© Kristof Vadino 1500 to 2000 people arrived daily in Lesbos during the last 2 months

EUROPEAN NETWORK TO REDUCE VULNERABILITIES IN HEALTH

IN THIS EDITION

EDITO

It is a great pleasure to introduce the first newsletter of the European Network to reduce vulnerabilities in health. Doctors of the World – Médecins du monde International Network is proud to host – thanks to an operating grant of the European Commission – a new network with members from 19 european states up to now. Our Network seeks to decrease health inequalities and to obtain more resilient health systems across Europe, better equipped to deal with the vulnerabilities that contribute to health inequalities. It aims at implementing and improving quantitative and qualitative data collection among the partners to improve quality of service delivery and build an evidence-based advocacy for people facing vulnerabilities.

LET US OPEN THE DOORS OF EUROPE!

Welcome and protection for migrants – without discrimination

"Off the coast of Lesbos a tragedy is unfolding every day. Children are drowning. Hundreds of teenagers are travelling alone and you can see anxiety, helplessness and despondency in their eyes. Yet those leaving Lesbos are still full of hope after being washed up on beaches, walking for hours under the blazing sun and sleeping at the roadside among the rubbish," recounts Dr Françoise Sivignon.

Working in the countries in crisis – Syria, Iraq, Lebanon, Jordan and Somalia – **at the gateways to Europe** – Algeria, Tunisia, Morocco and Turkey – and throughout Europe from Greece to the United Kingdom, for 30 years **the international network of Doctors of the World** has been taking action and campaigning for access to rights and care for migrants along the whole length of their journey.

In Serbia, Greece and Calais too, the response from the Authorities falls far short of meeting the needs we see.

Although the countries of the Middle East are hosting almost four million refugees (Lebanon alone has taken in over one million), Europe is proving slow in finding a long-term, durable solution to receive and protect these people.

Over 300,000 migrants have arrived in Greece and Italy since the beginning of the year. They have found themselves confronted by a wall of inhumanity raised by the countries of Europe. Whatever their reasons for migration, they should be received unconditionally – the fear and danger are unquantifiable.

On Lesbos, which has a population of 86,000, there are 18,000 migrants. Yet despite the crisis in Greece and on the island itself, there are daily acts of solidarity.

Even before we start to rethink the whole European asylum system, **legal, safe routes into the countries of Europe must be opened immediately** – it is time for these countries to demonstrate solidarity with each other and with the migrants.

"These borders and barbed wire fences are not worthy of Europe – Europe was built for peace and must welcome those fleeing poverty and armed conflict".

Dr Françoise Sivignon and Dr Nikitas Kanakis, Presidents of Doctors of the World France and Greece

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HEALTHCARE PROFESSIONALS NEED TO SYSTEMATICALLY SCREEN FOR VIOLENCE

Healthcare professionals need to systematically screen for violence.

Violence towards women, migrants, or gay and transgender people is a largely underestimated phenomenon. Yet asking whether a patient has suffered experiences of violence in the past should become as common as asking about allergies or surgical antecedents. Not asking about this aspect of medical history runs the risk of missing psychological problems (depression or post-traumatic stress disorder), and it also entails the risk of misdiagnosis or diagnostic errors when faced with unexplained physical disorders. It can also hinder the detection of sexually transmitted infections arising from sexual violence.

Many different forms of violence exist: violence can be physical, but also psychological, sexual or psychosocial in nature. The latter includes discrimination, suffering from hunger, administrative harassment and forced relocation. Secondary forms of violence include not being listened to or believed, refusal of care, administrative detention, etc. Perpetrators of violence may be security forces, trafficking networks or criminals, but can also be relatives or one's partner.

A number of studies have shown the importance of identifying previous experiences of violence among migrant populations, taking into account their frequency and their impact on the mental and physical health of the victims, as well as in the long term, many years after the original episode. To start with, migration is a violent experience by itself: migrating often implies losing all things that participate in building self-identity and maintaining autonomy (language, relatives, friends, cultural habits). At different steps of their trip, migrants are exposed to many dangers and life-threatening risks that have psychological, physical and social consequences.

