vaccination booklet.
The vaccine(s) that protect against tetanus, MMR (measles, mumps, and rubella, diphtheria and whooping cough are considered essential throughout the world, and most WHO Europe countries have included the vaccine against Hepatitis B in their national immunisation schedules.

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

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A total of 645 minor patients were seen by MdM programmes in 2014. They represent 4.1% of the total population. They were not vaccinated against tetanus.

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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. Mariana 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 my 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.’

Indeed, the municipality has recently introduced new legislation limiting undocumented migrant registration. Although her first child was registered and Mariana 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 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 health care coverage.

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

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

Spain: Article 3rd, al. 4 of Law 16/2003 (adapted by Article 1 of Royal Decree-Law 16/2003) 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 aged below the age of 18. Consequently, all children of authorised residents, asylum seekers and undocumented third-country nationals now have access to free vaccination. In accordance with the national vaccination programme. The vaccination of young children is performed by the health centre, while children at primary school are vaccinated by the school health system. There is a lack of legal clarity on whether children of undocumented EU citizens can access vaccination – in practice, they have to pay the full fees for vaccination.

SWITZERLAND: Children of asylum seekers and refugees have health insurance (if their parents do) which includes vaccination. Children of undocumented migrants have the same access as their parents. Either their parents can afford private health insurance for them (around €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 €80, 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.
As vaccination and health cards are requested for registration at state schools, not accessing healthcare can result in being excluded from school as well. Maríela, 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 work here. They 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 Maríela had a permit to reside, the new local regulation has made the registration with the Municipality of her second child more difficult. This, in turn, impedes obtaining a health card from the health centre.

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**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 €30 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.

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


79 Royal Decree Act 31/2002.
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. When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. 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’ was offered by the CADA. Due to a lack of funds, the Departmental social cohesion directorate (DDCS) refused to allocate them housing. The family is homeless, sleeping in the Armenian Church every now and then.

When the two-year-old daughter became ill, they visited the MdM clinic. The family hadn’t eaten for 24 hours. MdM alerted the DDCS again and received the same answer that there was no budget. MdM then made the exceptional decision to pay for a few nights in a hotel for the family. After alerting its network, the only ‘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.

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

MdM France – Nice – October 2014
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While many politicians denounce the humanitarian catastrophe taking place in Syria and talk about hosting Syrian refugees in France, the D. family would have spent a month living on the streets if an individual had not offered to take them in.
Among the migrant EU citizens encountered at MDm, 62.3% were from Romania, which corresponds to the significant numbers of Roma people from Romania reached by MDm’s mobile units in the Paris suburb of Saint-Denis, and referred to the clinic (n=0,356 people). People from Bulgaria form the second most significant EU nationality (14.8%), followed by EU migrants from Poland, Portugal, Spain and Italy.

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

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistan</td>
<td>122</td>
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<tr>
<td>Moldova</td>
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<tr>
<td>Ecuador</td>
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<tr>
<td>Bangladesh</td>
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<tr>
<td>Bulgaria</td>
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<tr>
<td>Cameroon</td>
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<tr>
<td>Romania</td>
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<tr>
<td>Argentina</td>
<td>160</td>
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<tr>
<td>Afghanistan</td>
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</tr>
<tr>
<td>Nigeria</td>
<td>155</td>
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</table>

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

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

### REASONS FOR MIGRATION

As in 2013, in the European countries, the reasons most often cited for migration were, overwhelmingly, economic: (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

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.

### FAMILY CONFLICTS

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### TO ESCAPE FROM WAR

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### TO JOIN OR FOLLOW SOMEONE

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### PERSONAL HEALTH REASONS

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### OTHER

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### TOTAL

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<table>
<thead>
<tr>
<th>Country</th>
<th>CH</th>
<th>DE</th>
<th>ES</th>
<th>NL</th>
<th>SE</th>
<th>UK</th>
<th>HAP</th>
<th>CAP</th>
<th>TR</th>
</tr>
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<tbody>
<tr>
<td>Missing</td>
<td>0.3</td>
<td>0.6</td>
<td>0.8</td>
<td>1.5</td>
<td>7.3</td>
<td>41.0</td>
<td>14.7</td>
<td>29.6</td>
<td>21.0</td>
</tr>
</tbody>
</table>

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

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<table>
<thead>
<tr>
<th>Country</th>
<th>CH</th>
<th>DE</th>
<th>ES</th>
<th>NL</th>
<th>SE</th>
<th>UK</th>
<th>WAP</th>
<th>CAP</th>
<th>TR</th>
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<tbody>
<tr>
<td>Morocco</td>
<td>122</td>
<td>672</td>
<td>93</td>
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<td>Brazil</td>
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<td>21</td>
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**Reasons for Migration by Country (%)**

<table>
<thead>
<tr>
<th>CH</th>
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<th>EL</th>
<th>ES</th>
<th>NL</th>
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<tr>
<td>19.7</td>
<td>6.77</td>
<td>7.27</td>
<td>7.05</td>
<td>5.68</td>
<td>5.26</td>
<td>19.6</td>
<td>51.6</td>
<td>50.2</td>
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<td>65.2</td>
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**Missing Data (%)**

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</table>
We had to drive far out into the countryside to a place near St Omer to visit the last, and most shocking, settlement where a group of 20 to 30 Syrians were living in a ditch. As we squelched down the remote muddy lane in the rain, it was hard to believe anyone could be living there. To our left were tilled fields, now just mud, and to our right were bushes, leading down into a long ditch. I had turned up my trousers to the knees to avoid getting muddied and I thought I looked silly. When we got closer a group of boys appeared from the bushes, with an adult. Recognising our logo (MdM) they huddled beneath our umbrella. Only the adult spoke, he was from Aleppo, as were all the boys, who stood with bare feet on the tops of their wet and mud-caked shoes. I stopped thinking about my trousers.

