Access to healthcare for people facing multiple health vulnerabilities

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ACCESS TO HEALTHCARE FOR PEOPLE FACING MULTIPLE HEALTH VULNERABILITIES

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

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

18TH MAY 2015

EXECUTIVE SUMMARY

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

Doctors of the World – Médecins du monde (MdM) teams are distinctive because they work both on international programmes and at home. 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/third-country nationals[01].

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%). Of those, the majority came to receive care too late - that is after the 12th week of pregnancy (58.2%). A large majority of pregnant women had no healthcare coverage (81.1%), were living below the poverty line and 30.3% reported poor levels of moral support.

The reported barriers to healthcare, as well as the analysis of the legal frameworks in the countries surveyed, confirm that restrictive laws and complex administrative processes to obtain access to care actually contribute to making people sicker. As in previous surveys, the barriers to accessing healthcare most often cited were financial inability to pay, administrative problems, lack of knowledge or understanding of the healthcare system and rights to care, and language barriers. It is thus hardly surprising that one patient in five said s/he had given up trying to access care or treatment in the last 12 months.

The data collected clearly deconstruct the myth of migration 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 exhorts all health professionals to provide care to all patients.

01 Third-country nationals refer to anyone who is not a citizen of one of the 28 European Union Member States.

2014 IN FIGURES

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

- → **8,656** were women
- → **42,534** social and medical consultations, of which **41,238** in the nine European countries
- → **23,240** diagnoses in the nine European countries

OF THE 310 PREGNANT WOMEN SEEN IN EUROPE:

- → **54.2% had no access to antenatal care**
- → **58.2% came to receive care too late** – after the 12th week of pregnancy (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

OF ALL THE PEOPLE SEEN IN THE NINE EUROPEAN COUNTRIES:

- → **43% were women**
- → **The median age was 35.8**
- → **93.6% were foreign citizens:**
  - 15.6% were migrant EU citizens and 78% citizens of non-EU countries
  - 6.4% of the patients seen were nationals (up to 30.7% in Greece and 16.5% in Germany)
- → **Foreign citizens had been living in the surveyed country for 6.5 years on average before consulting MdM**
- → **91.3% were living below the poverty line**
- → **64.7%** of patients were living in unstable or temporary accommodation and **9.7%** were homeless
- → **29.5%** declared their accommodation to be harmful to their health or that of their children
- → **18.4%** never had someone they could rely on and were thus completely isolated
- → **50.2%** had migrated for economic reasons, **28.2%** for political reasons and **22.4%** for family reasons: **only 3% had migrated for health reasons**
- → **34% had the right to reside in Europe**
- → **43.4%** were or had been involved in an asylum application

84.4% OF THE PATIENTS WHO WERE QUESTIONED ON THE ISSUE REPORTED THAT THEY HAD SUFFERED AT LEAST ONE VIOLENT EXPERIENCE:

- → **52.1%** had lived in a country at war
- → **39.1%** reported violence by the police or armed forces
- → **37.6%** of women reported sexual assault and **24.1%** had been raped
- → **10%** reported violence in the host country

HEALTH STATUS

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

BARRIERS TO ACCESSING HEALTHCARE

- → **62.9% of the people seen in Europe had no healthcare coverage**
- → **The most often cited barriers to accessing healthcare were financial problems in paying for care (27.9%), administrative problems (21.9%) and lack of knowledge or understanding of the healthcare system and of their rights (14.1%).**
- → **54.8% needed an interpreter.**
- → **During the previous 12 months:**
  - 20.4% had given up seeking medical care or treatment
  - 15.2% had been denied care on at least one occasion
  - 4.5% had experienced racism in a healthcare setting
- → **52% of patients without permission to reside said they restricted their movement or activity for fear of arrest.**

CONTENTS

INTRODUCTION TO THE 2014 SURVEY

THE CONTEXT IN 2014

THE CONTINUING EFFECTS OF THE ECONOMIC CRISIS

Health expenditure fell in half of the European Union countries between 2009 and 2012, and significantly slowed in the rest of Europe[02]. The public share of total spending on health globally declined between 2007 and 2012[03]. 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[04].

The crisis has led the World Health Organization (WHO) to (re)confirm that *"health systems generally need more, not fewer, resources in an economic crisis"*[05]. 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[06]. In addition, it does not automatically decrease the overall utilisation of healthcare services[07], 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[08]. Consequently, WHO warns that user fees should be used with great caution in view of their detrimental effects on vulnerable populations[09].

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[10]. *"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[11]. In Greece, 2.5 million people live below the poverty line (23.1% of the total population)[12]. Moreover, 27.3% of the total population live in overcrowded households, 29.4% state that they are unable to keep their home adequately warm, and 57.9% of the destitute population report that they are being confronted with payment arrears for electricity, water, gas, etc[13]. Crisis and austerity policies have left almost a third of the population without healthcare coverage[14]. Unemployment stood at 25.8% in December 2014[15], unemployment benefits were limited to 12 months[16], after which there was no minimum income guarantee[17]. 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[18].

02 OECD. Health at a glance: Europe 2014. Paris: OECD, 2014.

03 European Observatory on Health Systems and Policies. Economic crisis, health systems and health in Europe: impact and implications for policy. Geneva: WHO, 2014.

04 Eurostat. Self-reported unmet needs for medical examination, by sex, age and reason. 2015. Last accessed on 17/02/2015.

05 European Observatory on Health Systems and Policies. op. cit.

06 Dourgnon P, Grignon M. Le tiers-payant est-il inflationniste? Etude de l'influence du recours au tiers-payant sur la dépense de santé. Paris: CREDES, 2000.

07 Barer ML, Evans RG, Stoddart GL. Controlling health care costs by direct charges to patients: Snare or delusion? Toronto: Ontario, Economic Council, occasional paper 10, 1979.
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08 Majnoni d'Intignano B. Analyse des derniers développements et des réformes en matière de financement des systèmes de santé. Revue internationale de sécurité sociale 1991; 44: 10-1.

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09 CSDH. Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: WHO, 2008.

10 OECD. Focus on inequality and growth. OECD Directorate for Employment, Labour and Social Affairs. Paris: OECD. December 2014.

11 Eurofound. Access to healthcare in times of crisis. Dublin, 2014.

12 Collective. Statistics on income and living conditions 2013. Athens: Hellenic Statistical Authority, 2013.

13 Press release (13/10/2014) by the Hellenic Statistical Authority – Statistics on income and living conditions 2013 (income reference period 2012).

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

15 http://ec.europa.eu/eurostat/statistics-explained/index.php/Unemployment_statistics

16 European Commission. Your social security rights in Greece. Brussels, 2013.

17 In 2012, only 20,000 persons (3% of unemployed) could benefit from the long term unemployement assistance thanks to the raised income threshold. Koutsogeorgopoulou V et al. Fairly sharing the social impact of the crisis in Greece. OECD Economics Department; 9 January 2014, p36.

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

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 *sisa* (methamphetamine 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[19].

THE IMPACT OF THE CRISIS ON CHILDREN

An estimated 27 million children in Europe are at risk of poverty or social exclusion, with the economic and social crisis further increasing their vulnerability[20]. The national data collected by UNICEF clearly show the harmful impact of the crisis. Some 1.6 million more children were living in severe material deprivation in 2012 than in 2008 (an increase from 9.5 million to 11.1 million) in 30 European countries. The number of children entering into poverty during the crisis is 2.6 million higher than the number of those who have been able to escape poverty since 2008. Child poverty rates are soaring in Greece (40.5% in 2012 compared with 23% in 2008) and Spain (36.3% in 2012 compared with 28.2% in 2008)[21].

The latest available OECD data[22] indicate a rise in the number of low-birth-weight babies by more than 16% between 2008 and 2011, which has long-term implications for child health and development. Obstetricians have reported a 32% rise in stillbirths in Greece between 2008 and 2010, while fewer pregnant women have access to antenatal care services[23].

MIGRANTS IN DANGER AT EUROPE'S BORDERS

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

Although countries in North Africa, the Middle East and East Africa have been hosting the majority of the millions of displaced persons, there has also been a gradual increase in the number of asylum applications in the 28 Member States of the EU, to 626,820 in 2014[24] - an increase of more than 40% compared to 2013 according to UNHCR[25]. The fact that asylum seekers cannot freely choose where to lodge an asylum application (because the Dublin III regulation requires to request asylum in the EU country where asylum seekers arrived first) has serious consequences for their well-being and mental health. It also shows the clear lack of solidarity between Member States when it comes to migration issues.

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

Since the start of the Syrian crisis, of the total estimated 11.4 million Syrians who have fled their homes (over half of the total Syrian population), 3.8 million took refuge in neighbouring countries and 7.6 million were internally displaced[26]. Syrians were the largest group of people granted protection status in the EU-28 from 2012 to 2014; they also registered the highest recognition rates afforded by EU Member States with over 90% positive decisions since 2012[27]. However under 150,000 Syrians have sought asylum in the EU since the war began - less than 4 % of the conflict's total refugee population - and the majority of Syrians were resettled in two countries, Germany and Sweden[28].

Due to controls and walls on land migration routes, many migrants try to reach Europe through the Mediterranean Sea. In December 2014, the UNHCR estimated their total annual number at 200,000 (compared to 60,000 in 2013). Among those seeking a better future in Europe are large numbers of unaccompanied minors. In Italy and Malta alone, over 23,800 children had arrived by sea, including at least 12,000 unaccompanied, during the first nine months of 2014[29]. While 150,000 migrants were rescued under the Mare Nostrum operation, UNHCR estimates that around 3,400 people have died or have gone missing at sea (data as of November 2014).

A SYRIAN CHILD IN THE MIGRANT RECEPTION CENTRE AFTER HAVING JUST ARRIVED BY BOAT IN LESBOS - GREECE - 2014

19 Papatheodoridis G, Sypsa V, Kantzanou M, Nikolakopoulos I, Hatzakis A. Estimating the treatment cascade of chronic hepatitis B and C in Greece using a telephone survey. J Viral Hep 2015; 22: 409–15.

20 Save the Children. Child poverty and social exclusion in Europe: A matter of children's rights. Brussels: Save the Children, 2014.

21 UNICEF Office of Research. Children of the Recession: The impact of the economic crisis on child well-being in rich countries. Florence: UNICEF Office of Research, 2014.

22 OECD data: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT. *Last accessed on 16/02/2014.*

23 Vlachadis N, Kornarou E. Increase in stillbirths in Greece is linked to the economic crisis. BMJ 2013; 346: f1061.

24 Eurostat (2014), www.ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00191&plugin=1. Last accessed 18/03/2015

25 UNHCR. Asylum Trends 2014: Levels and Trends in Industrialized Countries. Geneva: UNHCR, 2015. http://www.unhcr.org/551128679.html

26 www.unocha.org/syria

27 European Commission. Facts and figures on the arrivals of migrants in Europe, Fact Sheet (13/01/2015)

28 ECRE / ELENA. http://www.ecre.org/component/downloads/downloads/824.html Information note on Syrian asylum seekers and refugees in Europe. 2013; and EUROSTAT: http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_quarterly_report)

29 UNHCR. So close, yet so far from safety, The Central Mediterranean Sea Initiative. 2014.

DANGEROUS MIGRATION ROUTES, EVEN IN 'HOST' COUNTRIES... CALAIS – FRANCE – 2014

Mare Nostrum ceased at the end of 2014. At the moment, the only initiative in place is the European down-scaled Frontex operation, Triton, the main focus of which is border management. Its more limited resources, mandate and geographical coverage (only within 30 miles of the Italian coast) have resulted in a downsizing of the search and rescue efforts. This means that many more people risk dying in their attempt to reach Europe, as the flows of migrants and therefore the risk of shipwrecks will not decrease in the Mediterranean[30].

RISING INTOLERANCE

Instead of focusing on the needs of vulnerable refugees, the European Council launched a joint police and border guard operation Mos Maiorum that took place over two weeks in October 2014. Although this joint operation was focused on apprehending *'irregular'* migrants and their facilitators, a quarter of the people encountered by the authorities were Syrian asylum seekers[31].

Although migrants contribute more in taxes and social contributions than they receive in benefits[32], and clearly make positive fiscal contributions[33], they are often falsely described as *'benefit-oriented'*. Furthermore, the crisis has first and foremost hit foreign-born workers: despite identical participation rates in the labour force across OECD countries, the average unemployment rate among foreign-born workers (13%) is significantly higher than that of native-born workers (9%). 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)[34].

During last year's European Parliamentary elections, the European Network Against Racism (ENAR) and the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA Europe) registered 42 hate speech incidents against minorities (migrants, LGBTI, Muslims and Roma)[35] by election candidates, five of whom currently sit in the newly elected Parliament.

In February 2015, Nils Muižnieks, the Council of Europe Commissioner for Human Rights, denounced the fact that *"despite advances in legislation and measures to combat intolerance and racism, discrimination and hate speech not only persist in France but are on the rise. [...] In recent years, there has been a huge increase in anti-Semitic, anti-Muslim and homophobic acts. In the first half of 2014 alone, the number of anti-Semitic acts virtually doubled. [...] The rising number of anti-Muslim acts, 80% of which are carried out against women, and homophobic acts, which occur once every two days, is also cause for great concern."*[36]

30 ECRE, Weekly bulletin, 10/10/2014. www.ecre.org/component/content/article/70-weekly-bulletin-articles/855-operation-mare-nostrum-to-end-frontex-triton-operation-will-not-ensure-rescue-at-sea-of-migrants-in-international-waters.html

31 www.statewatch.org/news/2015/jan/eu-council-2015-01-22-05474-mos-maiorum-final-report.pdf

32 OECD. Is migration good for the economy? Migration policy debates. Paris: OCDE, May 2014.

33 Dustmann C, Frattini T. The fiscal effects of immigration to the UK. The Economic Journal, in press.

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

35 ENAR / ILGA Europe (July 2014). http://www.enar-eu.org/IMG/pdf/nohateep2014_report_-_3_july.pdf

36 CoE. Press release, France: persistent discrimination endangers human rights. 2015.

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[37]:

BELGIUM: The Law of 19 January 2012[38] confirmed the practice of most public social welfare centres *(Centres Publics d'Action Sociale – CPAS)* towards newly arrived, destitute EU citizens: *"... the centre (CPAS) is not obliged to provide social assistance to European Union Member State nationals or members of their families during the first three months of their stay [...]"*. 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 for undocumented migrants. However, on 30 June 2014[39], 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 from outside the EU can benefit from the Urgent Medical Aid (Aide Médicale 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 *(Couverture Maladie Universelle complémentaire – CMUc)* and the complementary healthcare coverage acquisition assistance have been raised by 8.3%. By May 2014 (last available figures), 539,307 additional people were covered thanks to this positive measure (not including people covered by the specific healthcare coverage for undocumented migrants, State Medical Aid *(Aide Médicale de l'Etat – AME)*, the threshold of which is the same as for the CMUc). This measure should enable more than 750,000 additional individuals to have full health coverage. The full intent of this measure is expected by the end of 2015[40].