Scientific literature shows that victims never or rarely talk about violence (e.g. feelings of guilt). It is up to the health professionals to address the issue.

Those who don't, cannot measure how important this phenomenon is. Conversely, studies have shown that patients are usually quite open to such a systematic examination of past violent experiences – provided, of course, adequate time and a quiet room were given to address these issues, regardless of their origin, culture or social environment (the same is true for detecting domestic violence). Patients understand, accept and are very supportive of routine questions about these issues. Reluctance to ask these questions comes mostly from the doctors because of lack of information, lack of time and medical misconceptions, e.g. they may assume that the question might trigger negative feelings, a "fear of opening Pandora's box whereas our program is only intended for referring patients to the mainstream healthcare system", or because they do not know where patients can be referred to in case of positive response.

> ***"Have you been exposed to any violence throughout your life?"***

Many training tools for health professionals are available that facilitate screening for violence. A simple and very effective question is "Have you been exposed to any violence throughout your life?"

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2014 DOCTORS OF THE WORLD OBSERVATORY KEY DATA ON VIOLENCE

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 consequences: 12.4% of victims perceived their general health to be very bad versus 1.7% of the people who did not report an episode of violence.

Data about violence among 1,802 patients in 8 countries using a common social and health questionnaire in nine languages

The French interministerial mission for the protection of women against violence and the fight against trafficking (MIPROF) has coordinated the production of two short movies targeting health professionals. For 'Anna', directed by Johanna Bedeau and Laurent Benaïm, MdM supplied English subtitles.

Watch the subtitled short film or consult the entire toolkit (in French):

The tool deals with mechanisms and impact of (domestic) violence, screening during medical consultation, and follow-up and referral of women that are victims of violence. Systematic screening for violence in primary care and basic, non-specialized, care can prevent severe consequences. This is one of the reasons why access to healthcare needs to be universal, including migrants regardless of their residency status.

RECENT RELATED LITERATURE

Preventing and addressing intimate partner violence against migrant and ethnic minority women: the role of the health sector. WHO policy brief (2014).

Very strong report by Italian NGO Medici per I Diritti Umani "Move or die. Migratory routes from Sub-Saharan Countries to Europe" (07/2015) about the consequences on migrants' health of inhuman and degrading treatment and torture. Based on 500 testimonies in Sicily and Rome.

Isolation in detention in the Netherlands (05/2015), joint study by Doctors of the World NL, Amnesty International NL and the LOS Foundation (English summary report).

2014 report (05/2015) of the Greek Racist Violence Recording Network

"VULNERABLE GROUPS" OR VULNERABILITIES?

From a public health point of view, 'vulnerable groups' have been found to have high incidence and prevalence rates for certain diseases. For instance, injecting drug users across Europe are disproportionally hit by hepatitis and the ECDC reports that individuals from high incidence countries, prisoners, drug addicts, alcoholics, undocumented migrants, homeless, etc. are more likely to have Tuberculosis. Yet defining 'vulnerable groups' in a static manner ignores the subjective, interactional and contextual dimensions of vulnerabilities, as well as their dynamic nature, as described by social scientists such as Delor & Hubert. Two individuals in the same difficult situation do not necessarily take the same risks, and a given individual does not necessarily have the same vulnerability in different contexts, in different relationships, and at different points of his or her trajectory. In reality, everyone is likely to be 'vulnerable' at a given moment in his or her life.