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

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

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

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

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

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

MdM France – Calais – 2014

<table>
<thead>
<tr>
<th>Reasons for Migration</th>
<th>EU Citizens (n=418)</th>
<th>Others (n=3082)</th>
<th>P</th>
</tr>
</thead>
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<tr>
<td>Economic reasons, unable to earn a living in home country</td>
<td>81.8</td>
<td>48.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Political, Religious, Ethnic, Sexual Orientation</td>
<td>1.2</td>
<td>24.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>To escape from war</td>
<td>0.5</td>
<td>10.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>To join or follow someone</td>
<td>22.2</td>
<td>9.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Family conflicts</td>
<td>3.3</td>
<td>7.0</td>
<td>0.004</td>
</tr>
<tr>
<td>To ensure your children’s future</td>
<td>6.0</td>
<td>2.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Personal health reasons</td>
<td>2.9</td>
<td>2.5</td>
<td>0.88</td>
</tr>
<tr>
<td>To study</td>
<td>2.4</td>
<td>3.9</td>
<td>0.14</td>
</tr>
<tr>
<td>Others</td>
<td>5.0</td>
<td>7.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total</td>
<td>125.3</td>
<td>122.8</td>
<td></td>
</tr>
</tbody>
</table>
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“I was born in Eritrea, I left for Sudan and Uganda. In 2008, I got a diploma in Statistics. In Uganda, I have worked and earned about $6,000 to leave. I knew that it was tough in France, but not as much as it is. In England, I would like to resume my studies and open my own survey company.”

MdM France – Calais – 2014

<table>
<thead>
<tr>
<th>Reason</th>
<th>EU Citizens (%)</th>
<th>Others (%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic reasons, unable to earn a living in home country</td>
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<tr>
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<td>3.3</td>
<td>70.0</td>
<td>0.004</td>
</tr>
<tr>
<td>To ensure your children’s future</td>
<td>2.9</td>
<td>2.5</td>
<td>0.68</td>
</tr>
<tr>
<td>Personal health reasons</td>
<td>2.4</td>
<td>3.9</td>
<td>0.14</td>
</tr>
<tr>
<td>To study</td>
<td>0.0</td>
<td>1.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Others</td>
<td>5.0</td>
<td>11.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total</td>
<td>125.3</td>
<td>122.8</td>
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</tbody>
</table>
The majority (66.0%) of all people seen at the MGM centres in the nine European countries do not have permission to reside; 56.7% of citizens from non-EU countries and 9.3% of EU citizens (who have been in the country for over three months and do not have adequate financial resources and/or valid healthcare coverage) are in this situation. 63.0% 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.”

As a consequence of Directive 2004/38/CE, EU citizens staying for more than three months in a host Member State without sufficient resources or healthcare coverage find themselves in 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 from one country to the other: Switzerland (18.6%), Greece (19%) and Germany (38.9%) had the lowest figures. In contrast, 94.2% of patients seen in the Netherlands; 83.9% of those seen in Belgium. 67.9% of those seen in 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%), the number of foreign citizens with permission to reside (20.3%) and asylum seekers (11%).

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

In Switzerland, a significant majority of patients were asylum seekers (75%). In contrast to the other countries surveyed (asylum seekers represented 15.3% of the total in London and 13.4% in France). The main programme in Switzerland is actually aimed at asylum seekers housed in a reception facility in the canton of Neuchâtel and counted 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 14.3% had a residence permit in another EU country.

Overall, in the nine European countries, 43.4% of citizens from non-EU countries were or had been involved in an asylum application (N=4,440). Only a very small minority of asylum seekers were granted refugee status (5.6%) while four out of ten had already been rejected (39.6%).

Finally, those affected by the Dublin III/Eurodac regulation were relatively rare (between 1% and 3%) except in Stockholm and Munich where they respectively represented 10.5% and 10.3% of the total.