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 illness and severe pain› was reduced from 48 to 15 months.

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

THE NETHERLANDS: Since 2012, there has been a drastic increase in the amount a patient has to pay prior to being reimbursed for healthcare costs – from €220 to at least €375 a year in 2015 (up to €875 depending on the formula and insurance provider the individual has chosen)[41]. This has resulted in payment difficulties for an increasing number of patients. However, this payment of a contribution does not apply to minors (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 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, dental care *"that cannot be deferred"*, maternity care and abortion, and sexual and reproductive care. All children of undocumented parents have the same rights to medical and dental care as Swedish children. In February 2014, the National Board of Health and Welfare *(Socialstyrelsen)* came to the conclusion that the terms *"that cannot be deferred"* are *"not compatible with the ethical principles of the medical profession, are not medically applicable in health and medical care and risk jeopardising patient safety."* Indeed, it makes it very difficult for an individual to know whether s/he will be accepted for subsidised care or not. Furthermore, there is a lack of legal clarity on whether destitute EU citizens who have lost the right to reside are currently able to access healthcare on the same basis as undocumented migrants from outside the EU. The law merely stipulates that this is possible *"only in a few cases"*, without further precision. However, in December 2014, the Socialstyrelsen publicly announced that EU citizens should be considered as undocumented (and have the same access to care as asylum seekers and third-country nationals). But in practice, undocumented EU citizens still have to pay full fees for receiving healthcare in most hospitals.

UNITED KINGDOM: In May 2014, the government passed the new Immigration Act, setting out its intention to make it *"more difficult for 'illegal'[42] immigrants to live in the UK"*. According to the government, the Act is intended to:

- Introduce changes to the removals and appeals system, making it easier and quicker to remove those with no right to be in the UK;
- End the *'abuse'* of Article 8 of the European Convention on Human Rights – the right to respect for family and private life; and
- Prevent *'illegal'* immigrants accessing and abusing public services or the labour market.

Migrants seeking leave to enter the country for more than six months will have to pay an immigration health charge. The charges will be around €210 for international students and €280 for other

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

38 Law of 19 January 2012 modifying the legislation relating to the reception of asylum seekers. Available in French at www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2012011913

39 Constitutional Court judgment, 30 June 2014. Available in French at www.const-court.be/public/f/2014/2014-095f.pdf

40 www.cmu.fr

41 In February 2015, the Ministry of Health recognized the need to improve the *"quality and affordability of healthcare"*, by introducing a lower amount a patient has to pay prior to being reimbursed for healthcare costs, among other means.

42 Please note that MdM and its partners, especially the Platform for International Cooperation on Undocumented Migrants (PICUM), profoundly disagree with the use of the word 'illegal' to designate a person. Only the laws describing people as illegal are illegal. No-one on earth is illegal. *"Being undocumented is not an offense against persons, property or national security. It only belongs to the realm of administrative law... It does not make you an 'illegal' person."* www.picum.org

categories of migrants. The surcharge will be paid as part of the individual's visa fee, before their arrival in the UK, and would secure the same access to primary and secondary National Health Service (NHS) services during their stay as someone considered to be *'ordinarily resident'*.
The definition of *'ordinary residents'* will be changed so that all those who do not have indefinite leave to remain will be subject to the charge. Ordinary residence (giving full access to the NHS) was already restricted in 2004 (from anyone living in the UK for over one year to only people with a permit to stay). From 2015 onwards, this new restriction to cover only people with indefinite leave to remain will exclude those who have not been living in the UK for more than five years and have not made a successful application for indefinite leave to remain.

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

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

There is an impressive range of international texts and commitments 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 opinions published by its institutions and agencies. Below are the most recent and relevant expressions of commitment to health protection since MdM's previous European report in May 2014:

COUNCIL OF EUROPE

In its country conclusions on Spain[43] concerning health, social security and social protection, the European Committee of Social Rights (ECSR) condemns the exclusion of undocumented migrants from healthcare in Spain. In its country conclusions on Greece[44], the Committee questions whether the right to healthcare for pregnant women, adolescents and the uninsured is sufficiently guaranteed. Commissioner for Human Rights, Nils Muižnieks, reminded national governments that universal access to healthcare should not be undermined by austerity measures or the economic crisis[45]. 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 age[46]. Concerning migrant children, the Parliamentary Assembly (PACE) noted that, *"there is no legal instrument, or even consensus, with regard to procedures for assessing a person's age"*. The Assembly stressed the need to apply the benefit of the doubt, bearing in mind the higher interest of the child[47].

EUROPEAN UNION INSTITUTIONS

The European Parliament (EP) acknowledged that, *"access to the most basic healthcare services, such as emergency care, is severely limited, if not impossible, for undocumented migrants on account of the identification requirement, the high price of treatment and the fear of being detected and reported to the authorities"*[48]. The EP has also asked the Troika[49] not to include cuts in fundamental areas such as healthcare as a condition for financial assistance to euro area countries[50]. The Commission's EU Action Plan on HIV/AIDS for 2014-2016[51] (March 2014) includes access to prevention, treatment and care for undocumented migrants as an indicator. Following the Granada Declaration[52] 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"*[53]. The new Commissioner for Health, Vytenis Andriukaitis, former Minister of Health of Lithuania, is committed to the reduction of health inequalities in Europe. As he declared to a newly created Interest Group on Access to Healthcare in the European Parliament: *"In many countries, voters have already sent a clear message - they would not put up with policies that not only neglect citizens' right to access healthcare but eventually pushes them below poverty line."*[54] The EU Fundamental Rights Agency (FRA)[55] issued a paper on the Criminalisation of migrants in an irregular situation and of persons engaging with them[56], reiterating the fact that undocumented migrants' fear of detection deprives them of healthcare. Finally, the European Foundation for the Improvement of Living and Working Conditions (Eurofound) published an extensive report on Access to healthcare in times of crisis[57], which included a focus on the situation of specific groups in vulnerable situations, such as Roma, undocumented migrants, older people, people with chronic health conditions or disabilities and people with mental health problems.

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

44 www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/GreeceXX2en.pdf

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

46 CoE, Press release: France: persistent discrimination endangers human rights. 2015. Last accessed 18/02/2015.

47 PACE Resolution 1996. Migrant children: what rights at 18?, 2014.

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

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

50 EP resolution on Employment and social aspects of the role and operations of the Troika with regard to euro area programme countries (2014/2007(INI))

51 http://ec.europa.eu/health/sti_prevention/docs/ec_hiv_actionplan_2014_en.pdf

52 http://www.eupha-migranthealthconference.com/?page_id=1766

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

54 http://ec.europa.eu/commission/2014-2019/andriukaitis/announcements/inauguration-interest-group-access-healthcare-european-parliament_en

55 The FRA also published a report on fundamental rights at airports and another one on fundamental rights at land borders, completing earlier work on migrants' rights at Europe's southern sea borders.

56 http://fra.europa.eu/en/news/2014/fra-paper-criminalisation-irregular-migrants

57 Eurofound. Access to healthcare in times of crisis. Publications Office of the European Union: Luxembourg, 2014.

THE MDM INTERNATIONAL NETWORK'S DOMESTIC PROGRAMMES

Since 1980, the international aid organisation Doctors of the World – Médecins du monde (MdM) has been working for a world where barriers 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, Switzerland, the UK and the USA[58]. 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 frontline social and medical services for people who face barriers to the mainstream healthcare system. At home, MdM works mainly with people confronted with multiple vulnerabilities affecting their access to healthcare including homeless people, drug users, destitute nationals as well as European citizens, sex workers, undocumented migrants, asylum seekers and Roma communities.

MdM programs 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.

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. Fixed and mobile interventions (around 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 primary healthcare (child healthcare sometimes including vaccination, care for mental health issues, chronic conditions and sexual and reproductive health), specialist consultations and referrals to other health care providers (e.g. laboratories, hospital care, obstetric and pediatric care).

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

THE OBSERVATORY'S OBJECTIVES AND ACTIVITIES

In spite of the growing awareness and literature on health inequalities, the populations encountered through MdM 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 analysis, 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's 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, interactional 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 shaped by social determinants, many members of *vulnerable groups* are actually quite resilient.

Since 2006[59], 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.

58 In January 2015, 10 new organisations joined the MdM International Network to form the *European Network to Reduce Vulnerabilities in Health*, thus expanding the collaborative partnership to 10 new countries: Austria, Bulgaria, the Czech Republic, Hungary, Ireland, Italy, Norway, Poland, Romania and Slovenia. More on this at www.mdmeuroblog.wordpress.com.

59 Prior to the creation of the MdM International Network *Observatory on access to healthcare*, MdM France implemented in 1994 a common data collection tool in order to monitor the main social determinants of health, the barriers to access healthcare and the health status of its service users and publish the results. This led to the creation in 2000 of the Observatory of Access to healthcare in France.

PROGRAMMES SURVEYED

These programmes consist of fixed clinics that offer freely accessible frontline 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 reintegrate 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 fit the characteristics of each country's context, different packages of services and types of interventions have been developed over the years, as summarised below.

PROGRAMMES INVOLVED IN THE SURVEY AND SPECIFIC CHARACTERISTICS

COUNTRY CODE[60]	COUNTRY	SITES PARTICIPATING IN THE SURVEY	PROGRAMMES IN 2014 (IN ADDITION TO FREELY ACCESSIBLE FRONTLINE PRIMARY HEALTHCARE CONSULTATIONS AS WELL AS SOCIAL SUPPORT AND INFORMATION)
BE	BELGIUM	→ Antwerp → Brussels	In addition to social and medical services, provision of psychological support.
CH	SWITZERLAND	→ La Chaux de Fonds → Canton of Neuchâtel	Nurse-led consultations in asylum seeker centres (in the canton of Neuchâtel) and nurse consultation and social advice in the city of La Chaux de Fonds - mostly aimed at migrants.
DE	GERMANY	→ Munich	In addition to social and medical services, provision of paediatric, gynaecological, psychiatric and psychological consultations. For all people without healthcare coverage including undocumented migrants.
EL	GREECE	→ Athens → Patras → Chania → Perama → Mytilini → Thessaloniki	In addition to social and medical services, provision of psychological support and specialist consultations. In Mytilini, consultations are provided in reception centres for migrants who arrived by sea.
ES	SPAIN	→ Tenerife → Bilbao → Zaragoza → Seville → Valencia → Malaga → Alicante	In addition to social and medical services, the Spanish programmes offer awareness-raising and health promotion campaigns, training, intercultural mediation between professionals and programme users and awareness-raising of professionals working in public facilities.
FR	FRANCE	→ Saint-Denis → Nice	Tailored social and medical facilities to respond to the needs of groups who cannot access healthcare. Specialist consultations including psychiatry. Referral to mainstream healthcare system.
NL	NETHERLANDS	→ Amsterdam → The Hague	Provision of social advice and support to undocumented migrants from outside the EU for their integration into the regular health system. Additionally, over-the-counter medication (but no medical consultation), empowerment of migrant groups and awareness-raising of health professionals in the public system.
SE	SWEDEN	→ Stockholm	Provision of healthcare and patient referral to the public health system after informing them about their rights. EU citizens constitute the main group of patients but migrants from outside the EU are also attended. Psycho-social support and legal consultations regarding asylum are also provided as well as a follow-up of patient referrals.
TR	TURKEY	→ Istanbul	The Turkish-West African organisation ASEM (the Association for solidarity and support for migrants) in partnership with MdM FR, runs a social and medical clinic for asylum seekers, refugees and undocumented migrants in Istanbul. Patients are also given information on their rights, although they have very few legal avenues for treatment that is free or at little cost. ASEM has developed a strong link with West African communities.
UK	UNITED KINGDOM	→ London	The clinic in East London offers primary healthcare to excluded groups, especially migrants and sex workers. A large part of the work involves helping patients to register with a general practitioner, the entry point to the healthcare system. Additionally, social consultations are provided in a migrant centre in central London, and with an organisation supporting sex workers.

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 patients were men and the average age was 47. A quarter of the patients were Luxembourg nationals, followed by Romanian and Italian citizens. More than a quarter of patients encountered in 2014 were homeless. In Luxembourg the main barriers to social welfare in general and to healthcare in particular consist of administrative and financial difficulties. Even with healthcare coverage, patients are required to pay moderate user fees which were reported as an obstacle to seeking healthcare. Access to healthcare coverage depends upon having work and a residential address. Undocumented migrants have no healthcare coverage and only have access to emergency services. More and more hospitals require a deposit from people who don't present a healthcare coverage card. With regard to asylum seekers, during the three first months following the asylum request a voucher system covers only emergency consultations, the medication prescribed (by a doctor in Luxembourg) and emergency dental care.

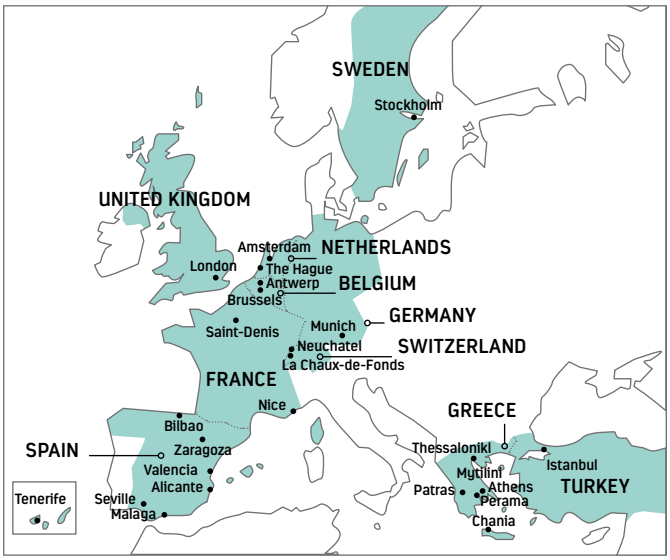
60 Throughout this document, countries are cited in alphabetic order by their official international code, according to European recommendations (Interinstitutional Style Guide, EU, Rev. 14 / 1.3.2012).

