MÉDECINS DU MONDE 世界医生组织 DOCTORS OF THE WORLD منظمة أطباء العالم LÄKARE I VÄRLDEN MEDICI DEL MONDO ΓΙΑΤΡΟΙ ΤΟΥ ΚΌΣΜΟΥ DOKTERS VAN DE WERELD MÉDICOS DO MUNDO MÉDICOS DEL MUNDO 世界の医療団 ÄRZTE DER WELT दुनिया के डॉक्टर MÉDECINS DU MONDE 世界医生组织 DOCTORS OF THE WORLD منظمة أطباء العالم LÄKARE I VÄRLDEN MEDICI DEL MONDO ΓΙΑΤΡΟΙ ΤΟΥ ΚΌΣΜΟΥ DOKTERS VAN DE WERELD MÉDICOS DO MUNDO MÉDICOS DEL MUNDO 世界の医療団 ÄRZTE DER WELT
Argentina | Belgium | Canada | France | Germany | Greece | Japan | Luxembourg | Netherlands | Portugal | Spain | Sweden | Switzerland | United Kingdom | United States of America

Access to healthcare for people facing multiple health vulnerabilities in 26 cities across 11 countries

Report on the social and medical data gathered in 2014 in nine European countries, Turkey and Canada.

Doroftei, aged 10, has not been vaccinated: ñ*I still cannot go to school*ò ï Saint-Denis ï France ï 2014

22 May 2015

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Executive summary

Europe is the cradle of human rights. Indeed, the range of international texts and State commitments that ensure peopleôs 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 ï 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 23,341 people in 26 programmes/cities in Belgium, Canada, France, Germany, Greece, the Netherlands, Spain, Sweden, Switzerland, Turkey and the United Kingdom[1]. It paints a bleak picture of the ó*cradle of human rights*ô.

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 ï including an increasing number of nationals ï 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[2].

Altogether, 62.9% of the people seen by MdM in Europe had no healthcare coverage.

Childrenôs 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%) ï 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 ó*host country*ô for 6.5 years on average before consulting MdM. Only 3% quoted health as one of the reasons for

[1] One of the countries participating in the survey, Canada, is not European. Yet MdM feels that Canada and the European countries in the survey share sufficient core values in order to make valid comparisons concerning access to healthcare.

[2] Third-country nationals refer to people who are not citizens of one of the 28 European Union Member States.

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 ósecurity issueô, 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 migration 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.

2014 in figures

23,341 patients seen in face-to-face medical and social consultations in 26 cities in 11 countries, of whom 22,171 patients were seen in the nine European countries

8,849 were women (8,356 in the nine European countries).

Detailed social & medical data on 15,949 patients, of whom 14,772 seen in the nine European countries

Detailed medical data on 9,609 patients seen (once or several times) by a doctor, of whom 8,521 seen in the nine European countries

43,152 social and medical consultations, of which 41,238 in the nine European countries

17,385 medical consultations, of which 15,749 in the nine European countries

25,410 diagnoses (23,240 in the nine European countries).

Of the 437 pregnant women, 310 were seen in Europe:

54.2% had no access to antenatal care

58.2% came to receive care too late ï 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

67.8% restricted their movements to varying degrees for fear of arrest

Personal health reasons were cited less frequently by pregnant women as reasons for migration (0.8% versus 4.0% for non-pregnant women) which reflects the *healthy migrant effect* of these young women and the absence of any push factor for migration related to their present pregnancy

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, and 100% of those seen in Montreal.

Of the 652 children, 623 were 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

12.4% of those who had experienced **violence perceived their mental health to be very bad versus 1.7%** of the people who did **not report an episode of violence**

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

Acronyms

AME	State Medical Aid (*Aide Médicale dôEtat*)
AMU	Urgent Medical Aid (*Aide Médicale Urgente*)
BE	Belgium
CA	Canada
CAP	Crude average proportion
CAPT	Crude average proportion in the total number of countries
CH	Switzerland
CMUc	Complementary Universal Medical Coverage (*Couverture Maladie Universelle complémentaire*)
CPAS	Public Social Action Center (*Centre Public dôAction Sociale*)
DE	Germany
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EL	Greece
ES	Spain
EU	European Union
FR	France
GP	General practitioner
HBV	Hepatitis B virus
HIV	Human immunodeficiency virus
HCV	Hepatitis C Virus
INSERM	National Institute of Health and Medical Research (*Institut National de la Santé et de la Recherche Médicale*)
MdM	Doctors of the World (Médecins du *monde* ï *MdM*)
NHS	National Health Service (UK)
NL	the Netherlands
OECD	Organisation for Economic Co-operation and Development
SE	Sweden
STI	Sexually transmitted infections
TB	Tuberculosis
TR	Turkey
UDM	Undocumented migrants
UK	the United Kingdom
WAP	Weighted average proportion (each country accounts for the same weight)
WAPT	Weighted average proportion in the total number of countries
WHO	World Health Organization

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[3]. The public share of total spending on health globally declined between 2007 and 2012[4]. At the same time, the overall populationôs 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[5].

The crisis has led the World Health Organization (WHO) to (re)confirm that ñ*health systems generally need more, not fewer, resources in an economic crisis*.ò Cuts in health expenditure are possible, but only if there already are social policies that support those who are experiencing or at risk of poverty, unemployment and social exclusion, and if the pre-existing levels of out-of-pocket payments are sufficiently low[6]. 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 ó*more responsible*ô ï thereby reducing the demand for healthcare and direct public health expenditure. Co-payment has been proven to be administratively complex[7]. It does not automatically decrease the overall utilisation of healthcare services[8], 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[9,10]. Consequently, WHO warns that user fees should be used with great caution in view of their detrimental effects on vulnerable populations[11].

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: ñ*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*ò.

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3 OECD. *Health at a glance: Europe 2014*. Paris: OECD, 2014.

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

5 Eurostat. *Self-reported unmet needs for medical examination, by sex, age and reason. 2015*. Last accessed on 17/02/2015. appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_silc_03&lang=en

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

7 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.

8 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.
Hurley J, Arbuthnot Johnson N. The Effects of Co-Payments Within Drug Reimbursement Programs. *Canadian Public Policy* 1991; 17: 473-89.

9 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.

10 Newhouse JP and the Insurance Experiment Group. *Free for all? Lessons from the RAND Health Experiment.* Cambridge, MA: Harvard University Press, 1993.

11 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: World Health Organization, 2008.

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[12]. ñ*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*ò.

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[13]. In Greece, 2.5 million people live below the poverty line (23.1% of the total population)[14]. 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[15]. Crisis and austerity policies have left almost a third of the population without healthcare coverage[16]. Unemployment stood at 25.8% in December 2014[17], unemployment benefits were limited to 12 months[18], after which there was no minimum income guarantee[19]. 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[20].

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[21].

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[22]. 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)[23].

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

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

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

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

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

17 ec.europa.eu/eurostat/statistics-explained/index.php/Unemployment_statistics

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

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

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

21 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.

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

23 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.

The latest available OECD data[24] 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[25].

Migrants in danger at Europeôs 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 local populations, 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[26] - an increase of more than 40% compared to 2013 according to UNHCR[27]. 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 where 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[28]. Syrians were the largest group of people granted protection status in the EU-28 from 2012 to 2014[29]; they also registered the highest recognition rates afforded by EU Member States with over 90% positive decisions since 2012[30]. However under 150,000 Syrians have sought asylum in the EU since the war began ï less than 4% of the conflictôs total refugee population ï and the majority of Syrians were resettled in two countries, Germany and Sweden[31].

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[32]. While 150,000 migrants were rescued under the Mare Nostrum operation, UNHCR estimates that around 3,400 people have died or have gone missing at sea (data as of November 2014).

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[24] OECD data: stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT. Last accessed on 16/02/2014.

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

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

[27] UNHCR. *Asylum Trends 2014: Levels and Trends in Industrialized Countries*. Geneva: UNHCR, 2015.

[28] www.unocha.org/syria

[29] European Commission. *Facts and figures on the arrivals of migrants in Europe*. Fact Sheet (13/01/2015).

[30] ECRE/ELENA. *Information note on Syrian asylum seekers and refugees in Europe.* 2013; and EUROSTAT: ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_quarterly_report

[31] Germany and Sweden respectively granted asylum to 23,860 and 16,295 Syrians in 2014, amounting to 60% of all Syrian refugees (Eurostat database on Asylum statistics).

[32] UNHCR. *So close, yet so far from safety, The Central Mediterranean Sea Initiative*. Geneva: UNHCR, 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[33].

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[34].

Although migrants contribute more in taxes and social contributions than they receive in benefits[35], and clearly make positive fiscal contributions[36], they are often falsely described as ó*benefit-oriented*ô 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)[37].

During last yearôs 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)[38] by election candidates, five of whom currently sit in the newly elected Parliament.

In February 2015, Nils Muiġnieks, the Council of Europe Commissioner for Human Rights, denounced the fact that ñ*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. [é] 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. [é] 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.*ò[39]

[33] 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

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

[35] OECD. *Is migration good for the economy? Migration policy debates*. Paris: OCDE, May 2014.

[36] Dustmann C, Frattini T. *The fiscal effects of immigration to the UK*. London: Centre for Research and Analysis of Migration, Discussion paper Series No 22/13, November 2013.

[37] OECD data on migration for 2013, www.data.oecd.org/migration, last accessed on 17/02/2015.

[38] ENAR / ILGA Europe (July 2014). #NoHateEP2014. Reporting hate speech in the #EP2014 campaign.

[39] CoE. *Press release, France: persistent discrimination endangers human rights*. 2015. Last accessed on 18/02/2015.

Recent legal changes, for better or worse

The year 2014 saw a number of positive and negative legislative changes that have influenced access to healthcare as summarised below[40]:

Belgium

The Law of 19 January 2012[41] confirmed the practice of most public social welfare centres (*Centres Publics dôAction Sociale ï CPAS)* towards newly arrived, destitute EU citizens: *ñé 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* [é]ò. 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[42], 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 ï 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 Presidentôs political commitments, from 1 July 2013 onwards, the thresholds for the complementary Universal Medical Coverage (*Couverture Maladie Universelle complémentaire ï 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 dôEtat ï 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.

Germany

Since March 2015, the German Federal government modified the Law on Asylum Seekers whereby the length of time where their access to healthcare is restricted to ñacute illness and severe painò passed from 48 to 15 months.

Greece

According to the Common Ministerial Decree 1465 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.

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[40] A full report on legal access to healthcare in 12 countries, published in May 2015, is available at www.mdmeuroblog.wordpress.com

[41] 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

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

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 ï from ú220 to at least ú375 a year in 2015 (up to ú875 depending on the formula and insurance provider the individual has chosen)[43]. 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 ñ*that cannot be deferred*ò, including medical examination and medicine covered by the Pharmaceutical Benefits Act, dental care ñ*that cannot be deferred*ò, maternity care and abortion, contraceptive counselling 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 ñ*that cannot be deferred*ò are ñ*not compatible with the ethical principles of the medical profession, are not medically applicable in health and medical care and risk jeopardising patient safety*.ò

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 ñ*only in a few cases*ò, 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 ñ*more difficult for* **á**illegalô[44] *immigrants to live in the UK*ò. 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 **á***abuse***ô** of Article 8 of the European Convention on Human Rights ï the right to respect for family and private life; and
- prevent **á***illegal***ô** 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 ú210 for international students and ú280 for other categories of migrants. The surcharge will be paid as part of the individualôs 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).

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

[44] 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. Committing a criminal offense does not make you an '*illegal*' person." www.picum.org

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.

Box 1. An overview of International and EU bodiesô commitment to health protection

There is an impressive range of international texts and commitments that ensure peopleôs 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 MdMôs previous European report in May 2014:

Council of Europe

In its country conclusions on Spain[45] 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[46], the Committee concludes that it has not been established that there are adequate measures for counselling and screening for the population at large, and for pregnant women and adolescents specifically. Greece offers ñ*manifestly inadequate*ò minimum levels of unemployment benefits and there is no legally established general assistance scheme that would ensure that everyone in need has an enforceable right to social assistance. In the light of the widely reported cuts to the public health system as from 2011, the Committee asks for clarifications as regards the assistance provided to uninsured people in need. In the meantime it reserves its position on whether the right to medical assistance is effectively guaranteed. The same goes for undocumented migrantsô effective access to emergency social assistance.

Following a collective complaint by the Conference of European Churches, the European Committee of Social Rights has found that **the Netherlands is violating the rights of irregular migrants under the European Social Charter**[47]. Denying them ó*emergency*ô / ó*necessary*ô medical assistance and accommodation is not in conformity with Article 13§4 (right to social and medical assistance) and with Article 31§2 (right to housing).

During 2014, Commissioner for Human Rights Muižnieks expressed serious concern about draft legislation that would allow expulsion following the rejection of any migrant's complaint that they have been victim of racist or other unlawful violence by law enforcement officers[48]. He also reminded national governments that universal access to healthcare should not be undermined by austerity measures and the economic crisis, referring to his country visits to Spain and Greece[49]. 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 highly questionable procedures such as bone age tests to determine their age[50].

Concerning migrant children, the Parliamentary Assembly (PACE) reminded Member States that ñ*there is no legal instrument, or even consensus, with regard to procedures for assessing a personôs age and stresses the need to apply the benefit of the doubt, bearing in mind the higher interest of the child.*ò Therefore, they called on Member States to grant young migrants the benefit of the doubt when assessing their age and to ensure that such assessment is made with their informed consent[51]. The Assembly also urged Member States to ñ*challenge the misconceptions that exist about migrants, and in particular those that portray them as being a burden on public finances and a threat to economic prosperity and social cohesion*[52]ò.

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

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

47 www.coe.int/T/DGHL/Monitoring/SocialCharter/Complaints/CC90Merits_en.pdf

48 www.unhcr.gr/1againstracism/en/commissioner-muiznieks-on-the-amendment-to-article-19-of-the-draft-immigration-code/

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

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

51 PACE Resolution 1996 (2014). Migrant children: what rights at 18?

52 PACE Resolution 1972 (2014). Ensuring that migrants are a benefit for European host societies.

European Union institutions

In February 2014, the European Parliament (EP) voted a **resolution on undocumented women migrants in the EU** (2013/2115(INI)), thereby acknowledging that ñ*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*ò. They remind Member States that the right to health is fundamental and that, consequently, health policies should be delinked from immigration control. Governments should refrain from imposing on healthcare practitioners the duty to report undocumented migrants and should ensure the provision of appropriate care and proper psychological, health and legal support.

The European Parliament (EP) acknowledged that, ***ñ****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*ò [53]. The EP has also asked the Troika[54] not to include cuts in fundamental areas such as healthcare as a condition for financial assistance to euro area countries.[55]

The Commissionôs EU Action Plan on HIV/AIDS for 2014-2016[56] (March 2014) includes access to prevention, treatment and care of undocumented migrants as an indicator. In its Communication on effective, accessible and resilient health systems[57] (April 2014), the Commission recalls that, despite their organizational and financial differences, national health systems are built on the common values of universality, access to good quality care, equity and solidarity. In September 2014, a report on Roma health[58], ordered by the Commission, reminded about Romaôs substantially lower (up to 20 years) life expectancy, higher rates of infant mortality and maternal health risks, and the multiple barriers to healthcare they face across the majority of countries surveyed.

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: ñ*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*.ò[59]

Finally, following the Granada Declaration[60] by public health researchers and professionals, the Council of the EU acknowledged that ñ*universal access to healthcare is of paramount importance in addressing health inequalities****ò*** *[****é*** *] 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*ò [61].

In 2014, the EU Fundamental Rights Agency (FRA)[62] issued a *Paper on criminalization of irregular migrants*[63], reminding Member States that ***ñ****because of a real or perceived danger of detection, migrants in an irregular situation are often too afraid to use medical facilities, send their children to school, register their childrenôs births or attend religious services. If the state encourages the general public to report migrants in an irregular situation to the*

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

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

55 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))

56 Commission staff working document. *Action plan on HIV/Aids in the EU and neighbouring countries 2014-2016*. Brussels: European commission, 2014.

57 European Commission. *Communication from the Commission on effective, accessible and resilient health systems*. Brussels: European Commission, 2014. http://ec.europa.eu/health/healthcare/docs/com2014_215_final_en.pdf

58 Collective. *Report on the health status of the Roma population in the EU and the monitoring of data collection in the area of Roma health in the Member States*. Brussels: European Commission, 2014.

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

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

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

62 The FRA also published one 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.

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

*immigration authorities, this will drive migrants further underground, depriving them of access to public services and making them more vulnerable to exploitation and abuse.***ò**

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* [64], 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.

[64] Eurofound. *Access to healthcare in times of crisis*. Luxembourg: Publications Office of the European Union, 2014. http://eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1442en.pdf

The MdM International Networkôs domestic programmes

Since 1980, the international aid organisation Doctors of the World ï 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 ï 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[65]. More than half of the MdM International Networkôs 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.

MdMôs 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 national as well as European citizens, sex workers, undocumented migrants, asylum seekers and Roma communities.

Box 2. 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.

MdM programmes are aimed at empowerment through the active participation of user groups, as a way of identifying health-related solutions and of combating the stigmatisation and exclusion of these groups. MdM supports the creation of self-support groups as a way of strengthening civil society and recognising experience-based expertise. MdM activities can thus lead to social change: amending laws and practices as well as reinforcing equity and solidarity.

The Observatoryôs 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 ï and thus are often referred to as á*invisible data*â.

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:

[65] 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.

- **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 MdMôs 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, 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 ï from undocumented migrants to all patients who attended MdM health centres throughout the MdM International Network.

Box 3. The Observatory on access to healthcare: a progressive expansion in focus and coverage

Since 1994, MdM France used a common data collection tool to collect and publish information on main social determinants of health, barriers to access health care and health status of its service users. This led to the creation in 2000 of the Observatory of Access to healthcare in France (*Observatoire de lôaccès aux soins*). Over the years this initiative grew geographically with the creation of the MdM European Observatory on access to healthcare in 2004.
In 2006 and 2008, the Observatory conducted surveys which focused specifically on undocumented migrants (all undocumented migrants seen during the survey) in 6 and 11 European countries respectively[1,2].
In 2012, the International Network Observatory presented the results of routine data collected from all the patients who attended MdM health centres, rather than just undocumented migrants, in five European cities (Amsterdam, Brussels, London, Munich and Nice)[3].
The 2013 report (based on data collected in 2012 in 14 cities across seven European countries) focused on the barriers to accessing healthcare and the living conditions of people excluded from healthcare systems in Europe in times of crisis and rising xenophobia[4].
Last yearôs report described the access of people facing multiple vulnerability factors on the basis of social and medical data of patients who accessed, in 2013, MdM programmes in 10 countries[5].
2011 data ï 4 838 patients ï 5 cities ï 5 countries (Europe)
2012 data ï 8 412 patients ï 14 cities ï 7 countries (Europe)
2013 data ï 18 098 patients ï 27 cities ï 10 countries (Europe + TR & CA)
2014 data ï 23 341 patients ï 26 cities ï 11 countries (Europe + TR & CA)

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.

1. Chauvin P, Parizot I, Drouot N, Simonnot N, Tomasino A. *European survey on undocumented migrantsô access to health care*. Paris: Médecins du monde European Observatory on Access to Health Care, 2007, 78 p. [19 cities in seven countries].
2. Chauvin P, Parizot I, Simonnot N. *Access to healthcare for undocumented migrants in 11 European countries.* Paris: Médecins du monde European Observatory on Access to Health Care, 2009, 154 p.
3. Chauvin P, Simonnot N. *Access to health care for vulnerable groups in the European Union ï 14 cities in seven countries - in 2012.* Paris: Doctors of the World-Médecins du monde International Network 2012, 90 p.
4. Chauvin P, Simonnot N, Vanbiervliet F. *Access to healthcare in Europe in times of crisis and rising xenophobia:*

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 both health professionals ï nurses, medical doctors, midwives, dentists, specialists etc. ï and social workers, support workers, psychologists and administrators etc. Table 1 provides specific information on the types of services provided in the locations contributing to this survey. To meet the various needs of patients and fit the characteristics of each countryôs context, different packages of services and types of interventions have been developed over the years, as summarised below.

Table 1. Programmes involved in the survey and specific characteristics.

Country code	**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
CA	Québec, Canada	Montreal	Since 2011, the migrant clinic offers frontline medical services for migrants without health insurance.
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 - Sevilla - 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 the groups who cannot access healthcare. Specialists' consultations including psychiatry. Referral to mainstream healthcare system.
NL	The 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	The 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.

Box 4. 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 up 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 donôt present a healthcare coverage card.

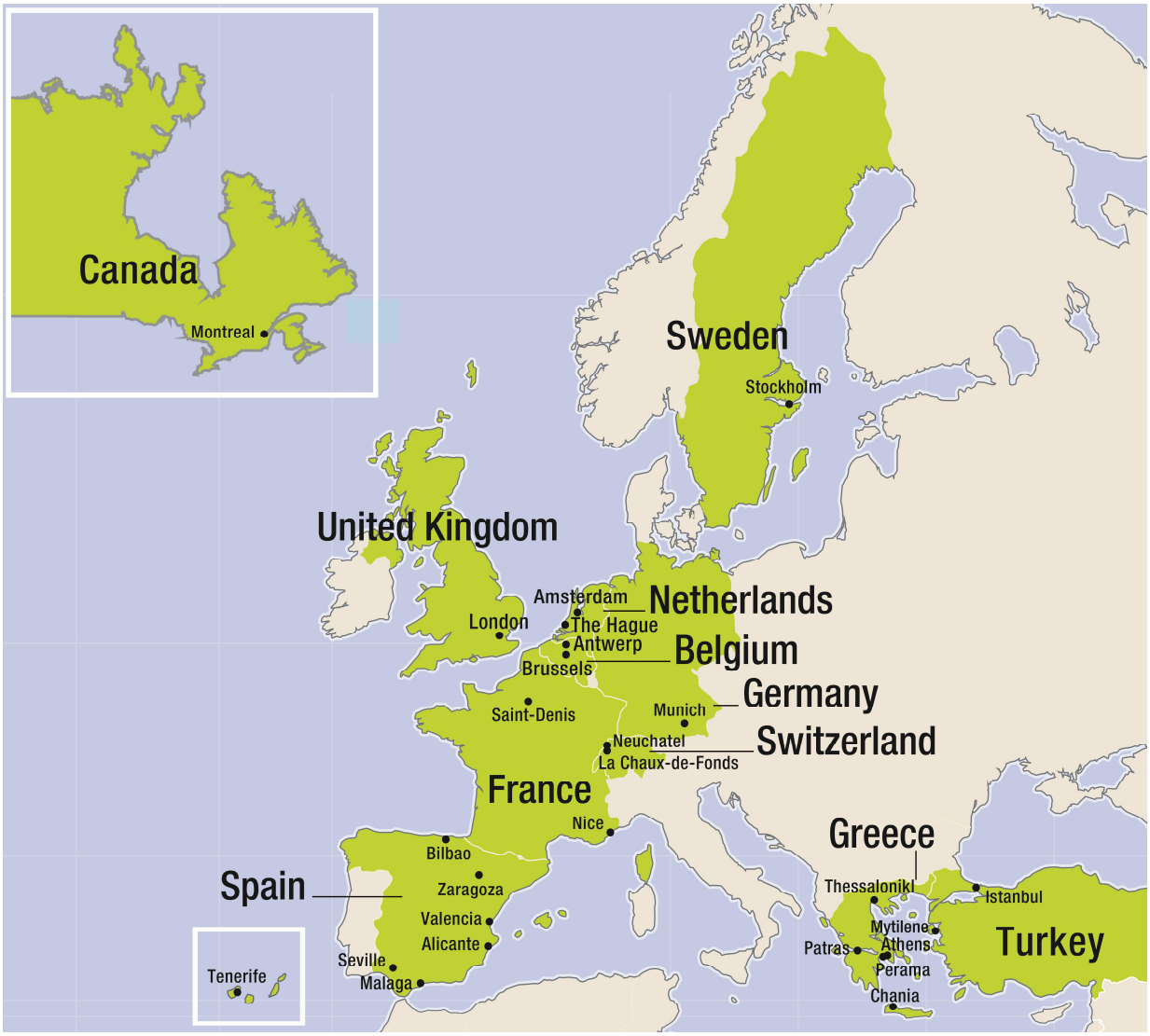
With regard to asylum seekers, during the three first months following the asylum request a voucher system covers only emergency consultations, the medication prescribed (by a doctor in Luxembourg) and emergency dental care.

Methods

Questionnaires and administration method

The data analysed in this report was collected by means of social and medical questionnaires administered to patients who attended a consultation in one of the 26 programmes in the 11 countries that contributed to the survey.

Figure 1. Map of the sites surveyed in 2014.



Every patient who attended a consultation with a health professional and support worker in one of the MdM programmes associated with the International Network Observatory in 2014 - between January 1st and December 31st - was administered at least one of the three standardized, multilingual forms - social questionnaire, medical questionnaire and medical re-consultation questionnaire(s). The questionnaires collect information about demographics and countries of origin, legal status, reasons for migration, living conditions, social isolation, work and income, violence, coverage of healthcare costs, barriers to accessing healthcare, giving up seeking healthcare, perceived health status - physical and psychological-, health conditions, acute and chronic disease and necessary treatment (please also refer to the social, medical and follow-up medical questionnaires in Appendix).

These generic social and medical questionnaires are reviewed each year thanks to the results of previous year analysis, Inserm recommendations and remarks made by the teams in the field to improve the quality of the data and analysis produced.

Additionally, this report provides testimonies collected throughout 2014 from patients willing to share their experiences. These stories[66] contribute to a better understanding of how the barriers and determinants to care described in this survey can be actually perceived by the populations met at MdM and how vulnerabilities are often intertwined.

Statistics

This report contains data in three different types of proportion:

The proportions by country are all *crude proportions* and include all the survey sites (irrespective of the number of cities or programmes[67]).

The European total proportions were calculated for the nine European countries and are, for the most part and unless otherwise indicated, *weighted average proportions* - i.e. the global proportion if all the countries had contributed for the same number of patients. This allows actual differences between countries to be corrected. So they each have the same weight in the overall total. *Crude average proportions* - where countries contribute proportionally to their numbers - are also given systematically in the tables and figures. In summary:

- **WAP** will refer to the weighted average proportion across the nine European countries;
- **WAPT** will refer to the weighted average proportion across the eleven countries (i.e. including Canadian and Turkish data);
- **CAP** will refer to the crude average proportion across the nine European countries;
- **CAPT** will refer to the crude average proportion across the eleven countries.

When numbers of respondents were low, or when subgroups of populations were examined, CAP and CAPT were preferably provided.

Three kinds of denominators are used. **Most often, the proportions are related to the number of patients**. In certain cases (always specified), proportions are related to the total number of visits or the total number of diagnoses.

[66] All names were changed.

[67] 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.

Table 2. Number of visits and patients by location.