### Administrative Status by Country (%)

<table>
<thead>
<tr>
<th>Country</th>
<th>BE</th>
<th>CH</th>
<th>DE</th>
<th>EL</th>
<th>ES</th>
<th>FR</th>
<th>AT</th>
<th>SE</th>
<th>UK</th>
<th>NL</th>
<th>CH</th>
<th>SE</th>
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<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>9.9</td>
<td>94.3</td>
<td>26.4</td>
<td>110.0</td>
<td>46.6</td>
<td>56.7</td>
<td>60.7</td>
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<td>1.4</td>
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<td>8.6</td>
<td>8.8</td>
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<td>9.5</td>
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<td>Total without permission to reside</td>
<td>83.9</td>
<td>16.8</td>
<td>38.1</td>
<td>17.0</td>
<td>63.5</td>
<td>67.9</td>
<td>94.2</td>
<td>47.3</td>
<td>58.0</td>
<td>54.7</td>
<td>66.0</td>
<td>63.2</td>
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<td>37.4</td>
<td>0.8</td>
<td>5.0</td>
<td>0.0</td>
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<td>1.0</td>
<td>7.3</td>
<td>4.7</td>
<td>1.8</td>
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<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>15.3</td>
<td>16.1</td>
<td>12.7</td>
<td>11.0</td>
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<td>Valid residence permit</td>
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<td>61.7</td>
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<td>20.9</td>
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<td>2.5</td>
<td>11.1</td>
<td>7.5</td>
<td>4.0</td>
<td>2.6</td>
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<tr>
<td>EU National Staying for less than three months (no residence permit required)</td>
<td>2.4</td>
<td>31.2</td>
<td>18.2</td>
<td>3.8</td>
<td>1.2</td>
<td>21.1</td>
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<td>24.3</td>
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<td>6.3</td>
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<td>0.1</td>
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<td>1.8</td>
<td>0.5</td>
<td>12.0</td>
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<td>11.1</td>
<td>1.7</td>
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<td>Total with permission to reside</td>
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<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>34.5</td>
<td>42.9</td>
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<td>0.8</td>
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<td>7.6</td>
<td>2.0</td>
<td>12.2</td>
<td>3.5</td>
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<td>Missing data (%)</td>
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<td>8.4</td>
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<td>7.3</td>
<td>7.0</td>
<td>2.7</td>
<td>32.6</td>
<td>1.6</td>
<td>71.0</td>
<td>8.8</td>
<td>16.3</td>
<td>21.6</td>
</tr>
</tbody>
</table>

A. Without adequate financial resources and/or healthcare coverage
B. In France, children do not require a residence permit and are therefore included in this category
C. Or equivalent situation (recent immigrants <90 days)
D. Suffer from chronic or severe illness
E. Adequate financial resources and valid healthcare coverage
F. Including voluntary/humanitarian protection

*The Dublin III regulation lays down the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (without EU Member State citizenship). Eurodac is the computerised central database of fingerprints data, as well as the electronic tool for transmission between the Member States and this central database.*
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 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 permit to reside can also be subject to expulsion procedures (stricter though than for citizens of non-EU countries).

The average proportion of people without a residence permit covers wide disparities from one country to the other: Switzerland (16.6%), Greece (19%) and Germany (38.9%) had the lowest figures (in contrast: 94.2% of patients seen in the Netherlands; 83.9% of those seen in Belgium; 67.9% of those seen in France). This is due to mass unemployment and economic problems in the country (which have primarily affected immigrants).

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

In Switzerland, a significant majority of patients were asylum seekers (75%). In contrast to the other countries surveyed (asylum seekers represented 15.3% of the total in London and 13.4% in France). The main programme in Switzerland is actually aimed at asylum seekers housed in three reception facilities in the canton of Neuchâtel and accounted for a majority of the patients.

In Sweden, 43.7% of patients had no permission to reside; a quarter were EU nationals staying for less than three months and 14.3% had a residence permit in another EU country.

In London, 57.5% of those coming to the centre were foreign nationals who did not have permission to reside and 15.3% were asylum seekers; 11.8% had a visa (the highest proportion observed in the European countries of the survey). In Istanbul, 63.3% of patients had no permission to reside; 16.0% were seeking asylum and 12.4% were recent immigrants (less than 90 days).
LIVING CONDITIONS

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

HOUSING CONDITIONS

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

Of the patients seen in eight European countries (all but Greece where the question was not asked), 9.7% were homeless (up to 20.0% in Stockholm) and 16.4% had been provided with accommodation for more than 15 days by an organisation (up to 83.0% in Switzerland where most patients are met at asylum seeker centres).

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

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

WORK AND INCOME

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

Almost all the 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).

SOCIAL ISOLATION

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).

MdM Germany – Munich – December 2014

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

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

MdM Netherlands – Amsterdam – November 2014

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

After living on the streets, he joined a group of around 100 homeless ex-asylum seekers who subsequently squatted a church and office buildings. He is now living in a derelict office building with small, cramped spaces. The windows in the building cannot be opened and there is no heating. There is only one shower, with no warm water. The group is dependent on charity from the neighbourhood which was a good thing. but when it was not available anymore.

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MdM Germany – Munich – December 2014
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HOUSING CONDITIONS

Overall, in the seven European countries where the question was asked, 64.7% of patients were living in unstable or temporary accommodation50 (this was particularly common in Switzerland, Sweden and the Netherlands). This proportion stood at 63.0% in Istanbul.

Of the patients seen in eight European countries (all but Greece where the question was not asked), 9.7% were homeless (up to 20.9% in Stockholm) and 16.4% had been provided with accommodation for more than 10 days by an organisation (up to 83.0% in Switzerland where most patients are met at asylum seeker centres).

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

29.5% of those questioned in Europe51 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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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).

SOCIAL ISOLATION

When asked about moral support54, one in two people said they could rarely or never rely on support if they needed it: 16.4% of patients 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).