METHODS

QUESTIONNAIRES AND METHOD OF ADMINISTRATION

The data analysed in this report[61] 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).

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[62]); 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.

Standard statistical tests were used for some comparisons: mainly the Chi-square test or Fisher's exact test when the figures were low. It should be noted that a $p < 0.05$ denotes a statistically significant difference.

NUMBERS SURVEYED

This report is based on the analysis of data from 23,040 individuals (15,648 with details), of whom 8,656 were women. In total 42,534 consultations were analysed (including 29,898 for which the whole questionnaire was administered in the nine European countries and 1,296 in Turkey).

NUMBER OF PATIENTS AND CONSULTATIONS BY COUNTRY

COUNTRY	NO. OF PATIENTS	%	NO. OF VISITS	%
BE[A]	2,366	15.	6,665	21.4
CH	395	2.5	1200	3.8
DE	538	3.4	1292	4.1
EL[B]	8,154 / 762	4.9	12,976 / 1,636	5.2
ES[A]	263	1.7	265	0.8
FR	8,839	56.5	17,165	55.0
NL[A]	123	0.8	123	0.4
SE	98	0.6	98	0.3
TR	869	5.6	1,296	4.2
UK	1,395	8.9	1,454	4.7
TOTAL (25 CITIES)	23,040/15,648	100	42,534/31,194	100

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

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

REASONS FOR CONSULTING MDM PROGRAMMES

The **vast majority of patients consulted MdM programmes to obtain medical care** (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).

61 The full epidemiological report Access to healthcare for people facing multiple vulnerabilities in health in 26 cities across 11 countries, including data collected in Canada (Montreal) and all 2014 data cross-analysis, published in May 2015, is available on www.mdmeuroblog.wordpress.com.

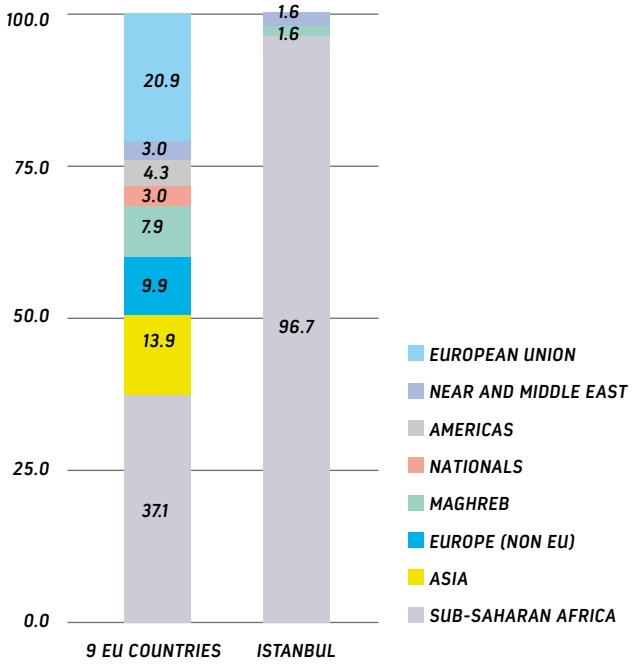
62 Within one country, if a programme in one city sees ten times fewer patients than another programme in another city, the former will count for one tenth of the latter.

FOCUS ON PREGNANT WOMEN

A total of 371 pregnant women were seen for consultations in 2014 (mainly in Belgium, Germany, France and Turkey) representing 2.4% of patients. The average age of the pregnant women was 27.8 in the European countries (29.1 in Istanbul) and the youngest was 14 years old.

Almost all the pregnant women seen (97.0%) were foreign nationals from sub-Saharan Africa (37.1%), the EU (20.2%), Asia (13.9%) and European countries outside the EU (9.9%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

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



Samira was a 22-year-old Congolese woman who lived in Turkey for three years. When she arrived at Eskisehir public health hospital, she was six months pregnant and felt unwell. She was referred to Osmangazi hospital, where €3,500 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.

ASEM Turkey – Istanbul – January 2015

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

ADMINISTRATIVE STATUS OF THE PREGNANT WOMEN INTERVIEWED

	% IN EUROPE (N=310)	% IN ISTANBUL (N=61)
CITIZEN OF NON-EU COUNTRY WITHOUT PERMISSION TO RESIDE	50.0	29.4
EU CITIZEN WITH NO PERMISSION TO RESIDE[A]	2.4	-
TOTAL WITHOUT PERMISSION TO RESIDE	52.4	29.4
NO RESIDENCE PERMIT REQUIREMENT (NATIONALS)[B]	4.3	17.6
ASYLUM SEEKER (APPLICATION OR APPEAL ONGOING)	33.3	29.4
VALID RESIDENCE PERMIT	7.1	5.9
EU NATIONAL STAYING FOR LESS THAN THREE MONTHS (NO RESIDENCE PERMIT REQUIRED)[B]	0.0	5.9
VISAS OF ALL TYPES[C]	3.6	11.8
SPECIFIC SITUATION CONFERRING RIGHT TO REMAIN[D]	2.4	0.0
TOTAL WITH PERMISSION TO RESIDE	50.7	70.6
TOTAL	100.0	100.0
MISSING DATA	1.9%	5.6%

A. Without adequate financial resources and/or healthcare coverage
B. Or equivalent situation (recent immigrants <90 days)
C. Tourism, short-stay, student, work
D. Including subsidiary/humanitarian protection

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, 37.5% had been refused asylum.

As a result of being undocumented, two thirds of the pregnant women (67.8%) 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[63].

63 The number of people living 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.

THREE GENERATIONS OF SOMALI ASYLUM SEEKERS WISHING TO KNOW WHAT THEIR FUTURE COULD BE. SWITZERLAND - 2014

A total of 49.3% of the pregnant women reported having one or more minor children. Nearly half of them (47.5%) were living apart from one or more of their minor children. In Istanbul, up to 74.1% were living without any of their children. Women who are separated from their children due to migration report considerable emotional strain, including anxiety, loss and guilt, and they are at greater risk of depression[64].

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[65]**.** 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.

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

64 Parreñas RS. Mothering from a distance: emotions, gender, and intergenerational relations in Filipino transnational families. Feminist studies. 2001; 27: pp. 361-90;
Miranda J, Siddique J, Der-Martirosian C, Belin TR. Depression among Latina immigrant mothers separated from their children. Psychiatric services. 2005; 56: pp. 717-20;
Bouris SS, Merry LA, Kebe A, Gagnon AJ. Mothering here and mothering there: international migration and post-birth mental health. Obs Gynecol Int. 2012; 2012: Article ID 593413, 6 p.

65 Women with no healthcare coverage were aggregated with those who are only entitled to use emergency services, which indicates that they do not have access to healthcare and have no healthcare coverage.

HEALTH CARE COVERAGE FOR PREGNANT WOMEN

	% IN EUROPE (N=310)	% IN ISTANBUL (N=61)
NO COVERAGE / ALL CHARGES MUST BE PAID	58.4	98.1
ACCESS TO EMERGENCY SERVICES ONLY	22.7	0.0
FULL HEALTHCARE COVERAGE	6.3	0.0
OPEN RIGHTS IN ANOTHER EUROPEAN COUNTRY	5.9	0.0
ACCESS TO GP WITH FEES	2.4	0.0
PARTIAL HEALTHCARE COVERAGE	2.1	0.0
FREE ACCESS TO GENERAL MEDICINE	1.1	1.9
ACCESS ON A CASE BY CASE BASIS	1.0	0.0

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[66] and, of those, 58.2% received care too late - that is after the 12th week of pregnancy[67].

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

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

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

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

Without access to timely – i.e. after 12 weeks of pregnancy – and regular antenatal care throughout the pregnancy, a number of risks can affect mothers and children:

➔ Mother to child transmission of HIV (and Hepatitis B)

➔ 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/HEN. What is the efficacy/effectiveness of antenatal care and the financial and organizational implications?

66 The more recent the pregnancy the fewer women had access to care prior to MdM (16.3 weeks on average in women with no access to care prior to MdM versus 20.8 weeks for those with access to health care, p<0.001).

67 Response rate = 78.5% and 57.4% respectively.

A LEGAL OVERVIEW OF ACCESS TO CARE FOR PREGNANT WOMEN[68]

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 pregnant women do not have any access to antenatal and postnatal care.

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

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

With regard to termination of pregnancy, they have to pay approximately €340 in public hospitals. Article 79(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 card.

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 €5 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 throughout pregnancy, which is around €7,000 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.

68 For all details and references to the laws, please consult the full legislative report on access to healthcare in 12 countries published in May 2015 on www.mdmeuroblog.wordpress.com.

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

At the end of 2013 the Spanish government proposed to repeal the 2010 law on sexual and reproductive health and voluntary interruption of pregnancy, thereby revoking the right of girls and women to decide themselves if and when they want a child. The draft law would only allow termination of pregnancy in the case of rape or if the pregnancy posed a serious physical or mental health risk to women (to be attested by two different doctors not working at abortion facilities).

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

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

At the same time, the MdM International Network ran a campaign for the right of women to decide if and when they want to have children, for access to contraception and for access to safe and legal abortion. The campaign was called Names not Numbers[69] 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."*

69 www.youtube.com/watch?v=KTr9RiJ7VII

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MDM PARTICIPATION IN THE EUROPEAN MOBILISATION AGAINST THE SPANISH ANTI-ABORTION LAW – PARIS – FRANCE – FEBRUARY 2014

FOCUS ON CHILDREN VACCINATION

BUILDING UP TRUST AND CONFIDENCE IS ESSENTIAL. PAEDIATRIC CONSULTATION – MUNICH MDM GERMANY

The vaccine(s) that protect against tetanus, MMR (measles, mumps and rubella), diphtheria and whooping cough are considered essential throughout the world, and most WHO Europe countries have also included the vaccine against Hepatitis B in their national immunisation schedules[70].

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[71].

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

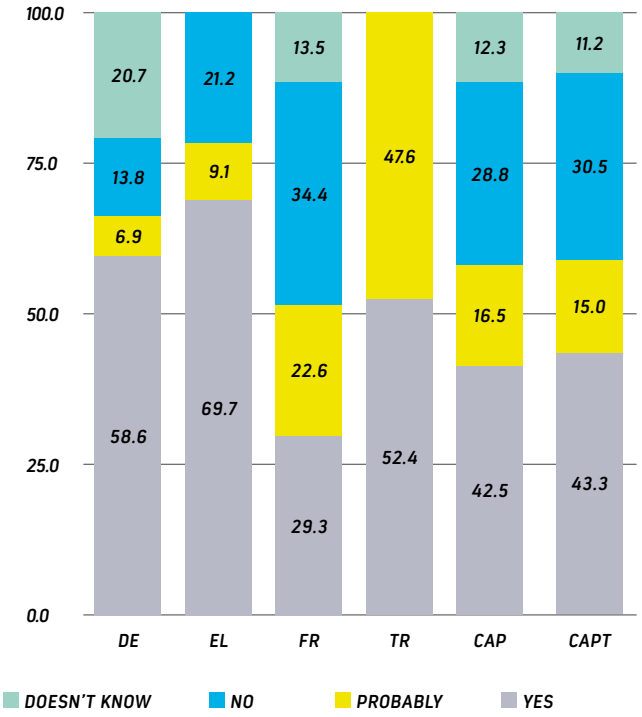
A total of 645 minor patients were seen by MdM programmes in 2014. They represent 4.1% of the total population. No minors were seen in Sweden.

70 www.euro.who.int/en/health-topics/disease-prevention/vaccines-and-immunization/vaccine-preventable-diseases

71 Herd immunity applies to measles, rubella, varicella (chickenpox), polio and whooping cough. For infections for which humans do not form a reservoir (e.g. tetanus, rabies), vaccines only offer individual protection.
Smith P. Concepts of herd protection and immunity. London: London School of Hygiene & Tropical Medicine, 2009.

In Europe[72], only 42.5% of minors who responded had been vaccinated against tetanus. In France, only 29.3% of minors had definitely been vaccinated[73]. In Istanbul, this applied to 52.4%.

TETANUS VACCINATION COVERAGE AMONG MINORS (%)

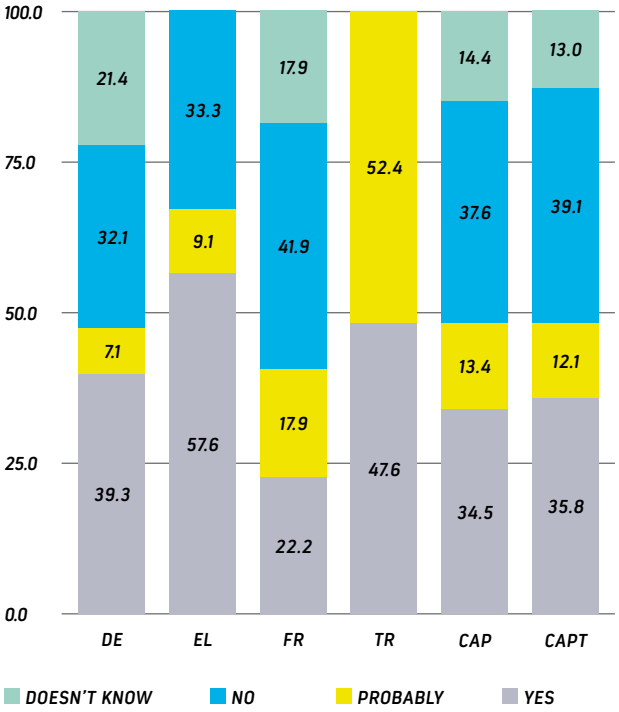


The rates of vaccination against hepatitis B (HBV) were even lower: the average proportion of vaccinated minors in Europe was 38.7%. The HBV vaccination rate was very low in France (22.1%). In the European countries, following the WHO recommendation to incorporate hepatitis B vaccine as an integral part of national infant immunisation programmes[74], the immunisation coverage in the general population is averaging 93%[75].