Locations[68]	No. of patients	%	No. of visits	%
BE (Antwerp)	1011	4.3	3028	7
BE (Brussels)	1355	5.8	3637	8.4
CA (Montréal)	301	1.3	618	1.4
CH ï La Chaux de Fonds	104	0.4	281	0.7
CH - Canton of Neuchâtel	291	1.2	919	2.1
DE (Munich)	538	2.3	1292	3
EL (Athens)	2699	11.6	2859	6.6
EL (Chania)	355	1.5	608	1.4
EL (Mytilini)	1169	5	1245	2.9
EL (Patras)	933	4	1189	2.8
EL (Perama)	1373	5.9	4053	9.4
EL (Thessaloniki)	1625	7	3022	7
ES (Alicante)	27	0.1	28	0.1
ES (Bilbao)	51	0.2	51	0.1
ES (Malaga)	50	0.2	50	0.1
ES (Sevilla)	28	0.1	28	0.1
ES (Tenerife)	44	0.2	45	0.1
ES (Valencia)	17	0.1	17	0
ES (Zaragoza)	46	0.2	46	0.1
FR Saint-Denis	6488	27.8	11719	27.2
FR Nice	2351	10.1	5446	12.6
NL The Hague	8	0	8	0
NL, Amsterdam	115	0.5	115	0.3
SE, Stockholm	98	0.4	98	0.2
TR, Istanbul	869	3.7	1296	3
UK, London	1395	6.0	1454	30.3
Total	23341	100.0	43152	100.0

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

In the following analyses, the proportions presented relate to all the responses given (unless stated otherwise). The proportion of missing data is systematically indicated when it exceeds 10%. Missing data is related to one of the following three situations: either the question was not asked in certain countries (who decided to modify the common questionnaires); or the issue was not raised by certain programmes or volunteers (relating to certain issues, such as for example violence); or (but more rarely) the interviewee preferred not to answer the question. In the present process of data collection, the distinction between the two last situations is impossible to make at the time of the analysis, which does constitute a limitation to the interpretation of the data since the real denominator of the answers is not known (see for instance the section dedicated to violence where it is discussed in details).

All the data processing and analysis have been developed using R, an open source free statistical software.

[68] 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)

Numbers surveyed

This report is based on the analysis of data from 23,341 individuals (15,949 with details), of whom 8,849 were women, including 437 were pregnant women.

In total 43,152 consultations were analysed (29,898 for which the whole questionnaire was administered in the nine European countries and 1,914 in CA and TR) and 25,410 different diagnoses were reported by the volunteer doctors.

Table 3. Number of patients and consultations by country.

Pays	No. of patients	%	No. of visits	%
BE	2366	14.8	6665	21.0
CA	301	1.9	618	1.9
CH	395	2.5	1200	3.8
DE	538	3.4	1292	4.1
EL[69]	8154 / 762	34.9 / 4.8	12976 / 1636	5.1
ES	263	1.6	265	0.8
FR	8839	55.4	17165	54.0
NL	123	0.8	123	0.4
SE	98	0.6	98	0.3
TR	869	5.4	1296	4.1
UK	1395	8.7	1454	4.6
Total (26 cities)	23341 /15949	100	43152/ 31812	100

100% of consultations provided in CA, CH, DE, FR, TR and UK were included and analysed. In the other countries, sampling procedures were used to randomly select patients who were administered the Observatory standard questions:

- In Greece, 100% of consultations were included for the six main social indicators, following which a random sample of 10% patients (5% in Athens) were fully interviewed;
- In Belgium, 9 questions were not asked to all the patients but only to a subsample (1 out of 7);
- In Spain[70], each site had its own sampling strategy: 1 out of 4 service users in Tenerife, first consultation of the day in Zaragoza[71], only the new patients at their first visit in Bilbao and Valencia, 1 every 2 consultations in Alicante, and a convenience sample in Sevilla and Malaga;
- In the Netherlands, the sample was also a convenience sample;
- In Stockholm, only EU migrants were systematically questioned. Undocumented migrants from non-EU countries were interviewed with a very short set of questions before referral and no medical information are available.

The data used in this report is collected in first line health clinics often busy and relying mainly on volunteers. Their main purpose is to provide quality services to patients. While efforts are being made to progressively improve the quality of the data collected, the conditions of data collection have implications on the overall quality that are inherent to this type of action research. Additionally, and although a sampling system is in place in most locations, there are other locations where the lack of human resources, time and interpreters limited the social and medical consultation time, thus having an impact on the quantity and quality of data collected.

[69] 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 (supposedly 1/10 in Chania, Mytilini, Patras, Perama and Thessaloniki and 1/20 in Athens).

[70] A big progress was made in Spain in 2014 in comparison to 2013 where questionnaires had only been filled in for one month.

[71] Convenience samples do not constitute a proper random sample

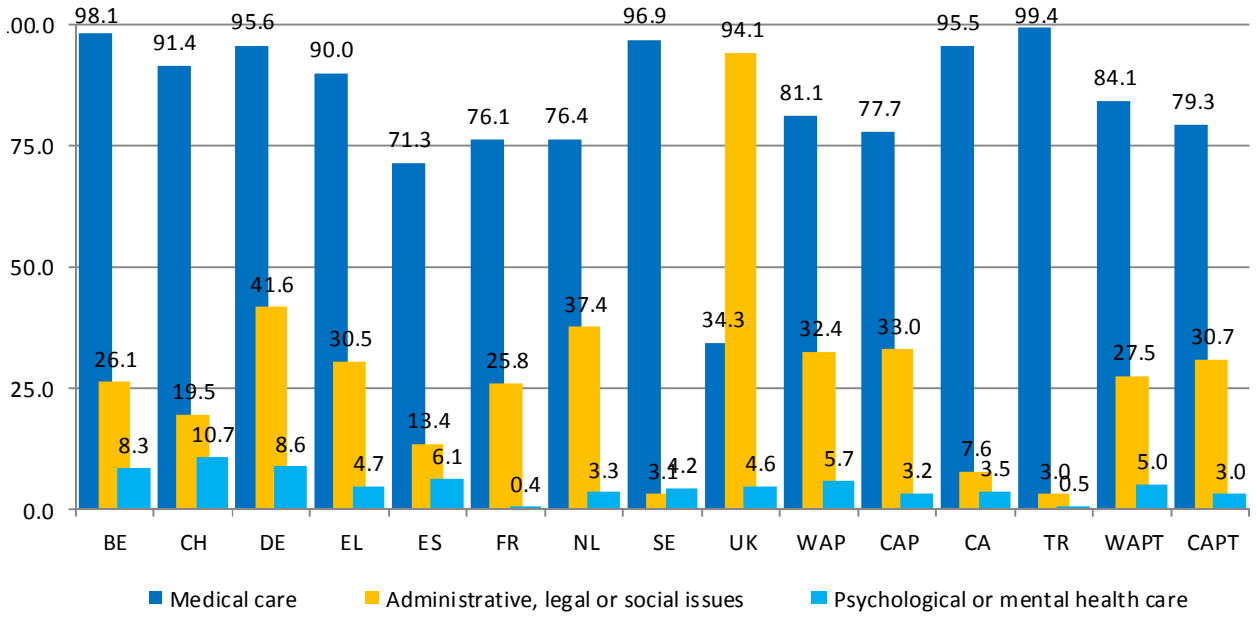
Reasons for consulting MdM programmes

The **vast majority of patients consulted MdM programmes to obtain medical care** (81.1% in Europe, 95.5% in Montreal, 99.4% in Istanbul). In London, looking for help in order to register with a GP was coded into administrative reason to consult. It means that the main concern of patients seen was still to access healthcare.

On the other hand, consulting MdM for an administrative, legal or social issue is also common: one third of patients seen in Europe for one of these reasons (alone, or more often, together with a health problem).

Psychological support or mental issues were not exceptional reasons for consultation, particularly in Switzerland (10.7%) where the patients are mainly asylum seekers. The low numbers of mental health issues reported for reasons for consultation is clearly an underrepresentation of actual mental health needs, especially if you compare to the actual diagnoses related to mental health issues (10.6%)[72]. This highlights the need for health professionals to have strong skills for detecting mental health issues at primary care level.

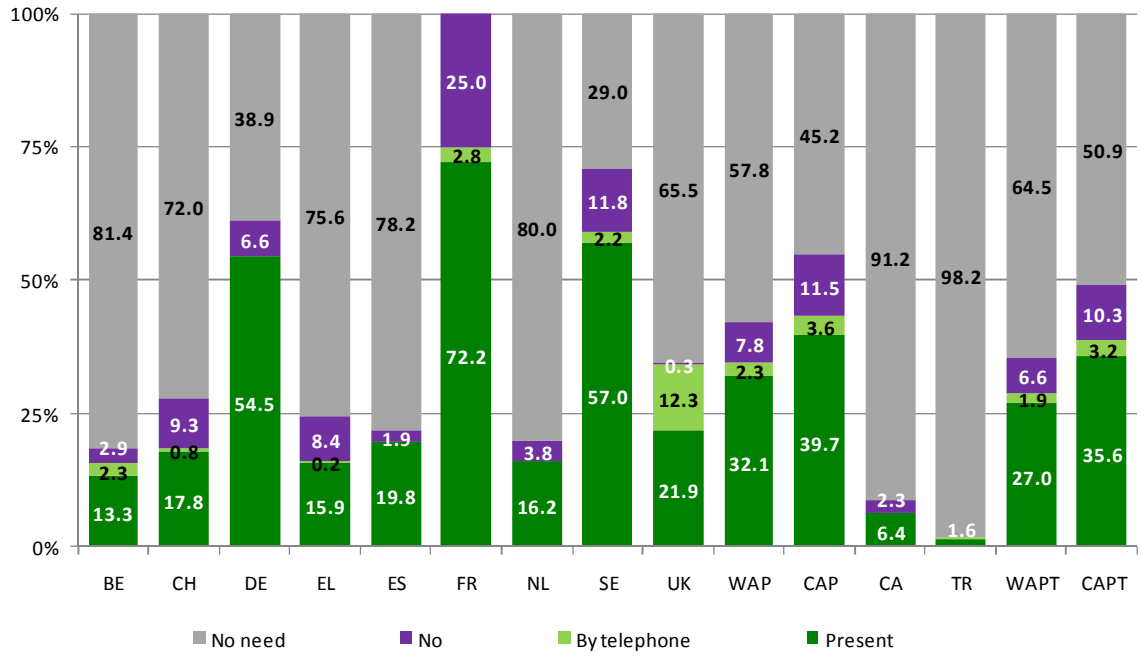
Figure 2. Reasons for consulting MdM programmes, by country (%).



Overall, **54.8% of the patients seen in the European countries needed an interpreter during the consultation** (CAP): for 39.7% of all patients, MdM could avail interpretation services (whether in person or by phone) and for 3.6% it was not possible although needed. Wide disparities are observed from one country to another, with e.g. Sweden 71% of the patients met were in need of an interpreter and 61.1% in Munich.

[72] See also section *Health problems by biological system*.

Figure 3. Proportion of patient with interpretation needs (more frequent situation in the case of multiple consultations)



Focus on pregnant women

A total of 437 pregnant women were seen for consultations in 2014, 310 of whom were in the nine European countries taking part in the survey (mainly in Belgium, Germany and France), representing 2.7% of patients and 7.5% of women.

The average age of the pregnant women was 27.8 (30.4 in Montreal and 29.1 in Istanbul) and the youngest was 14 years old. Their average age at their first pregnancy was 24 (range=13-40).

The lowest proportion of pregnant women of all the women consulting was in Greece (0.8%), Spain (1.5%) and France (2.4%). In Greece, this is explained by the fact that the majority of those consulting are Greek or European and their access to care remains, despite the crisis, relatively better than for those who are from outside of Europe. In France, access to care remains globally acceptable ï compared to other European countries - for pregnant women in the public sector (in the mother and child care services and at hospital), regardless of their status and health coverage. Having said this, around two pregnant women a month are still seen in consultations in each of the two CASOs included in the survey.

Conversely, this proportion was particularly high in Munich (28.4%), Switzerland (20.0%), and the Netherlands (15.5%), but also in Montreal[73] (33.5%) and Istanbul (20.9%).

Table 4. Numbers of pregnant women by country and as a percentage of total women seen.

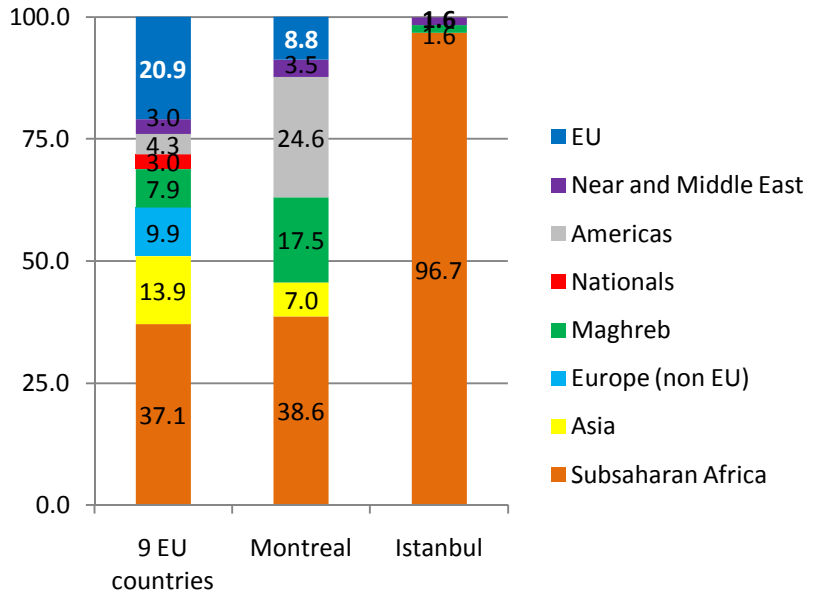
	No. pregnant	% of pregnant women (N=437)	% of women (N=5827)
BE	71	16.2	7.9
CA	66	15.1	33.5
CH	21	4.8	20.0
DE	85	19.5	28.4
EL	3	0.7	0.8
ES	2	0.5	1.5
FR	66	15.1	2.4
NL	9	2.1	15.5
SE	3	0.7	9.4
TR	61	14.0	20.9
UK	50	11.4	7.5
Total	437	100.0	7.5

In the nine European countries surveyed, 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%). None of them were nationals, except in Munich (N=8, 9.4%) and in London (N=1, 2.2%).

In Montreal, the three main groups of origin were Sub-Saharan Africa (38.6%), Americas (including the Caribbean Islands, 24.6%) and Maghreb (17.5%). In Istanbul, almost all the pregnant women (96.7%) were from sub-Saharan Africa.

[73] Specific attention to pregnant women without health coverage is given in Montreal MdM program, as they have no access to prenatal care, in partnership with the Doulas of Montreal Birth Companions.

Figure 4. Geographical origin of pregnant women in the nine European countries, Montreal and Istanbul.



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

Table 5. Administrative status of the pregnant women interviewed.

	% in Europe (n=310)	% in Montreal (n=66*)	% in Istanbul (n=61)
Citizen of non-EU country without permission to reside	50.0	100.0	29.4
EU citizen with no permission to reside[1]	2.4	-	-
Total without permission to reside	*52.4*	*100.0*	*29.4*
No residence permit requirement (nationals)[2]	4.3	0.0	17.6
Asylum seeker (application or appeal ongoing)	33.3	0.0	29.4
Valid residence permit	7.1	0.0	5.9
EU national staying for less than three months (no residence permit required)[2]	0.0	0.0	5.9
Visas of all types[3]	3.6	0.0	11.8
EU national with permission to reside[4]	0.0	0.0	0.0
Residence permit from another EU country	0.0	-	-
Specific situation conferring right to remain[5]	2.4	0.0	0.0
Total with permission to reside	*50.7*	*0.0*	*70.6*
Total	100.0	100.0	100.0
Missing data (%)	*1.9*	*50.0**	*5.6*

*% are given in Montreal for information purposes only (very small numbers due to low response rate)
[1]Without adequate financial resources and/or health coverage
[2] Or equivalent situation (recent immigrants <90 days)
[3] Tourism, short-stay, student, work
[4] Adequate financial resources and valid healthcare coverage
[5] 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 and Montreal, 27.3% and 79.7% (though the numbers are very small) were in this situation respectively.**

Among migrants, pregnant women had migrated more frequently to join or follow someone (31.4% versus 18.2% of the other non-pregnant women, p<0.001) or to study (7.6% versus 2.8%, p=0.001, which may reflect only an *age effect*). On the opposite, **personal health reasons were far less frequent** (0.8% versus 4.0%), which reflects the *healthy migrant effect* of these young women and the **absence of any push factor for migration related to their present pregnancy. It did not appear either to be planned since exactly the same proportion of women, pregnant or not, reported to have migrated to ensure the future of their children**.

Table 6. Reasons for migration: comparison between pregnant women and the other women (in the 11 countries, %).

	Pregnant women (N=236*)	Others (N=3082)	p
Economic reasons, unable to earn a living in home country	46.6	52.1	0.15
Political, religious, ethnic, sexual orientation	11.9	21.1	0.002
To escape from war	8.5	11.9	0.15
To join or follow someone	31.4	18.2	<0.001
Family conflicts	7.2	6.5	0.72
To ensure your children' future	4.2	4.2	0.96
Personal health reasons	0.8	4.0	0.02
To study	7.6	2.8	0.001
others	8.9	9.6	0.74
Total	127.1	130.4	

*Response rate=57.1% (236/413 immigrant pregnant women)

Of the pregnant women seen in Europe, 55.3% were living in temporary accommodation, only a third (34.9%) had their own house or flat and 8.1% were homeless. In Montreal, 79.7% lived in their own house or flat, 17.0% were temporary housed and a few (3.4%) were living at their work place (no home, no squat). In Istanbul, 72.1% had their own house or flat to live and a quarter (24.6%) were temporary housed (1.6% were homeless).

In total, 62.9% of pregnant women seen in Europe considered their accommodation to be unstable; this proportion was only 22.8% in Montreal, and 55.0% in Istanbul.

In Europe 22.9 % considered that their **housing conditions were harmful to their health or that of their children** for 54.2% and 11.1% in Istanbul and Montreal, respectively.

Very few of these women were engaged in an activity that provided them with an income (16.0%) and **the vast majority (89.2%) were living below the poverty line**[74]. In Montreal and Istanbul, respectively 8.6% and 41.0% had a job, and 91.5% and 100% were below poverty line.

[74] 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.

Nina is a 23 years Bulgarian woman: ñ*I came to Munich with my boyfriend who works here. When I got pregnant we were both very happy and excited about the good news. But now I cannot start a job here myself, employers are not interested in pregnant women. I still have my European Health Insurance Card from Bulgaria, but it does not cover childbirth. The insurance considers that I should deliver in Bulgaria. I canôt: I would be on my own, as my boyfriend does not have holidays. I heard the delivery in Germany is very expensive; we do not have that much money. If we were married, I could be insured on my husbandôs family insurance. We cannot organize the many documents that we need for wedding in Germany (birth certificates, certificates of no impediment, and so on). Getting married in Bulgaria is not possible as my boyfriend is only free in weekends. Besides, the pregnancy makes me feel dizzy very often, I canôt travel and organize all these things*.ò

MdM Germany ï Munich ï September 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 (41.4% were living apart from all their minor children). These figures were very different in Montreal (where 81.0% of pregnant women were living with all their children) and Istanbul where 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[75].**

Of those surveyed, 30.3% of pregnant women declared that 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 and in Montreal (51% had never or only sometimes somebody to rely on). 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.

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 ú3,620.

MdM UK ï London ï 2014

Regardless of their administrative status, 81.1% of pregnant women seen by MdM in Europe had no healthcare coverage[76]. 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%) Montreal (100.0%) 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, except, for example, in France where prenatal care is available free of charge for all women, regardless of their healthcare coverage and, theoretically, their administrative situation. Similarly, in Spain pregnant women without permission to reside are supposed to be provided with prenatal and postnatal care, as well as care during their delivery, the same as any other woman, but they need to get a pregnancy health card before.

[75] Parreñas RS. Mothering from a distance: emotions, gender, and intergenerational relations in Filipino transnational families. *Feminist studies* 2001; 27: 361-90.
Miranda J, Siddique J, Der-Martirosian C, Belin TR. Depression among Latina immigrant mothers separated from their children. *Psychiatric services* 2005; 56: 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; Article ID 593413, 6 p.

[76] 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.

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 ú3,500 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 ï Istanbul ï January 2015

In Switzerland, 62% had complete health coverage (due to their asylum seeker status for most of them), in the Netherlands, 87.5% could consult a health professional with some fees[77]. In Sweden, 66.7% had access to subsidized care, i.e. they had to pay some fees to access healthcare.

Table 7. Healthcare coverage for pregnant women.

	% in Europe (n=310)	% in Montreal (n=66*)	% in Istanbul (n=61)
No coverage / all charges must be paid	58.4	100.0	98.1
Access to emergency services only	22.7	0.0	0.0
Full healthcare coverage	6.3	0.0	0.0
Open rights in another European country	5.9	0.0	0.0
Access to GP with fees	2.4	0.0	0.0
Partial healthcare coverage	2.1	0.0	0.0
Free access to general medicine	1.1	0.0	1.9
Access on a case by case basis	1.0	0.0	0.0

*% are given in Montreal for information purposes only (very small numbers due to low response rate)

At the time of their first consultation in MdM, the pregnant women seen in MdM were on average at their 15.6th week of pregnancy (50% were between 10th and 20th weeks of pregnancy). This average was almost the same in Istanbul (16.8 weeks) and higher in Montreal (20 weeks, but numbers are small)..

Vivian, from Central Africa, is undocumented. Her husband obtained the refugee status. Vivian was 20 weeks pregnant when she faced barriers in accessing antenatal consultations: she wasnôt even accepted on the waiting list because she had no health coverage. Antenatal consultations were covered by MdM CA. She finally delivered in the Central hospital. As her medical condition worsened Vivian was referred to another hospital. The bill from both hospitalizations rose up to 35,000 ú. The couple has no financial resources to reimburse.

MdM Canada ï Montreal ï February 2014

Among the pregnant women in the nine European countries, 54.2% had not had access to antenatal care when they came to MdMôs free health centres[78] and, of those, 58.2% received care too late - that is after the 12th week of pregnancy[79].

Pregnancies for undocumented migrant women should be considered as *ôhigh risk pregnanciesô* and, as such, should be carefully monitored[80].

[77] Pregnant women – as any undocumented migrant from non EU-countries - are asked to pay a part of the bill of the consultation at a GP, a midwife, or a gynaecologist. In case they cannot pay, the health provider can get reimbursed 100% of the costs for a pregnancy-related consultation by a State run system (and 80% of the costs for an issue not related to the pregnancy).

[78] 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).

[79] Response rate = 78.5% and 57.4% respectively.

More generally, in 2009, a systematic literature review on stillbirth, neonatal mortality and infant mortality among migrants in Europe[81] found that over half of the 55 studies reviewed reported worse mortality outcomes for migrants compared to the respective non-migrant population and that refuges were more particularly vulnerable.[82]

Box 5. Risks faced by mothers and children without access to timely antenatal care[83]

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

Antenatal care, also known as prenatal care, is the set of interventions that a pregnant woman receives from organised 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 individualised based on her own needs and wishes.
Without access to timely ï i.e. from 12 weeks of pregnancy ï 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, which can cause abortion, premature rupture of the 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 the first months of the babyôs life, as well as no future family planning, no advice about breast feeding, vaccinations etc.

A longitudinal follow-up study of all pregnant women presenting to the MdM UK clinic was implemented in the second semester of 2014[84]. The clinic could ask 35 of the 85 pregnant migrant women a set of questions about their experiences during their pregnancy, labour, and the immediate postnatal period. The study confirmed the deterrent effect of entitlement checks and charging in a population with little access to primary care. Among the experiences shared by the respondents, a number had been billed for their maternity care with amounts ranging from 1,500£ to 6,000£ (2,100ú - 8,400ú) and reported very negative experiences: ñ*The whole experience with NHS was very very poor; it puts mothers under pressure if you cannot afford charges. When I got the bill, because I couldnôt pay in one go, I have to pay an extra 300£ (420ú)ò:* Another woman explains that she had no antenatal care appointments and gave birth prematurely at 28 weeks. Her preterm baby died from an overwhelming infection and she felt this was the result of negligence. She was billed 2,620£ (3,700ú) after losing her baby. Another lady also ñ*lost the baby at 42 weeks and felt very unsupported at the hospitalò*: She was later on billed 1,500£ (2,100ú). Antenatal care was frequently received late and was often lower than the minimum standards for antenatal care, leaving the women and their unborn child at increased risk of pregnancy-associated complications.

MdM UK ï London ï 2014

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80 Wolff H, Epiney M, Lourenco AP, Costanza MC, Delieutraz-Marchand J, Andreoli N, Dubuisson JB, Gaspoz JM, Irion O. Undocumented migrants lack access to pregnancy care and prevention. *BMC Public Health* 2008; 8: 93.

81 Gissler M, Alexander S, MacFarlane A, Small R, Stray-Pedersen B, Zeitlin J, Zimbeck M, Gagnon A. Stillbirths and infant deaths among migrants in industrialized countries. *Acta Obstet Gynecol Scand* 2009; 88: 134-48.

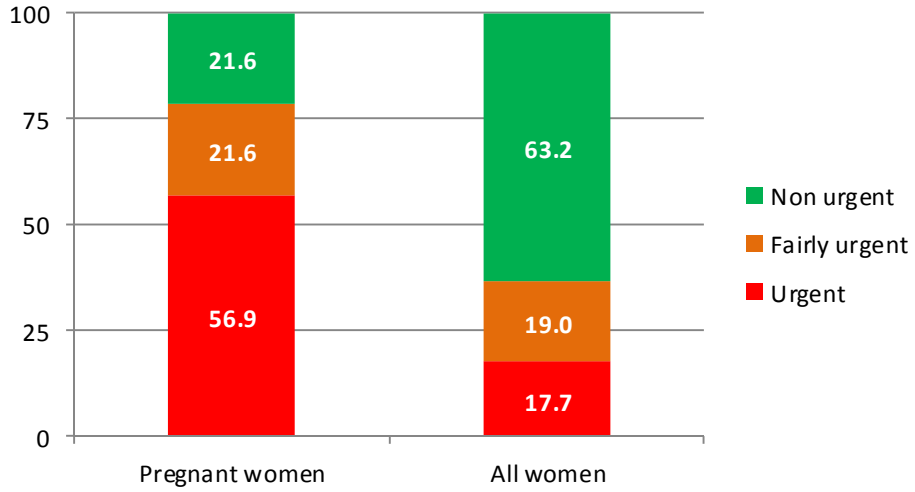
82 Reeske A, Razum O. Maternal and child health. *In*: Rechel B, Mladovsky P, Devillé W, et al, eds. *Migration and health in the European Union*. Berkshire: Open University Press (European Observatory on Health systems and Policies Series), 2011.

83 Banta D. *What is the efficacy/effectiveness of antenatal care and the financial and organizational implications?* Copenhagen: WHO Regional Office for Europe (Health Evidence Network report), 2003.

84 Shortall C, McMorran J, Taylor K, Traianou A, Garcia de Frutos M, Jones L, Murwill P. *Experiences of pregnant migrant women receiving ante/peri and postnatal care in the UK: a longitudinal follow-up study of Doctors of the World's London drop-in clinic attendees*. Unpublished, 2014. http://b.3cdn.net/droftheworld/08303864eb97b2d304_lam6brw4c.pdf

When the women first presented for a medical consultation, the doctors considered that 78.5% of them required urgent (56.9%) or fairly urgent care (21.6%); i.e. more than twice as often as all women (78.5% versus 36.7%[85], $p<10^{-6}$).