Mdm Germany – Munich – December 2014

Karl, aged 40, is from a German minority in Romania. "I came from Romania about one month ago. I came to work there as a security guard. The problem is that they tell you you will earn €400 a month, but it really you do not. I earned only €180 a month. I had health insurance there, through my work, which was a good thing. But when I lost my job I lost my insurance as well. My cousin told me that he had a job for me here, but when I came, it was not available anymore. Now that I am here I want to give it a chance. But it is a vicious circle. I need to have a registered address at the municipality to get a job, but to have an address you need money to pay for housing. I have to apply each time for a place to sleep and this way it is very hard to find a job."
In Germany, 73.6% of patients only had access to emergency healthcare. In another European country (which is in line with the high number of Europeans 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 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 at all. Foreign nationals without permission to reside have no rights to any healthcare coverage. As the social crisis in Greece worsened, more and more Greek nationals and foreign citizens with permission to reside also lost their healthcare coverage due to the lack of contributions through their employment or their inability to pay for it.

In the Netherlands, 82.5% of patients seen in Amsterdam and The Hague could access general practitioners, albeit with a financial contribution, and 14% had no access at all. In Spain, 56.1% of patients seen only had access to emergency care. While undocumented migrants are supposed to have access to free emergency care, in practice cases where they are entitled for the emergency care they received were visited by MDM as well as reported by the Ombudsman in Spain.

In Sweden, half of the patients (47.5%) had no access to healthcare at all, a quarter (28.7%) had access to some subsidised healthcare—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.

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

The absence of any coverage concerned 70.4% of migrant EU citizens in Europe, and 15.1% had access to emergency services only. They were even less frequently fully covered than nationals of non-EU countries (3.7% versus 8.3%, p<0.001), although 8% of them had healthcare rights in another EU country.

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 country in which 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 mostly be explained by the fact that the countries concerned (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.

Zoé, a 60-year-old Moroccan woman, is undocumented. She lives at her sister’s home. Zoé 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. Zoé had urgent medical coverage (AMU specifically for undocumented migrants) for a while, but she had to renew it too often, besides it was hard to get to the CPAS each time. Zoé 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?”

Zoé 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 CPAS defines the period, which varies from one day to six months.

MDM Belgium – Brussels – December 2014

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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 reconocced among the patients received, as noted above). In Munich, asylum seekers, refugees and undocumented migrants are redirected to facilities within the mainstream healthcare system. 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 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.

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BARRIERS IN ACCESS TO HEALTHCARE

Only 23.0% of all patients surveyed in seven European countries said they had experienced no difficulty in accessing healthcare before going to an MDM clinic. Another third (33.9%) had not tried to access healthcare; with huge differences between France (48.9%) and Denmark (9.0%) at the bottom and Sweden (42.0%) and the UK (52.2%) at the top. While some of these people may not have needed healthcare, it is also true that others have internalised the various barriers to accessing healthcare to such an extent that they did not even try to seek it.

In the previous surveys, the four reasons most frequently cited by patients seen in Europe were related to:

- financial barriers (27.9%), a combination of charges for consultations and treatment, upfront payments and the prohibitive cost of healthcare contribution credits;
- administrative problems (21.9%), including restrictive legislation and difficulties in collecting all the documentation needed to obtain any kind of healthcare coverage, as well as administrative malfunctioning;
- a lack of knowledge or understanding of the healthcare system and of their rights (14.9%);
- language barriers (12.7%). Yet, 54.8% (CAP) of the consultations required the assistance of an interpreter – whether this need was fulfilled (35.7% had an interpreter, in person or on the phone) or not (15.5%). This seems to indicate that the language barrier is under-reported.

It is very different in Istanbul where four situations are reported by more than 40% of patients, i.e. by a much higher proportion of patients than in Europe: the absence of any previous recourse to healthcare (45.9%), the cost of consultations and treatment (44.6%), the language barrier (40.9%) and the fear of being reported or arrested (45.9%). The proportion of patients reporting a bad previous experience in the healthcare system in Istanbul is also particularly high (216%).

One out of five patients stated that they could not or did not try to access healthcare to such an extent that they did not even try to seek it. Maria is a 38-year-old unemployed Greek nurse. She had healthcare coverage until 2009. Earning about €4000 per month, she had an undenied job as a care worker for an elderly woman. “My income covers accommodation and food. I used to work in France, and everything went smoothly. I could afford neither the cost of required examinations nor the medicines”.

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 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 or drugs are sometimes not available at the hospital, her baby is still medically monitored and vaccinated by MDMS services.

MMf Greece – Chania – September 2014

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

MMf Sweden – Stockholm – October 2014

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 2002, 22.0% in 2003 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 MDMS. Since the Royal Decree 16/2002, 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 MDMS 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 MDMS 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

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 during the previous 12 months was reported by 15.2% of patients seen by MDMS in Europe – in Istanbul, 37% of the patients experienced this situation and a quarter in Spain.

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

After her wife’s death, Ahmed could not work and take care of his daughter on his own and Sonia was placed in a foster family. Miriam had diabetes, which she was not aware of. Miriam died in hospital a few weeks later. Her daughter was 26 months old.

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Only 23.0% of all patients surveyed in seven European countries and in Turkey had experienced no difficulty in accessing healthcare before going to an MDM clinic. Another third (33.9%) had not tried to access healthcare; with huge differences between France, the UK 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 healthcare.