Rather than labelling 'drug users', 'sex workers', 'Roma', 'homeless' or 'migrants', 'vulnerable' people, we prefer talking about **vulnerabilities in health**. In order to stay alive, find safety and a better future for their children, people can survive a one to two year journey crossing Sudan or Niger deserts, suffering degrading treatment or torture in Libya. The hunger, the thirst and fear while crossing the Mediterranean sea bring them in afierce situation. In addition, they have to face the inability of the European Union to agree on a meaningful response to their arrival on Europe. Are they really vulnerable? Prior and during their journey none or little of the basic needs as described by Maslow (physiological, safety, belongingness, esteem) have been met. Nevertheless, they try and succeed to pass all obstacles and successfully reach Europe. Yet, lack of safe and legal migration channels increase the vulnerability of people while they really need rest, support and humanity for recovering from all the torments they went through.

The picture of a man with wrist trauma has been taken in Calais (France), where 3,500 people currently live in slums with little or insufficient access to sanitation, scarce access to drinking water, food, or healthcare. In response to the high health risks faced by migrants and the authorities' inaction, MdM France has had to mobilize emergency teams that are normally only deployed in humanitarian crisis in developing countries. The patients we see, have often been confronted with traumatic events; some have been tortured, have broken bones, walked long distances, passed barbed wire fences, slipped in trucks or jumped from bridges on top of trains…

On the other hand, many members of 'vulnerable groups' are actually quite resilient: e.g. many Roma people can count on a large social network, some sex workers get organized in a collective movement that opposes criminalization (of their work and / or their clients) through legal action, etc. Therefore, when tackling health inequalities through targeted actions, the concept of 'vulnerability' seems more useful, inclusive and yet at the same time more precise than 'vulnerable groups'.

Furthermore, multiple vulnerability factors can have a cumulative effect: their combined impact is more than the sum of the individual elements (e.g. living in the street, with a chronic psychiatric disorder, being without healthcare coverage). "Vulnerability factors" also highlight the fact that vulnerability can be a transitory situation secondary to particular circumstances, and not a permanent state (as is the fact when one is included in a 'vulnerable group').

This approach is complementary to a 'social determinants' / 'health inequalities' point of view. The advantage of a 'vulnerabilities' approach, however, is that it also allows us to analyse very specific situations and factors, from a bottom-up perspective, that are not captured in population studies on social determinants.

Examples of structural or institutional vulnerabilities include: legal, administrative, financial (and geographical) barriers to access healthcare, the international geopolitical and migration context, the difficulties that specific groups (e.g. asylum seekers, undocumented migrants, destitute EU citizens, Roma, sex workers, drug users, people in detention centres, etc.) face in accessing education, housing, work & revenues, and justice. It also includes labour exploitation, migration policies that criminalize migrants and lead to (structural) violence or human smuggling, etc.

As a consequence of these structural vulnerabilities, migrants and ethnic minorities, women, sexual minorities, people living with HIV or hepatitis, people in situation of handicap, drug users, sex workers, etc. have to face (internalized) xenophobia, racism, discrimination or stigma. Living as an undocumented migrant means constant fear of being arrested (and expelled). Due to the fact that an asylum decision takes years and brings constant insecurity about the future, there is constant stress.

Evidently, individual differences in resilience can make people react in very different ways to structural vulnerabilities: for instance, some will suffer more serious mental health impacts of substance addiction or of suffering violence than others. Feeling like you always have to rely on services makes some people loose self-esteem or autonomy. Some migrants will deal with the experience of being uprooted more effectively than others, who might internalise feelings of alienation. Social capital and information capital (i.e. knowing your rights) can play a big role in people's resilience to vulnerability factors.

RECENT RELATED LITERATURE

"Access to healthcare for people facing multiple health vulnerabilities"
May, 2015

The 2015 European report is based on 42,534 face-to-face medical and social consultations provided to 23,040 individuals seen in 25 cities in nine European countries and Turkey. The quantitative analyses are supported by case studies and an analysis of the legal framework concerning access to healthcare (both in theory and in practice).

To access the documents in English
Consultez les documents en français
Consulte los documentos en español

© Olivier Papegnies / Collectif Huma
June 2015 – Calais area

EACH HEALTH PROFESSIONAL CAN MAKE THE DIFFERENCE: VIDEOS

MdM released two videos on the importance of access to vaccination for all children and antenatal care for all pregnant women.