Figure 5. Frequency of treatment deemed urgent by doctors (at the first consultation).



Altogether, in Europe, only half of the pregnant women[86] did know their HIV status when they arrived in MdM and, among them, 14.3% were HIV positive; which is a dramatically high prevalence.

This underlines the importance of HIV systematic screening of pregnant women living in such precarious situations. Their testing is an absolute emergency (regardless their past history of previous testing). However **for 42.1% of the pregnant women seen in the nine European countries, no sufficient data was collected about their history of HIV testing or about their HIV status!** Obviously, there is no excuse to miss such a question when receiving a pregnant woman and it is hoped that these missing values are only due to data underreporting from the volunteers.

Similar figures were observed for HBV tests: 43.0% of missing data among the pregnant women seen in the nine European countries (although testing is recommended as a good medical practice for all pregnant women from high endemic countries[87]), **only half of them had been tested in the past and 11.1% of them were positive**. It should be reminded that vertical (mother-to-child) transmission is one of the main routes of transmission of HBV and that neonatal infection is the major risk of being further chronic carrier of the virus.

Surprisingly, there was fewer missing data for HCV (29.4%) but, then, as for the other viruses, only half of the pregnant women had been tested in the past, and 2.8% of them knew that they were positive.

Among all the pregnant women seen in the nine European countries[88], 67.1% wished to be screened for one or the other of these viruses. Obviously, ALL these pregnant women should be tested but one third (34.3%) did not know where to go to get them tested[89].

[85] Response rate = 77.1% and 42.8% respectively.
[86] N=120/253 since 42.1% of pregnant women were not asked about their history of HIV testing nor about their HIV status.
[87] See below the part of the document dedicated to screening for a list of the world regions concerned.
[88] Response rate = 66.6%
[89] Response rate at 62.4%

Only 30 pregnant women were asked if they wanted their pregnancy to be interrupted (abortion): six out of them said yes[90].

A legal overview of access to care for pregnant women[91]

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 ú250).

France

Undocumented pregnant women can obtain full health coverage 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 ó*unfit for travel*ô ï 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 ú1,033 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 ñunable to prove that they have entered and are residing in the country legallyò. So undocumented pregnant women have no health coverage. However, undocumented pregnant women have now access to free delivery but not to pre and post-natal care. New changes might occur in May 2015.

With regard to termination of pregnancy, undocumented pregnant women have to pay approximately ú340 in public hospitals. The article 41 of Law 3907/2011 establishes that undocumented pregnant women may not be removed from the territory during their pregnancy and for six months after delivery.

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.

[90] This question was added to the questionnaire for the first time in 2014. This explains the very low answer rate. In view of the importance of raising the topic during the consultation with pregnant women, efforts should be put in informing and training staff and volunteers. Better answer rates are expected next year.

[91] For all details and references to the laws, please consult the full legislative report *Access to healthcare for migrants in Europe: update of legislations in 12 countries*, published in May 2015, on www.mdmeuroblog.wordpress.com.

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 ó*pregnancy individual health card*ô 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 ó*cannot be postponed*ô. They have access to maternity care and termination of pregnancy. They have to pay a fee of around ú5 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 ú300 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 doctorôs fees.

UK

Maternity care for undocumented pregnant women ï including antenatal care, delivery and postnatal care ï 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 ú7,000 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.

Laura is a 24 years old Cameroonian woman. Firstly registered in Italy, she lives in Belgium for two years to study nursing. When she became pregnant, she gave up her studies. She repeatedly requested the renewal of her European health insurance card in Italy, without success. Therefore she visited MdM in Brussels: ñthere are always barriers in accessing healthcare when we are undocumented. I had a health insurance before but it has not been renewed. I have to advance money, but I am not refunded, even not half of the bill!ò Laura fears for the coming future, the cost of her delivery, she doesnôt know how to get medical care for herself and her baby.

MdM Belgium ï Brussels ï December 2014

Box 6. Mobilisation for womenôs 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*[92] 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: ñWe 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.ò

[92] EN:www.youtube.com/watch?v=KTr9RiJ7VlI

Focus on children vaccination

The vaccine(s) that protect against tetanus, MMR (measles, mumps and rubella), diphtheria and whooping cough are considered essential throughout the world, and most WHO Europe countries have also included the vaccine against Hepatitis B in their national immunisation schedules[93].

There are good reasons to consider these vaccines essential. Tetanus comes with high lethality rates[94]. Severe whooping cough leads to poor weight gain, and children may develop apnoea and cyanosis. It remains an important cause of death for infants aged 10 days to two months[95]. Measles can lead to otitis, pneumonia, and even to encephalitis. Even years after being apparently cured, Measles can lead to the rapidly evolving and fatal subacute sclerosing panencephalitis (SSPE)[96]. Diphtheria can lead to serious respiratory, cardiac and neurologic damage[97]. Finally, HBV infections at birth or in early childhood are at the highest risk of further HBV chronic carriage, itself leading to progressive liver disease, cirrhosis and ultimately primary hepatocellular carcinoma[98].

Many vaccines not only protect the individual but also the community, through the mechanism of *herd immunity*: vaccinating an individual will also help keep the others around that person 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. For instance, vaccination coverage rates need to be above 95% in order to eradicate measles. For diphtheria, coverage rates need to be above 85%, for whooping cough it needs to be between 92 and 94%[99]. Clearly, the vaccination rates described in this report are insufficient in order to achieve the aforementioned public health goals.

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 652 minor patients were seen by MdM in 2014. They represent 4.1% of the total population. No minor was seen in Sweden.

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

94 According to the ECDC, the overall death rate is close to 50%, depending on the clinical presentation, patient's age and medical support. http://ecdc.europa.eu/en/healthtopics/tetanus/Pages/index.aspx last accessed on 18/02/2015

95 Gabutti PG, Rota MC. Pertussis: A Review of Disease Epidemiology Worldwide and in Italy. *Int J Environ Res Public Health* 2012; 9: 4626-38.

96 www.ecdc.europa.eu/en/healthtopics/measles/Pages/health_professionals.aspx, last accessed on 18/02/2015

97 www.nhs.uk/Conditions/Diphtheria/Pages/Complications.aspx, last accessed on 18/02/2015

98 www.ecdc.europa.eu/en/healthtopics/hepatitis_b/pages/index.aspx, last accessed on 18/02/2015

99 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.

Table 8. Number of minors by country.

	No. of minors	%	% in Europe	% among all patients seen	No. of respondents to vaccination questions*	% missing data vaccination among minors
BE	97	14.9%	15.6%	4.1%	7	92.8%
CH	25	3.8%	4.0%	6.3%	6	76.0%
DE	34	5.2%	5.5%	6.5%	29	14.7%
EL	90	13.8%	14.4%	13.4%	33	63.3%
ES	1	0.2%	0.2%	0.4%	1	0.0%
FR	351	53.8%	56.3%	4.0%	133	62.1%
NL	1	0.2%	0.2%	0.8%	1	0.0%
UK	24	3.7%	3.9%	1.7%	2	91.7%
Total EU	623	95.6%	100.0%	4.3%	254	63.7%
CA	7	1.1%		2.4%	0	100.0%
TR	22	3.4%		2.6%	21	4.5%
Total	652	100%		4.1%	282	63.9%

**For the most frequently asked question (tetanus)*

Geographical origins of minors are very different from one country to another. For instance, two thirds of those seen in Istanbul were Sub-Saharan African, versus half in Switzerland, a third in France and a quarter in Belgium. It is noteworthy that 19%, 65% and 30% of minors seen in Belgium, Munich and France were from the EU. Altogether, EU was the second most frequent origin of minors seen in the 6 European countries after Africa.

Figure 6. Geographical origin of minors (in the countries where at least 10 minors had been recorded).

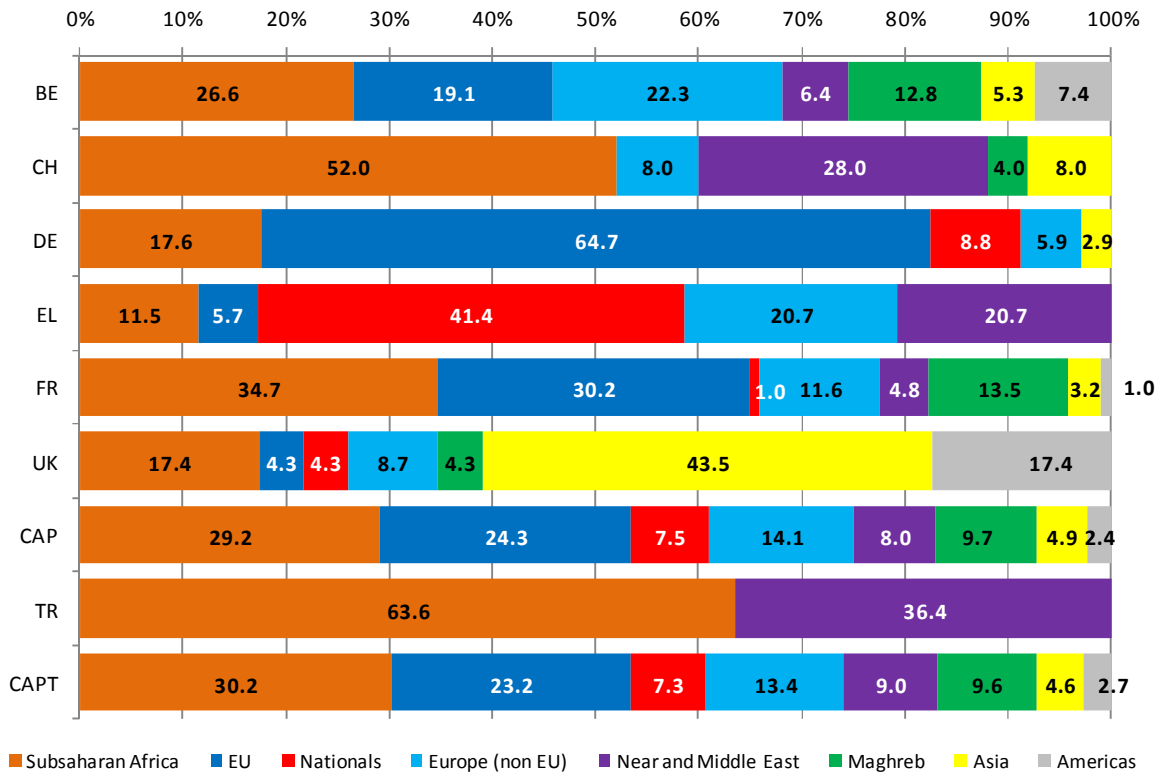


Table 9. Top ten most frequently recorded nationalities among minors, by country (in those with more than 10 minors seen).

BE	**no.**	**CH**	**no.**	**DE**	**no.**	**EL**	**no.**
Romania	10	Syria	7	Bulgaria	16	Greece	35
Morocco	10	Eritrea	4	Romania	3	Afghanistan	15
Congo RD	9	Guinea	3	Germany	3	Albania	14
Albania	5	Somalia	2	Nigeria	2	Nigeria	4
Russia	4	Tunisia	1	Hungaria	2	Romania	3
Kosovo	3	Sri Lanka	1	Tanzania	1	Bulgaria	3
Guinea	3	Congo RD	1	Somalia	1	Syria	2
Republic of the Congo	3	Mongolia	1	Serbia	1	Georgia	2
Cameroon	3	Mali	1	Senegal	1	Ukraine	1
Brazil	3	Georgia	1	Montenegro	1	Sudan	1
FR	**no.**	**UK**	**no.**	**TR**	**no.**	**In all the countries**	**no.**
Romania	77	Bangladesh	7	Afghanistan	5	Romania	93
Mali	36	Brazil	3	Congo DR	4	Mali	37
Ivory Coast	22	Nigeria	2	Cameroon	3	Greece	35
Algeria	14	India	2	Syria	2	Albania	32
Morocco	12	Albania	2	Senegal	2	Afghanistan	26
Tunisia	11	Sierra Leone	1	Uganda	1	Morocco	23
Guinea	11	UK	1	Nigeria	1	Ivory Coast	23
Russia	10	Poland	1	Iraq	1	Bulgaria	22
Cameroon	10	Jamaica	1	Ghana	1	Congo RD	18
Albania	10	Eritrea	1	Eritrea	1	Guinea	17

Data on vaccination was collected among small numbers of minors by country. Therefore, details are only given for those with more than 25 respondents (DE, EL, FR, TR), for information purposes only. It should be noted that only the French results were computed on more than 100 minors. All the total figures are given in crude average proportion among the total number of respondents in all the countries.

Remarks on methodology

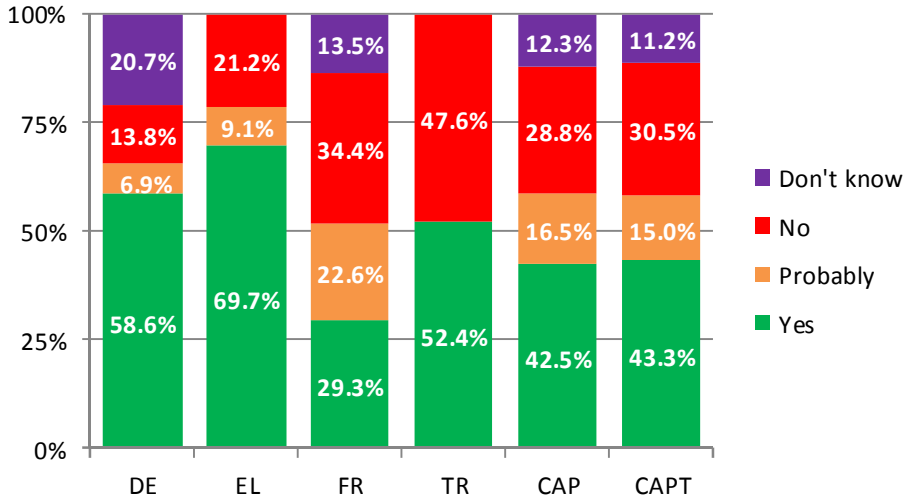
The response rates are identical for all antigens: that is to say, for a given patient questions about vaccinations were filled in systematically, in approximately equal proportions.

In Europe[100]**, only 42.5% of minors who responded had been vaccinated against tetanus** (and 16.5% only *probably*). In France, only 29.3% of minors had definitely been vaccinated[101]. In Istanbul, this applied to 52.4%.

[100] The rate of children seen in MdM clinics for whom the 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.

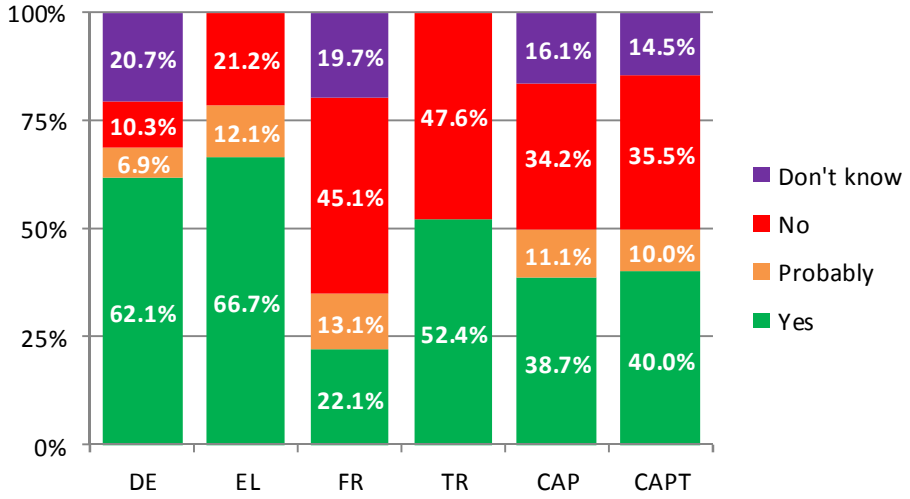
[101] This means that MdM doctors or nurses had seen the vaccination booklet.

Figure 7. Vaccination coverage against tetanus amongst minors.



The rates of vaccination against **hepatitis B** (HBV) were even lower**: the average proportion of vaccinated minors in Europe was 38.7%** (and 11.1% only *probably*). The HBV vaccination rate was very low in France (22.1%).

Figure 8. Vaccination coverage against hepatitis B amongst minors.



The majority of European countries follow the WHO recommendation to incorporate hepatitis B vaccine as an integral part of their national infant immunisation programme[102]. For these countries, the immunisation coverage in the general population is averaging 93%.[103] However, a number of countries do not currently require children to be vaccinated and consequently the rates for these countries are significantly lower than in other countries. For example, in Sweden, vaccination against hepatitis B is not part of the general infant vaccination programme, but is provided to high risk groups such as children with mothers who are infected by HBV. In France, although the hepatitis B vaccination is not given systematically, it is still highly

[102] Summary of WHO Position Papers - Recommendations for Routine Immunization (updated 30 May 2014).
[103] OECD. Childhood vaccination programmes. In: *Health at a Glance 2013.* Paris: OECD, 2013.

recommended for all infants as well as a booster for all children aged under 16[104]. The immunisation coverage rate for the general population is gradually rising after the drop in the 1990s (the immunisation coverage with three doses was 74% at 24 months in 2011 in the mother and child protection centres and 61% at the same age in 2010 in the private sector[105]).

The rates for **mumps, measles and rubella (MMR) and pertussis/whooping cough** vaccinations were almost the same as for hepatitis B**: respectively 34.5% and 39.8%.** 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.**

Figure 9. MMR Vaccination coverage among children.

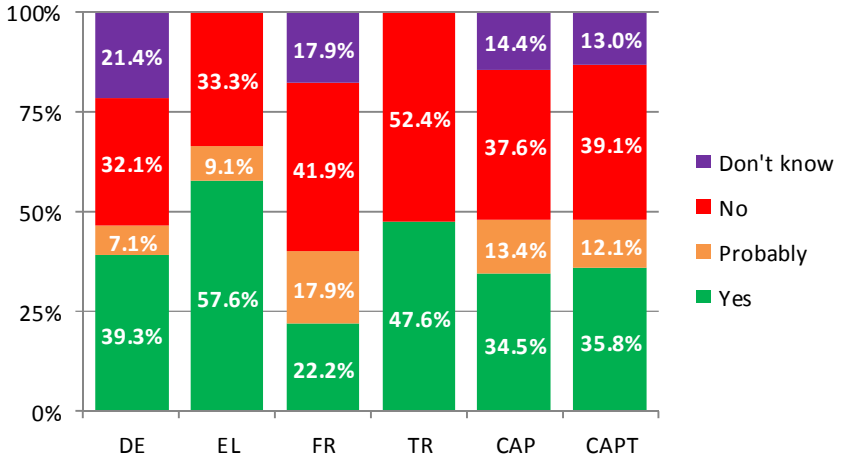
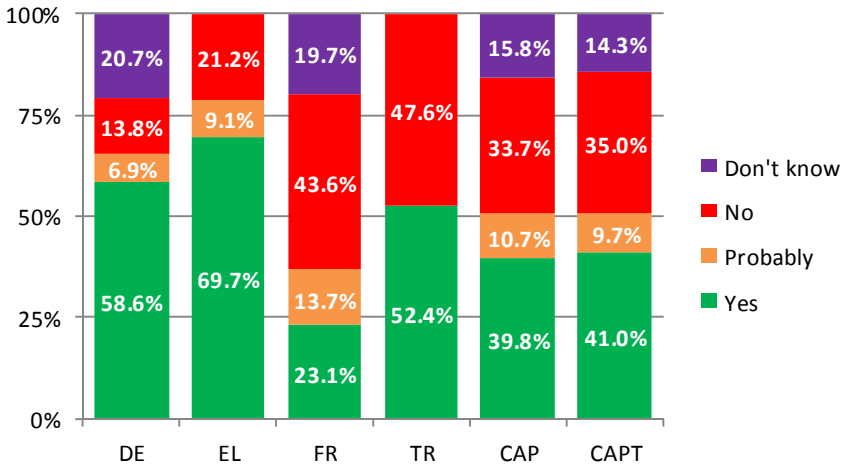


Figure 10. Pertussis vaccination coverage rate among children.



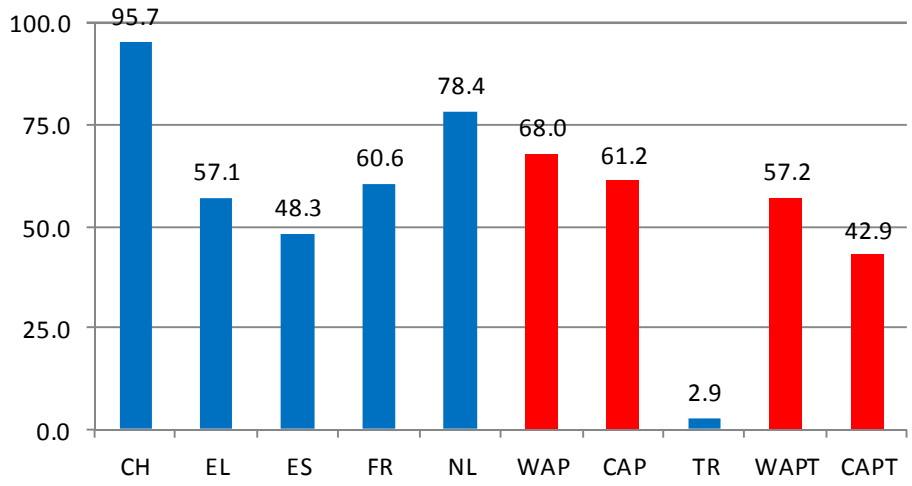
[104] The French Public High Council for Public Health (HCSP) recommends that "*all children or adolescents aged 16 or under, who have not previously been vaccinated, should be offered immunisation against hepatitis B when going for a medical consultation or check-up*". (*Vaccination calendar 2013*. Paris, 2013, p. 14.)

[105] Fonteneau L, Guthman JP, Levy Bruhl D. *Estimation des couvertures vaccinales en secteur libéral à travers l'échantillon généraliste des bénéficiaires en France – 2004-2009*. Saint-Maurice: InVS, Août 2010.

Knowledge of where to go for vaccinations

The persons asked about vaccination for their children were also asked whether they knew where to go for vaccinations: 61.2% did know where to go to get their child vaccinated in the five European countries where the question was asked**. It means that 38.8% of patients did not know where to go to have their children vaccinated. In Istanbul, almost nobody knew where to go to have their child vaccinated.**

Figure 11. Knowledge of where to go for vaccinations (for minors).



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. ñ*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.*ò 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 ï Tenerife ï 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[106].

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[107].

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

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 ú45) and the costs of the vaccines (around ú70 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 havenôt 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 ï often in the same cell as adults.

Netherlands

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

Spain

Article 3*ter*, al. 4 of Law 16/2003 (added by Article 1 of Royal Decree-Law 16/2012)[108] provides that ñ*in any case, foreigners who are less than 18 years old receive healthcare under the same conditions as Spanish citizens***ò**. This provision states clearly that all minors in Spain, whatever 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

[107] 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

[108] Royal Decree-Act 16/2012.

undocumented EU citizens can access vaccination ï 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 ú80 per month), so children have access to vaccinations; or they cannot pay the contributions so they have to pay all doctorôs fees. Childrenôs 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 ó*citizen number*ô. The children of undocumented migrants have no access to prevention or care. Those born in Turkey may have access to vaccination at a family health centre but they need to be registered in the civil registry. Otherwise, each vaccine costs around ú18, added to the ú43 medical consultation costs.
Unaccompanied minors waiting for a decision on international protection can access healthcare, those who are rejected cannot.

United Kingdom

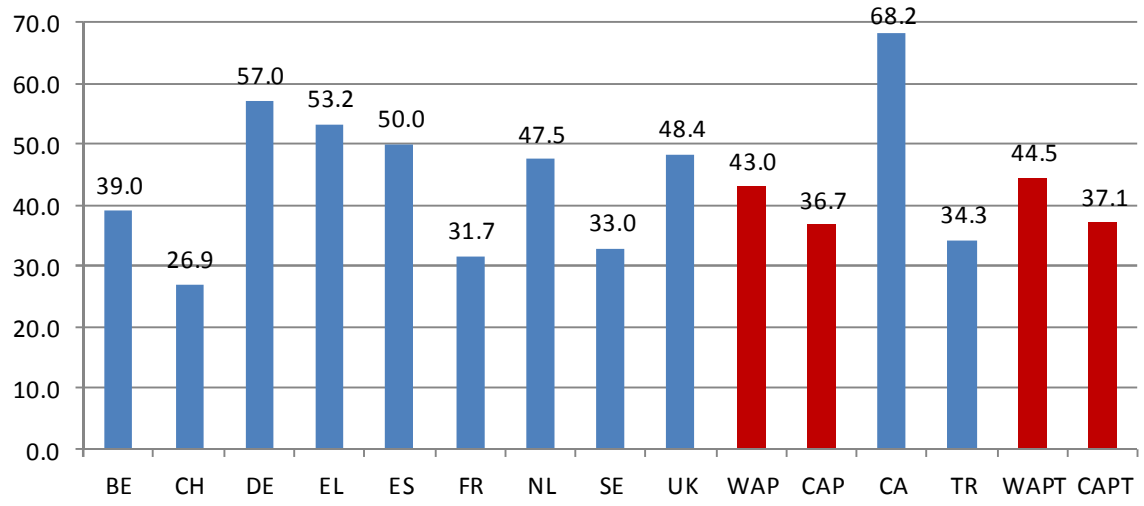
The children of undocumented migrants have the same entitlement to care as adults. They can register with a GP and receive free vaccinations but they will be charged for secondary healthcare. In practice, children are only accepted in GP practices if at least one of their parents is already registered. Unaccompanied minors seeking asylum or with refugee status enter local authority care, meaning that, like asylum seekers, they are exempt from all charges.

Demographic characteristics

Sex and age

In total, 43% of the patients seen in Europe were women. Only French, Swiss and Swedish sites encountered less than a third of women among the patients. In Germany, MdM offers women clinics twice a month. In Spain, the MdM teams are mobilised on gender equality and have a proactive approach towards women. In Greece, many sites received Greek citizens and, among them, more women than men. The proportion of women was particularly high in Montreal.

Figure 12. Proportion of women by country surveyed.



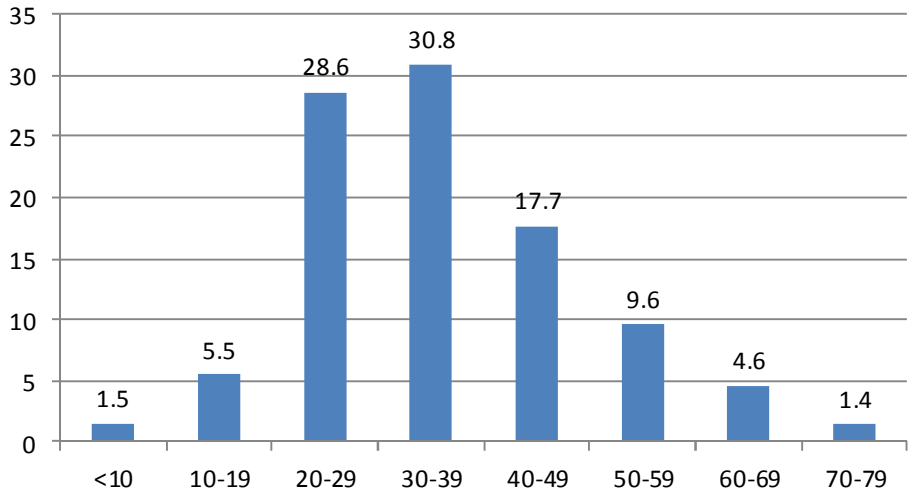
The average age of the patients seen by MdM in Europe was 35.8 (median = 35, slightly older than last year when the median age was 32). Half of the patients were between 25 and 46.