As in the previous surveys, the four reasons most frequently cited by patients seen in Europe were related to:

- financial barriers (27.9%):
  - a combination of charges for consultations and treatment, upfront payments and the prohibitive cost of healthcare coverage contributions;
- administrative problems (21.9%), including restrictive legislation and difficulties in collecting all the documentation needed to obtain any kind of healthcare coverage, as well as administrative mal-functioning;
- a lack of knowledge or understanding of the healthcare system and of their rights (14.9%);
- language barriers (12.7%). Yet, 54.8% (CAP) of the consultations required the assistance of an interpreter – whether this need was fulfilled (39.7% had an interpreter, in person or on the phone) or not (15.5%). This seems to indicate that the language barrier is under-reported.

It is very different in Istanbul where four situations are reported by more than 40% of patients, i.e. by a much higher proportion of patients than in Europe: the absence of any previous recourse to healthcare (45.9%), the cost of consultations or treatment (44.6%), the language barrier (40.9%) and the fear of being reported or arrested (45.9%). The proportion of patients reporting a bad previous experience in the healthcare system is also particularly high (216% versus 2.3% on average in Europe, p<0.001). Only 1% of patients said that they had no difficulties when seeking care (versus 23% in Europe, p<0.001). All these dramatic differences reflect the tremendously limited access to healthcare for migrants (particularly those undocumented) in Turkey.

### 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 2002, 22.0% in 2013 and 15.0% in 2014. The interpretation of this decrease is difficult since, unfortunately, the surveyed sites have changed over time (as well as the sample procedure from one year to another). However, it is useful to note that these figures do not represent the general situation of migrants in Spain, but should be taken as an indicator of those migrants who contact MDM. Since the Royal Decree 16/2002, the MDM Spain teams have explored different channels for integrating migrants into the mainstream health 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). 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

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% of the patients experienced this situation and a quarter in Spain.

Maria is a 38-year-old unemployed Greek nurse. She had healthcare coverage until 2003. 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 don’t need to worry about the cost of healthcare. I could afford neither the cost of the consultations nor the medications”.

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

### BARRIERS TO ACCESS IN SEVEN EUROPEAN COUNTRIES AND IN TURKEY (%)

<table>
<thead>
<tr>
<th>Country</th>
<th>No difficulties</th>
<th>Administrative problems</th>
<th>No knowledge or understanding of the system</th>
<th>Language barrier</th>
<th>Healthcare coverage too expensive</th>
<th>No healthcare coverage obtained</th>
<th>Fear of being reported or arrested</th>
<th>Healthcare coverage in another EU country</th>
<th>Previous experience in the healthcare system</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>DE</td>
<td>0.3</td>
<td>0.9</td>
<td>0.5</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>EL</td>
<td>0.3</td>
<td>0.9</td>
<td>0.5</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>ES</td>
<td>0.3</td>
<td>0.9</td>
<td>0.5</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>FR</td>
<td>0.3</td>
<td>0.9</td>
<td>0.5</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>NL</td>
<td>0.3</td>
<td>0.9</td>
<td>0.5</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>SE</td>
<td>0.3</td>
<td>0.9</td>
<td>0.5</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>turKey</td>
<td>21.9</td>
<td>44.6</td>
<td>44.6</td>
<td>44.6</td>
<td>44.6</td>
<td>44.6</td>
<td>44.6</td>
<td>44.6</td>
<td>44.6</td>
<td>44.6</td>
</tr>
</tbody>
</table>

104. In 2014, 37% of patients gave up seeking healthcare. In addition, the medical staff discovered that many of the patients had never sought healthcare in Spain. 31% of patients responded that they had been refused healthcare.

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

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. Unfortunately, only a few patients reported having been victims of rape. Although it is not mandatory for individuals to show their identification papers to the police/authorities, it is possible that many undocumented migrants are not aware of this and still fear being arrested, thus explaining the high number of people having reported such a limitation.

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

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

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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 nationality because they did not yet have a residence permit. Suffering from pain and bleeding, Sofia went to the emergency department of the maternity hospital in Malaga. According to her and the friend who accompanied her, the doctor said that without healthcare coverage she could not be attended. After two weeks her pain increased and she went back to the health centre. She was denied care “until her administrative situation gets solved.”

She went to 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 practitioners immediately referred her to the emergency department at the maternity hospital, which diagnosed her as having had a miscarriage that “should have been attended to a month earlier.” Sofia and her husband have filed a complaint in court. Although highly restrictive, the Roga decree provides access to care for pregnant women and children. Even this limited access is not always guaranteed.

MdM Spain – Malaga – January 2014

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MDM Spain – Malaga – January 2014

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

MDM FR – Saint-Denis – August 2014

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 their lifetime, with 34.4% among all patients, p<0.001. Patients from Sub-Saharan Africa and Latin America were over-represented among the victims of violence but no origin was exempt from violence, including (obviously) EU citizens and nationals. Experiences of violence affected both sexes and all ages. Asylum seekers were disproportionately highly represented among victims of violence (57.6% compared with 34.4% among all patients, p<0.001).