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

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

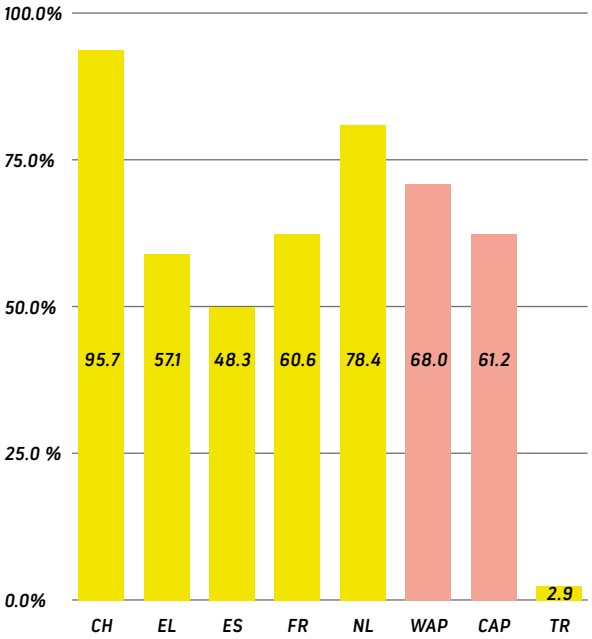
MMR VACCINATION COVERAGE AMONG CHILDREN (%)



KNOWLEDGE OF WHERE TO GO FOR VACCINATIONS

In total, 38.8% of the people asked about vaccination did not know where to go to have their children vaccinated in the five European countries where the question was asked. In Istanbul, almost nobody knew where to go to have their child vaccinated.

KNOWLEDGE OF WHERE TO GO FOR VACCINATIONS (FOR MINORS, %)



72 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.

73 This means that MdM doctors or nurses had seen the vaccination booklet.

74 Summary of WHO Position Papers - Recommendations for Routine Immunization (updated 30 May 2014).

75 OECD. Childhood vaccination programmes. In: Health at a glance 2013. Paris: OECD, 2013.

As vaccination and health cards are requested for registration at state schools, not accessing healthcare can result in being excluded from school as well: Mariela, from Paraguay, has a permit to reside as well as a work permit in Spain, where she lives with her two children, aged 11 and 15. *"I cannot send one of my children to school because I have to show his health card. In the public health centre, they told me that he is not allowed to get one as he is not registered with the Municipality."*

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

MdM Spain – Tenerife – December 2014

MDM NURSE FEEDING HER PATIENT'S BABY – MDM UK – LONDON – DECEMBER 2014

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[76].

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[77].

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

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

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

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

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

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

SPAIN: Article *3ter*, al. 4 of Law 16/2003 (added by Article 1 of Royal Decree-Law 16/2012)[78] provides that *"in any case, foreigners who are less than 18 years old receive healthcare under the same conditions as Spanish citizens"*. This provision states clearly that all minors in Spain, regardless of their administrative status, will be granted access to healthcare services, including vaccinations, under the same conditions as Spanish minors (i.e. free of charge). Nonetheless, the acquisition of an individual health card for the children of undocumented migrants is not so easy. Therefore, they are sometimes denied care and/or vaccination. It is clearly a problem of the implementation of the law; public health centres do not know how to deal with these minors and may refuse to take care of them until they have a health card.

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

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

TURKEY: Asylum seekers must summit a claim to the Social Aid and Solidarity Foundation to obtain access to subsidised healthcare for their children. To this end, they must prove their lack of financial resources and obtain a residence permit giving them a *'citizen number'*. The children of undocumented migrants have no access to prevention or care. Those born in Turkey may have access to free vaccination at a family health centre but they need to be registered in the civil registry. Otherwise, each vaccine costs around €18, added to the €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.

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

77 Circular DSS/2A no 2011-351 of September 8, 2011. Available in French at www.sante.gouv.fr/fichiers/bo/2011/11-10/ste_20110010_0100_0055.pdf

78 Royal Decree-Act 16/2012.

DEMOGRAPHIC CHARACTERISTICS

SEX AND AGE

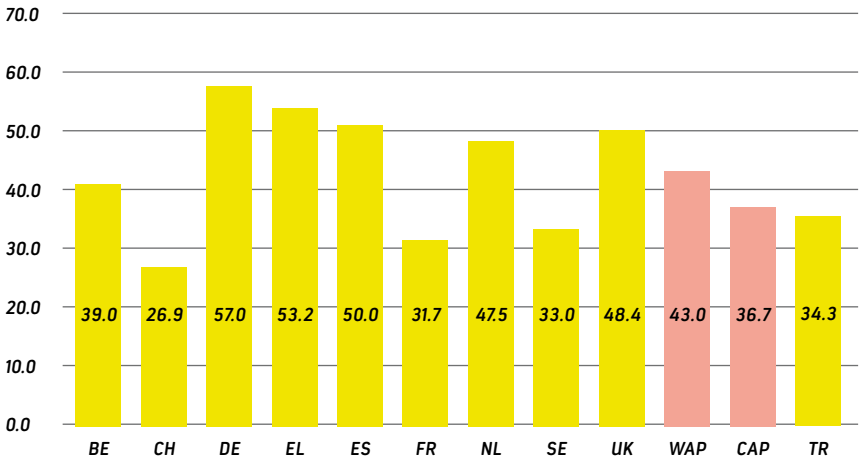
In total, 43% of the patients seen in Europe were women (34.3% in Istanbul). **The average age of the patients seen by MdM in Europe was 35.8** (30.8 in Istanbul) and half of the patients were between 25 and 46 (26 and 36 in Istanbul).

Overall, 645 minors were received at MdM clinics, amounting to 4.1% of all patients (up to 5% in Belgium and France, 10% in Switzerland and 14% in Greece).

In France, the number of unaccompanied migrant minors also increased, with the majority converging towards the Parisian area (Paris and Saint-Denis)[79]. Indeed the number of unaccompanied minors visiting MdM in and around Paris tripled in 2014, with most children not having any healthcare coverage and half being homeless at their first encounter with MdM. Psychological issues were very common for most of these children, indicating the need for adequate psychosocial and medical support[80].

Although there are few comprehensive data on the total number of unaccompanied children present in Europe or arriving each year, significant numbers of unaccompanied minors have arrived in Europe since 2008 (the most reliable statistics are those related to unaccompanied children who have applied for asylum[81]). In view of the increase noted at some MdM clinics, a question was added to the 2015 survey to better comprehend the number of unaccompanied minors and their access to healthcare. This issue will be further documented in next year's report.

PROPORTION OF WOMEN BY COUNTRY SURVEYED



4% OF ALL PATIENTS SEEN IN THE PROGRAMMES PARTICIPATING IN THE SURVEY WERE MINORS IN 2014. PARIS SUBURBS - FRANCE - 2014

79 Carsin C, Emmanuelli J, Crosnier M, Pautrat C, Messias B, Debart MH, Planté S. Évaluation du dispositif relatif aux mineurs isolés étrangers mis en place par le protocole et la circulaire du 31 mai 2013. Paris: IGA, July 2014.

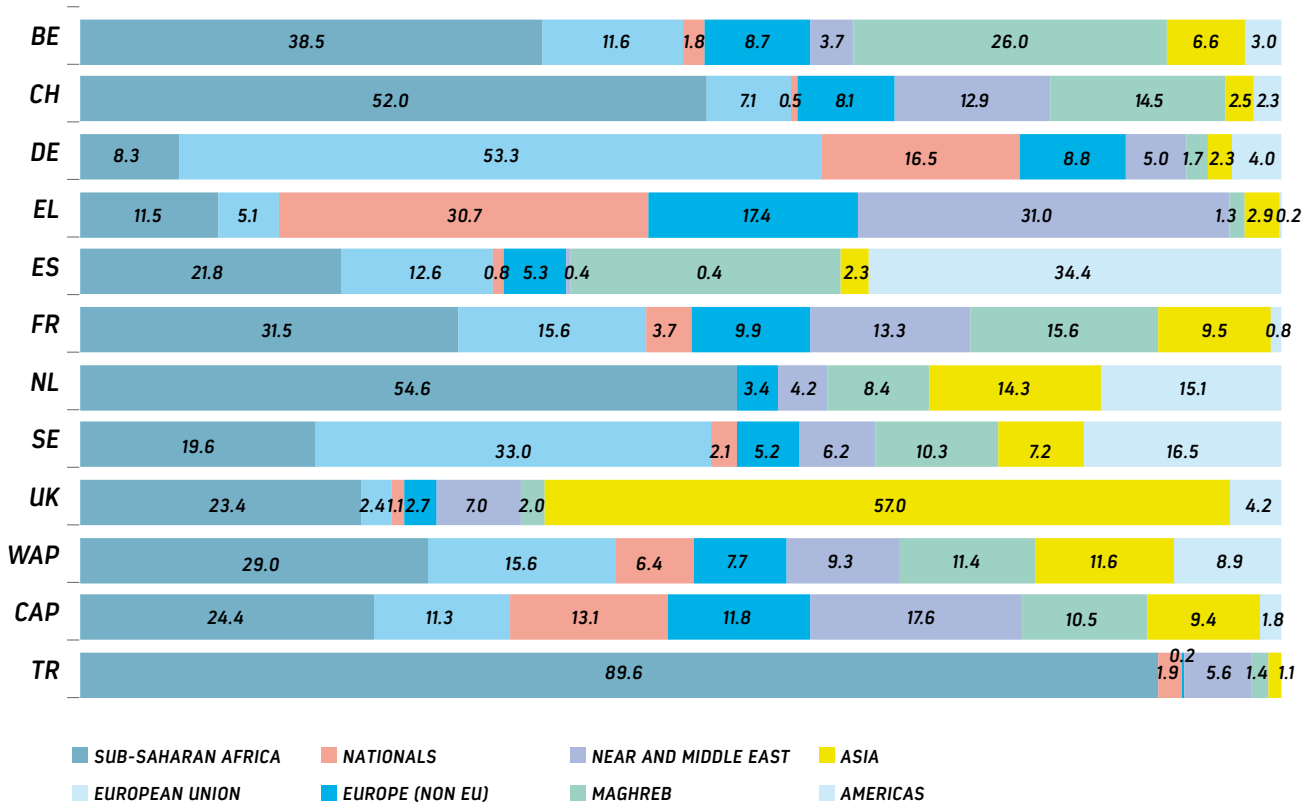
80 Information provided by the MdM Delegation Ile de France.

81 European Parliament resolution of 12 September 2013 on the situation of unaccompanied minors in the EU (2012/2263(INI));
European Council on Refugees and Exiles. Right to justice: Quality legal assistance for unaccompanied children. Comparative report : Brussels, 2014.

NATIONALITY AND GEOGRAPHICAL ORIGIN

In Europe, an overwhelming majority of patients seen by MdM programmes in 2014 were foreign nationals (93.6%)[82].

PATIENTS' GEOGRAPHICAL ORIGINS BY COUNTRY SURVEYED (%)



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

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

82 Missing values : respectively 1.5% in BE, 0.3% in CH, 1.1% in DE, 2.2% in EL, 0.0.% in ES, 9.7% in FR, 3.3% in NL, 1.0% in SE, 9.0% in UK, and 2.0% in TR.

In the nine European countries, patients mostly originated from sub-Saharan Africa (29.0%), followed by the European Union (15.6%), Asia (11.6%), Maghreb (11.4%), Near and Middle East[83] (9.3%) and the Americas (essentially Latin America: 8.9%).

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

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

The nationalities most frequently encountered varied from one location to another: Africa (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

BE	*NO.*	*CH*	*NO.*	*DE*	*NO.*	*ES*	*NO.*
Morocco	473	Eritrea	93	Bulgaria	156	Morocco	51
DR Congo	189	Syria	36	Germany	90	Romania	24
Guinea	152	Morocco	22	Romania	53	Nicaragua	17
Cameroon	118	Cameroon	21	Hungary	13	Nigeria	12
Romania	96	Tunisia	17	Serbia	11	Venezuela	10
Algeria	85	Algeria	17	Poland	11	Senegal	9
Nigeria	64	Nigeria	16	Nigeria	9	Cameroon	9
Senegal	51	Somalia	14	Spain	9	Algeria	8
Mongolia	45	Portugal	10	Croatia	9	Guinea	7
Bulgaria	43	Spain	10	Afghanistan	9	Argentina	7
EL	*NO.*	*FR*	*NO.*	*NL*	*NO.*	*SE*	*NO.*
Greece	2212	Romania	1035	Nigeria	25	Romania	24
Afghanistan	1497	Pakistan	929	Ghana	14	Morocco	6
Albania	883	Ivory Coast	572	Suriname	9	Ghana	5
Syria	424	India	529	Indonesia	7	Nigeria	4
Nigeria	244	Tunisia	457	Morocco	4	Senegal	3
Georgia	212	Mali	457	Eritrea	4	Peru	3
Bulgaria	212	Morocco	393	Somalia	3	Georgia	3
Somalia	181	Algeria	392	Sierra Leone	3	Gambia	3
Bangladesh	174	Cameroon	283	Philippines	3	Bolivia	3
Pakistan	122	Moldova	277	Ecuador	3	Bangladesh	3
UK (1)	*NO.*	*UK (2)*	*NO.*	*TR (1)*	*NO.*	*TR (2)*	*NO.*
Philippines	179	Nigeria	50	Senegal	141	Guinea	38
India	164	Vietnam	41	Nigeria	115	Uganda	36
Bangladesh	160	Pakistan	37	DR Congo	102	Gambia	29
Uganda	130	Sri Lanka	33	Cameroon	102	Afghanistan	24
China	115	Brazil	31	Ivory Coast	53	Ghana	20

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

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[84] (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[85], 0.9% in Turkey). There is no correlation between the number of people who migrate for health reasons, among others, and the level of legal restrictions and barriers to accessing healthcare in the 'host' country. This is yet more proof to deconstruct the myth of migration for health.