Overall, 652 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). No minor was seen in Sweden. The clinics in Spain, Netherlands, UK, Canada and Turkey nearly didnôt see any minor (less than 4% of the patients seen); 5% of patients were minor in Belgium and France, 10% in Switzerland and 14% in Greece.

Table 10. Age distribution of patients: mean, median, country interquartile range, years.

	Mean	*Minimum*	*Lower quartile*	*Median*	*Higher quartile*	*Maximum*
BE	35.0	0.0	27.0	34.0	44.0	83.0
CH	29.6	0.0	21.8	29.0	37.0	76.0
DE	37.3	0.0	24.0	36.0	52.0	96.0
EL	34.9	0.0	15.5	36.0	55.0	83.0
ES	38.6	17.0	28.0	36.0	48.0	89.0
FR	34.0	0.0	26.0	32.0	41.0	86.0
NL	38.2	1.0	29.0	36.0	45.0	64.0
SE	35.5	18.0	28.0	35.0	44.0	58.0
UK	38.7	0.0	29.0	37.0	47.0	85.0
Total 9 European countries	35.8	4.0	25.0	35.0	46.0	80.0
CA	39.9	0.0	30.0	37.0	50.8	83.0
TR	30.8	0.0	26.0	31.0	36.0	69.0

Figure 13. Population distribution per age group (%) in the 11 countries.



Box 7. Governments failing to protect unaccompanied minors

An increasing number of unaccompanied minors

While there is no comprehensive data on the total number of unaccompanied children[109] present in Europe or arriving each year, significant numbers of unaccompanied minors arrived in Europe since 2008 (the most reliable statistics are those related to unaccompanied children who applied for asylum)[110].

Although unaccompanied children are of various nationalities depending on the host country, Afghans still represent a large portion of the total number of unaccompanied children arriving in Europe (other main countries of origin included Algeria, Syria, Morocco and Somalia)[111].

In France, the number of unaccompanied migrant minors also increased, with the majority converging towards the Parisian area (Paris and Saint-Denis)[112]. Indeed the number of unaccompanied minors visiting MdM in and around Paris tripled in 2014 (average age of 16.5, with a majority coming from sub-Saharan Africa). Most children did not have any healthcare coverage and half were 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[113].

Countries do not meet their commitment to protect unaccompanied children

Although the special needs and particular vulnerability of unaccompanied children have been recurrently reaffirmed by various European and UN bodies[114], Governments often fail to fulfil their responsibilities to protect

[109] The EU definition (e.g. Qualification Directive) refers to a minor (a third-country national or a stateless person below the age of 18 years) who arrives on the territory of the Member States unaccompanied by an adult responsible for him or her whether by law or by the practice of the Member State concerned, and for as long as he or she is not effectively taken into the care of such a person. It includes a minor who is left unaccompanied after he or she has entered the territory of the Member States.

[110] European Council on Refugees and Exiles. *Right to Justice: Quality Legal Assistance for Unaccompanied Children. Comparative report*. Brussels: ECRE, 2014.
Collective. *Safe and Sound: What States can do to ensure respect for the best interests of unaccompanied and separated children in Europe*. Geneva: UNHCR & UNICEF, 2014.
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, juillet 2014.

[111] European Council on Refugees and Exiles. Op.cit.

[112] Carsin C, Emmanuelli J, Crosnier M, Pautrat C, Messias B, Debart MH, Planté S. Op.cit.

[113] Information provided by the MdM Delegation Ile de France.

[114] The protection of all children's rights has been repeatedly reaffirmed in various reference documents of the European Union (the Treaty of Lisbon). The special needs and particular vulnerability of unaccompanied children

unaccompanied minors. Gaps are reported in the infrastructure and services as well as obstacles in the effective access of adequate support including accommodation, education, health and legal assistance[115].

Bone age testing (x ray) is widely practiced to exclude minors from access to protection, thus supposedly making them adults. These tests are against medical ethics as they have no health indication. Furthermore their validity has never been proved[116]. The Royal College of Pediatricians estimates the margin of error can sometimes be as much as 5 years either side[117]. On this matter, the European Parliament deplored in a resolution in 2013 ñthe unsuitable and intrusive nature of the medical techniques used for age assessment in some Member States, which may cause trauma, and the controversial nature and large margins of error of some of the methods based on bone maturity or dental mineralization [é]ò, before recalling ñ*that age assessment must be conducted with due respect for the childôs rights and physical integrity, and for human dignity, and that minors should always be given the benefit of the doubtò and ñthat medical examinations should only be conducted when other age assessment methods have been exhausted and that it should be possible to appeal against the results of this assessment*[é]ò[118]. The Parliamentary Assembly of the Council of Europe also recently reconfirmed that ñthere is no legal instrument, or even consensus, with regard to procedures for assessing a personôs ageò and stresses the need to apply the benefit of the doubt, bearing in mind the higher interest of the child[119].

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 yearôs report.

- mentioned, among others, in the EU Agenda for the Rights of the Child - were reaffirmed in a recent Resolution of the European Parliament on Unaccompanied Children.

[115] UNHCR & UNICEF. Op. cit.

[116] On the question of bone age tests as a tool to estimate minors' age:
Pruvost MO, Boraud C, Chariot P. Skeletal age determination in adolescents involved in judicial procedures: from evidence-based principles to medical practice. *J Med Ethics* 2010; 36:71-4.
Focardi M, Pinchi V, De Luca F, Norelli GA. Age estimation for forensic purposes in Italy: ethical issues. *Int J Legal Med* 2014; 128: 515-22.
Chariot P, Caussinus H. Age estimation in undocumented migrant adolescents: medical response to judicial authorities. *Presse Med* 2015; 44: 99-100.

[117] Royal College of Paediatrics and Child Health. *The Health of Refugee Children - Guidelines for Paediatricians.* London: November 1999.

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

[119] PACE Resolution 1996 (2014). Migrant children: what rights at 18?

Nationality and geographical origin

Remarks on methodology

According to the United Nations definition, an immigrant is a person born in a country other than the one in which s/he resides (this therefore includes foreign-born nationals, i.e. with the nationality of the country where they currently reside). Foreign or immigrant populations should not therefore be confused: a foreigner can be born in the country where he resides, an immigrant may have been naturalised. The label of immigrant is a permanent one (an individual continues to belong to the immigrant population, even if he acquires the nationality of the country of residence). The geographic origin of an immigrant is defined by his country of birth and not by his nationality at birth.

In France, according to the definition adopted by the High Council of Integration (HCI), an immigrant is a foreign born foreigner who resides in France. French born people born abroad and living in France are therefore not included (notably, French people born in former French colonies).

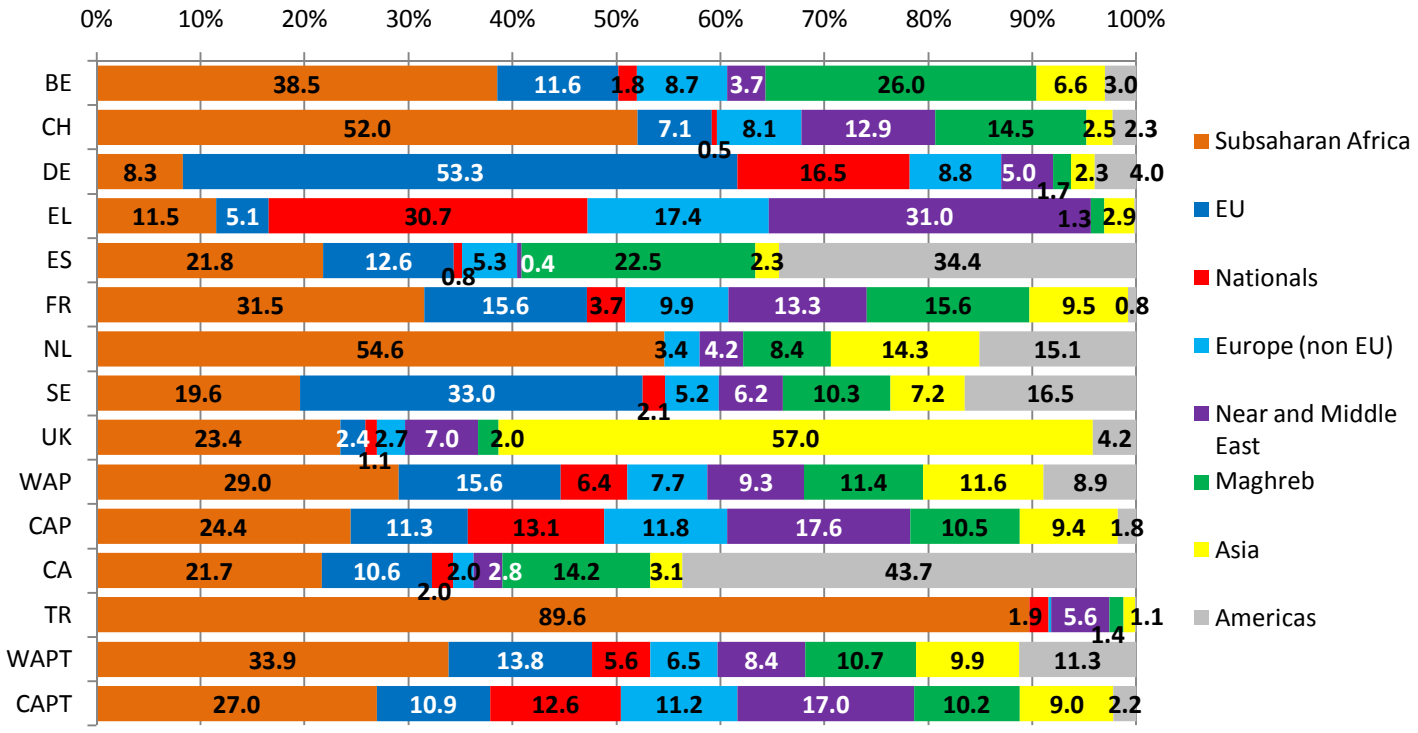
For MdM however, only nationalities at the time of the consultations are recorded.

In Europe, an overwhelming majority of patients seen by MdM programmes in 2014 were foreign nationals (93.6%)[120].

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[121] (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%.

Figure 14. Patientsô geographical origins by country surveyed.

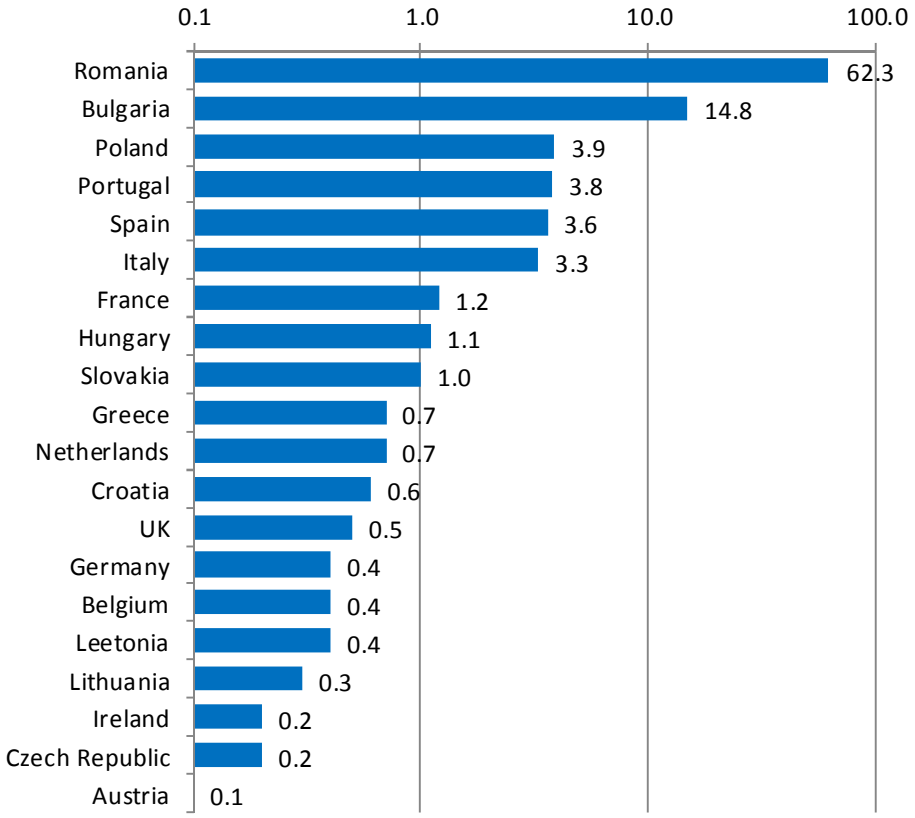


[120] Missing values: respectively 1.5% in BE, 0.3% in CH, 1.1% in DE, 2.2% in EL, 0.0.% in ES, 9.7% in FR, 3.3% in NL, 1.0% in SE, 9.0% in UK, 14.2% in CA and 2.0% in TR.

[121] 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.

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 MdMôs 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.

Figure 15. Frequency of migrant EU citizens (except nationals) seen in European MdM programmes*.



*Also 1 individual (<0. 01%) from Cyprus, Denmark, Estonia, Finland, Malta, Slovenia and Sweden (not represented in the figure)

European averages cover major disparities from one location to another (as in previous years) depending on the migratory routes specific to each of them, themselves related to their own historical context (especially for the former colonial nations) and their geographic location.

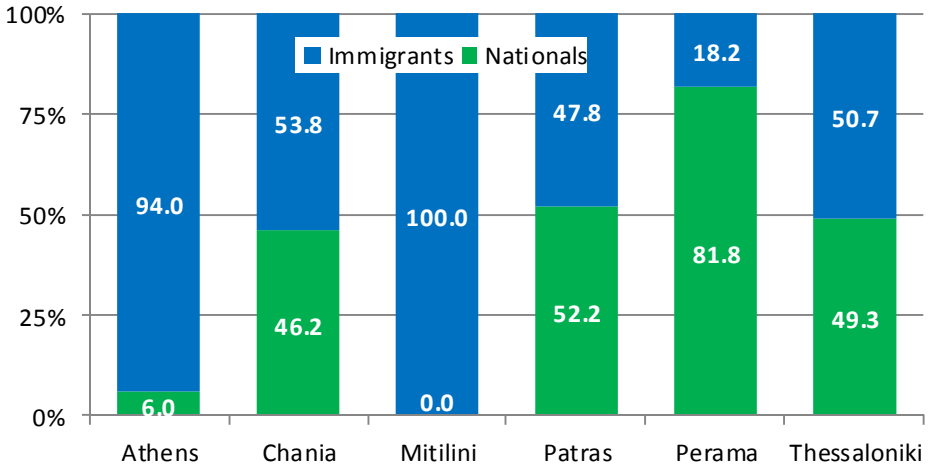
Africa (including the Maghreb) remains the top continent of origin for patients seen in Belgium and France, while this is Asia for patients seen in London (including Philippines, India, Bangladesh, Sri Lanka and Pakistan in Londonôs top 10 nationalities). The following characteristics on service usersô nationalities emerged in the surveyed locations:

- In **France,** the three most common nationalities were Romanian, Pakistani and Ivorian.
- In **Belgium**, most people attending the MdM centres originated from Morocco, the Democratic Republic of Congo and Guinea.
- In the **Netherlands**, there were more Nigerians and Ghanaians than Surinamese people.
- In **Munich**, the largest group were Bulgarians, followed by Germans and Romanians (similar to 2013). In Munich; a 40% increase of the proportion of nationals was observed between 2013 and 2014 (from 11.7% to 16.5%). Two main reasons could explain this increase: MdM was very active in the media and NGO platforms during the recent reform of health coverage in Germany. The Open.med project in Munich became more known among Germans without health insurance or with a debt/administrative problems with their health insurance. More Germans came to MdM for help to reactivate their health

insurance, often needing medical assistance at the same time. It is also possible that the German patients visiting the clinic were those affected by the financial crisis, especially (previously) self-employed, students and pensioners without health insurance.

- **In Sweden**, the most numerous group is from Romania and a third of patients were from EU (33%). The Swedish clinic attends in priority undocumented EU citizens (social and medical care) as they are excluded from subsidized care. However undocumented migrants from non-EU countries are also attended and they are provided information on where to access subsidized care during a social consultation.
- **In Spain**, a majority of patients were from Maghreb (Morocco in the first place), Latin America (34.4%) and Sub-Saharan Africa (21.8%).
- In **Greece**, the largest numbers of patients were Greeks, then Afghan, Albanian and Syrian. The proportion of Greek citizens slightly increased between 2013 and 2014 (from 24.8% to 30.7%) when, at the same time, patients from Near and Middle East decreased from 52.0% in 2013 to 31.0% in 2014. This can be probably explained by the fact that many Syrian asylum seekers could access healthcare rapidly after their arrival, following the reform of asylum procedures. In Perama, a vast majority of patients were Greek, so were half of them in Chania, Patras and Thessaloniki.

Figure 16. Proportion of nationals and migrants in the five Greek centres.



- **In Montreal**, Americans (43.7% including Mexican, Haitian, US and Peruvian citizens) and sub-Saharan Africans (21.7%) were the most numerous but France and USA appeared also in its top ten.

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 hadnôt 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 ï Nice ï October 2014

Table 11. Top ten most frequently recorded nationalities, by country.

BE	**no.**	**CH**	**no.**	**DE**	**no.**	**ES**	**no.**
Morocco	473	Eritrea	93	Bulgaria	156	Morocco	51
Congo DR	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	Surinam	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	Moldavia	277	Ecuador	3	Bangladesh	3
UK	**no.**	**CA**	**no.**	**TR**	**no.**		
Philippines	179	Mexico	33	Senegal	141		
India	164	Haiti	27	Nigeria	115		
Bangladesh	160	Algeria	21	Congo DR	102		
Uganda	130	Cameroon	20	Cameroon	102		
China	115	France	16	Ivory Coast	53		
Nigeria	50	USA	10	Guinea	38		
Vietnam	41	Morocco	9	Uganda	36		
Pakistan	37	Tunisia	6	Gambia	29		
Sri Lanka	33	Peru	6	Afghanistan	24		
Brazil	31	Congo Brazzaville	6	Ghana	20		

Box 8. Immigration in Europe and in the OECD

In 2013, approximately 240 million international migrants were identified around the world, of whom six in ten live in developed countries[122]**.** Based on the total population, international migrants represented around 3.2% of the global population in 2013, compared to 2.9% in 1990. Of these international migrants, only one third moved from a South country to a North country (South-North migration), whilst the other two thirds moved within South countries (South-South migration) or between North countries (North-North migration).[123]

Highlights on migration flows to OECD countries[124]

- There are more than 115 million (im)migrants in OECD countries, about 10% of the population. Migration flows are close to four million annually.
- Data for 2013 suggested that permanent migration flows to the OECD had begun to rebound. This had partially been driven by the large increase recorded in the number of migrants to Germany, driven largely by inflows from central and Eastern Europe and, to some extent, southern Europe, and again in 2013 making it the second most important destination country in the OECD after the United States.
- Other European countries also saw increasing flows in 2012, with inflows to Sweden, Switzerland, France and Finland reaching historical heights although the numbers involved remain relatively low as a percentage of the population in the latter two countries.
- Inflows declined in a number of southern European countries, amid continuing economic uncertainty. In 2012, inflows to Spain fell by 28%, to Italy by 19% (2011/2012) and to Portugal by 12% (2012/2013).
- Meanwhile, the United Kingdom saw inflows stabilize in 2013 to around 30,000 persons, the lowest level recorded since 2003.
- The composition of migration flows also varied sharply, with family migration almost unchanged over 2011, labour migration down 10% (mainly in Italy and Spain, otherwise mainly stable), and intra-EU migration up 12%.
- In 2013, intra-EU migration saw its second year of double-digit increases but this jump largely reflected increases in just a few destination countries, most notably Germany.

In 2014, the Syrian Arab Republic remained the main country of origin of asylum-seekers in industrialized countries. Provisional data indicate that some 149,600 Syrians requested refugee status in 2014 - the highest number recorded by a single group among the industrialized countries since 1992. This number more than doubles the number of 2013 (56,300 claims) and is 17 times more than in 2011 (8,700 claims).

In 2014, the 28 Member States of the EU[125] together accounted for 80% of all new asylum claims submitted in Europe - 570,800 asylum claims in 2014, a 44% increase compared to 2013 (396,700). Germany and Sweden accounted for 30% and 13% of asylum claims in the EU, respectively. The Syrian Arab Republic, Iraq, Afghanistan, Serbia, Kosovo and Eritrea were the five top source countries of asylum-seekers in 2014.

[122] OECD. *International migration outlooks 2013*. Paris: OECD, 2013.

[123] UNDP. *Human Development Report 2013. The Rise of the South: Human Progress in a Diverse World*. New York: UNDP Editions, 2013.

[124] OECD. Is migration really increasing? *Migration Policy Debates*, May 2014.
OECD. *International Migration Outlook 2014*. Paris: OECD, 2014.

[125] UNHCR. *Asylum Trends 2014: Levels and Trends in Industrialized Countries*. Geneva: UNHCR, 2015.

Length of stay by foreign nationals in the survey country

These data are available in seven countries only (including five of the nine European countries), but generally with a low response rate[126]. These results are therefore given for information purposes only.

On average, in the five European countries, foreign citizens had been living in the country for nearly 6.5 years; half of them had been there for between three and eight years. Patients had been living for the longest periods in Spain (8.9 years) and the shortest periods in Istanbul (2.6 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.

Volunteers must be informed of the importance of filling this question in order to be able to advocate again and again on this issue.

Table 12. Distribution of length of stay for non-nationals: mean, median, range and interquartile by country, in years.

	Mean	*Minimum*	*Lower quartile*	*Median*	*Upper quartile*	*Maximum*
CH	5.3	1.0	2.0	3.0	5.2	24.0
DE	6.9	1.0	1.0	3.0	8.2	51.0
ES	8.9	2.0	6.0	8.0	11.0	26.0
NL	8.1	1.0	3.0	5.0	11.5	35.0
UK	6.5	1.0	3.0	6.0	9.0	27.0
Total 5 countries	6.5	1.0	3.0	4.0	8.0	28.0
CA	6.7	1.0	2.8	5.0	7.0	39.0
TR	2.6	1.0	1.0	2.0	3.0	28.0

Reasons for migration

As in previous years, the migrants were asked about their reasons for migrating. Multiple responses were possible.

As in 2013, in the European countries, the reasons most often cited for migration were, overwhelmingly, economic[127] (50.2%), political (19.3% in total, including 8.9% to escape from war) and family reasons (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[128], 3.8% in Canada and 0.9% in Turkey). No significant association was observed between reporting a reason for migration related to health and the length of residence in the host

[126] Missing values: respectively 37.8% in CH, 73.7% in DE, 30.4% in ES, 88.2% in NL, 80.0% in UK, 79.5% in CA and 55.2% in TR.

[127] *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."

[128] 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.

country (both means were around 12 to 14 months, p=0.38); in other words: people declaring having moved for a health reason were not the most recently arrived.

ñ*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.

ñThere is so much we donôt have here, still it is better than Aleppo. But we will not be here long,ò *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?*ò

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

Table 13. Reasons for migration by country.

	CH	DE	EL	ES	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
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	13.5	69.1	49.1	52.5
Political, religious, ethnic, sexual orientation	45.2	5.4	13.3	8.5	26.3	26.3	23.4	21.2	19.3	17.3	28.1	21.5	21.2
To escape from war	58.0	5.4	14.4	3.1	3.5	0.0	4.6	12.7	8.9	3.2	13.3	11.7	9.6
To join or follow someone	14.6	26.9	5.7	13.2	14.9	5.3	12.8	13.3	14.6	41.1	3.3	15.3	13.4
Family conflicts	5.1	3.5	2.7	6.6	12.3	5.3	10.8	6.6	7.8	3.2	2.2	5.7	6.3
To ensure your children' future	0.6	6.4	4.2	4.3	0.9	7.0	3.3	3.8	3.8	3.8	0.0	3.4	2.9
Personal health reasons	0.6	3.5	1.9	5.8	7.0	0.0	2.6	3.1	3.0	3.8	0.9	2.9	2.6
To study	0.0	3.1	0.4	1.9	0.9	3.5	6.1	2.3	3.8	10.8	2.0	3.2	3.8
others	4.5	11.1	9.8	4.7	6.1	10.5	17.9	9.2	12.9	21.6	2.9	9.9	11.1
Total	148.3	133	125.1	118.6	108.7	110.5	121.1	123.6	124.3	118.3	121.8	122.7	123.4
*Missing Data**	*60.3*	*19.4*	*60.8*	*1.5*	*7.3*	*41.8*	*14.7*	*29.4*	*21.8*	*37.5*	*7.8*	*27.9*	*25.7*

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

In **Switzerland**, where a majority of patients are asylum seekers, 45.2% came for political reasons and another 58.0% to escape from war.

In **Canada**, two reasons accounted for the majority of answers: to join or follow someone (41.1%) and to study (10.8%). Political reasons and war were cited by 17.3%.

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 ó*host*ô country. In the Netherlands 7% of the reasons for migration were linked with health although it is very complicated to access care in the country for undocumented migrants, especially if they are EU citizens. Spain follows with 5.8%, where, since 2012 there is no access for undocumented migrants in the mainstream health system. In Germany, where access to healthcare is particularly difficult for people lacking authorization to reside, the rate of

migration for health reasons, although still very low (3.5%), is still the 3rd. **In other words, these figures show once again how access to healthcare is not a pull factor for undocumented migrants**

In **London** also, only 2.6% of people gave health as a reason for migration, demonstrating once again that **the discourse against migrants said to come to take advantage of the British healthcare system is without foundation**.

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

Table 14. 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	

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 ... ñ*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.*ò

MdM France ï Calais ï 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[129] 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, ñ*All Union citizens shall have the right of residence on the territory of another Member State for a period longer than three months if they [é) 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.*ò

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[130], 83.9% of those seen in Belgium, 67.9% of those seen in France[131] and 63.5% of those seen in Spain were in this situation.

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

In Greece, the overwhelming majority of patients have the right to reside in Greece (83%). This is due to the large numbers of Greek and foreign citizens who do not need a permit (37.4%), the number of foreign citizens with permission to reside (20.9%) and asylum seekers (11%).

In Spain, 25.9% of patients were nationals from non-EU countries 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).

[129] 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

[130] In the Netherlands, the programme is specifically geared towards undocumented migrants from outside the EU.

[131] 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.

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).

The highest proportion of patients with a permission to reside (68.0%) was observed in **Montreal**, Switzerland apart. Approximately one patient out of five had a visa (19.1%).

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).

Table 15. Administrative status by country.