Routine data collected from 23,040 patients seen by MdM in 25 European cities in 2014 show that only one third (34.5%) of **children** seen across Europe had been vaccinated against mumps, measles and rubella (MMR), and only slightly more (42.5%) against tetanus. Moreover, more than half (54.2%) of the **pregnant women** surveyed in MdM clinics had not access to antenatal care. The overwhelming majority had no health coverage (81%).
Each health professional can make the difference even in countries where barriers to vaccination and antenatal care exist (i.e. lack of health coverage, residency status…).
Doctors of the World – Médecins du monde International Network runs more than 170 programmes across Europe for people excluded from health care systems that face multiple vulnerabilities.

Watch and disseminate the videos!
Video on antenatal care
Video on vaccination

FURTHER READINGS

July 2015 - WHO consolidated guidelines on HIV testing services, July 2015- watch the video

New WHO Observatory report "Economic crisis, health systems and health in Europe: impact and implications for policy"

Release of a new COMPAS report (Oxford University) on "Service provision to irregular migrants in Europe"

September 2015, Statement of the Council of Europe Commissioner for Human Rights concerning the refugee reception crisis: "Europe can do more to protect refugees"

August 2015- Amnesty International's decision-making forum adopted a resolution on the protection and the rights of sex workers.

OUR NETWORK

The European network to reduce vulnerabilities in health was founded in 2015 with NGOs and academic partners from 19 European countries.
The network is built around four objectives:

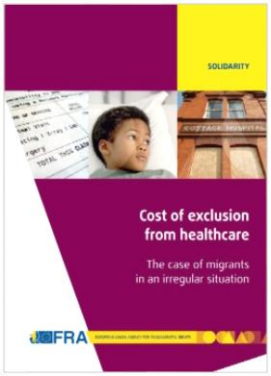
1. Members acquire greater capacity and skills in reducing vulnerabilities in health, through mutual learning on improved service delivery, empowerment, data collection and advocacy
2. People facing vulnerabilities access to higher quality healthcare in the programmes run by Members
3. Based on the Network's common data collection, academics acquire greater understanding about how vulnerabilities contribute to health inequalities.
4. Local, regional, national and EU health authorities have an enlarged evidence base concerning vulnerabilities in health that can be integrated into health policy-making through the Network's data collection.

The network's members are all organizations reaching out to rejected populations at the margins and with complex physical, mental and social problems such as undocumented migrants, asylum seekers, Roma, drug users, sex workers, homeless nationals, children and women facing multiple vulnerabilities factors.

The members are: **Austria** (Center for Health and Migration), **Belgium** (Doctors of the World), **Bulgaria** (Bulgarian Family Planning and Sexual Health Association - BFPA), **Czech Republic** (Consortium of Migrants assisting organization in the CZ), **France** (Doctors of the World), **Germany** ((Doctors of the World), **Greece** (Doctors of the World), **Hungary** (Menedék), **Ireland** (Migrant Rights Centre Ireland-MRCI), **Italy** (Naga), **Norway** (Health Centre for Undocumented Migrants), **Poland** (Association for Legal Intervention -SIP), **Romania** (Carusel), **Slovenia** (Slovene Philanthropy), **Spain, Sweden, Switzerland, the Netherlands and UK** (Doctors of the World).

COST OF EXCLUSION FROM HEALTHCARE

Beginning of September 2015, the EU Fundamental Rights Agency published its study "Cost of exclusion from healthcare – The case of migrants in an irregular situation", comparing the cost of providing timely access to screening and treatment for undocumented migrants to providing emergency treatment only, in Germany, Greece and Sweden.



The economic model shows that regular access to hypertension prevention results in cost-savings of around 9% in Germany and Greece and about 8% in Sweden, and much more looking at a timeframe of 5 years or more. Providing access to prenatal care may generate savings of up to 48% in Germany and Greece, and up to 69% in Sweden, over the course of two years.

FOR FURTHER INFORMATION :

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