REASONS FOR MIGRATION BY COUNTRY (%)

	CH	DE	EL	ES	NL	SE	UK	WAP	CAP	TR
ECONOMIC REASONS, UNABLE TO EARN A LIVING IN HOME COUNTRY	19.7	67.7	72.7	70.5	36.8	52.6	39.6	51.4	**50.2**	69.1
POLITICAL, RELIGIOUS, ETHNIC, SEXUAL ORIENTATION	45.2	5.4	13.3	8.5	26.3	26.3	23.4	21.2	19.3	28.1
TO ESCAPE FROM WAR	58.0	5.4	14.4	3.1	3.5	0.0	4.6	12.7	8.9	13.3
TO JOIN OR FOLLOW SOMEONE	14.6	26.9	5.7	13.2	14.9	5.3	12.8	13.3	14.6	3.3
FAMILY CONFLICTS	5.1	3.5	2.7	6.6	12.3	5.3	10.8	6.6	7.8	2.2
TO ENSURE YOUR CHILDREN'S FUTURE	0.6	6.4	4.2	4.3	0.9	7.0	3.3	3.8	3.8	0.0
PERSONAL HEALTH REASONS	0.6	3.5	1.9	5.8	7.0	0.0	2.6	3.1	**3.0**	0.9
TO STUDY	0.0	3.1	0.4	1.9	0.9	3.5	6.1	2.3	3.8	2.0
OTHER	4.5	11.1	9.8	4.7	6.1	10.5	17.9	9.2	12.9	2.9
TOTAL	**148.3**	**133**	**125.1**	**118.6**	**108.7**	**110.5**	**121.1**	**123.6**	**124.3**	**121.8**
MISSING DATA (%)[A]	60.3	19.4	60.8	1.5	7.3	41.8	14.7	29.4	21.8	7.8

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

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

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

"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

©JOSÉ SALVADOR GUTIERREZ

WORK ACCIDENT SUFFERED BY A GHANAIAN SEASONAL WORKER IN A GREENHOUSE – ALMERIA SPAIN – 2014

Lastly, no significant difference was observed in the frequency of health reasons for migration between EU citizens and other migrants: both being very low (2.9% and 2.5% respectively, p=0.68). Of course, the most frequent other reasons for migration were very different between the two groups: EU citizens had migrated mostly for economic (81.8%) and family reasons (to join or follow someone: 22.2%) and the others had done it for the four main reasons mentioned above.

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

REASONS FOR MIGRATION: COMPARISON BETWEEN EU CITIZENS (EXCEPT NATIONALS) AND OTHER MIGRANTS (%)

	EU CITIZENS (N=418)	*OTHERS (N=3082)*	*P*
ECONOMIC REASONS, UNABLE TO EARN A LIVING IN HOME COUNTRY	81.8	48.3	<0.001
POLITICAL, RELIGIOUS, ETHNIC, SEXUAL ORIENTATION	1.2	24.9	<0.001
TO ESCAPE FROM WAR	0.5	10.6	<0.001
TO JOIN OR FOLLOW SOMEONE	22.2	11.6	<0.001
FAMILY CONFLICTS	3.3	7.0	0.004
TO ENSURE YOUR CHILDREN' FUTURE	6.0	2.5	<0.001
PERSONAL HEALTH REASONS	2.9	2.5	0.68
TO STUDY	2.4	3.9	0.14
OTHERS	5.0	11.5	<0.001
TOTAL	*125.3*	*122.8*	

MIGRATION POLICIES SHOULD FOCUS ON PROTECTION. MIGRANTS DREAMING OF ASYLUM IN THE UK. CALAIS, FRANCE 2014

ADMINISTRATIVE SITUATION

The majority (66.0%) of all people seen at the MdM centres in the nine European countries do not have permission to reside: 56.7% of citizens from non-EU countries and 9.3% of EU citizens (who have been in the country for over three months and do not have adequate financial resources and/or valid healthcare coverage). **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[86] 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/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 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 (16.8%), Greece (17%) and Germany (38.1%) had the lowest figures. In contrast, 94.2% of patients seen in the Netherlands[87], 83.9% of those seen in Belgium, 67.9% of those seen in France[88] and 63.5% of those seen in Spain were in this situation.*

THE FRENCH STATE MEDICAL ASSISTANCE IS A FULL HEALTHCARE COVERAGE MECHANISM FOR UNDOCUMENTED MIGRANTS, UNDER SPECIFIC CONDITIONS AND ADMINISTRATIVE CONSTRAINTS. ASSISTANCE FROM SUPPORT WORKERS IS HELPFUL! PARIS, FRANCE – 2014

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 (37.4%), the number of foreign citizens with permission to reside (20.9%) and asylum seekers (11%).

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

In Switzerland, a significant majority of patients were asylum seekers (71.5%), in contrast to the other countries surveyed (asylum seekers represented 15.3% of the total in London and 13.4% in France). The main programme in Switzerland is actually aimed at asylum seekers housed in three reception facilities in the canton of Neuchâtel and accounted for a majority of the patients.

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

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

In Istanbul, 63.2% of patients had no permission to reside; 16.0% were seeking asylum and 12.4% were recent immigrants (less than 90 days).

86 This Directive was effectively transposed into the legislation of all EU Member States in around 2008. http://emn.ie/files/p_20100813041839directive%202004.38.EC.pdf

87 In the Netherlands, the programme is specifically geared towards undocumented migrants from outside the EU.

88 In Belgium and France, access for undocumented migrants to personal healthcare coverage if they are destitute (through AME in France and AMU in Belgium) remains very complex. Authorized residents are referred to the mainstream system without attending a social or medical consultation in MdM.

ADMINISTRATIVE STATUS BY COUNTRY (%)

	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	TR
CITIZEN OF NON-EU COUNTRY WITHOUT PERMISSION TO RESIDE	70.5	15.4	9.0	14.3	54.9	59.1	94.2	26.4	**57.5**	44.6	**56.7**	61.2
EU CITIZEN WITH NO PERMISSION TO RESIDE[A]	13.4	1.4	29.1	2.7	8.6	8.8	0.0	20.9	0.5	9.5	**9.3**	2.0
TOTAL WITHOUT PERMISSION TO RESIDE	**83.9**	**16.8**	**38.1**	**17.0**	**63.5**	**67.9**	**94.2**	**47.3**	**58.0**	**54.1**	**66.0**	**63.2**
NO RESIDENCE PERMIT REQUIREMENT (NATIONALS)[B C]	1.8	0.6	17.2	**37.4**	0.8	5.0	0.0	2.2	1.0	7.3	4.7	1.8
ASYLUM SEEKER (APPLICATION OR APPEAL ONGOING)	3.9	**71.5**	3.2	11.0	2.4	13.4	2.5	3.3	**15.3**	14.1	12.7	16.0
VALID RESIDENCE PERMIT	1.8	6.1	4.4	20.9	25.9	3.9	2.5	1.1	1.1	7.5	4.0	2.6
EU NATIONAL STAYING FOR LESS THAN THREE MONTHS (NO RESIDENCE PERMIT REQUIRED)[D]	2.4	3.1	18.2	3.8	1.2	2.1	0.0	24.2	1.3	6.3	3.0	10.6
VISAS OF ALL TYPES[D]	1.4	0.6	7.6	0.5	2.8	2.8	0.0	2.2	11.8	3.3	3.6	1.3
EU NATIONAL WITH PERMISSION TO RESIDE[E]	2.8	0.3	5.0	2.7	2	1.5	0.0	2.2	0.3	1.9	1.7	0.1
RESIDENCE PERMIT FROM ANOTHER EU COUNTRY	1.0	0.3	3.4	1.6	0.4	1.4	0.0	14.3	0.4	2.5	1.4	0.1
SPECIFIC SITUATION CONFERRING RIGHT TO REMAIN[F]	0.4	0.6	1.8	0.5	1.2	2.0	0.0	0.0	3.3	1.1	1.7	0.7
TOTAL WITH PERMISSION TO RESIDE	**15.5**	**83.1**	**60.8**	**83.0**	**36.7**	**32.1**	**5.0**	**49.5**	**34.5**	**42.9**	**34.0**	**33.2**
DON'T KNOW	0.5	0.3	1.2	4.4	0.0	0.0	0.8	3.3	7.6	2.0	1.2	3.5
TOTAL	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
MISSING DATA (%)	**7.1**	**9.4**	**4.8**	**73.0**	**2.7**	**32.6**	**1.6**	**7.1**	**8.8**	**16.3**	**23.6**	**4.3**

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)

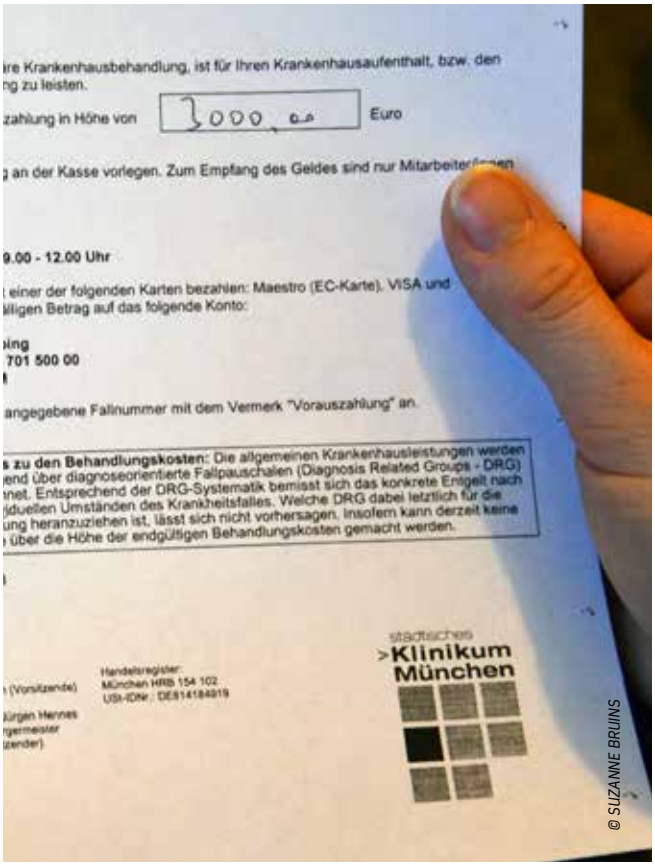
D. Tourism, short-stay, student, work

E. Adequate financial resources and valid healthcare coverage

F. Including subsidiary/humanitarian protection

Overall, in the nine European countries, **43.4% of citizens from non-EU countries were or had been involved in an asylum application (N=4,410). 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[89] **were relatively few (between 1% and 3%)** except in Stockholm and Munich where they respectively represented 10.5% and 10.3% of the total.



STANDARD DEPOSIT OF €3,000 REQUESTED FROM PATIENTS WITHOUT HEALTH INSURANCE FOR BEING TREATED OR OPERATED ON IN HOSPITAL – MDM GERMANY – 2014

89 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 (www.asylumlawdatabase.eu). EURODAC is the computerised central database of fingerprint data, as well as the electronic tool for transmission between the Member States and this central database.

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**[90] (this was particularly common in Switzerland, Sweden and the Netherlands)[91]. This proportion stood at 63.0% in Istanbul[92].

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 (38.8%, up to 62.6% in France) or to have his/her own home (29.5%), which by no means always represented stable accommodation and furthermore could also be overcrowded. In Istanbul 75.2% lived in their own flat or house; as in 2013, homeless people were extremely rare.

29.5% of those questioned in Europe[93] **deemed their accommodation to be harmful to their health or that of their children.** In Istanbul, this proportion reached 57.9%[94].

ASYLUM SEEKERS IN THE CANTON OF NEUCHÂTEL, SWITZERLAND, HOUSED IN NUCLEAR SHELTERS OPENED TO ACCOMMODATE THE SURGE OF ASYLUM SEEKERS IN 2014

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

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

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

MdM Netherlands – Amsterdam – November 2014

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

91 The question was not asked in Belgium and in Greece. In the other countries, the missing values accounted for 14.7% in CH, 4.2% in DE, 1.5% in ES, 34.7% in FR, 13.0% in NL, 4.1% in SE and 8.8% in UK.

92 Response rate at 96.8%.

93 Missing values: 65.1% in CH, 41.8% in DE, 20.6% in EL, 11.8% in ES, 27.6% in NL, 16.3% in SE, 69.6% in UK.

94 Response rate at 95.0%.

PERAMA: GREEK CHILDREN, AGED BETWEEN THREE AND SEVEN, WHOSE PARENTS ARE UNEMPLOYED. WHILE THEY HAVE SOME INCOME FOR BASIC NEEDS (HOUSING AND FOOD), THEIR CONDITIONS HAVE DRASTICALLY WORSENED IN THE LAST TWO YEARS. THEY DO NOT HAVE ELECTRICITY OR RUNNING WATER ANYMORE AND HAVE TO MANAGE WITH CAR BATTERIES AS THEIR CENTRAL POWER SOURCE

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

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

MdM Germany – Munich – December 2014

WORK AND INCOME

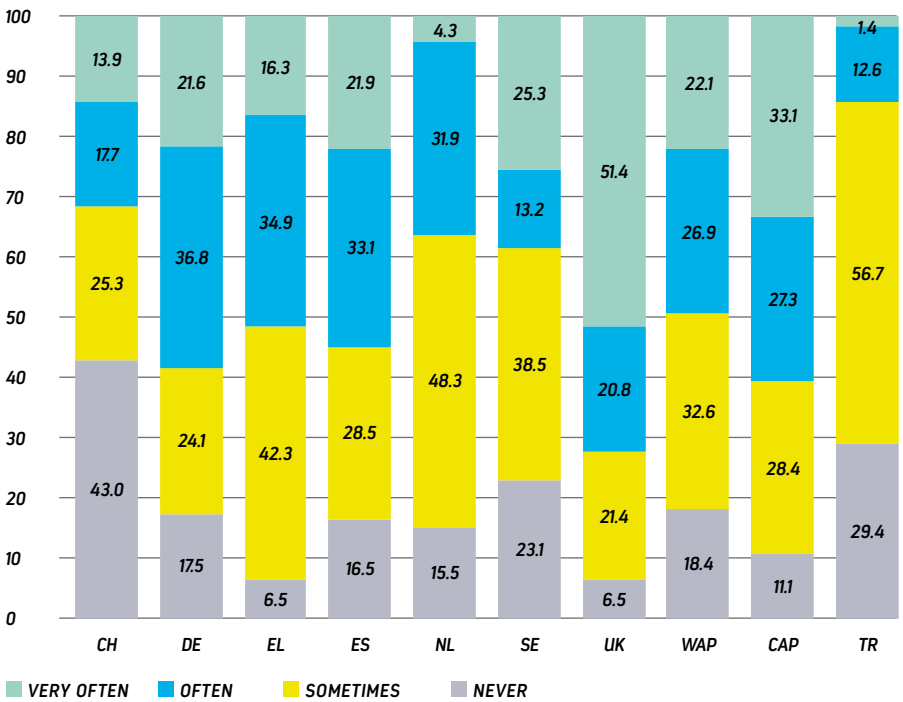
A slim majority of people attending MdM centres in Europe had no permission to reside and therefore did not have permission to work. It is therefore unsurprising that **only 21.9% of them reported an activity to earn a living in the eight European countries** (question not asked in Belgium)[95].