	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
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	28.9	61.2	44.7	56.5
EU citizen with no permission to reside[1]	13.4	1.4	29.1	2.7	8.6	8.8	0.0	20.9	0.5	9.5	9.3	0.4	2.0	8.0	8.6
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*	*29.3*	*63.2*	*52.7*	*65.1*
No residence permit requirement (nationals)[2a 2b]	1.8	0.6	17.2	37.4	0.8	5.0	0.0	2.2	1.0	7.3	4.7	2.1	1.8	6.4	4.4
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	3.0	16.0	13.2	12.7
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	23	2.6	8.5	4.3
EU national staying for less than three months	2.4	3.1	18.2	3.8	1.2	2.1	0.0	24.2	1.3	6.3	3.0	5.1	10.6	6.5	3.6
Visas of all types[3]	1.4	0.6	7.6	0.5	2.8	2.8	0.0	2.2	11.8	3.3	3.6	19.1	1.3	4.5	3.8
EU national with permission to reside[4]	2.8	0.3	5.0	2.7	2	1.5	0.0	2.2	0.3	1.9	1.7	0.0	0.1	1.5	1.6
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	0.4	0.1	2.1	1.3
Specific situation conferring right to remain[5]	0.4	0.6	1.8	0.5	1.2	2.0	0.0	0.0	3.3	1.1	1.7	15.3	0.7	2.4	1.9
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*	*68.0*	*33.2*	*47.3*	*34.9*
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	2.6	3.5	2.2	1.4
Total	100	100	100	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*	*20.6*	*4.3*	15.6	24.2

[1] Without adequate financial resources and/or health coverage
[2a] In France, children who are foreign nationals do not require a residence permit and are therefore included in this category
[2b] Or equivalent situation (recent immigrants <90 days)
[3] Tourism, short-stay, student, work
[4] Adequate financial resources and valid healthcare coverage
[5] Including subsidiary/humanitarian protection

Both EU citizens and citizens from non-EU countries were in majority without any permission to reside in the country where they were interviewed (respectively 63.2% and 66.2% had no permission to reside, $p<0.001$).

Table 16. Comparison of administrative status by country between nationals, EU citizens and non EU citizens.

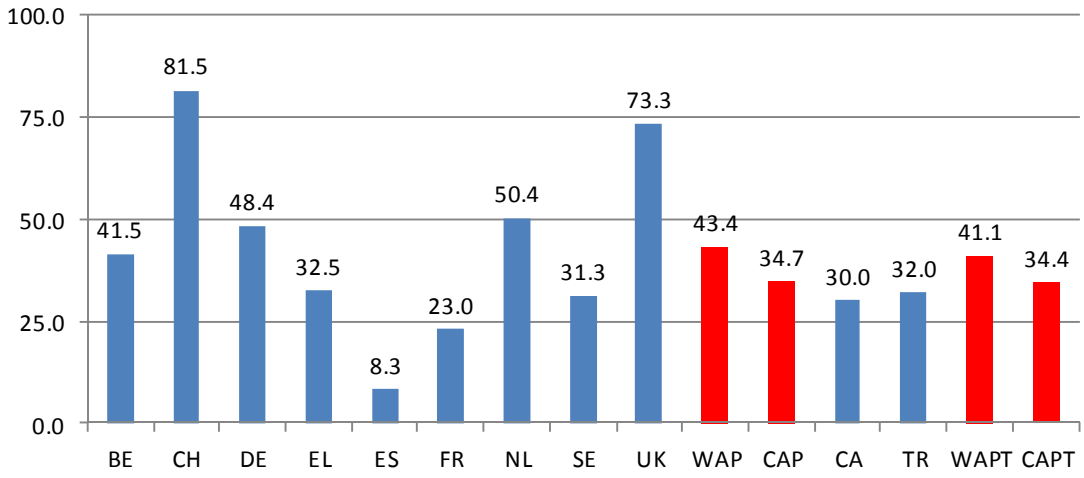
	Nationals (N=531)	EU citizens (N=1197)	Citizens from non-EU countries (N=11605)
Citizen from non-EU countries without permission to reside	-	-	66.2
EU citizen with no permission to reside[1]	-	63.2	-
Total without permission to reside	-	*63.2*	*66.2*
No residence permit requirement[2]	99.0	4.6	5.4
Asylum seeker (application or appeal ongoing)	-	0.3	14.7
Valid residence permit	-	1.1	5.2
EU national staying for less than three months (no residence permit required)[3]	0.7	18.0	-
Visas of all types[4]	-	0.3	4.1
EU national with permission to reside[5]	-	10.4	-
Residence permit from another EU country	-	1.1	1.4
Specific situation conferring right to remain[6]	0.8	0.5	1.8
Total with permission to reside	*99.6*	*36.4*	*32.6*
Donôt know	0.4	0.4	1.2
Total	100.0	100.0	100.0
Missing Data	*0.0*	*7.9*	*0.4*

*Comparing EU citizens and citizens from non-EU countries.

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).** As seen earlier, they were particularly numerous in Switzerland (81.5%) and in London (73.3%). The French programmes were less concerned (23.0%) ï as was the Stockholm programme (31.3%) - and the proportion was very low in Spain (8.3%).

All the proportions with regard to patients seeking asylum (or previously involved in an asylum process) are in the same range than in the previous survey in 2013, except in London where it increased by 40% between 2013 and 2014.

Figure 17. Proportions of patients involved in an asylum application by country.



Only a very small minority of asylum seekers were granted refugee status (between 1.1% and 5.6% depending on whether a CAP or WAP is calculated), **(5.6%) while four out of ten had already been rejected (WAP 39.6%)**. The proportion of those rejected is the highest in Belgium (80.7%), as well as in the Netherlands (60.3%) and in Sweden (63.2%). They are most frequent in Montreal (81.5%).

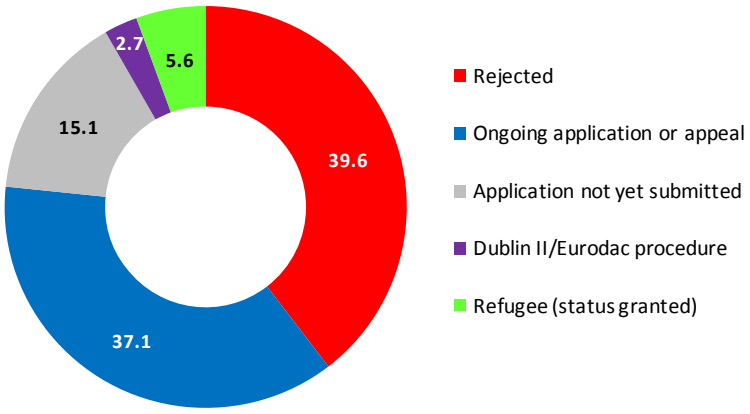
Finally, those affected by the Dublin III/Eurodac regulation[132] **were relatively few (between 1% and 3%)** and their proportions seem to have even decreased in Belgium, France or the Netherlands over the last year. Conversely, **they represented 10.5% of the asylum seekers in Stockholm and 10.3% of them in Germany.**

Table 17. Situations of those concerned by asylum seeking, at the time of their arrival at MdM, by country (%).

	BE (N=609)	CH (N=301)	DE (N=39)	EL (N=37)	ES (N=18)	FR (N=251)	NL (N=56)
Rejected	80.7	19.5	23.1	15.8	38.9	20.2	60.3
Ongoing application or appeal	16.9	79.5	28.2	65.8	33.3	43.5	19.0
Application not yet submitted	0.5	0.0	30.8	10.5	0.0	36.3	15.5
Dublin II/Eurodac procedure	1.0	0.0	10.3	0.0	0.0	0.0	1.7
Refugee (status granted)	1.0	1.0	7.7	7.9	27.8	0.0	3.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Missing Data	*23.5*	*0.7*	*15.2*	*22.4*	*14.3*	*0.2*	*1.7*

	SE (N=19)	UK (N=691)	WAP	CAP	CA (N=63)	TR (N=234)	WAPT	CAPT
Rejected	63.2	34.7	39.6	36.8	81.5	2.1	40	35.2
Ongoing application or appeal	15.8	31.7	37.1	38.4	12.3	49.1	35.9	38.6
Application not yet submitted	10.5	31.6	15.1	23.2	4.6	33.8	15.8	23.6
Dublin II/Eurodac procedure	10.5	0.6	2.7	0.6	0.0	0.0	2.2	0.5
Refugee (status granted)	0.0	1.4	5.6	1.1	1.5	15.0	6.1	2.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Missing Data	*9.5*	*0.8*	*9.8*	*6.2*	*4.4*	*4.9*	*8.9*	*6.7*

Figure 18. Situation for asylum seekers (at 1st visit to MdM) (%) WAP



[132] 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 computerized central database of fingerprint data, as well as the electronic tools for transmission between the Member States and this central database.

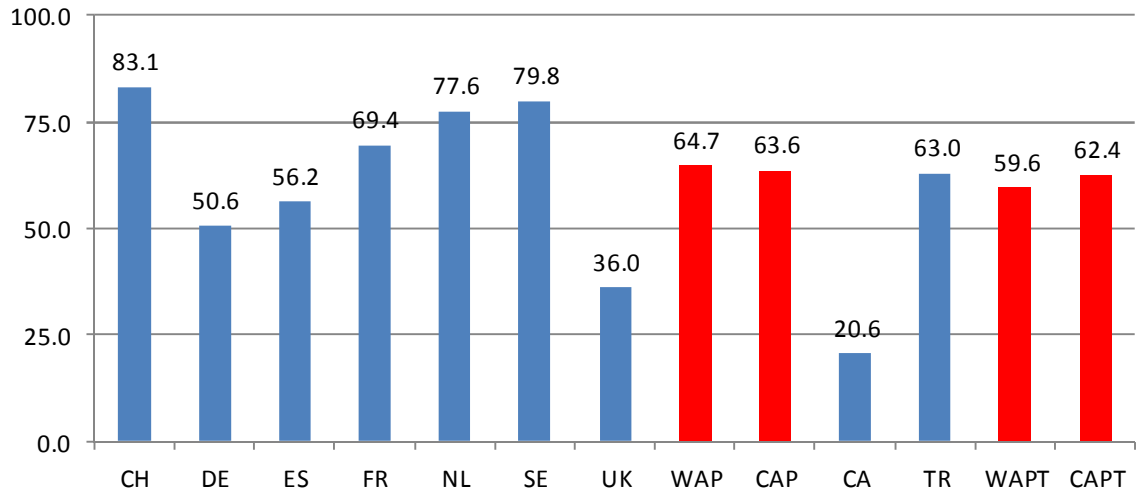
Living conditions

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**[133] (this was particularly common in Switzerland, Sweden and the Netherlands) [134]. This proportion stood at 63.0% in Istanbul and 20.6% in Montreal[135].

Figure 19. Proportion of patients living in unstable or temporary accommodation by country.



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 Montreal 67.7% lived in their own flat or house; in Istanbul this figure was 75.2%. Like in 2013, homeless were extremely rare in Istanbul.

[133] 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.

[134] 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.

[135] Respective response rates at 96.8% and 82.1 %.

Mercy is three months pregnant and lives in a crowded accommodation with her partnerôs family. She had no access to antenatal care prior to visiting the clinic.
Mercy explains to MdM staff: ñ*My visa has already expired. Iôm nearly three months pregnant. I arrived in London in December 2012. I live with my partner, together with his parents and his brother. Itôs so difficult. That houseé no rooms. There are only two small rooms. We stay in the living room. Itôs stressful. My situation now? Things are difficult. Itôs difficult to rent. Itôs very expensive to rent. Our wages are not enough to get our own house which is why we stay in his parentsô house.*ò

MdM United Kingdom ï London ï September 2014.

Table 18. Housing condition by country.

	BE	CH	DE	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Sheltered with family members or friends	34.4	7.4	41.2	39.3	62.6	64.8	37.9	23.0	38.8	48.4	24.3	21.9	35.7	46.0
Own home	50.7	8.5	34.1	35.1	7.7	13.0	20.0	67.1	29.5	25.8	67.7	75.2	37.9	30.2
Accommodation provided for >15 days by an organisation	2.2	83.0	8.8	14.9	5.7	7.4	7.4	1.8	16.4	7.4	4.0	0.2	13.5	6.9
Homeless	11.2	0.8	14.5	5.0	12.3	7.4	20.0	6.5	9.7	11.0	1.2	0.8	8.0	10.0
Camp	0.1	0.0	0.2	0.8	7.9	7.4	14.7	0.1	3.9	4.6	0.0	0.0	3.1	4.2
Squat	1.2	0.3	0.0	1.9	3.8	0.0	0.0	0.2	0.9	2.4	0.4	0.0	0.8	2.2
Working place	0.2	0.0	1.2	3.1	0.0	0.0	0.0	1.3	0.7	0.3	2.4	1.8	1.0	0.5
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Missing data	*4.3*	*10.6*	*3.0*	*0.0*	*33.1*	*12.2*	*3.1*	*8.6*	*9.4*	*21.3*	*15.2*	*2.5*	*9.3*	*21.7*

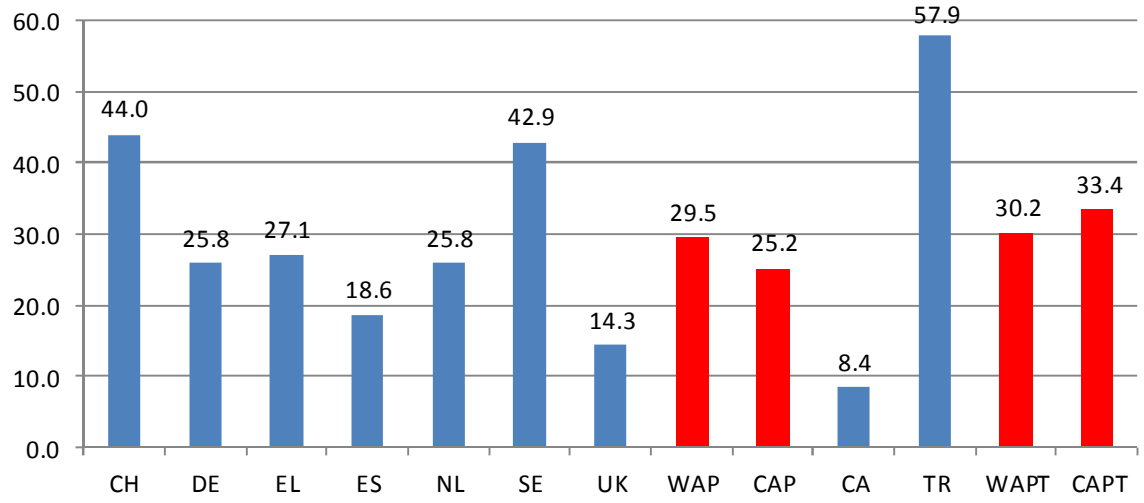
29.5% of those questioned in Europe[136] **deemed their accommodation to be harmful to their health or that of their children.** In Istanbul, this proportion reached 57.9%. In Montreal, only 8.4% described their housing as being harmful to their health[137].

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 MdMôs 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 ï Amsterdam ï November 2014

[136] 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.
[137] Response rate = 95.0% and 74.3% respectively.

Figure 20. Proportion of patients living in accommodation they deem harmful to their health or that of their children, by country.



Emmanuel, a 39 year old man fled from Ivory Coast due to political violence. He arrived in Spain in 2006 where he applied for asylum but was frequently harassed by Spanish police. He arrived in 2010 in the Netherlands. Being undocumented, he cannot get health coverage. He is now living in a squatted garage (the ñrefugee garageò). The garage is damp, cold and dirty. Rats and mice have been reported. The building has a very limited number of toilets. Despite efforts by the occupants, there are continuously pools of water in the building, which create an extra risk of spreading diseases. There are no showers, no warm water and no possibility to wash clothes. Living conditions are already detrimental to health (physical and mental). In addition, there is continuous unrest, tension and there are frequent conflicts and fights between the 130 occupants.

MdM Netherlands ï Amsterdam ï November 2014

Box 9. Living conditions, health and access to health care of homeless families in the Greater Paris area

In 2013, and for the first time in France, a representative epidemiological survey was conducted among homeless families in the Greater Paris area (a region where one of the survey sites - Saint-Denis - is located) by the *Observatoire du Samusocial de Paris*. A random sample of 801 homeless families (among a total population estimated at 10,300) was interviewed in 17 languages by an investigator, a psychologist and a nurse. Half of them were female single-parent families and 94% of the parents were born outside France but were living in France for an average of five years. Half of their children who lived with them were born in France (72% of these families had at least one child born in France and 25% had at least one child who did not live with them, mostly residing abroad) when 46% of adults had no permission to reside in France, 33% had a legal residence status, 12% were asylum seekers and 9% were nationals. The overwhelming majority of the families (90%) were living below the poverty line and more than 20% of them had no income at all. Yet, 38% did not receive any social benefit (up to 65% for the undocumented ones).

Malnutrition was a major problem in homeless families, as demonstrated by the high prevalence of food insecurity (more than 80% of families), anaemia (50% of mothers and 40% of children) and overweight and obesity (more than 30% of mothers were obese and more than 20% of children were overweight). Homeless mothers experience high rates of depressive disorders (30%) and 20% of children had a suspicion of mental health trouble according to the Strength and Difficulties Questionnaire.

Almost a quarter of these homeless families had no contact with social services even if they had been homeless for three years on average. It may be due to the multiple moves from one shelter to another (on average 2.2 times per year, up to 3.8 times during the first two years of homelessness). Fortunately 90% of homeless children were enrolled in school and more than 95% had seen a doctor at least once in the past 12 months and 75% had consulted in a free mother and child clinic (for one child in five, these clinics were their only source of medical care). This proportion is much higher than those observed among the children seen in the French MdM programmes: in 2013, only 40% of MdM children patients in France had consulted in a free mother and child clinic. This is an illustration of the fact that MdM is receiving a population more particularly excluded from usual sources of care.

Source: Guyarvach E, Le Méner E, Vandentorren S. *Enfants et familles sans logement*. Paris: Observatoire du Samusocial de Paris, October 2014.

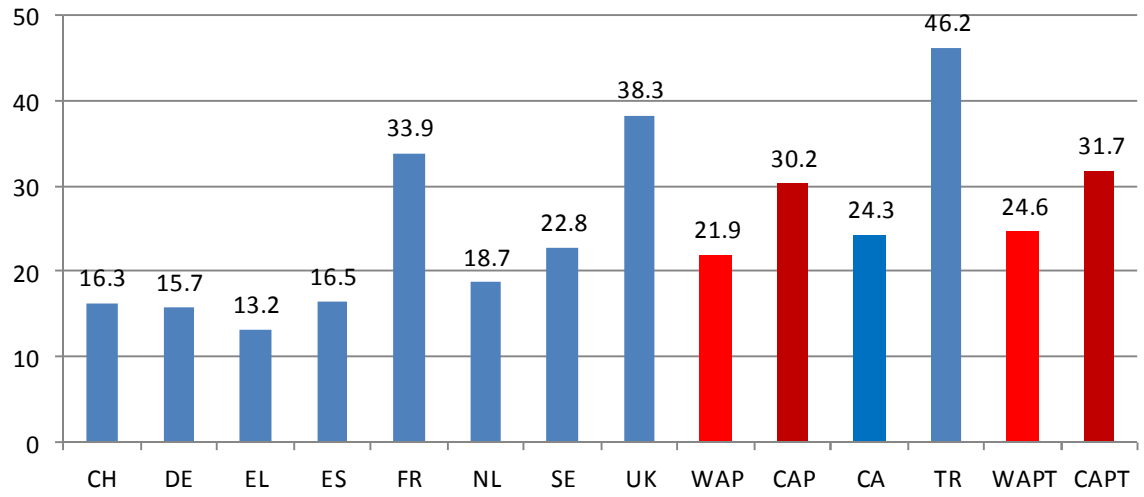
Work and Income

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)[138].

Like last year, this proportion was higher in France (33.9%, where 73% of the patients were seen in Saint-Denis, a close suburb of Paris) and in London (38.3%). In Istanbul, up to 46.2% of the patients reported an economic activity. These highest proportions in the Greater Paris area, in London and in Istanbul may reflect the opportunities to access to the non-declared labour market in big cities (Paris and London being the two most populous World metropolitan cities in Western Europe[139]).

Almost all the people surveyed in the eight European countries (91.3%) were living below the poverty line[140] (on average, over the past three months, taking into account all sources of income[141]).

Figure 21. Proportion of patients with an activity to earn a living by country.



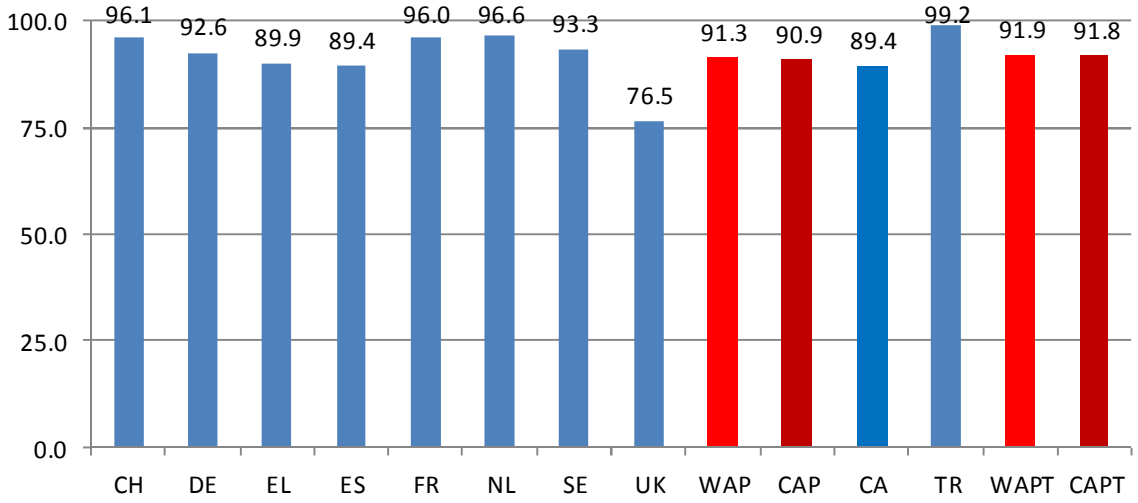
[138] Missing data: 63.5% in CH, 33.1% in DE, 19.7% in El, 11.1% in ES, 50.6% in FR, 45.5% in NL, 12.0% in SE, 56.1% in UK, 4.9% in TR.

[139] Parizot I, Chauvin P, Paugam S, Firdion JM, eds. *Les mégapoles face au défi des nouvelles inégalités : mondialisation, santé, exclusion et rupture sociale*. Paris: Flammarion Médecine-Sciences, 2002.
Rodwin VG, Gusmano MK. The World Cities Project. *J Urban Health* 2013; 79: 445-63.

[140] 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.

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

Figure 22. Proportion of patients living below the poverty line by country.



Karl, aged 40, is from a German minority in Romania: ñ*I came from Romania about one month ago. I used to work there as a security guard. The problem is that they tell you that you will earn ú400 a month, but in reality you do not. I earned only ú180 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. Iôve had bronchitis for a couple of days. Iôve never had this before. I stay in a place with 16 men in one room, and they arenôt very healthy, I think my living situation is now affecting my health.*ò

MdM Germany ï Munich ï December 2014

Social isolation and family situation

When asked about moral support[142], 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 ($p<0.01$).

[142] 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.

Figure 23. Availability of support when needed by country.

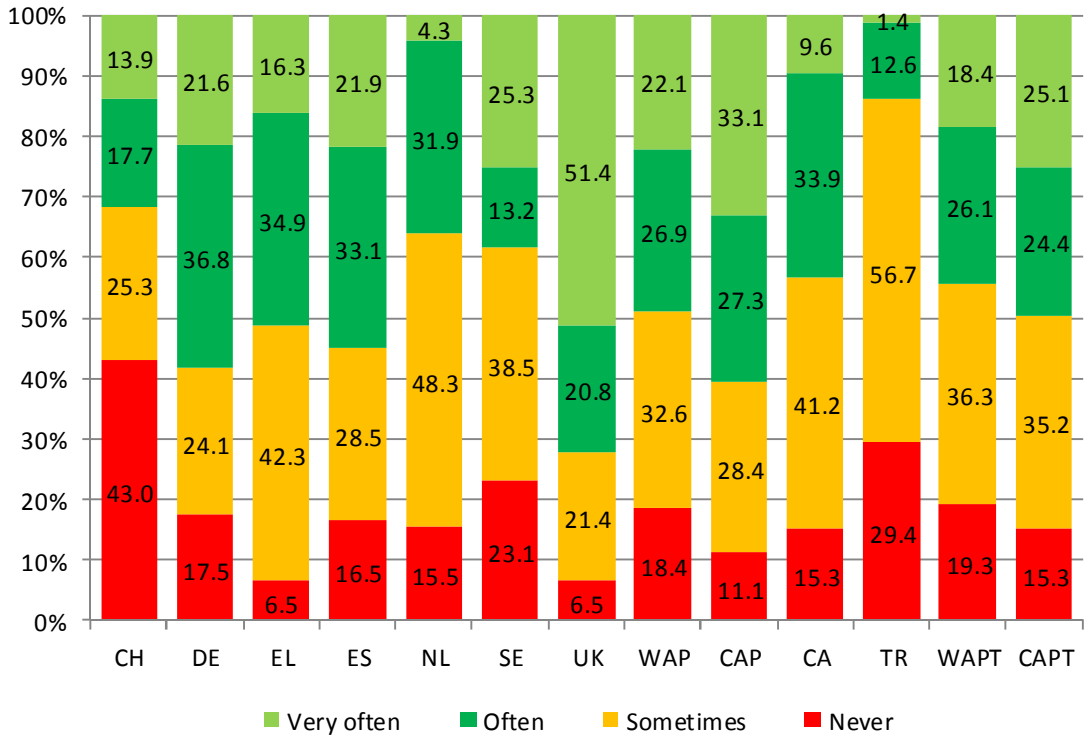
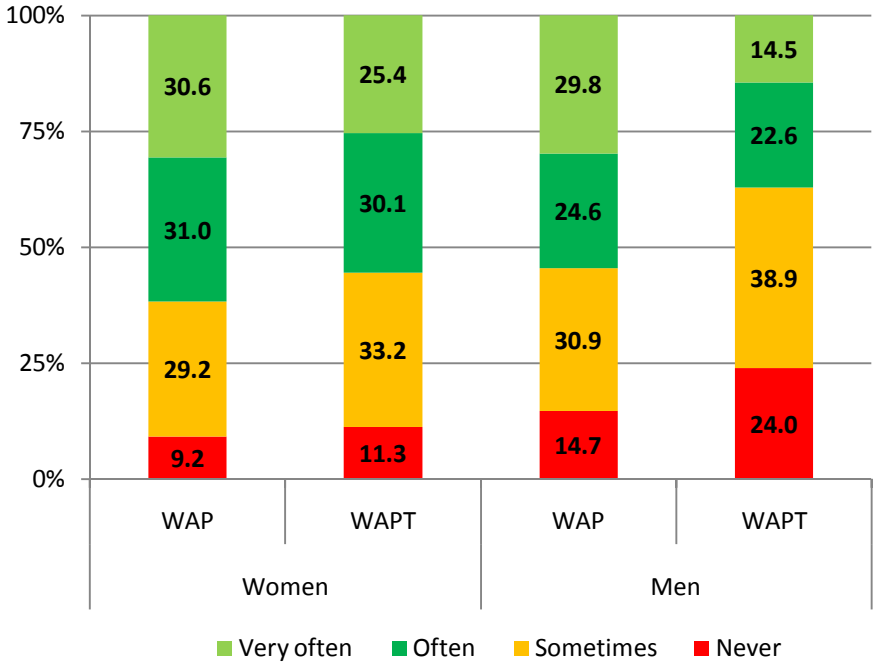
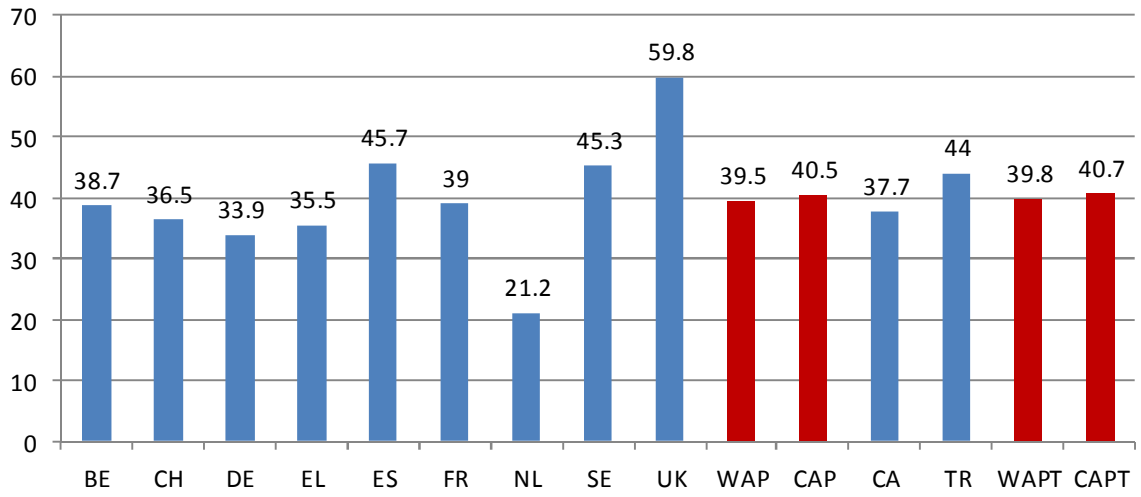


Figure 24. Availability of support when needed by gender.