Unfortunately, the experience of violence is still under-diagnosed in MDM programmes and so violence remains insufficiently screened by the MDM teams. Only 9% of patients (237 women, 12% and 1,082 men, 10.5%) were questioned on the issue at all times during their first consultation or follow-up visit.0

©jérôme Sessini – MGD Num Photos for MDM

TODAY THIS FAMILY WILL SLEEP IN A TENT IN THE CENTRE OF LONDON INSTEAD OF HAVING ACCESS TO DECENT ACCOMMODATION – FRANCE – 2014

TohS, 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 had full sexual health screening, is accessing counselling and has antenatal care for her pregnancy. She is receiving some financial support whilst her claim is assessed.

MDM UK – London – 2014

RAPID RALLY 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 occasionally, frequently or very frequently). This proportion was particularly high in London (83.9%), the Netherlands (88.4%) and Istanbul (85.9%), whereas, as mentioned before, the fear of being reported or arrested was a frequently cited barrier in accessing healthcare. In Spain, this proportion was lower (57.9%).

Although it is not mandatory for individuals to show their identification papers to the police/directors and in some European countries, it is possible that many undocumented migrants are not aware of this and still fear being arrested, thus explaining the high number of people having reported such a limitation.

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109 However, it is not mandatory for individuals to show their identification papers to the police authorities in Spain, Denmark, the UK and Turkey data may be considered representative.

110 Asylum seekers were disproportionately highly represented among victims of violence (57.6% compared with 34.4% among all patients, p<0.001).

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112 Unfortunately, the experience of violence is still under-diagnosed in MDM programmes and so violence remains insufficiently screened by the MDM teams. Only 9% of patients (237 women, 12% and 1,082 men, 10.5%) were questioned on the issue at all times during their first consultation or follow-up visit.
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 376% of women (compared with 73% of men) and rape (34.8%), 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 57.7% of sexual assaults, 37.9% of incidents of documents or money being confiscated, 19.1% 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 1.7% 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.

**Violence by Gender (among patients interviewed on this subject in eight European countries in %)**

**Perceived Health Status According to Reported Violence (among patients interviewed about experiences of violence, in %)**

**Violence at Different Stages of Migration in the 8 European Countries (% of reported episodes)**

**Table:**

<table>
<thead>
<tr>
<th>Type of Violence</th>
<th>Country of Origin</th>
<th>During the Journey</th>
<th>In the Host Country</th>
<th>Missing Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have lived in a country at war</td>
<td>76.8</td>
<td>68.0</td>
<td>76.8</td>
<td>68.0</td>
</tr>
<tr>
<td>Physically threatened/imprisoned/tortured for ideas</td>
<td>71.5</td>
<td>62.1</td>
<td>71.5</td>
<td>62.1</td>
</tr>
<tr>
<td>Violence by police or armed forces</td>
<td>76.4</td>
<td>62.1</td>
<td>76.4</td>
<td>62.1</td>
</tr>
<tr>
<td>Beaten up or injured (domestic or not)</td>
<td>85.8</td>
<td>73.3</td>
<td>85.8</td>
<td>73.3</td>
</tr>
<tr>
<td>Sexually assaulted or molested</td>
<td>62.5</td>
<td>62.1</td>
<td>62.5</td>
<td>62.1</td>
</tr>
<tr>
<td>Rape</td>
<td>67.6</td>
<td>70.0</td>
<td>67.6</td>
<td>70.0</td>
</tr>
<tr>
<td>Psychological violence</td>
<td>75.8</td>
<td>73.1</td>
<td>75.8</td>
<td>73.1</td>
</tr>
<tr>
<td>Money or documents confiscated</td>
<td>33.7</td>
<td>37.9</td>
<td>33.7</td>
<td>37.9</td>
</tr>
<tr>
<td>Hunger</td>
<td>41.0</td>
<td>47.1</td>
<td>41.0</td>
<td>47.1</td>
</tr>
<tr>
<td>Genital mutilations</td>
<td>30.0</td>
<td>30.0</td>
<td>30.0</td>
<td>30.0</td>
</tr>
<tr>
<td>Other forms of violence</td>
<td>55.8</td>
<td>60.0</td>
<td>55.8</td>
<td>60.0</td>
</tr>
</tbody>
</table>
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### VIOLENCE AT DIFFERENT STAGES OF MIGRATION IN THE 8 EUROPEAN COUNTRIES (% OF REPORTED EPISODES)

<table>
<thead>
<tr>
<th>Stage of Migration</th>
<th>Country of Origin</th>
<th>During the Journey</th>
<th>Host Country</th>
<th>Missing Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have lived in a country at war</td>
<td>30.0</td>
<td>20.0</td>
<td>40.0</td>
<td>60.0</td>
</tr>
<tr>
<td>Physically threatened, imprisoned or tortured for ideas</td>
<td>70.5</td>
<td>82.6</td>
<td>45.1</td>
<td>17.8</td>
</tr>
<tr>
<td>Violence by police or armed forces</td>
<td>70.4</td>
<td>19.9</td>
<td>37.0</td>
<td>17.8</td>
</tr>
<tr>
<td>Beaten up or injured (domestic or not)</td>
<td>60.0</td>
<td>73.1</td>
<td>17.2</td>
<td>12.6</td>
</tr>
<tr>
<td>Sexually assaulted or molested</td>
<td>62.3</td>
<td>62.8</td>
<td>177.6</td>
<td>12.6</td>
</tr>
<tr>
<td>Rape</td>
<td>70.3</td>
<td>28.3</td>
<td>25.1</td>
<td>33.5</td>
</tr>
<tr>
<td>Psychological violence</td>
<td>75.8</td>
<td>67.3</td>
<td>19.7</td>
<td>12.6</td>
</tr>
<tr>
<td>Money or documents confiscated</td>
<td>53.7</td>
<td>79.9</td>
<td>23.5</td>
<td>21.3</td>
</tr>
<tr>
<td>Hunger</td>
<td>60.8</td>
<td>174.0</td>
<td>40.8</td>
<td></td>
</tr>
<tr>
<td>Genital mutilations</td>
<td>70.0</td>
<td>30.0</td>
<td>30.0</td>
<td></td>
</tr>
<tr>
<td>Other forms of violence</td>
<td>55.6</td>
<td>48.4</td>
<td>12.6</td>
<td>27.6</td>
</tr>
</tbody>
</table>