Almost all the people surveyed in the eight European countries (91.3%) were living below the poverty line[96] (on average, over the past three months, taking into account all sources of income[97]).

SOCIAL ISOLATION

When asked about moral support[98], **one in two people said they could rarely or never rely on support if they needed it:** 18.4% of patients seen in seven European countries replied that they never had anyone they could rely on or turn to if the need arose and one third (32.6%) said they could rely on such support only sometimes. In Istanbul, 86.1% of patients were isolated: 29.4% said they could never rely on anyone for moral support and 56.7% said they could do so only occasionally. Altogether, men more often reported being isolated and without support than women (p<0.01).

AVAILABILITY OF SUPPORT WHEN NEEDED BY COUNTRY (%)



95 Missing data: 63.5% in CH, 33.1% in DE, 19.7% in EI, 11.1% in ES, 50.6% in FR, 45.5% in NL, 12.0% in SE, 56.1% in UK, 4.9% in TR.

96 The number of people living on the financial resources of the respondent was not calculated. 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.

97 Missing data: 67.3% in CH, 15.4% in DE, 20.8% in EI, 3.1% in ES, 64.8% in FR, 4.9% in NL, 9.2% in SE, 13.3% in UK, 8.4% in TR.

98 Unfortunately, the question was not asked in Belgium or France. Missing values were very frequent in Switzerland (80.0%). In the other countries, missing values were: 24.1% in DE, 21.8% in EL, 0.8% in ES, 5.7% in NL, 7.1 in SE, 13.2% in UK, and 7.1% in TR.

ACCESS TO HEALTHCARE

COVERAGE OF HEALTHCARE CHARGES

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

COVERAGE OF HEALTHCARE CHARGES BY COUNTRY (%)

	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	TR
NO COVERAGE[A] / ALL CHARGES MUST BE PAID	**91.9**	15.9	**73.6**	**85.1**	62.0	**92.3**	14.0	48.7	**82.7**	62.9	85.5	**98.7**
FULL HEALTHCARE COVERAGE[B]	5.1	**74.9**	4.7	5.6	**33.7**	4.1	3.5	5	4.7	15.7	7.6	0.1
PARTIAL HEALTHCARE COVERAGE[C]	0.3	7.9	3.1	9.1	3.1	2.2	**82.5**	**28.7**	0.0	15.2	3.2	0.8
HEALTHCARE RIGHTS IN ANOTHER EU COUNTRY	1.5	1.3	**15.5**	0.2	0.0	1.4	0.0	**15.0**	0.0	3.9	1.9	0.0
ACCESS ON A CASE-BY-CASE BASIS	1.1	0.0	3.1	0.0	0.0	0.0	0.0	1.2	0.0	0.6	0.4	0.0
FREE ACCESS TO GP SERVICES	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**9.0**	1.1	1.0	0.4
CHARGEABLE ACCESS TO SECONDARY HEALTHCARE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	3.6	0.6	0.4	0.0
TOTAL	100	100	100	100	100	100	100	100	100	100	100	100
MISSING DATA	6.1	3.3	1.9	36.2	2.7	33.6	7.3	18.4	17.0	14.1	23.1	9.5

A. Including *No coverage / all charges must be paid* and *Access to emergency services only*

B. As much as it exists in the country, meaning that care may still require out-of-pocket payments

C. Including those who have to pay part of the costs of the GP consultation.

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

The proportion of patients with no healthcare coverage was particularly high in France (92.3%) and Belgium (91.9%). These rates can mostly be explained by the fact that the centres concerned (Nice, Saint-Denis, Brussels and Antwerp) only accept patients with no effective healthcare coverage, while people who do have healthcare coverage are redirected to facilities within the mainstream healthcare system. In theory, undocumented migrants in both countries have 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 validity period of the AMU, each CPAS defines the period, which varies from one day to six months.

MdM Belgium – Brussels – December 2014

In Germany, 73.6% of patients only had access to emergency healthcare. 15.5% were entitled to healthcare coverage in another European country (which is in line with the high number of Europeans among the patients 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 14.0% had no access at all.

In Spain[99], 61.6% of patients seen only had access to emergency care. While undocumented migrants are supposed to have access to free emergency care, in practice cases where they are billed for the emergency care they received were witnessed by MdM as well as being reported by the Ombudsman in Spain[100].

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[101] – 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 8.1% of them had healthcare rights in another EU country.

Adrian and Izie are two–year-old Greek twins. The children have serious asthma that requires hospitalisation and regular treatment. Asthma attacks can be reduced by taking medication and avoiding exposure to known triggers. The family lives in a poor environment (humidity in the house, lack of heating). Without any income, the family is covered by the Social Welfare insurance which has been irregular, leaving the children without treatment from time to time, as their parents couldn't financially compensate for the periods with no coverage. The availability of drugs is irregular at the hospital. In addition, administrative procedures for requesting a yearly social welfare booklet takes two to six months, during which the family has no free access to treatment. MdM guaranteed their continuous access to the prescribed medication.

MdM Greece – Perama – September 2014

COVERAGE OF HEALTHCARE: COMPARISON BETWEEN NATIONALS, EU CITIZENS AND MIGRANTS FROM NON-EU COUNTRIES

	NATIONALS (N=531) %	*EU CITIZENS (N=15197) %*	*CITIZENS OF NON-EU COUNTRIES (N=11,605) %*	*P**
NO COVERAGE[A]/ ALL CHARGES MUST BE PAID	50.6	70.4	82.4	<0.001
ACCESS TO EMERGENCY SERVICES ONLY	18.5	15.1	3.3	<0.001
FULL HEALTHCARE COVERAGE	16.0	3.7	8.3	<0.001
PARTIAL HEALTHCARE COVERAGE[B]	14.5	2.4	2.3	0.990
HEALTHCARE RIGHTS IN ANOTHER EU COUNTRY	0	8.1	0.9	<0.001
ACCESS ON A CASE-BY-CASE BASIS	0	0.1	0.4	-
FREE ACCESS TO GP SERVICES	0.0	0.2	0.9	0.004
CHARGEABLE ACCESS TO SECONDARY HEALTHCARE	0.3	0.0	0.5	-
TOTAL	*100.0*	*100.0*	*100.0*	
MISSING DATA %	*24.8*	*23.6*	*19.0*	

A. Comparing EU citizens and citizens of non-EU countries.

B. Including those who have to pay fees to access GPs.

99 It should be noted that, since September 2012, between 750,000 and 873,000 migrants in Spain have lost their healthcare coverage (Legido-Quigley H, Urdaneta E, Gonzales A, et al. Erosion of universal health coverage in Spain. *Lancet* 2013; 382: 1977).

100 Report from the Ombudsmen in Spain published in January 2015 about patient rights in emergency units highlighting that, *"daily practices in health centres uncover problems in emergency care for undocumented migrants, which should be provided in equal conditions and free of charge"*: Las urgencias hospitalarias en el Sistema nacional de salud: derechos y garantías de los pacientes. Joint study by the Ombudsmen. Madrid: January 2015.

101 For migrants from non-EU countries, a primary care consultation with a GP or a gynaecologist costs around € 5. The same amount must be paid when a patient is referred by a GP to an emergency unit or a specialist consultation. Direct access to emergency care is charged at € 40.

BARRIERS IN ACCESS TO HEALTHCARE

Only 23.0% of all patients surveyed in seven European countries reported that they had experienced no difficulty in accessing healthcare before going to an MdM clinic[102]**.**

Another third (33.9%) had not tried to access healthcare; with huge differences between France (4.9%) 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 likely that others have internalised the various barriers to accessing healthcare to such an extent[103] that they did not even try to seek it.

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 malfunctioning;
- **a lack of knowledge or understanding of the healthcare system and of their rights (14.1%);**
- **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 (11.5%). 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 (41.5%), 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** (21.6% 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, $p<10^{-6}$). All these dramatic differences reflect the tremendously limited access to healthcare for migrants (particularly those undocumented) in Turkey.

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

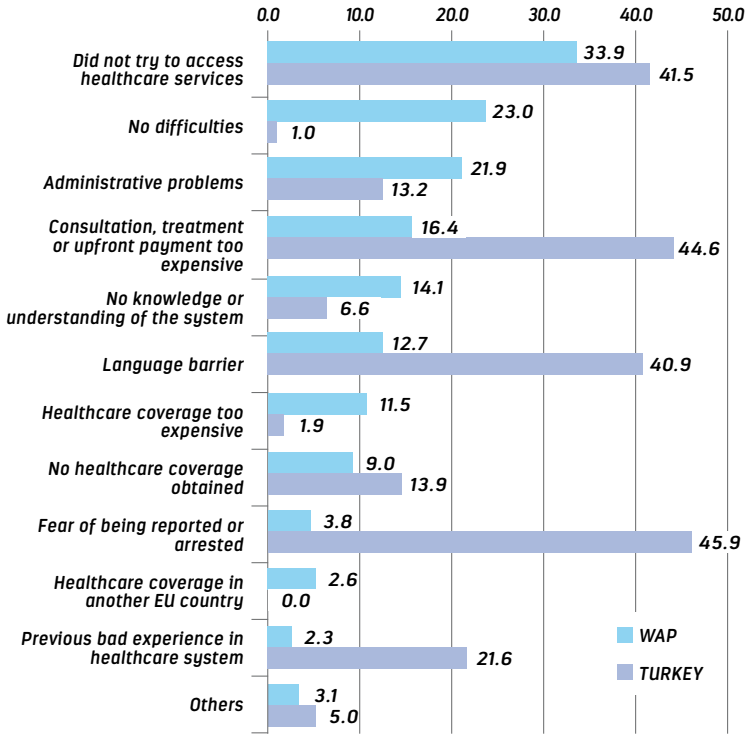
In Greece, thanks to the new presidential decree of 5 June 2014, anyone living legally in Greece and without healthcare coverage can receive a free examination at a hospital. Nonetheless, this decree is not well known or not applied. Therefore, for its enforcement, MdM social workers provide printed 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 MdM services.

MdM Greece – Chania – September 2014

The story of Said, a 23-year-old from Turkey, demonstrates the misunderstanding by the medical staff of the new 2013 law giving access for undocumented migrants to healthcare "that cannot be deferred": *"I tried to get an appointment for a doctor's consultation but was given the information that a social security number is needed to book an appointment and that I needed to pay €185 for the visit. Then they told me that I could only get treatment if I was an asylum seeker and referred me to a hospital instead. I told them what Doctors of the World Sweden had told me, that the appointment should only cost €5. I then asked the staff if they knew about the new law and they did not."*

MdM Sweden – Stockholm – October 2014

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



102 No data in Belgium and Switzerland.

103 They also may have perceived more significant barriers than exist in reality, because of their lack of knowledge about their rights in the few countries where they have some.

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[104] and up to 61.2% reported the same thing in Istanbul.

The frequency of people giving up seeking healthcare has significantly decreased in Spain since 2012: it was 52.0% in 2012, 22.0% in 2013 and 15.0% in 2014. The interpretation of this decrease is difficult since, unfortunately, the surveyed sites have changed over time (as well as the sample procedure from one year to another). However, it is useful to note that these figures do not represent the general situation of migrants in Spain, but should be taken as an indicator of those migrants who contact MdM. Since the Royal Decree 16/2012, the MdM Spain teams have explored different channels for integrating migrants into the mainstream health services[105]. 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**[106]. In Istanbul, 37.1% of the patients experienced this situation and a quarter in Spain.

MOBILE HARM REDUCTION UNIT FOR DRUG USERS – STREETS OF ATHENS – GREECE – 2014

Johan, a 74-year-old German man, explains: *"When my partner died, I lost the house. I do not have my own place anymore; I sleep at my daughter's mostly. I didn't want to apply for money from the state. I was always independent, did all sorts of jobs, such as caretaker, looking after horses and working as a hair dresser. But I am old now and can't work that much anymore. My children and friends help me out. I haven't had health insurance for a couple of years now. I tried to make money as long as I could and then paid for my doctors' visits privately. Sometimes I got tablets from the pharmacy for which you don't need a prescription. I started to have heart problems and last week I had swollen legs, so I went to the hospital for a check-up. I told them I don't have health insurance. They didn't warn me and after some examinations they told me I had to stay longer and pay €3000! Well then... I really did feel ill! I gave them all the money I could and then left immediately, with the urological catheter still in me. I hope you can remove it. I'm not going back to that hospital!"*

MdM Germany - Munich - December

Miriam was a 35-year-old Moroccan woman. Her husband, Ahmed, had worked in Spain from 1991 to 2007, undeclared for the first nine years. When his company went bankrupt, Ahmed and Miriam unsuccessfully looked for work and finally moved to Belgium, where they also got undeclared jobs. Miriam gave birth to a girl (Sonia) in December 2012. Affected by a cardiac abnormality, the baby underwent surgery, although the parents did not have sufficient financial means. The CPAS refused to cover the expenses, claiming the parents had legal documents in Spain where they had rights to care. As they had left Spain four years before, the response from the CPAS is clearly unsatisfactory, as rights to healthcare coverage only last for one year. The child needed a second operation, but the parents still had no financial means. A second healthcare coverage request was rejected, as the CPAS stated that the father was financially responsible for his daughter's operation costs. The surgery was delayed. The father worked hard but still could not cover the bill. Three requests were rejected.