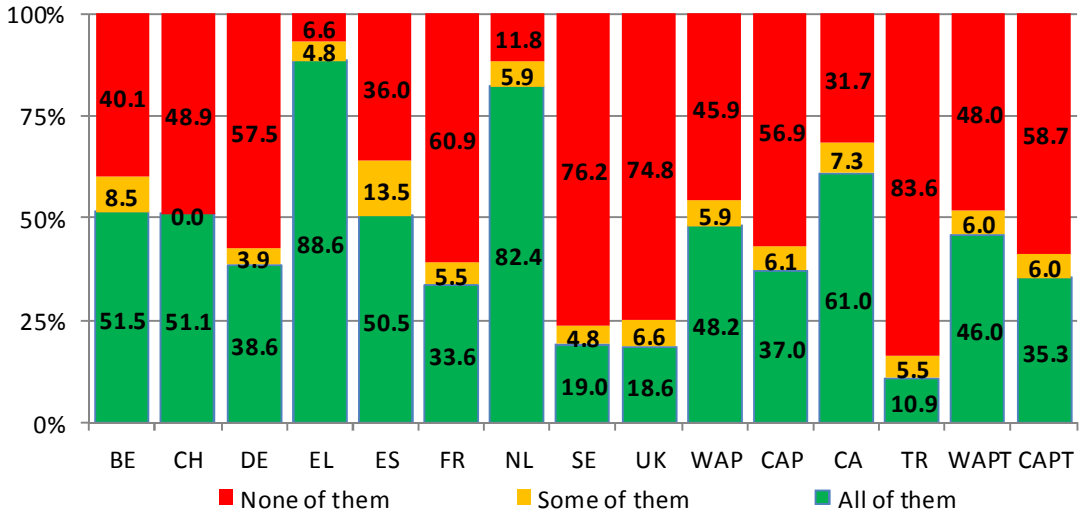
Around 40% of patients had children under 18 years old in the nine European countries (and in the eleven countries as well)[143]. This proportion was the highest in London (but with a lot of missing values).

Figure 25. Proportion of patients having children under 18 years old by country surveyed.



Among them, less than half lived with all their children in the European countries. It was particularly rare in Stockholm, London and Istanbul, but very frequent in Greece ï where numerous patients were Greek citizens, see below ï as well as in the Netherlands. 15% of patients lived with only some of them. As previously mentioned, parents separated from their children **are under considerable emotional strain** which constitutes one more negative determinant of health.

Figure 26. Proportion of patients living with their children by country surveyed.



[143] The proportion of missing values is important for this question in all the countries except in SE (3.1%), Spain (7.3%) and TR (4.8%): 59.3% in BE, 65.3% in CH, 22.1% in DE, 25.7% in EL, 37.4% in FR, 35.0% in NL, 42.5% in London, and 23.0% in CA.

Access to healthcare

Coverage of healthcare charges

Two thirds (62.9%) of patients seen in the MdM European centres had no healthcare coverage[144] when they first came to MdM programmes.

Table 19. Coverage of healthcare charges by country.

	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
No coverage / all charges must be paid	91.9	14.9	0.0	84.9	0.4	92.3	14.0	47.5	82.7	47.6	80.6	90.5	98.7	56.2	82.0
Access to emergency services only	0.0	1.0	73.6	0.2	61.6	0.0	0.0	1.2	0.0	15.3	4.9	0.0	0.0	12.5	4.5
Full healthcare coverage*	5.1	74.9	4.7	5.6	33.7	4.1	3.5	5	4.7	15.7	7.6	9.5	0.1	13.7	7.2
Partial healthcare coverage**	0.3	7.9	3.1	9.1	3.1	2.2	82.5	28.7	0.0	15.2	3.2	0.0	0.8	12.6	3.0
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	0.0	3.2	1.8
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	0.0	0.5	0.3
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	0.0	0.4	0.9	0.9
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	0.0	0.5	0.4
Total	100	100	100	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*	*18.2*	*9.5*	*14.0*	*23.9*

* As much as it exists in the country, meaning that care may still require outï of-pocket payments

** Including those who have to pay 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

[144] The figures were aggregated for people who have no healthcare coverage and those who only have access to emergency care.

do have healthcare coverage are redirected to facilities within the mainstream healthcare system. In theory, undocumented migrants in both countries have relatively favourable conditions of access to healthcare; in practice, however, administrative barriers and the time taken to process files and applications for periodic renewal of access increase the frequency of situations and interim periods where they have no effective healthcare coverage.

Zoe, a 60-year-old Moroccan woman, is undocumented. She lives at her sisterôs home. Zoe visits MdM for a regular consultation and anticipates possible problems due to her age. She explains how difficult it is to stand for hours outside in the cold with many other patients who do not have access to the healthcare system. Nevertheless she doesnôt want to postpone the visit and wait too long until it is too late. Zoe had urgent medical coverage (AMU, specifically for undocumented migrants) for a while, but she had to renew it too often, besides it was hard to get to the CPAS each time. Zoe sums up the absurdity of the situation: ñ*Why donôt they offer at least one-year medical cards? These cards cover only 15 days and, if you are not sick within this period, itôs useless. When you are sick, it is an emergency, while getting the card takes time, what is an emergency for them?*ò Zoe would like to work in order to contribute to her familyôs needs: ñ*It is possible to work undeclared but you canôt contribute to anything. You are nobody when working undeclared. You make a bit of money, but you have no rights to healthcare. I donôt know much about the Belgian system but it is unfair sometimes*ò. 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 ï Brussels ï 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 some undocumented patients being reported to the police at an emergency unit. The team held a meeting with hospital staff from the five Munich Hospitals to inform them about the option not to report undocumented migrants in the case of emergencies ï 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.

Adrian and Izie are twoï 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 couldnôt 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 health 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 ï Perama ï September 2014

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[145], 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[146].

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 ï i.e. by paying a reduced fee for a defined package of care[147] ï 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 Canada and Turkey, the vast majority of those consulting had no coverage at all for their health expenses (90.5% and 98.7% respectively).

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.

Table 20. 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 / 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**	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*	

*Comparing EU citizens and citizens of non-EU countries.
** Including those who have to pay fees to access GPs.

[145] 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).

[146] 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*". See: Estudio Conjunto de Los Defensores del Pueblo. *Las urgencias hospitalarias en el Sistema nacional de salud: derechos y garantías de los pacientes*. Madrid: Defensor de Pueblo, 2015.

[147] 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.

Clara was 17 when she fled West Africa in 2007. She had no document to request asylum and gave up obtaining the refugee status. Although being undocumented, she wants to settle down in Antwerp. But she started feeling sick. Her Flemish teacher contacted MdM as she had pains which were due to a uterine fibroma.
The Public Social Action Centre (CPAS, Centre Public d'Action Sociale) refused to cover the cost of the surgery, as her landlord did not let her use her address. The fibroma had grown very much above the navel: Clara looked like a pregnant woman. When her navel ruptured, she had to be operated but the fibroma was not totally removed. The CPAS refused to cover the surgery, MdM mediated towards the hospital so that they accept not to charge Clara. As the fibroma was still growing, a new request for health coverage was made to cover expenses for a second surgery. Clara eventually managed to find a person who accepted to give the address to the administration. The operation is successful and all required documentation has been gathered: medical certificate, proper domiciliation certificate and a pro-forma of the costs.
However, as described by Greet, physician at MdM ñ*It is appalling that three years have passed between the finding and removal of the fibroma. A time during which Claraôs health visibly deteriorated.*ò

MdM Belgium ï Antwerp ï December 2014

Barriers to access 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[148].

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[149] that they did not even try to seek it.

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

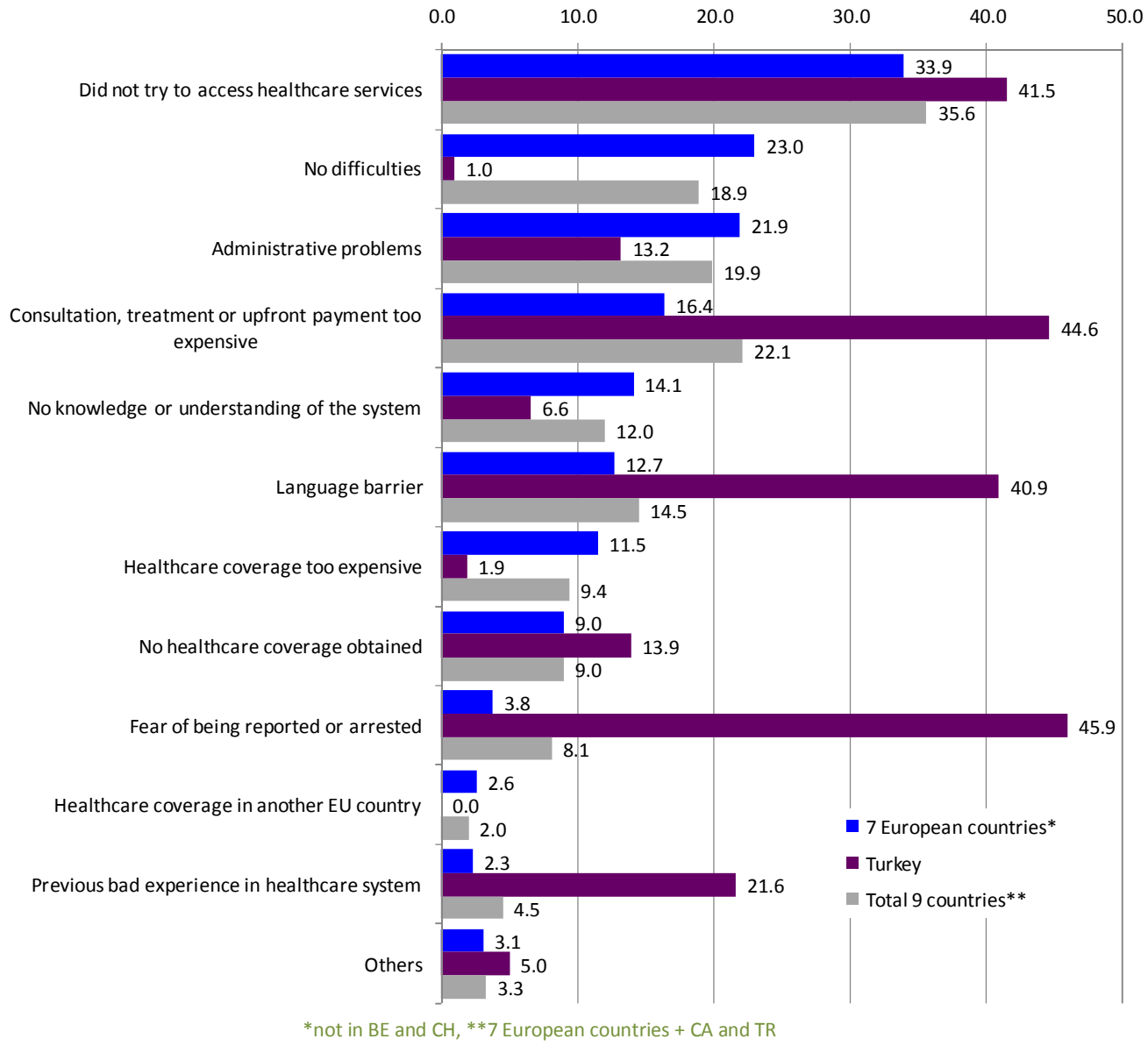
- **financial barriers (27.9%)**, a combination of charges for consultations and treatment, upfront payments and the prohibitive cost of healthcare coverage contributions;
- **administrative problems (21.9%),** including restrictive legislation and difficulties in collecting all the documentation needed 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) or 42.2% (WAP) of the consultations required the assistance of an interpreter ï whether this need was fulfilled (32.1% had an interpreter, in person or on the phone) or not (7.8%). 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 barriers (40.9%) and the fear of being reported or arrested (45.9%). **The proportion of patients reporting a bad previous experience in healthcare system is also particularly high** (21.6% versus 2.3% in 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.

[148] No data in Belgium and Switzerland.

[149] 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.

Figure 27. Rates of barriers to access healthcare in seven European countries, in Turkey and in the total of nine countries.



*not in BE and CH, **7 European countries + CA and TR

Maria is a 39-year-old unemployed Greek nurse. She had healthcare coverage until 2009. Earning about ú400 per month, she has an undeclared job as a care worker for an elderly woman. ñ*My income covers accommodation and food*é *I was pregnant and without healthcare coverage, I could afford neither the costs of required examinations nor the medicines*ò. 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 patientôs 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 ï Chania ï 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 ñthat cannot be deferredò: ñ*I tried to get an appointment for a doctorôs consultation but was given the information that a social security number is needed to book an appointment and that I needed to pay ú185 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 ú5. I then asked the staff if they knew about the new law and they did not.*ò

MdM Sweden ï Stockholm ï October 2014

Table 21. Barriers to access healthcare by country.

	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Did not try to access healthcare services	26.1	35.6	34.3	4.9	42.3	42.0	52.2	33.9	16.2	41.1	41.5	35.6	19.0
No difficulties	19.0	45.4	30.3	5.5	40.5	17.3	2.7	23.0	9.8	8.1	1.0	18.9	9.0
Administrative problems	23.6	3.6	32.3	47.3	9.9	7.4	29.4	21.9	39.4	12.2	13.2	19.9	36.5
Consultation, treatment or upfront payment too expensive	76.2	6.2	1.6	9.9	4.5	14.8	1.8	16.4	13.1	39.6	44.6	22.1	16.3
No knowledge or understanding of the system	20.9	5.2	5.9	37.5	6.3	6.2	16.6	14.1	29.9	3.0	6.6	12.0	27.3
Language barrier	36.9	1.8	3.5	29.4	0.9	2.5	14.2	12.7	24.8	0.5	40.9	14.5	25.6
Healthcare coverage too expensive	53.4	7.0	11.8	0.0	1.8	3.7	2.7	11.5	5.0	2.5	1.9	9.4	4.7
No healthcare coverage obtained	5.4	1.5	14.2	16.9	6.3	8.6	9.8	9.0	14.0	4.1	13.9	9.0	13.7
Fear of being reported or arrested	7.7	0.8	1.2	0.4	2.7	2.5	11.3	3.8	2.5	0.5	45.9	8.1	6.1
Healthcare coverage in another EU country	14.5	0.3	0.0	1.1	0.0	2.5	0.0	2.6	1.8	0.0	0.0	2.0	1.6
Previous bad experience in healthcare system	1.9	2.1	4.7	2.0	0.9	2.5	1.9	2.3	2.0	3.0	21.6	4.5	3.7
Other	6.4	4.9	0.8	1.5	0.0	4.9	3.4	3.1	2.3	3.0	5.0	3.3	2.5
Total	292.0	114.4	140.6	156.4	116.1	114.9	146.0	154.3	160.8	117.6	236.1	159.3	166.0
Missing data	*1.7*	*42.4*	*3.1*	*43.7*	*9.8*	*17.3*	*31.5*	*21.4*	*35.5*	*33.4*	*20.2*	*22.6*	*37.6*

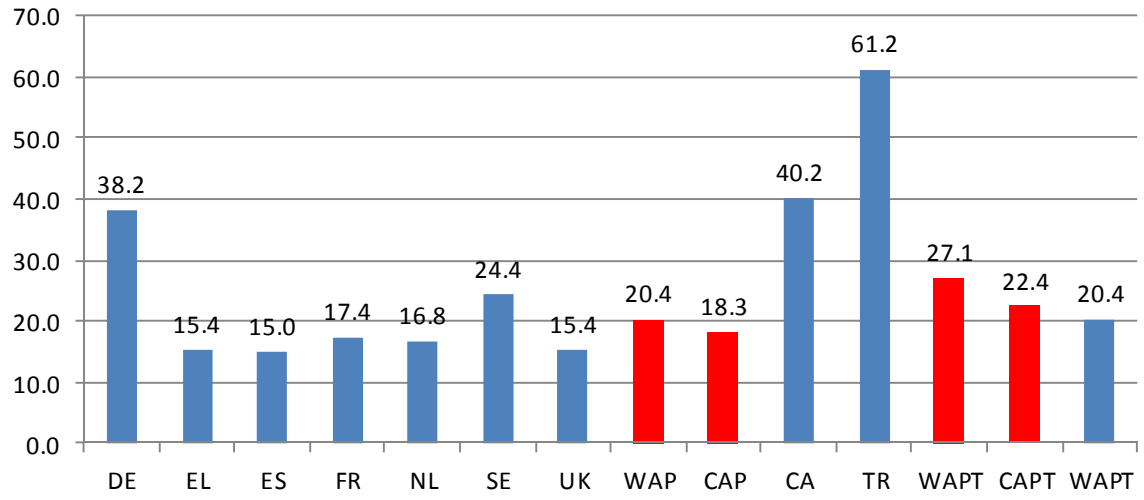
Giving up seeking healthcare

One patient in five (20.4%) said that they had given up trying to access healthcare or medical treatment in the course of the previous 12 months and up to 61.2% reported the same thing in Istanbul.

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, UK and Canada[150]; so, this figure must be taken with great caution.

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[151]. 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.

Figure 28. Proportion of patients that gave up seeking healthcare by country.



Johan, a 74-year-old German man, explains: ñ*When my partner died, I lost the house. I do not have my own place anymore; I sleep at my daughterôs mostly. I didnôt 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 canôt work that much anymore. My children and friends help me out. I havenôt had health insurance for a couple of years now. I tried to make money as long as I could and then paid for my doctorsô visits privately. Sometimes I got tablets from the pharmacy for which you donôt 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*

[150] Missing values: 29.3% in DE, 43.3% in EL, 0.8% in ES, 40.5% in FR, 8.1% in NL, 16.3% in SE, and 65.5% in UK. In CA and in TR, the respective proportions of missing values were 42.9% and 22.4%.

[151] 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.

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 ï Munich ï December 2014

Ana, from Venezuela is 29 and arrived in Spain in September 2013. She came to MdM to understand how she could get the Medical Card for accessing healthcare. She explained that she became pregnant in November 2013 and went to the nearest public health centre. The health centre staff did not provide her with the appropriate information on the care she was entitled to and did not give her the health card for pregnant women. She then changed her registration address in order to access another public health centre where she could eventually get her health card and the medical care she needed.
Although she finally lost her baby, she did not go to the Health Centre to get the required follow up care «*because I was frightened that they would take my health card away*.»

MdM Spain ï Tenerife ï March 2014

Evan's parents moved from Greece to Germany when his mother was eight months pregnant. Evan was born in a hospital in Munich. His father, from Albania, lost his job: «*I did all sorts of jobs, painted houses and drove transport vans; we have nothing in Greece anymore. I need to find a job here now. At the social welfare office they say that my wife should work too, but she just delivered and she can't work yet. I have 5€ left for this week, and we still have to buy diapers and milk for my son*». Evan stays with his mother in a temporary dorm provided by the municipality during winter. They share the room with many other women and children. His father cannot sleep with them; he seeks a place to sleep in a dorm for men. Every three days his parents have to apply again for a warm bed. When his parents brought Evan to the doctor for his first vaccinations, they did not have his vaccination booklet: «*The doctor told us, that we need to bring it at all times, but because of the constant moving from place to place, our stuff got lost*» said his father. The doctor thinks that the unstable living situation affects Evan and therefore he cries more than other babies: «*Normally, this stage takes several weeks, in his case it is much longer*». Evan's father has dental problems for a couple of days, but he has not considered going to a dentist yet *: «We have enough problems already, we've just received a bill from the hospital for the blood examinations they did before the delivery of my wife, and it was already 300€! Imagine, how high the bill for the delivery is going to be?»* MdM DE team anyhow recommended him to go to a dentist in the MdM network and gave him some painkillers. After Evans vaccinations, the doctor advised Evan's mother to go to the gynecologist at MdM since she hadn't seen a doctor since she gave birth. She is happy to have a baby, even in these hard conditions, she had wanted to become a mother for 10 years.

MdM Germany ï Munich ï December 2014

Denial of access to healthcare

Here also, in 2014, proportions were not valid in Belgium and Switzerland (where less than 10% of people were asked this question) and the response rate was particularly low in Greece, France and UK[152]; this figure must therefore be taken with great caution.

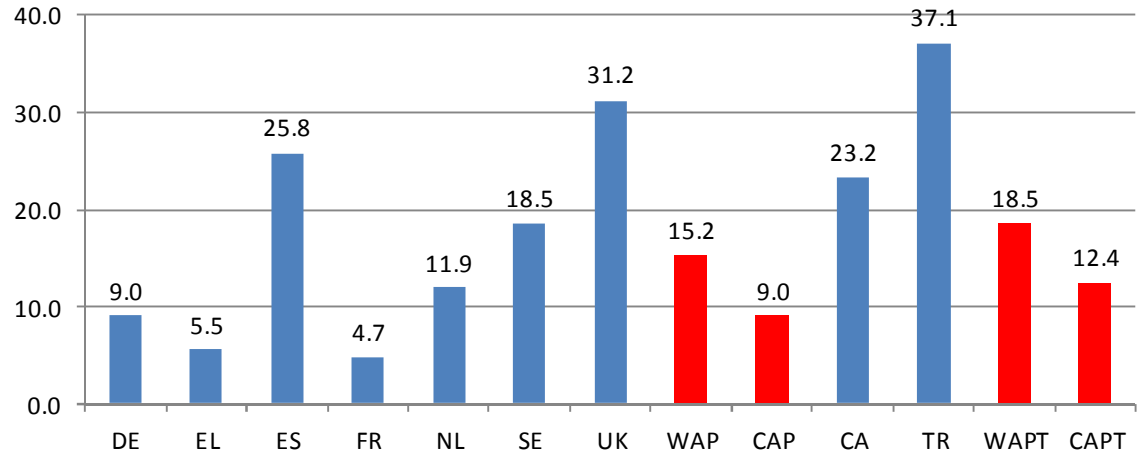
Denial of access to healthcare refers to any behaviour voluntarily adopted by a health professional that results, directly or indirectly, in failure to provide healthcare or medical treatment appropriate to the patient's situation.

Denial of access to healthcare (over the previous 12 months) was reported by 15.2 % of patients seen by MdM in Europe. In Istanbul, 37.1% of the patients experienced this situation and a quarter in Spain.

[152] 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, and 62.0% in UK. In CA and in TR, the respective proportions of missing values were 43.2% and 22.4%

In Spain, the percentage of people being denied access has decreased in 2014 compared to 2013 (around 52% patients had been denied access in 2013). This may be explained by the same reasons as previously described, i.e. the work of MdM teams in Spain in integrating migrants in the mainstream health services since the introduction of the Royal Decree 16/2012[153].

Figure 29. Denial of access to healthcare rate over the past 12 months, by country.



Helena, 37, from Albania, lives in France with her only 13 years old daughter. They are Asylum seekers in a ñpriority processò. In case they need some care they are only entitled to the specific *Urgent and Essential Care Fund* valid only in hospitals. Some hospitals have a department dedicated to ensuring access to care for destitute people without health coverage (Permanences dôAccès aux Soins de Santé, PASS). Helena had a breast cancer that was operated but she started worrying that there might be new symptoms. Mammography and echography confirm she has a nodule; a biopsy is prescribed in a short delay. The Nice University hospital has an agreement with the anticancer centre - the only public referral place in Nice to deliver tests and care for breast cancer. Nevertheless the Center does not consider being compelled to use the Urgent and Essential Care Fund. While Helenaôs case requires an urgent consultation, it took MdM five weeks of negotiations before Helena could finally get an appointment.

MdM France ï Nice ï November 2014

Sofia, a 45-year-old woman from Morocco, was pregnant. Her husband was about to obtain Spanish nationality, but she could not register under her husbandôs 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 couldnôt be attended. After two weeks her pain increased and she went back to the health centre. She was denied care ñ*until her administrative situation gets solved*ò. She went to MdM a week later. With the intervention of MdM, the health centre ñ*solved the case*ò 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 ñshould have been attended to a month earlierò. 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 ï Malaga ï January 2014

[153] This concerns the migrants accessing MdM centres, not all migrants in Spain. MdM Spain provides direct follow up and accompaniment of patients to health centres and hospitals, as well as mediation with health professionals (primary care professionals, administrative staff, etc.).

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 daughterôs 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 daughterôs 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 wifeôs death, Ahmed could not work and take care of his daughter on his own and Sonia was placed in a foster family. Sonia should have the foster familyôs 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.