### PERCEIVED HEALTH STATUS ACCORDING TO REPORTED VIOLENCE (AMONG PATIENTS INTERVIEWED ABOUT EXPERIENCES OF VIOLENCE, IN %)

<table>
<thead>
<tr>
<th>Type of Violence</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Bad</th>
<th>Very Bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health</td>
<td>20.0</td>
<td>25.0</td>
<td>10.0</td>
<td>5.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Physical health</td>
<td>30.0</td>
<td>12.5</td>
<td>40.0</td>
<td>5.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Mental health</td>
<td>35.0</td>
<td>5.0</td>
<td>42.5</td>
<td>5.0</td>
<td>2.5</td>
</tr>
</tbody>
</table>

### OTHER FORMS OF VIOLENCE

- Living in a country at war
- Physically threatened, imprisoned or tortured for ideas
- Violence by police or armed forces
- Beaten up or injured (domestic or not)
- Sexually assaulted or molested
- Rape
- Psychological violence
- Money or documents confiscated
- Hunger
- Genital mutilations
- Other forms of violence

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HEALTH STATUS

SELF-PERCEIVED HEALTH STATUS

A majority (58.2%) of patients seen by MdM in Europe perceived their general health status as poor. However, 22.9% of patients perceived their physical health as bad or very bad, and this goes up to 27% 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 (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 should have been treated earlier.

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

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

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

MdM Greece – Patras – October 2014

URGENT CARE AND NECESSARY TREATMENT

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

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

PATIENTS HAD RECEIVED LITTLE HEALTHCARE BEFORE COMING TO MdM

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

Altogether, 57.9% of the patients requiring treatment had not received care before coming to MdM. Thus for these patients MdM represents their first point of contact with a primary healthcare provider. This figure was also particularly high in Switzerland (74.8%), Germany (72.6%) and France (69.2%) and, above all, in Istanbul (98.9%).

HEALTH PROBLEMS LARGELY UNKNOWN PRIOR TO ARRIVAL IN EUROPE

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

In other words, among the patients who suffered from one or several chronic conditions, 70.2% hadn’t received any medical follow-up before going to MdM (for at least one of their chronic health conditions). Except in Greece, where this situation was uncommon (92.2%), 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, 37.9% 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 not pay 100% of health costs.
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Since she could not regularly take the medication, she had an episode of high blood pressure which took her to the emergency department. From there she was directed to the hospital to which she had to be transferred. Since then, Natalia has been treated at the MdM Polyclinic which provides the cost of drugs and medication.

MdM Greece – Patras – October 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. I was growing up in a psychiatric ward, which specialised in treating patients from different cultural backgrounds. My 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. Peter, 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. However, the threat at 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 police 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

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. 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.

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 anxiery, stress and psychoticism problems (5.9%), major depressive syndromes (2.9% of consultations). Obviuously psychotic disorders were much rarer (0.5%). Problems related to using psychocactive substances were almost non-existent (0.4%). Overall, 10% of medical consultations for women patients dealt with gynaecological problems: normal pregnancy and postnatal issues (9.0% and 0.3%) were most frequent – (1.7%). 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 anxiery, stress and psychoticism problems (5.9%), major depressive syndromes (2.9% of consultations). Obviuously psychotic disorders were much rarer (0.5%). Problems related to using psychocactive substances were almost non-existent (0.4%). Overall, 10% of medical consultations for women patients dealt with gynaecological problems: normal pregnancy and postnatal issues (9.0% and 0.3%) were most frequent – (1.7%).

IT career but when your health is not good it affects everything that you aspire to. But I believe that now is my time to shine. I’m looking forward to starting work and I’m looking forward to having a place of my own.”

MdM UK – London – September 2014

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A MORE EFFECTIVE HEPATITIS C TREATMENT. BUT UNAFFORDABLE!

It is estimated that 85 million people worldwide are infected with hepatitis C, a liver infection that often causes potentially life-threatening cirrhosis and cancer. There is currently no vaccine against hepatitis C. Treatments available come with serious side effects and with low cure rates (50% to 70%). A new generation of drugs now brings great hope. ‘Direct-acting antivirals’ are better tolerated by patients and the cure rate exceeds 90%! However, the first drug of 45 kind, sofosbuvir is sold at exorbitant prices (e.g. €44,000 in France for the full course of treatment).

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

MdM welcomes real medical innovation, but exorbitant prices put at risk the very existence of our public health model, which is based on solidarity and equity. This is why in February 2015, MdM op posed the patent for sofosbuvir at the European Patent Office.