In 2014, in severe pain, Miriam visited MdM Belgium, which referred her to hospital. She had had these pains for a while but did not dare to go 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 his wife's death, Ahmed could not work and take care of his daughter on his own and Sonia was placed in a foster family. Sonia should be by the foster family's healthcare coverage, yet despite the medical certificate, the registration at the CPAS still has not been completed until today. The last request to the CPAS was finally accepted at the end of 2014.

MdM Belgium - Antwerp- December 2014

104 In 2014, proportions are not valid in Belgium and Switzerland (where less than 10% of people were asked this question) and the response rate was particularly low in France and the UK; so, this figure must be treated with great caution.

105 Please also note that the pool of practitioners who have made a conscientious objection, i.e. who have refused to exclude undocumented migrants from healthcare, has increased.

106 For information purposes only: proportions not valid in Belgium and Switzerland: less than 10% of people were asked this question and the response rate was particularly low in Greece, France and the UK. Missing values: 30.4% in DE, 43.3% in EL, 0.8% in ES, 58.6% in FR, 11.4% in NL, 17.3% in SE, 62.0% in UK and 22.4% in TR.

RACISM IN HEALTHCARE SERVICES

Fortunately, only a few patients reported having been victims of racism in a healthcare facility, in Europe at least: approximately 4.5% of patients reported such an experience in the six countries where the question was asked[107]**. This proportion was the highest in Istanbul** (38.7% with a response rate of 77.5%).

FEAR OF BEING ARRESTED

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

In Europe, half of the interviewed patients (52.0%) reported such a limitation (either sometimes, frequently or very frequently)[108]**. This proportion was particularly high in London**[109] **(83.9%), the Netherlands (69.4%) and Istanbul (85.0%),** where, 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%).

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

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

MdM Spain – Malaga – January 2014

TONIGHT, THIS FAMILY WILL SLEEP IN A TENT IN THE CENTRE OF LYON INSTEAD OF HAVING ACCESS TO DECENT ACCOMMODATION – FRANCE – 2014

107 Missing values: respectively 34.8% in DE, 45.3% in EL, 0.8% in ES, 23.6% in NL, 19.4% in SE, 68.7% in UK.

108 Due to either low numbers of respondents or high proportions of missing values, only Spanish, Dutch, UK and Turkish data may be considered separately.

109 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.

EXPERIENCES OF VIOLENCE

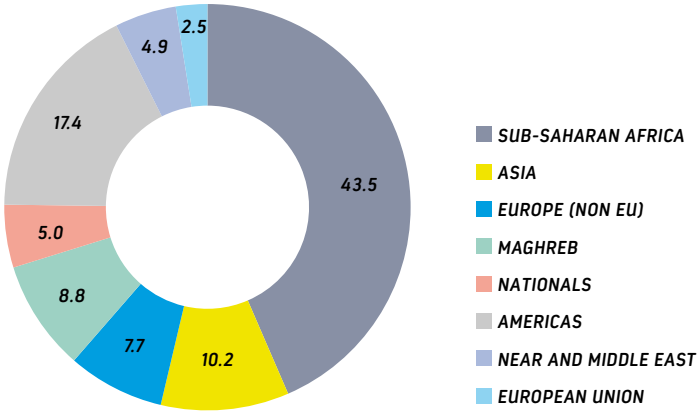
It is crucial to identify previous experiences of violence among migrant populations, in view of their frequency and impact on the mental and physical health of the victims even many years after the original episode[110] (such as depression or post-traumatic stress disorder, risk of diagnostic errors 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[111].

In 2014, 1,809 patients were interviewed about violence[112]. Among them, 84.4% reported at least one violent experience in BE, CH, DE, EL, ES, FR, NL and UK (83.5% of women and 85.8% of men).

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

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

GEOGRAPHICAL ORIGINS OF VICTIMS OF VIOLENCE (IN THE EIGHT EUROPEAN COUNTRIES SURVEYED, IN %)



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

Suspecting she was pregnant, Sally was looking for a doctor and therefore contacted MdM. MdM referred her to the National Referral Mechanism (the national government process for identifying victims of human trafficking and ensuring they receive the appropriate protection and support) and got her access to medical care and counselling. Sally is now registered with a GP who she is seeing regularly, has 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

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

110 Baker R. Psychological consequences for tortured refugees seeking asylum and refugee status in Europe. In: Basoglu M, ed. Torture and its consequences. Cambridge, Cambridge University Press, 1992, pp. 83-106.
Weinstein HM, Dnasky L, Lacopino V. Torture and war trauma survivors in primary care practice. West J Med 1996; 165: 112-8;
Loutan L, Berens de Haan D, Subilia L. La santé des demandeurs d'asile: du dépistage des maladies transmissibles à celui des séquelles post-traumatiques. Bull Soc Pathol Exotique 1997; 90: 233-7;
Vannotti M, Bodenmann P. Migration et violence. Med Hyg 2003; 61: 2034-8.

111 Collective. Soigner les victimes de torture exilées en France. Livre blanc. Paris: Centre Primo Levi, May 2012, p.9.

112 Unfortunately, the experience of violence is still seldom raised in MdM programmes and so violence remains insufficiently screened by the MdM teams: only 11.3% of patients (727 women, 12.3%, and 1,082 men, 10.5%) were questioned on this issue at any time during their first consultation or follow-up.

The types of violence most frequently reported in the eight European countries were:

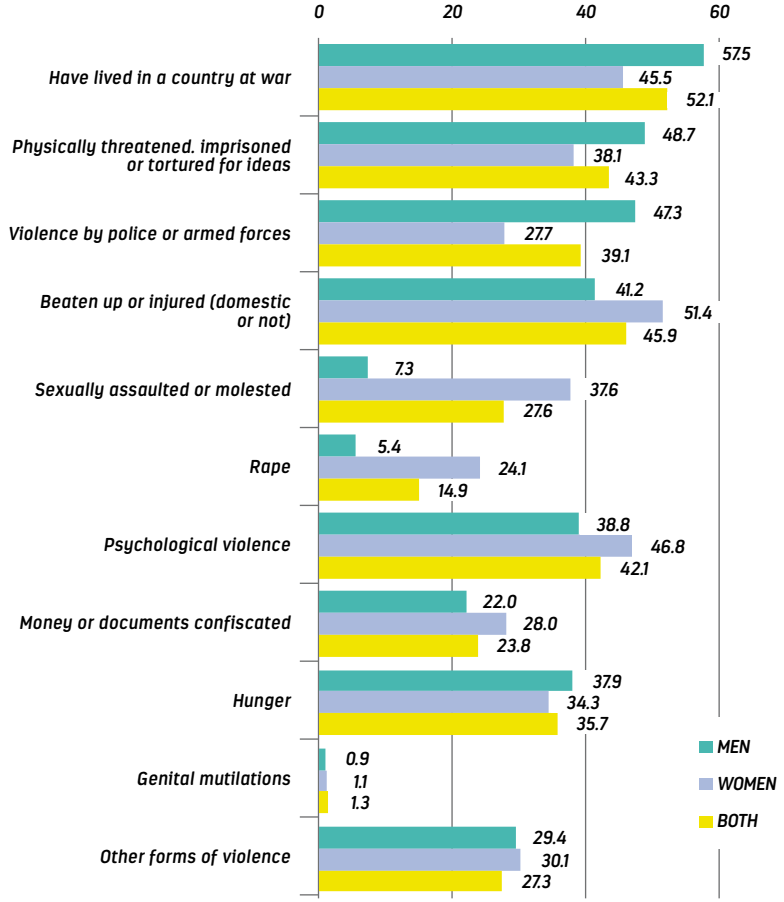
- living in a country at war (52.1%), physical threats, imprisonment or torture for one's ideas (43.3%) and violence perpetrated by the police or armed forces (39.1%);
- beating or injury as a result of domestic or non-domestic violence (45.9%);
- psychological violence (42.1%);
- hunger (35.7%);
- sexual assault (27.6%), reported by 37.6% of women (compared with 7.3% of men) and rape (14.9%), reported by 24.1% women and 5.4% of men. A quarter of the total numbers of sexual assaults reported were reported by male patients.
- confiscation of money or documents (23.8%).

Among the respondents, 9.8% reported having experienced violence after having arrived in the countries surveyed. 21.1% of the reported rapes took place after the victim's arrival in the host country, as did 17.7% of sexual assaults, 37.1% of incidents of documents or money being confiscated, 19.1% of psychological violence and 40.8% of experiences of hunger.

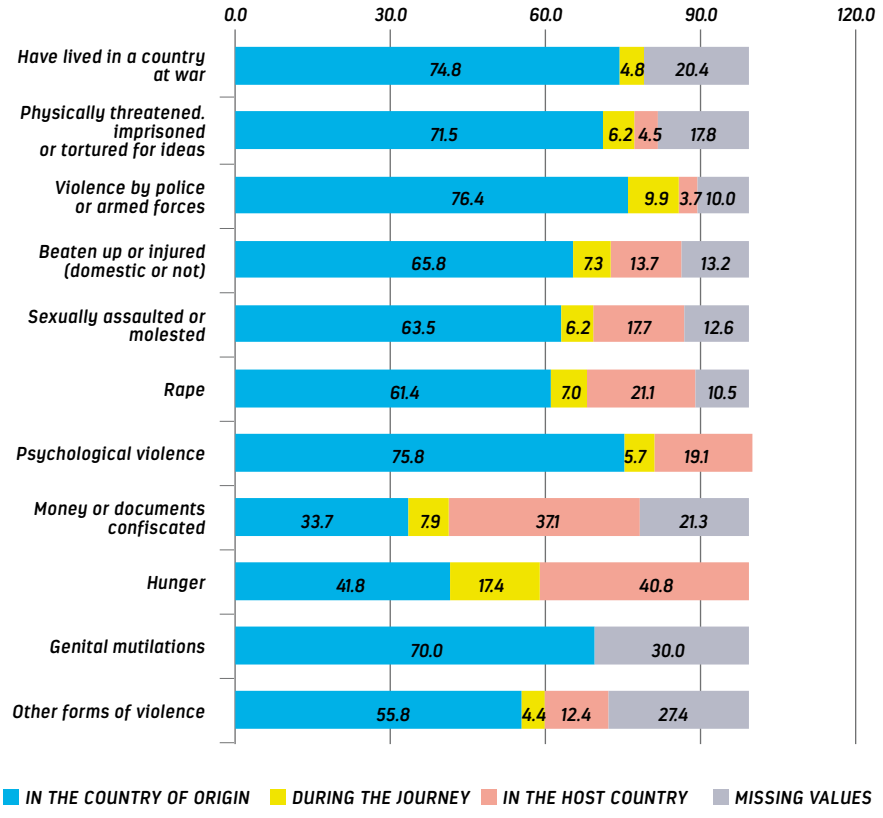
The perceived health status of patients who reported at least one experience of violence was significantly worse in terms of general, mental and physical health (p <0.001) than the perceived health of patients who did not report an episode of violence. Of these, 71.4% perceived their mental health to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

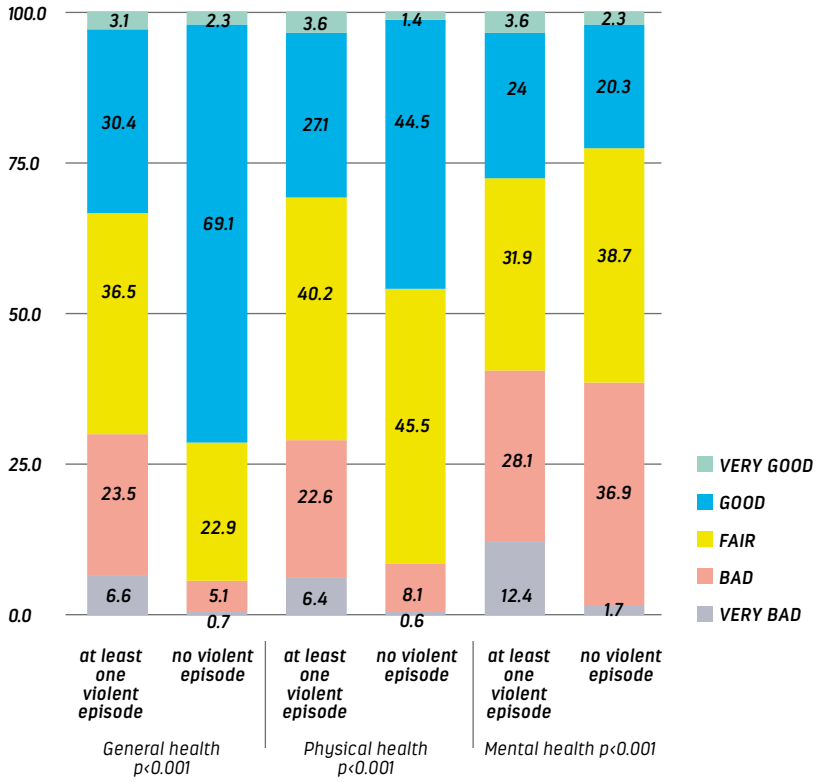
VIOLENCE BY GENDER (AMONG PATIENTS INTERVIEWED ON THIS SUBJECT IN EIGHT EUROPEAN COUNTRIES IN %)



VIOLENCE AT DIFFERENT STAGES OF MIGRATION IN THE 8 EUROPEAN COUNTRIES (% OF REPORTED EPISODES)



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



IRANIAN VICTIM OF RACIST ATTACK: THREE MEN IN BLACK IN ATHENS ATTACKED SAID. ONE OF THEM BIT HIS EAR OFF. "IN EUROPE, I DIDN'T SEE ANY CIVILISATION, I DIDN'T SEE ANY LOVE" – GREECE – 2014

HEALTH STATUS

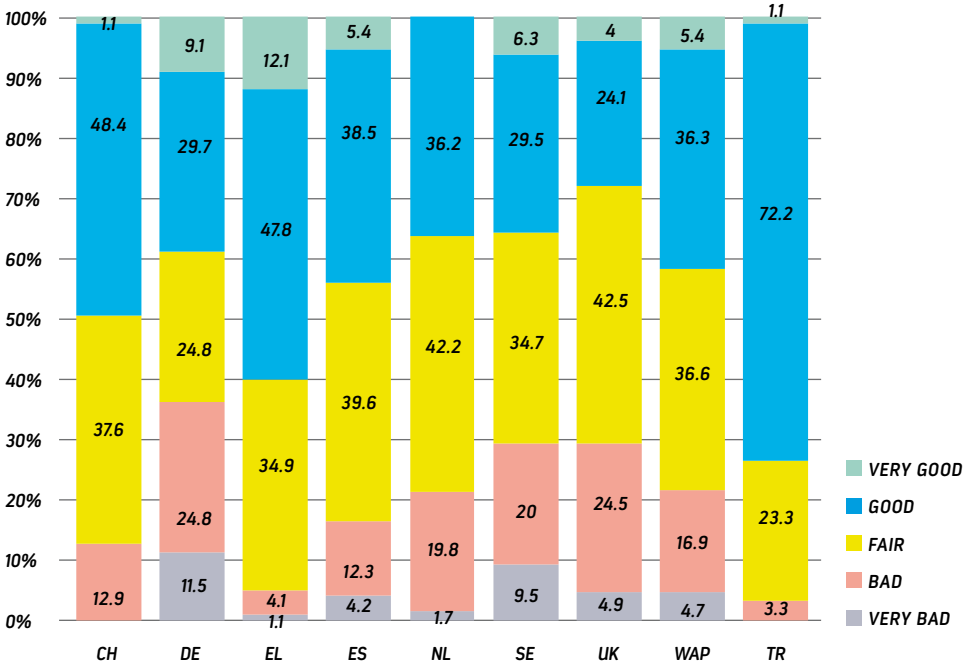
SELF-PERCEIVED HEALTH STATUS

A majority (58.2%) of patients seen by MdM in Europe[113] perceived their general health status as poor[114]. However, 22.9% of patients perceived their physical health as *bad* or *very bad*, and this goes up to 27.1% for their mental health.