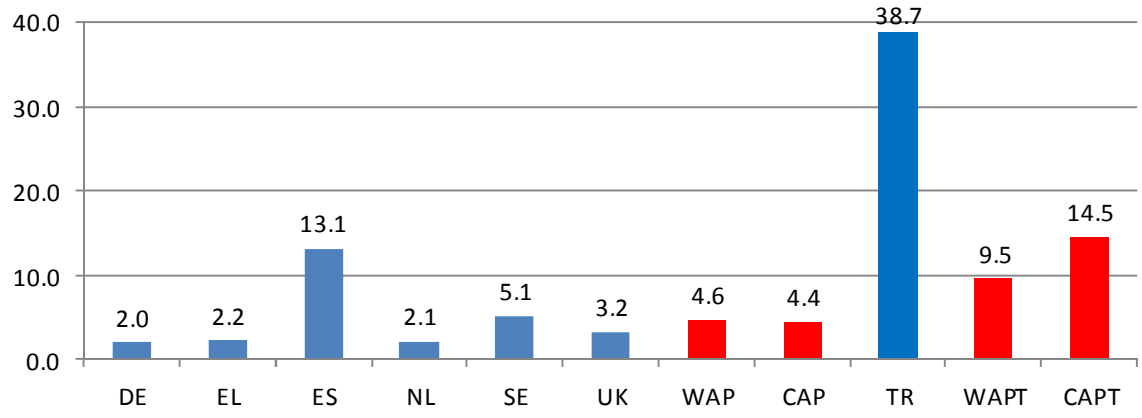
MdM Belgium ï Antwerp ï December 2014

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[154].

This proportion was the highest in Istanbul (38.7% with a response rate of 77.5%). In Montreal, the question asked was not the same: people were asked about discrimination in healthcare services, all types considered. Globally, 21.7% of the patients seen in Montréal reported such experiences.

Figure 30. Proportion of patients who have been victims of racism in a healthcare facility over the past 12 months.



Khaled, aged seven, and his mother Bintou are from Mali. They arrived in France in April 2014. Deaf since birth, Khaled had never received the appropriate medical care in Mali. Growing up without any communication means, he didnôt get understanding of the world around him, Khaled is very anxious and disturbed. Under the State Medical Assistance (Aide Médicale dôEtat) Khaled could be attended by the Ear Nose Throat service of the child hospital.

[154] 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.

During the consultation, the only solution proposed to Bintou and Khaled is to learn the sign language, with the specialist adding that it ñcan certainly be learnt in the country of originò. The specialist urged Bintou to go back to Mali so that her son can be taken care of in a deaf and mute school, and that the family could be together, highlighting that she has ñabandonedò her four children.
Confronted with the lack of understanding of the specialist, Bintou eventually decided to go to another hospital that accepted to provide the required care to Khaled.

MdM France ï Saint Denis ï June 2014

Fear of being arrested

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

Unfortunately, either numbers of respondents were small or proportions of missing values were high, which limits considerably the interest of detailed data by country. Only Spanish, Dutch, English and Turkish data may be considered by themselves. **In Europe, half of the interviewed patients (52.0%) reported such a limitation** (either sometimes, frequently or very frequently). This proportion was particularly high in London[155] (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%).

Table 22. Proportion of undocumented migrants who limited their movement for fear of being arrested, by country.

	DE	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
n	13	134	994	98	19	660			28	359		
	100.0	57.5	27.4	69.4	73.7	83.9	68.7	52.0	67.9	85.0	70.6	57.4
Missing Data	*27.8*	*3.6*	*50.3*	*14.0*	*20.8*	*5.8*	*20.4*	*31.7*	*22.2*	*3.8*	*18.5*	*32.3*

Rafiq, 41-year-old from Bangladesh, explains to MdM staff: ñ*I went to the medical clinic. They asked me about my social security number and I told them that I did not have one, because I am an undocumented migrant. They said that I should go to the emergency care at a hospital so I went there. I had to wait for a long time there and the staff was making a lot of phone calls, so I got scared that they were calling the police. I went home and I do not dare to go back*.ò

MdM Sweden ï Stockholm ï October 2014

In May 2014, MdM UKôs helpline received a call from a man who was worried about his wife. She was pregnant and had been bleeding for the last few days. He thought she might be having a miscarriage. He was too frightened to take her to hospital because she was undocumented and thought they would be arrested. Over the next few days he called a number of times, pleading for help and we continued to encourage him to attend the emergency unit with his wife to get the urgent care she needed. The patient was too frightened to give his name or number so MdM UK staff werenôt able to follow up and never got to know what happened to his wife.

MdM UK - London - 2014

[155] 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

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 ï London ï 2014

Not asking about this aspect of medical history runs the risk of missing psychological problems (depression or post-traumatic stress disorder[156]), and it also entails the risk of misdiagnosis or diagnostic errors when faced with unexplained physical disorders[157]. It can also hinder the detection of sexually transmitted infections due to sexual violence.

A number of studies have shown the importance of identifying previous experiences of violence among migrant populations, taking into account their frequency[158] 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.

The patients met at MdM rarely raised experiences of violence spontaneously during their consultation and there are not always outward signs that lead one to detect it. Conversely, patients are usually quite open, in all studies, to such a line of questioning in the 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[159]). 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[160].

[156] 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.

[157] Weinstein HM, Dnasky L, Lacopino V. Torture and war trauma survivors in primary care practice. *West J Med* 1996; 165: 112-8.

[158] 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.

[159] Bradley F, Smith M, Long J, O'Dowd T. Reported frequency of domestic violence: cross sectional survey of women attending general practice. *Br Med J* 2002; 324: 271.
Chen PH, Rovi S, Washington J, et al. Randomized comparison of three methods to screen for domestic violence in family practice. *Ann Fam Med* 2007; 5: 430-5.
Garcia-Esteve L, Torres A, Navarro P, Ascaso C, Imaz ML, Herreras Z, Valdés M. Validación y comparación de cuatro instrumentos para la detección de la violencia de pareja en el ámbito sanitario. *Med Clin (Barc)* 2011; 137: 390-7
Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation. *Ann Intern Med* 2012; 156: 796-808.
Abrahams N, Devries K, Watts C, Pallitto C, Petzold M, Shamu S, García-Moreno C. Worldwide prevalence of non-partner sexual violence: a systematic review. *Lancet* 2014; 383: 1648-54.

[160] Sprague S, Madden K, Simunovic N, Godin K, Pham NK, Bhandari M, Goslings JC. Barriers to screening for intimate partner violence. *Women Health* 2012; 52: 587-605.

As migrants do form the majority of the people who receive support from the MdM domestic programmes, the impact of MdM services amongst these people and the quality of the healthcare provided are both dependent on taking into account this violence the patients may have faced**.** It is a real opportunity for the patients and an issue of good medical practice (and responsibility). The issue of female genital mutilation can also be cited as women will not speak about it spontaneously, nor would it be identified by a GP unless there was specific focus on it; the same is also true for domestic violence...

It is therefore essential that the teams are sensitized and trained on this screening. They should systematically build networks with organizations dedicated to support victims of violence in order to refer the concerned patients, sometimes including providing specific care. This is not always necessary as **the needed care can often be provided through usual primary healthcare services**.

Hannah is from a Turkish minority from Bulgaria where she married Brian. They left the country to find a job in Belgium. Their three year old daughter Selma goes to preschool. ñ*We cannot find any fix work in Belgium. Occasionally Brian works undeclared for Turkish companies. We rent a room in a Turkish house for 340€/month, we have to pay even when Brian earns no money. It is very stressful. Brian drinks a lot and gets violent. He has beaten me up a lot and threatened to throw me into the streets. I have spent some nights with Selma in a shelter for women victims of violence. Alerted by the neighbours, the police came at home but I have never filed a complaint against Brian*ò. Selma says she loves him and that he is good for her. ñ*I would like that he stops drinking and beating me. He is the only person I know here, I feel totally dependent. I don't feel strong enough for working. Brian says I should be a prostitute if I want to earn money. [é] I feel so frightened that Selma wakes up at night. I feel shameful for our living conditions. I avoid any contact with the women from the Turkish minority of Bulgaria as I can't trust them at all. [é] I have palpitations and thyroid disorder. In the MdM health center I can talk about my problems and find solutions to improve my conditions*ò Hannah learns Flemish and takes sewing lessons to get some work. ñI *feel now a bit relieved, but we have just the money for the rent, not enough for the bills or the medical treatment. I go to food banks. This is how we survive. As I come from a European country the Public Social Action Centre (CPAS) does not cover our medical and pharmacy expenses. But as I left Bulgaria in 2010, I have neither health coverage there nor in Belgium.***ò**

MdM Belgium ï Antwerp ï December 2014

Remarks on methodology

Each medical volunteer is free to speak about experience of violence with each patient, or not. This pragmatic choice obviously severely limits data interpretation. The frequencies reported are in no way representative of the prevalence of violence amongst the patients seen. We cannot dismiss the fact that some volunteers and staff may have chosen whom they asked about this issue. Conversely, some cases undoubtedly escaped the notice of the medical doctor, as questions were not asked systematically.

Many primary health professionals working with migrants are in favour of a systematic questioning of all patients about their history of violence as above-mentioned and we plea for such a systematic approach to be progressively implemented in MdM programmes.

As every year, not all the items related to violence were addressed, which is logical given that we do not recommend asking the questions one by one but instead opening up the discussion on violence with each patient who may have experienced it him/herself or whose relatives and friends may have been affected; this approach encourages them to talk. Of course, this choice precludes a systematic approach and runs the risk of missing previous history that will not be spontaneously recounted. Luckily, this ultimately affects less than 10% of the patients questioned. The type of violence for which we got the most responses is the first one ï *country at war* ï which is also the least ódifficultô item to discuss for the caregiver and the person. Insofar as violence is asked about, sexual assault and rape were discussed as often with men as with women (in nearly 95% of cases), which is a good attitude. In 2014, the line for *subject not discussed during consultation* has been moved from the bottom to the top of the questionnaire as recommended after the analysis of 2013 data. Unfortunately, it had no consequence on the response rate, still very lowé . Doctors seem definitively reluctant to speak about experienced violence.

In 2014, 1,809 patients were interviewed about violence. This means that, despite all the medical justifications for a systematic screening of violence, these issues are 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 1082 men, 10.5%) were questioned on this issue, at any time during their first consultation or follow up.

- Only Spanish and Turkish data came from a large proportion of patients: 76.0% of patients were interviewed about experience of violence in the Spanish sample and patients were quasi systematically interviewed about it in Istanbul (although not on sexual violence).

- In Switzerland, Munich, Greece and London, between 10% and 16% of patients were asked about their history of violence.

- In Belgium, France, and Montreal, patients were rarely questioned[161].

- In Stockholm, the issue of violence was never raised.

Table 23. Proportion and number of patients interviewed about violence by country.

	% interviewed among the total no. of patients	no.	% of the total number of interviewed patients
BE	4.0	95	5.2
CH	11.9	47	2.6
DE	11.8	63	3.5
EL	15.3	117	6.4
ES	76.0	200	11.0
FR	2.2	194	10.7
NL	26.0	32	1.8
UK	16.0	223	12.3
Total 9 UE	6.5	971	53.7
CA	0.3	1	0.0
TR	96.3	837	46.3
Total	11.3	1809	100.0

Malika, aged 29, is from a small village of North Mali. She was washing clothes in the river with other women of her village when she was kidnapped by a group of men. The attackers claimed belonging to the Islamic cause and wanted to teach them how women should behave according to those precepts. During 21 days and nights, Malika was subject to the yoke of her captors. Death was promised to whoever of the young women would try to escape. They finally managed to escape after three weeks, attracting the attention of a pick-up driver carrying passengers who agreed to take them away. The four young women decided to go their own direction. Malika reached Mauritania where she worked for a family for several months, saved money and finally stowed away on a ship to Marseille. She did not know anybody and reached Nice by chance. Malika had never left her country and her family before.
She ends up in a totally unknown land, alone and severely traumatized. She is oriented to the appropriate services that help her for an application for asylum. She is not provided with housing as she is single, major and without any children. Sometimes Malika accesses the night shelter of the Community Centre for Social Action but often there is no room and she has to spend the night outside. MdM provides her medical and psychological care. At night, she seeks refuge near places of entertainment where she feels being less at risk of aggression. When the lights go out she tries to sleep on the beach or in a door corner. The day she wanders from bench to bench in gardens and streets. Night and day she is subject to threats and proposals that put at risk her already fragile existence.

MdM France ï Nice ï June 2014

[161] Globally, the origin of interviewed patients (i.e. the country/programme where they were interviewed) is far more diverse than in 2013 – which is good! Indeed, in 2013, the vast majority of people asked about violence were in Greece and, consequently, almost 80% of cases reported came from patients seen through the Greek programmes. In 2014, half of the victims were interviewed in Istanbul but, within the nine European countries, their countries of interview were quite diverse (see following table).

In 2014, 84.4% of people in the eight European countries who were asked about experiences of violence reported at least one violent experience (83.5% of women and 85.8% of men). Last year, this proportion was 76.3%; the difference does not mean that violence is more frequent because people were not questioned systematically. As long as people are not systematically interviewed, the prevalence estimates among MdM patients cannot be determined.

These types of violence affected both sexes and all ages (on average the victims were 35 years old at the time of the survey, but the youngest was less than one year old). **Asylum seekers,** as might be expected, **were disproportionately highly represented among** victims of violence (CAPT = 57.6% compared with CAPT = 34.4% among all patients, p<0.001).

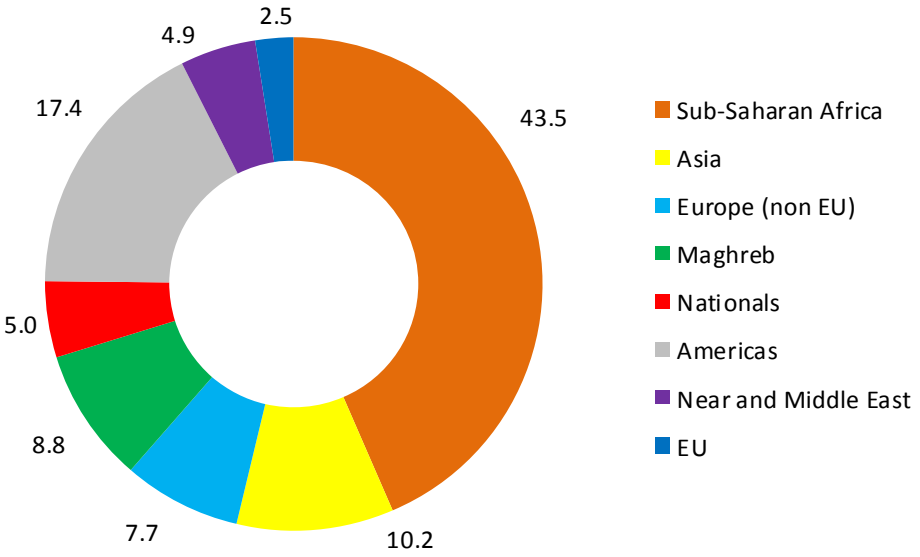
Patients from Sub-Saharan Africa and Latin America were over-represented among the victims of violence but no origin was exempt from violence, including (obviously) EU citizens and nationals.

Table 24. Top 10 nationalities of people interviewed and reporting violence

	No.
Afghanistan	62
Morocco	43
Ivory Cost	43
Uganda	38
Guinea	33
Pakistan	32
Nigeria	31
Cameroon	31
Congo DR	29
Bangladesh	26

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 ***ñ****hidden in the forest****ò***. With other people seeking to make the Strait of Gibraltar crossing, he built a makeshift shelter. He was repeatedly ***ñ****arrested and beaten up by the Moroccan police****ò***. Fadel said that his ***ñ****companions were not coming back after being arrested****ò***.
One day, Fadel was arrested and badly beaten. He was sent to hospital where he was in a coma for a week: ñW*hen I woke up, I couldn****â****t remember anything, only the beatings by the police*ò.
He tried again to cross the Strait and eventually managed to reach Spain, then France in June 2014.
MdM FR ï Saint-Denis ï August 2014

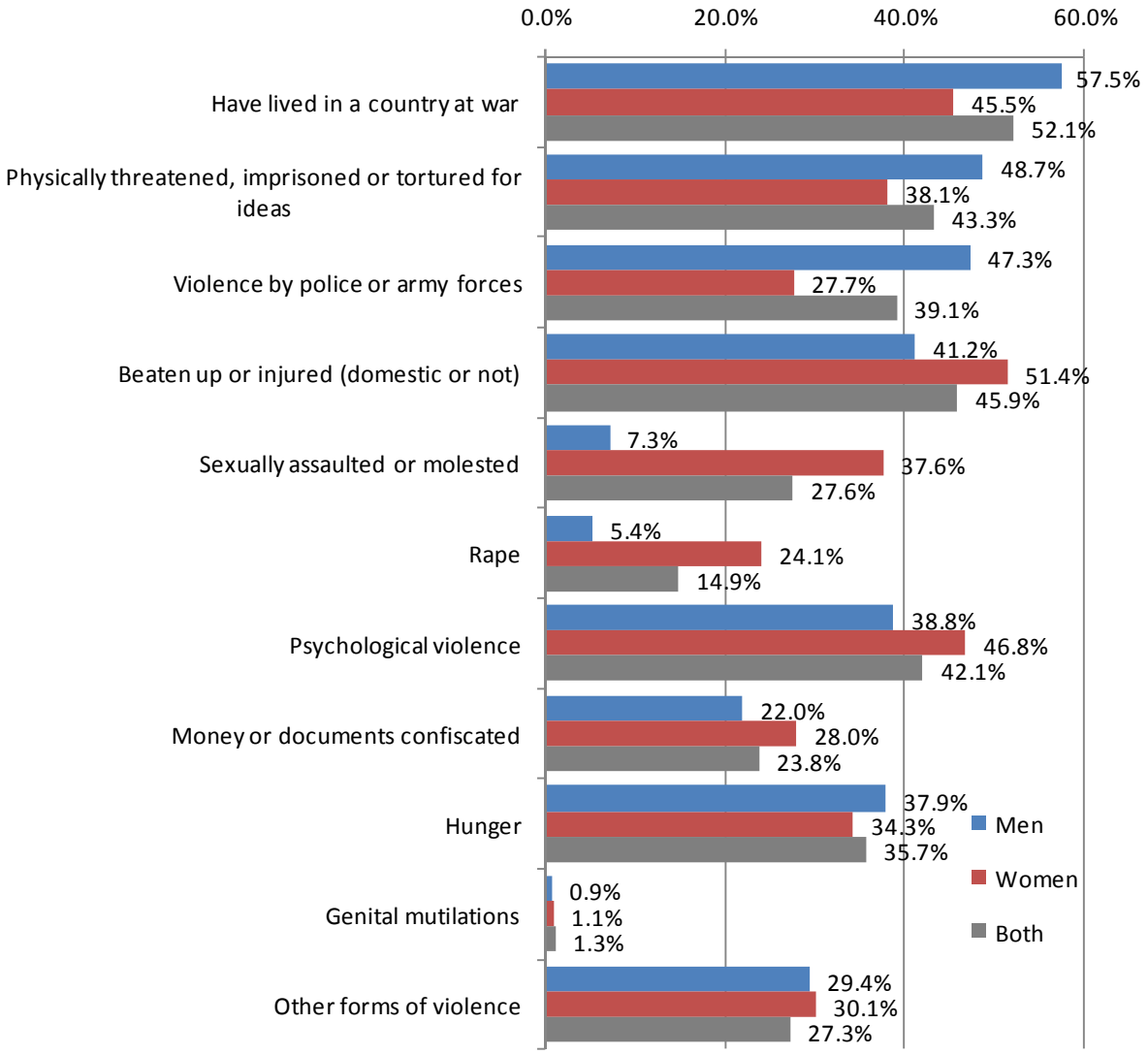
Figure 31. Geographical origins of victims of violence (in the eight European countries surveyed).



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 oneôs 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%).

Figure 32. Rates of violence by gender (among patients interviewed on this subject in eight European countries)



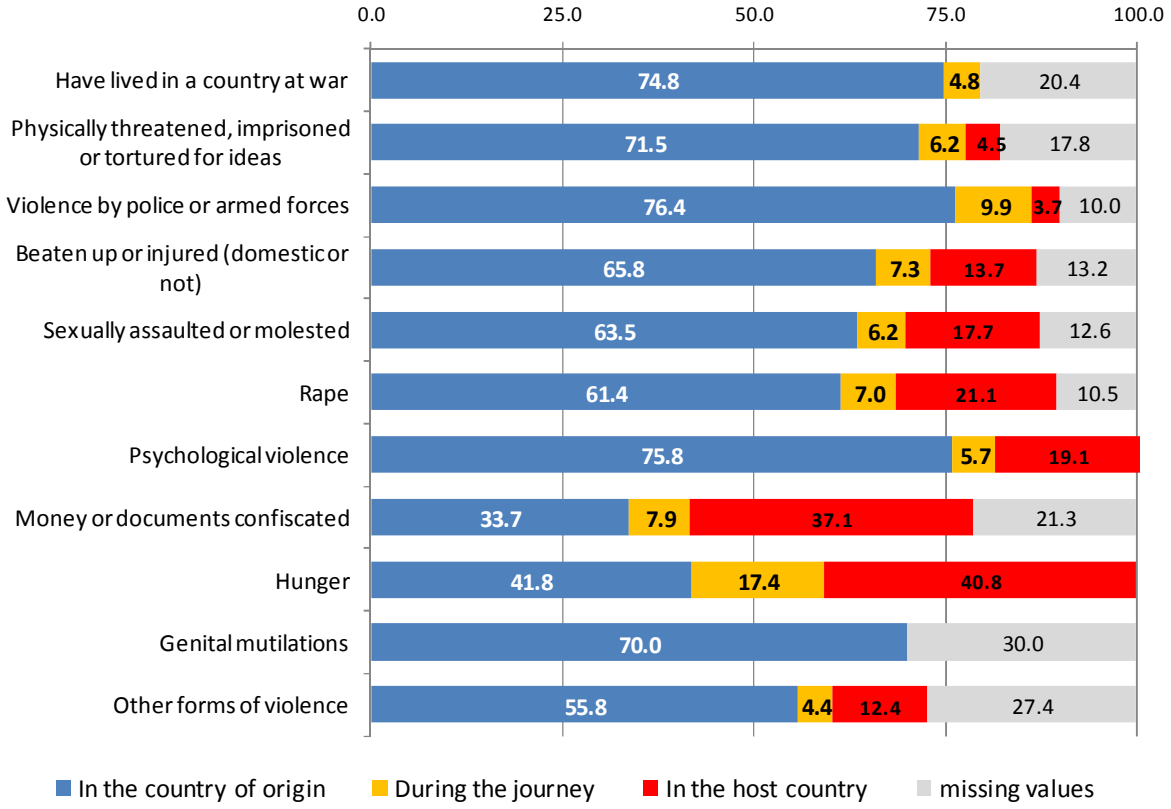
Lecture note: 57.5% of the men interviewed about violence have lived in a country at war when 24.1% of the women interviewed about violence had been raped.

It is not unusual for people to experience violence after having arrived in the countries surveyed. **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 victimôs 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.

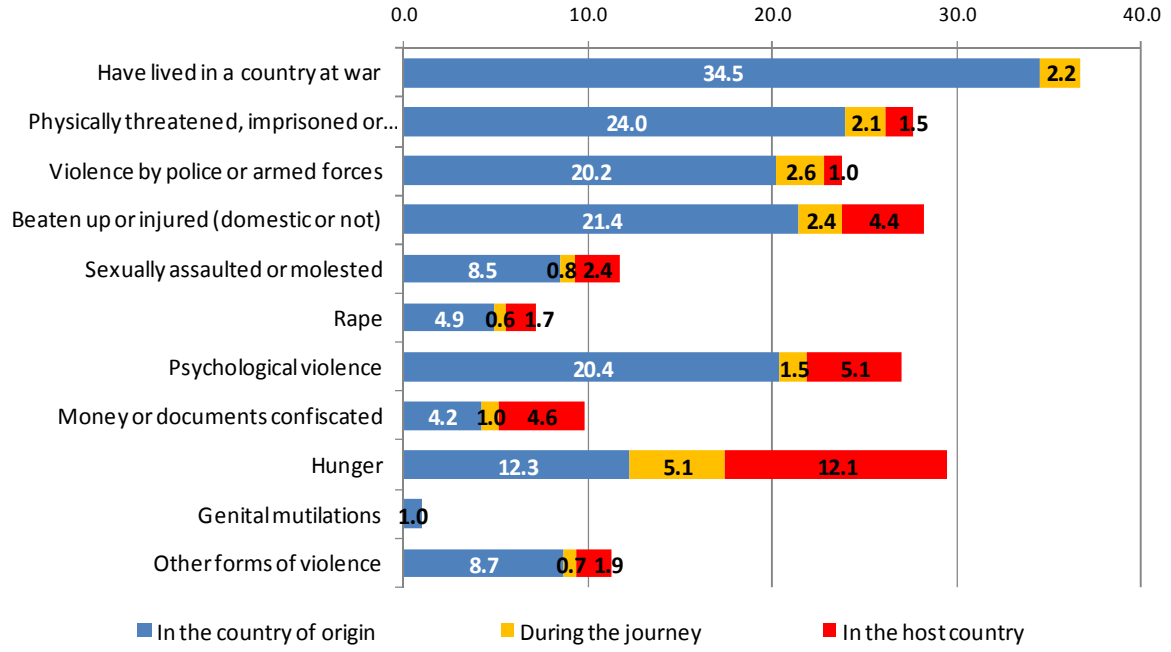
In Istanbul, due to a misunderstanding on the question, the team mostly asked the question on violence that happened in the country of origin. This may explain why only 6.5% of people who were asked about experienced violence reported at least one violent experience (6.0% among men and 7.4% among women, with no rape or sexual aggression reported among women for instance). The team in Turkey has had frequent stories relating sexual violence reported by the patients they saw.

Figure 33. Proportion of violence at different stages of migration in the eight European countries (% of reported episodes)



Lecture note: 61.4%% of the reported histories of rape(s) occurred in the country of origin, 7.0% during the journey and 21.1% in the host country, but another 10.5% were reported without any details about the stage of migration when they occurred.

Figure 34. Frequency of violence at different stages of migration (% of interviewed people in the eight European countries).



Lecture note: 12.3% of people interviewed about violence had specified that they had suffered from hunger in their country of origin, 5.1% during the journey and 12.1% since their arrival in the host country (declaration without details about the stage of migration when violence occurred are not shown here (see Fig. 32 for the total frequency).

Azfar has been living in the Netherlands for years. He has been placed in an immigration detention centre for the past eight months. He was already in detention in 2009. At that time he spent 14 days in an isolation cell where he felt very unsafe and traumatized.

During his current stay in the detention centre he has often been threatened to be placed in an isolation cell. He was put in isolation for 48 hours as result of a dispute with the director of the detention centre about spending extra time outside his cell. After six months of detention, Azfar was told that his application for asylum was rejected. This outcome increased the panic attacks he was already subject to. Azfar asked for a psychologist who suggested that he spends a night in the isolation cell to calm him down. Azfar explained how much heôs scared to be in the isolation cell.

After this, Azfar has had difficulties trusting the psychologist. He explains that many people in detention are affected with psychological problems, resulting in frequent conflicts. Some people cry all day, others are aggressive and demolish their cell.

Azfar is very affected by this environment and is often unable to sleep. He has developed psychological complaints as a result of the migrant detention centre and the lack of perspective. He suffers from fear and panic attacks. He has feelings of aggression towards others and himself and although he controls these emotions, they affect him and he feels unstable. Constant conflicts between guards and detainees, the medical staff and detainees and between detainees create an unsafe atmosphere. He has stopped participating in sports activities to avoid conflicts with fellow detainees. Azfar would like to speak to a person he can trust and who can calm him down and tells him how to do things differently. He wants to control his feelings and thoughts again. In the opinion of Azfar, the detention and the manner in which it is carried out are intended to get people to leave the country. He feels treated like an object and not a person with rights.