MdM wants affordable medicines for hepatitis C for all –
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%), consultation problems (4.2%) and contraception problems (1.7%).

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“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 hold 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.”

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 told her that I had never been registered at any practice. She arranged an appointment for me and everything was sorted out for me before I left the clinic. I was referred to two different social groups as well as counselling. I walked out of the clinic that day a very happy person. For once I was excited because I knew that at least I had someone to talk to. Sometimes all we need is someone who we can confide in and talk to.”

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

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

“Not everyone was able to get information about what was happening around them. Some people didn’t even know what was going on. I feel so sad that so many people, so many people crying, so many people having a bad time because of the way they are being treated. Some of them were even violent. I used to cry at times and I’d rush out of the clinic. I don’t want to think about it.”

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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.

MdB 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 MdB over the past year clearly show that the crisis and austerity policies are still having negative consequences on people’s health. In addition, as the Council notes, “the scale of effects on health of the economic crisis and the reduction in public health expenditures may only become apparent in the following years”.

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

The right of children to health and care is one of the most basic, most universal and most essential human rights. However, while it holds its Fundamental Rights Charter and the 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. MdB urges the European Union to develop the necessary mechanisms to transform its impressive body of soft recommendations into hard facts when it comes to the most basic human rights of children and pregnant women. If the EU is not about making its Member States respect human rights, what is 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 gynaecological care. 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, MdB will continue to provide appropriate medical care to all people without discrimination. MdB refuses all restrictive legal measures to alter medical ethics and exhorts all health professionals to take care of all patients regardless of their administrative status and the existing legal barriers.
CONCLUSION

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

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

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

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

The right of children to health and care is one of the most basic, most universal and most essential human rights. 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 impressive body of soft recommendations into hard facts when it comes to the most basic human rights of children and pregnant women. If the EU is not about making its Member States respect human rights, what is it about?

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

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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121 European Commission Communication on effective, accessible and resilient health systems. COM(2014) 2007(INI)
125 Member States on the economic crisis and the reduction in public health expenditures may only become apparent in the following years”.
126 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.
127 www.eupha-migranthealthconference.com/?page_id=1766
129 Council conclusions on the economic crisis and the reduction in public health expenditures may only become apparent in the following years”.
ACKNOWLEDGEMENTS

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ACRONYMS

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AME</td>
<td>STATE MEDICAL AID (AIDE MEDICALE DE L’ETAT)</td>
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<td>AMU</td>
<td>URGENT MEDICAL AID (AIDE MEDICALE URGENTE)</td>
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<td>BELGIUM</td>
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<td>CAP</td>
<td>CRUDE AVERAGE PROPORTION</td>
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<td>CAPT</td>
<td>CRUDE AVERAGE PROPORTION INCLUDING TURKEY</td>
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<tr>
<td>CMUC</td>
<td>COMPLEMENTARY UNIVERSAL MEDICAL COVERAGE (COUVERTURE MALADIE UNIVERSELLE COMPLEMENTAIRE)</td>
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<td>CPAS</td>
<td>PUBLIC SOCIAL WELFARE CENTRE (CENTRE PUBLIC D’ACTION SOCIALE)</td>
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<td>DE</td>
<td>GERMANY</td>
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<td>ECDC</td>
<td>EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL</td>
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<td>ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT</td>
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<td>WAPT</td>
<td>WEIGHTED AVERAGE PROPORTION INCLUDING TURKEY</td>
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AUTHORS

Pierre Chauvin and Cécile Vuillermoz - Department of Social Epidemiology, Pierre Louis Institute of Epidemiology and Public Health (INSERM – Sorbonne University, LIPMAC)

Nathalie Simonnot Frank Vanbiervliet et Marie Vicart - Médecins du monde / Doctors of the World International Network

Anne-Laure Macherey and Valérie Brunel - Médecins du monde / Doctors of the World International Network

CONTRIBUTORS

This report would not have been possible without the contribution of all the coordinators and teams of volunteers and employees from the various Doctors of the World – Médecins du monde programmes and ASEM, where the data was collected and more particularly:

Lucie Gouet, MDIM International Network
BE: Sophie Damien, Kathleen Debruyne, Stéphane Heymans, Raissa Sablèmdry & Michel Roland
CH: Bernard Boeri & Janine Derron
DE: Suzanne Bruins, Sabine Furst & Heinz-Jochen Zanker
EL: Eleni Chronopoulou, Konstantina Kyriakopoulou & Christina Samarzi
ES: José Atienza, Ramon Esteso & Begoña Santos Olmeda
FR: Audrey Arneodo, Marielle Chappuis & Agnès Gilhno
LU: Sylwia Martin
NL: Gerrit Beckers, Koen Bolhuis & Margreet Krostee
SE: Johannes Mossier, Hannes Olauzon, Ina Seright & Louise Tilbuis
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AUTHORS

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Anne-Laure Macqueray and Valérie Brunel - Médecins du monde / Doctors of the World International Network

CONTRIBUTORS

Lucie Gouté, MD International Network
BE: Sophie Damien, Karthikeyen Debruyne, Stéphane Heymans, Raissa Sabendany & Michel Roland
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DE: Suzanne Bruns, Sabine Furst & Heinz-Jochen Zanker
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