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

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

SELF-PERCEIVED HEALTH STATUS BY COUNTRY (%)



CHRONIC HEALTH CONDITIONS

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

More than half of the patients (55.3%) who consulted a doctor in the eight European centres were diagnosed with at least one chronic health condition[115]. In Istanbul, 36.7% of patients seen had at least one chronic health condition.

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

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

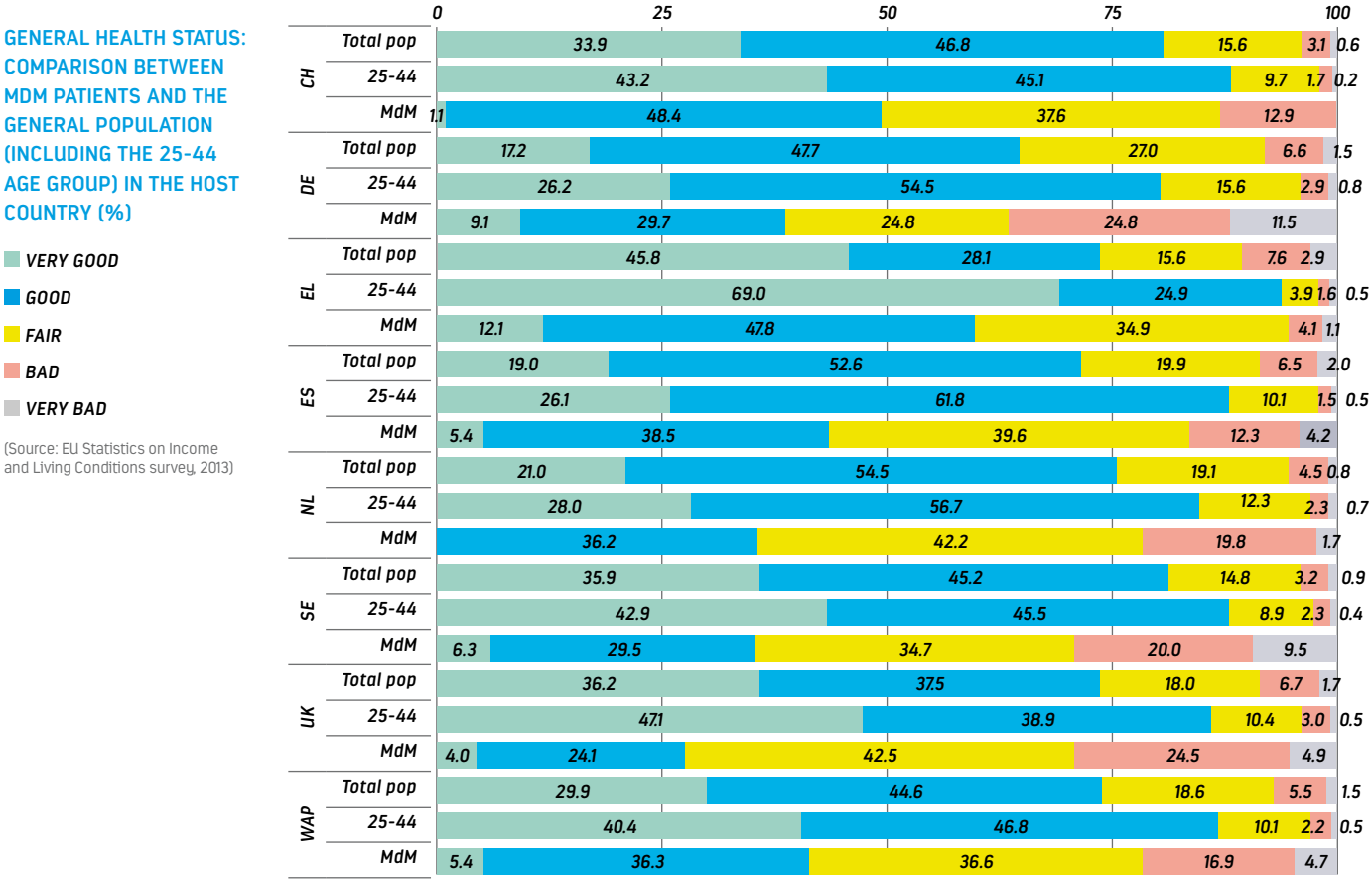
MdM Greece – Patras – October 2014

113 In the seven European countries surveyed. The questions were not asked in France and only the question about general health status was asked in Belgium but with a very low response rate (4%). Missing values: 76.5% in CH, 18.8% in DE, 20.5% in EL, 0.8% in ES, 5.7% in NL, 3.1% in SE, 13.2% in UK, 5.0% in TR.

114 *Poor health status* refers to the answers *Very bad, Bad* and *Fair.*

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

GENERAL HEALTH STATUS: COMPARISON BETWEEN MDM PATIENTS AND THE GENERAL POPULATION (INCLUDING THE 25-44 AGE GROUP) IN THE HOST COUNTRY (%)



(Source: EU Statistics on Income and Living Conditions survey, 2013)

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[116] **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[117]. This percentage was significantly higher in Switzerland[118] (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 (63.7%). **In Istanbul, almost all the patients were in this situation.**

Altogether, 57.9% of the patients requiring treatment had not received care before coming to MdM. Thus for these patients MdM represents their first point of contact with a primary healthcare provider. This figure was also particularly high in Switzerland (74.8%), Germany (72.6%) and France (61.2%) and, above all, in Istanbul (98.9%).

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 third of patients seen in Istanbul and less than 10% of patients seen in Greece.

In other words, among the patients who suffered from one or several chronic condition(s), 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 (10.2%), 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 (97.7%).

HEALTH PROBLEMS LARGELY UNKNOWN PRIOR TO ARRIVAL IN EUROPE

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

Looking at the diagnoses in detail, very few of the patients may have migrated due to these chronic conditions, as the majority of the reported diagnoses are not life threatening. In Istanbul, 31.7% of the patients were in this situation. This shows again how the idea of migration for health reasons is false: in Istanbul, foreign citizens must pay 100% of health costs.

116 For information purposes, missing values: 29.4% in CH, 34.4% in DE, 68.2% in EL, 24.0% in ES, 60.8% in FR, 35.8% in NL, 69.2% in UK, 4.7% in TR. Question not asked in Belgium.

117 Treatments were regarded as essential if failure to provide them would almost certainly mean deterioration in the patient's health or a significantly poorer prognosis; in other cases they were classed as precautionary. There is no question here of *unnecessary* treatment, or of simple *comfort*.

118 In Switzerland, patients are seen by nurses.

HEALTH PROBLEMS BY ORGAN SYSTEM

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

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% of consultations) and depressive syndromes (2.9% of consultations). Obviously, psychotic disorders were much rarer (0.5%). Problems related to using psychoactive substances were almost non-existent (0.4%).

Overall, 10% of medical consultations for women patients dealt with gynaecological problems: normal pregnancy and postnatal issues (11.0% and 0.3%) were most frequently reported, followed by other unspecified gynaecological problems (5.2%), menstruation problems (4.2%) and contraception (1.7%).

Peter, a 29-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 retreated and he became a more sociable man, made some friends in a church in a city nearby and travelled there by train, with the permission of his doctors. However, the threat of being expelled remained. One day he called me in fear from his room in the hospital. He had been apprehended in the train, for no reason as he had a ticket. He was nearly arrested because the policemen thought they recognised him* "from a list of people with illegal status who had to be arrested"*"*. While Peter was more or less cured of his phobias, he was still taking strong medication and now, suddenly, the reality of the fear of being harassed and arrested by the police entered his life. This event occurred when Peter was still a patient at the psychiatric hospital and he had a permit to stay. Even though they apologised, the attitude of the police was harmful for Peter who now has a new fear that inhibits him from socialising.

MdM Netherlands – Amsterdam – November 2014

A MORE EFFECTIVE HEPATITIS C TREATMENT... BUT UNAFFORDABLE!

It is estimated that 185 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 its kind, sofosbuvir, is sold at exorbitant prices (e.g. €41,000 in France for the full course of treatment).

This means that social security systems in many countries have started to select the most seriously ill patients to benefit from the new treatment. 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 abusive prices put at risk the very existence of our public health model, which is based on solidarity and equity. This is why, in February 2015, MdM opposed the patent for sofosbuvir at the European Patent Office. MdM wants affordable medicines for hepatitis C for all.[119]

119 See (in French) : https://mdmeuroblog.wordpress.com/2015/03/24/hepatitis-c-mdm-opposes-patent-for-sofosbuvir/

MEDICAL CONSULTATION AT ASEM – ISTANBUL – TURKEY – 2014

The testimony shared by Trenton, a 26-year-old Ugandan man, illustrates how violence, discrimination and social isolation can build up into a vicious circle of vulnerabilities, with a serious impact on health and particularly mental health: *"I was born in Uganda. I grew up in a tough situation. I didn't have parents to look after me and was raised by an aunt who wasn't in the country much. So growing up was tough and I didn't have anyone to talk to. Uganda is a society where people of my sexual orientation are not accepted. The homophobia in the country is extreme and it's tough growing up in such an environment. I managed to get out of the country and came to the UK."*

"When I first came to the UK I thought life would be so easy. I thought I would be free. But it turned out that wasn't the case. In the UK I had to live with a person close to my family and so it wasn't easy for me to express myself. I had to hide who I was and I had to pretend that I was happy and this was hurting me on the inside. As a human being, if you continue hiding who you are and 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."

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

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

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

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

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

MdM UK – London – September 2014

CONCLUSION

European stakeholders increasingly recognise the impacts that the economic crisis and austerity measures have had on the accessibility of national healthcare services. In 2014, following repeated calls by NGOs and the European Parliament[120], both the Commission[121] and the Council[122] 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[123], 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,

120 European Parliament resolution of 4 July 2013. Impact of the crisis on access to care for vulnerable groups (2013/2044(INI));
European Parliament resolution of 4 February 2014 on Undocumented women migrants in the European Union (2013/2115(INI));
European Parliament resolution of 13 March 2014 on Employment and social aspects of the role and operations of the Troika with regard to euro area programme countries (2014/2007(INI))

121 European Commission Communication on effective, accessible and resilient health systems. COM(2014) 215 final.

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

123 ECDC Technical Report. Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA. Stockholm 2014.

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"*[124]. 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"*[125]. 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[126] 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[127]. 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.

124 PACE Resolution 1997. Migrants and refugees and the fight against Aids. 2014.

125 EU guidelines on the death penalty. http://www.eeas.europa.eu/human_rights/guidelines/death_penalty/docs/guidelines_death_penalty_st08416_en.pdf

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

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

THE RIGHT OF CHILDREN TO HEALTH AND CARE IS ONE OF THE MOST BASIC, UNIVERSAL AND ESSENTIAL HUMAN RIGHTS. ATHENS, GREECE 2014

ACRONYMS

AME	STATE MEDICAL AID (AIDE MÉDICALE DE L'ETAT)
AMU	URGENT MEDICAL AID (AIDE MÉDICALE URGENTE)
BE	BELGIUM
CAP	CRUDE AVERAGE PROPORTION
CAPT	CRUDE AVERAGE PROPORTION INCLUDING TURKEY
CH	SWITZERLAND
CMUC	COMPLEMENTARY UNIVERSAL MEDICAL COVERAGE (COUVERTURE MALADIE UNIVERSELLE COMPLÉMENTAIRE)
CPAS	PUBLIC SOCIAL WELFARE CENTRE (CENTRE PUBLIC D'ACTION SOCIALE)
DE	GERMANY
ECDC	EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL
EL	GREECE
ES	SPAIN
EU	EUROPEAN UNION
FR	FRANCE
GP	GENERAL PRACTITIONER
HBV	HEPATITIS B VIRUS
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HCV	HEPATITIS C VIRUS
MDM	DOCTORS OF THE WORLD (MÉDECINS DU MONDE – MDM)
NHS	NATIONAL HEALTH SERVICE (UK)
NL	NETHERLANDS
OECD	ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT
SE	SWEDEN
TR	TURKEY
UK	UNITED KINGDOM
WAP	WEIGHTED AVERAGE PROPORTION (EACH COUNTRY ACCOUNTS FOR THE SAME WEIGHT)
WAPT	WEIGHTED AVERAGE PROPORTION INCLUDING TURKEY
WHO	WORLD HEALTH ORGANIZATION

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HOW LONG WILL THEY REMAIN WITH NO OTHER PROSPECT BUT WALLS? CALAIS – FRANCE – 2014

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