MdM Netherlands ï Amsterdam ï May 2014

Table 25. Violence among women by country.

	BE (n=41)	CH (n=20)	DE (n=40)	EL (n=47)	ES (n=98)	NL (n=14)	UK (n=119)	WAP	CAP	TR (n=184)	WAPT	CAPT
Have lived in a country at war (n=133)	37.5	91.7	54.8	27.7	16.8	7.7	27.6	45.5	35.3	7.4	41.2	22.1
Physically threatened, imprisoned or tortured for ideas (n=83)	52.9	66.7	8.7	8.5	4.2	30.8	32.9	38.1	24.5	3.5	34.2	14.3
Violence by police or armed forces (n=53)	37.5	42.9	12.5	4.3	6.3	0	17.9	27.7	16	2.8	24.9	9.4
Beaten up or injured (domestic or not) (n=132)	68.2	81.8	21.7	8.5	25.5	66.7	39.0	51.4	39.6	100.0	0.7	51.2
Sexually assaulted or molested (n=77)	57.1	33.3	14.8	4.3	10.4	50	31.2	37.6	25.7	0.0*	33.5	13.2
Rape (n=48)	61.1	33.3	13	4.3	8.5	23.1	25.3	24.1	17.4	0.0*	21.1	8.6
Psychological violence (n=125)	80	85.7	16.7	14.9	29.9	58.3	41.9	46.8	37	4.9	41.5	21.4
Money or documents confiscated (n=51)	38.5	62.5	4.3	14.9	9.8	45.5	20.3	28	17.5	1.8	24.7	9.3
Hunger (n=81)	64.3	0	13	19.1	20.4	100	50	7.6	34.3	25.1	3.9	30.9
Genital mutilations (n=8)	0	0	0	0	1.1	0	5.4	1.1	2.2	0.0	0.9	0.9
Others (n=54)	57.1	60	20.8	2.2	3.5	100	9.1	30.1	35.4	19.6	0.4	31.5

*not asked

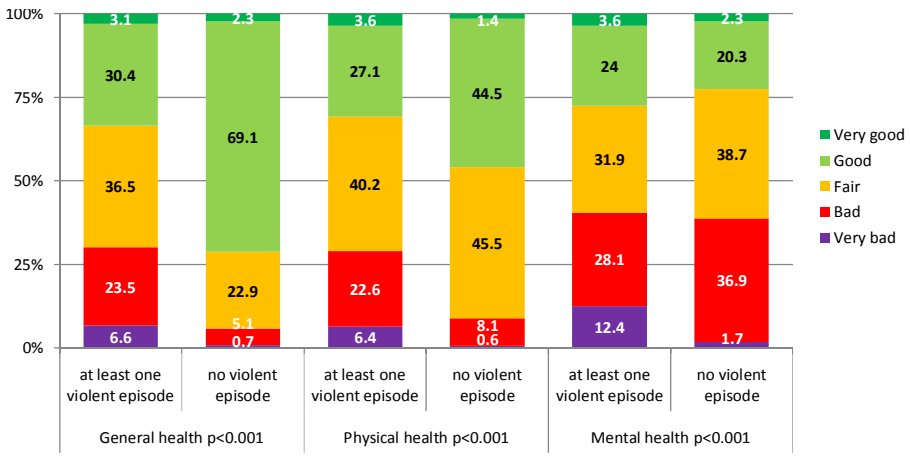
Table 26. Violence among men by country.

	BE (n=54)	CH (n=27)	DE (n=22)	EL (n=56)	ES (n=101)	NL (n=18)	UK (n=102)	WAP	CAP	TR (n=539)	WAPT	CAPT
Have lived in a country at war (n=252)												
	67.7	63.6	57.9	50	26	50	44.7	57.5	55.1	5.9	51.8	26.9
Physically threatened, imprisoned or tortured for ideas (n=183)												
	63.0	65.0	33.3	27.3	13.4	38.9	48.6	48.7	45.8	2.6	43.6	20.2
Violence by police or armed forces (n=161)												
	79.4	68.4	41.2	5.5	14.7	31.2	37.9	47.3	41.2	2.8	42.3	18.0
Beaten up or injured (domestic or not) (n=110)												
	52.0	80.0	50.0	3.6	14.3	23.5	6.4	41.2	32.6	0.9	36.7	12.8
Sexually assaulted or molested (n=19)												
	23.1	0.0	16.7	0.0	3.2	0.0	8.2	7.3	4.7	0.2	6.4	1.6
Rape (n=9)												
	0.0	0.0	23.1	0.0	2.1	6.2	6.2	5.4	3.6	0.0*	4.7	1.1
Psychological violence (n=97)												
	66.7	82.4	30.8	7.3	11.8	29.4	42.9	38.8	28.7	2.8	34.3	11.8
Money or documents confiscated (n=51)												
	43.8	27.3	25.0	3.6	11.7	18.8	24.1	22.0	16.3	1.7	19.5	6.4
Hunger (n=154)												
	43.8	8.3	43.8	21.8	28.9	37.5	18.5	37.8	42.9	2.0	33.8	17.7
Genital mutilations (n=2)												
	0	0	0	3.6	1.8	0	0.0	0.9	1.6	0.0	0.8	0.3
Others (n=62)												
	55.6	54.5	38.5	0	3.8	13.3	40.4	29.4	19.8	0.4	25.8	6.5

*not asked

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 general 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 mental 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.

Figure 35. Perceived health status according to violence (among patients interviewed about experiences of violence)



Health status

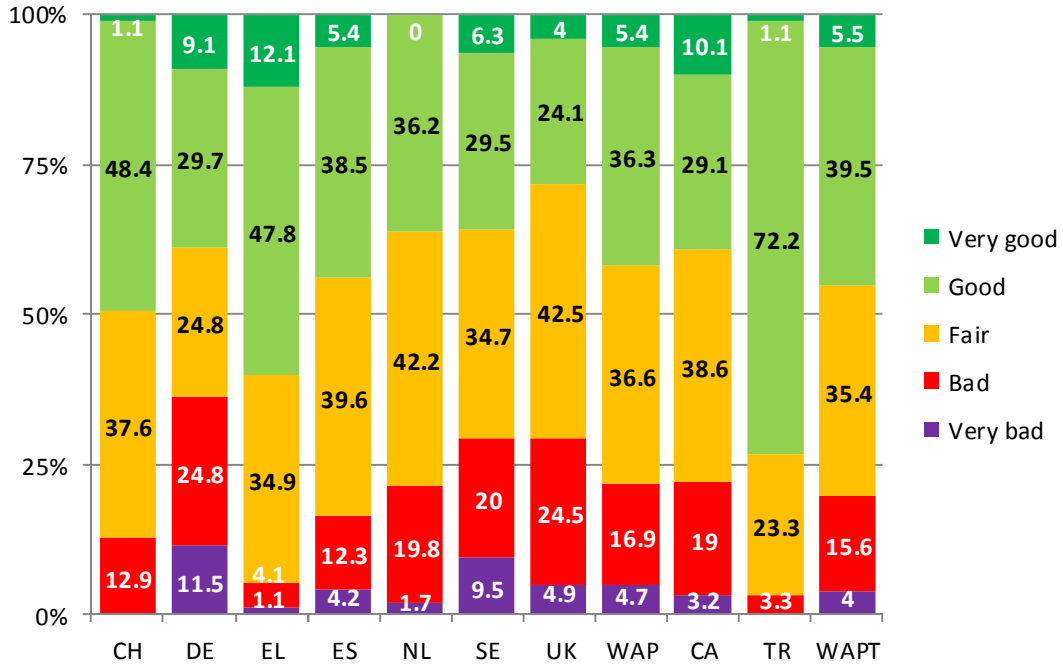
Self-perceived health status

A majority (58.2%) of patients seen by MdM in Europe[162] perceived their general health status as poor[163], and 21.6% perceived it as very bad or bad.

Furthermore, 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*)

Figure 36. Self-perceived health status by country.



[162] 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.

[163] Poor health status refers to the answers *Very bad*, *Bad* and *Fair*.

Figure 37. Perceived physical health status by country.

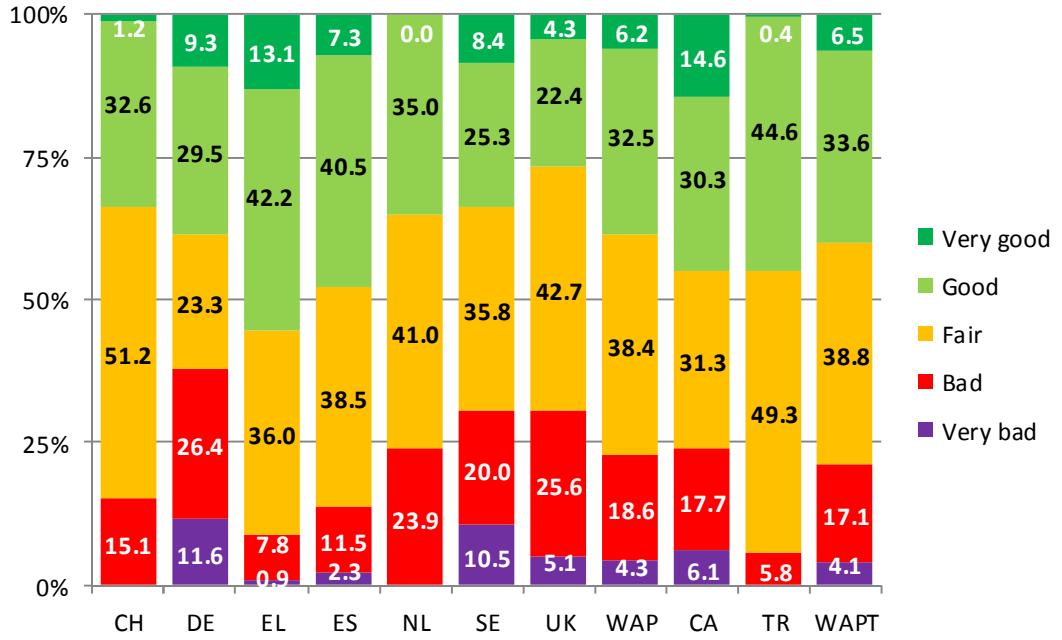
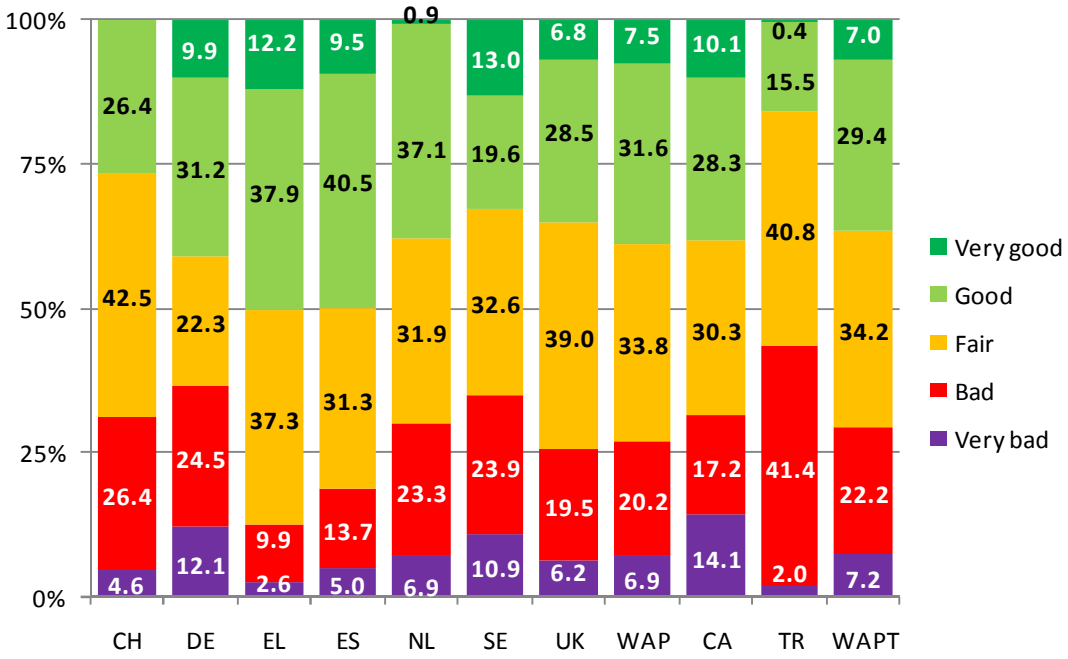


Figure 38. Perceived psychological health status by country.

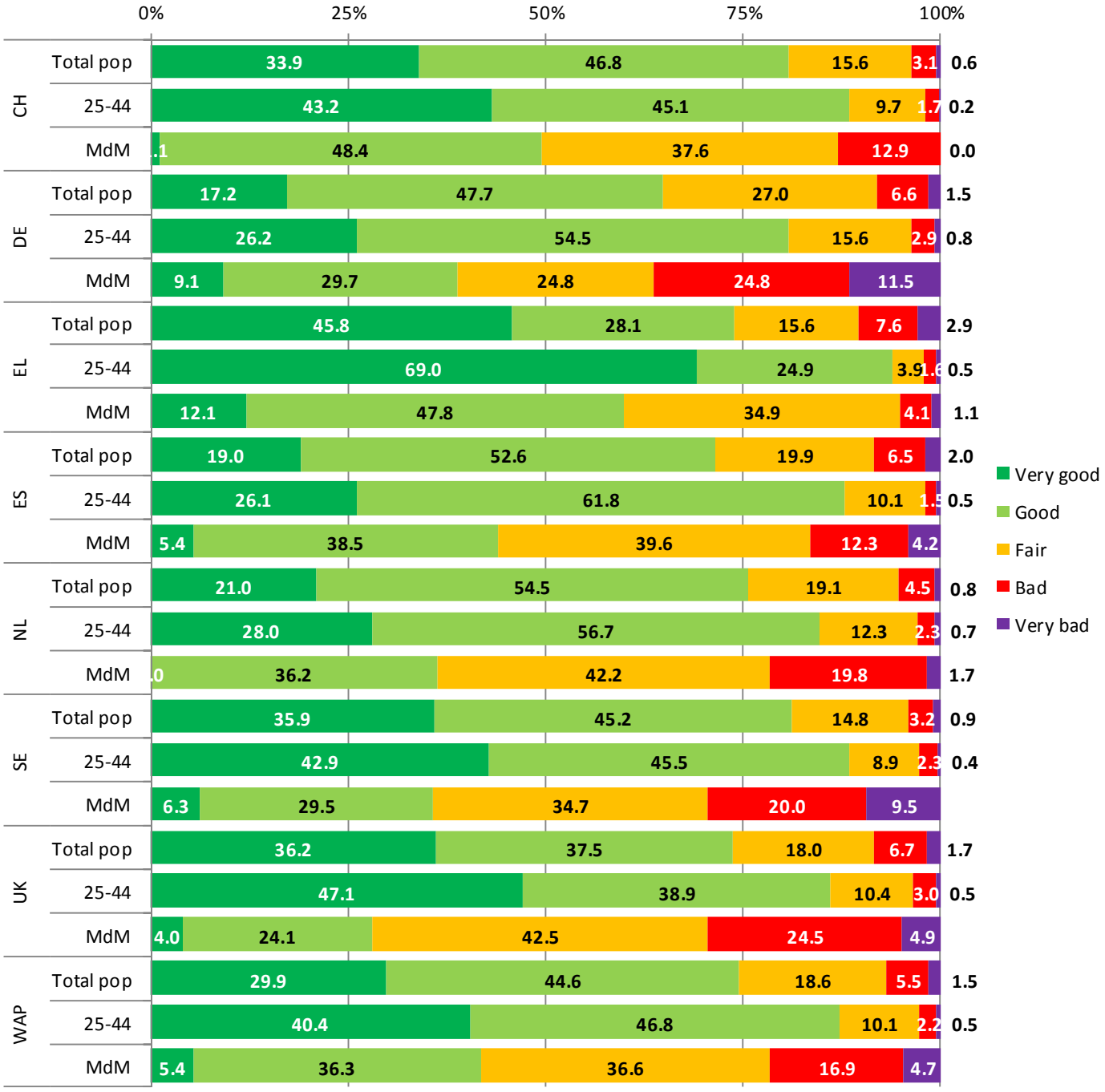


Comparing these data with those in the general population of the host countries ï obtained from the EU Statistics on Income and Living Conditions survey in 2013 (latest year available)**-, MdM patientsô health status was worse than that of the general population in all countries, regardless of the age group considered,** i.e. 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 ñbadò or ñvery badò 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).

Figure 39. General health status: comparison between MdM patients and the general population of host country (total population or 25-44 years old only), by country.



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

Altogether, **only 41.7% of the patients met by MdM in 2014 perceived themselves to be in very good or good health whereas in the general 25-44 years old population this proportion was 87.2 %** (in 2013). Inversely, 16.9% and 4.7% of MdM patients reported a bad or very bad health status respectively, against 2.2% and 0.5% of the 25-44 years old adults in the general population of these seven countries.

Contraception

Overall, questions about contraception were both rarely asked and with high levels of missing data[164]. Even if it can be difficult to question this subject in some cases, **it is unfortunate that these opportunities to speak with the women met in MdM clinics about contraception were missed**.

Globally, 18.3% (in the eight European countries where it was asked sometimes) and 17.2% (in the same + Montreal and Istanbul) of adult women reported that they were using contraception[165] and, respectively, 15.4% and 11.6% that they would like to [166].

Only two countries had good response rates: in Spain (response rate = 89.1%), 36.8% of adult women were using contraception and 10.6% would like one. In Istanbul (response rate = 95.9%), 6.6% of adult women reported using contraception and 1.5% would like to.

Françoise shared that she requested for an abortion at the Nice hospital ñ*when I specified that my CMU request was on progress I have been requested a deposit cheque to obtain any appointment*.ò Clearly, requesting cheques to persons that have no bank cheque book constitutes one more administrative hurdle. Documents that are difficult or even impossible to have when undocumented are often requested as prerequisite for surgery care at hospital department that are dedicated to ensuring access to care for destitute people without health coverage (PASS).

MdM France ï Nice ï January 2014

Taniaôs State Medical Assistance request was under progress when she got a drug induced abortion and needed a follow up treatment: anti-inflammatory, pain-killer, anti-immune globulin. Tania got the first two medications but not the anti-immune globulin that cost 70 euros. Tania cannot afford this amount. Due to administrative problem, the information of her status was not passed on and she remained without this drug that is included in the WHO list of essential medicine. MdM calls the abortion centre for application of the access to care for destitute people (PASS) and the specific Urgent and Essential Care Fund . Tania could finally get the treatment

MdM France ï Nice - June 2014

Chronic and acute health conditions

Health professionals[167] 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. In this part of the report, the denominator used for computing proportion is the number of patients who saw a doctor at least once during their visit(s) to MdM programmes (N=9,609).

Half of the patients (53.0 %) seen by a doctor in the eight European centres[168] were diagnosed with at least one acute health condition[169]. In Montreal and Istanbul, 61.3% and 79.3% of patients had at least one acute health condition respectively[170].

[164] This question was asked for the first time which explains the very low answer rate. In view of the importance of raising the topic during the consultation with women, it is hoped that more attention will be given in asking this question in 2015.

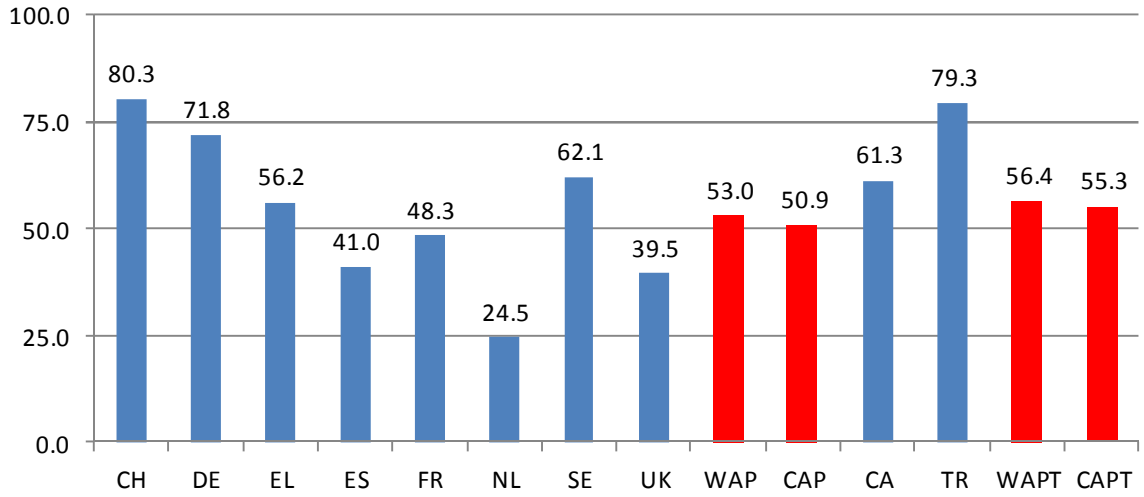
[165] Missing data (among adult women only) : 77.3% in BE, 64.9% in CH, 41.1% in DE, 84.3% in EL, 10.9% in ES, 79.5% in FR, 62.5% in NL, 89.9% in UK, 81.1% in CA, 4.1% in TR.

[166] Missing data (among adult women only) : 84.9% in BE, 75.3% in CH, 67.5% in DE, 48.4% in ES, 89.7% in FR,70.8% in NL, 10.4% in TR.

[167] In Switzerland, nurses are providing consultations and are responsible for filling in the medical questionnaires (diagnoses and treatments). Everywhere else, doctors provide medical consultations.

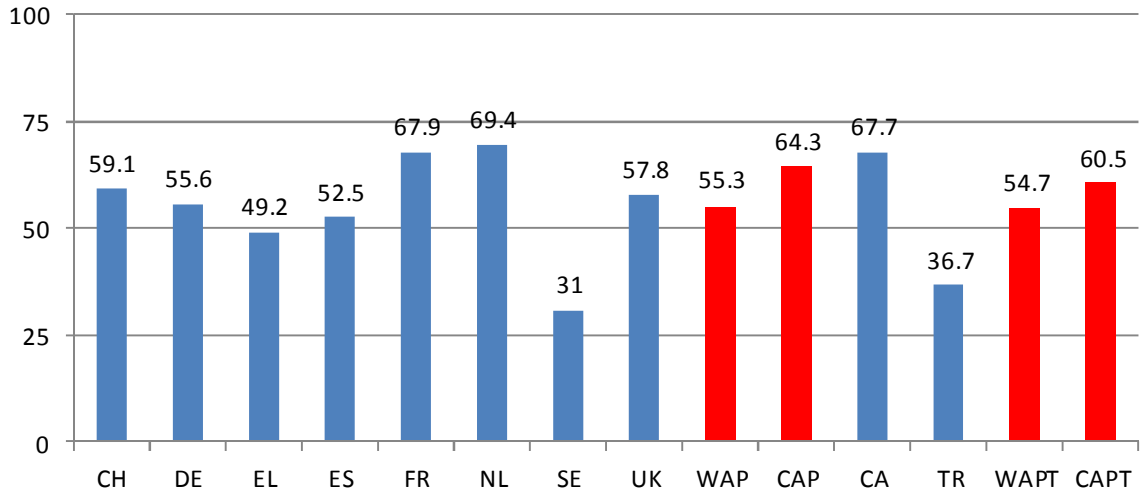
[168] No data in Belgium.

Figure 40. Proportion of patients with at least one acute health condition, by country.



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[171]. This proportion is significantly higher in France (67.9%) and in the Netherlands (69.4%). In Montreal and Istanbul, 67.7% and 36.7% of patients seen had at least one chronic health condition respectively.

Figure 41. Proportion of patients with at least one chronic health condition, by country.



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. ñ*I was able to cover the cost of the drugs for the first six monthsé as I couldnôt afford it anymore, I had to stop*ò. Since she could not regularly take the medication, she had an episode of high blood pressure which took her to

[169] At least once if they had several consultations.

[170] Missing values: respectively 19.0% in CH, 29.6% in DE, 21.2% in EL, 1.0% in ES, 26.9% in FR, 8.4% in NL, 59.7% in SE, 5% in UK, 41.2% in CA, 0.0% in TR.

[171] 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, 39.7% in CA, 0.1% in TR.

the emergency department. From there she was directed by the social services of the local hospital to MdMôs Polyclinic in Patras. Since then, Natalia has been treated at the MdM Polyclinic which covers the cost of medical tests and medication.

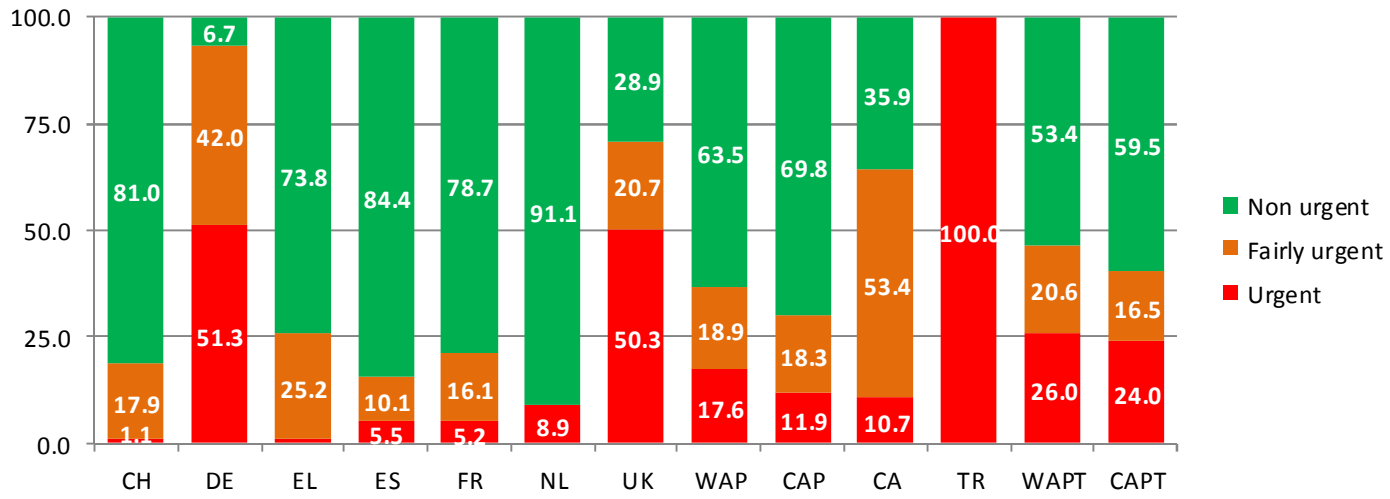
MdM Greece ï Patras ï October 2014

Urgent care

In total, more than one third (36.5%) of patients needed urgent or fairly urgent care when they visited MdM in the seven European countries[172]**.** This proportion was notably the highest in Munich and in London. These results should be interpreted with caution in view of the various response rates in the different countries[173]: in Greece, France, UK and Montreal, response rates are quite low and data are given for information purposes only.

In Istanbul (with an excellent response rate), 100% of the patients were reported in a situation of urgent care need.

Figure 42. Frequency of urgent care by country.



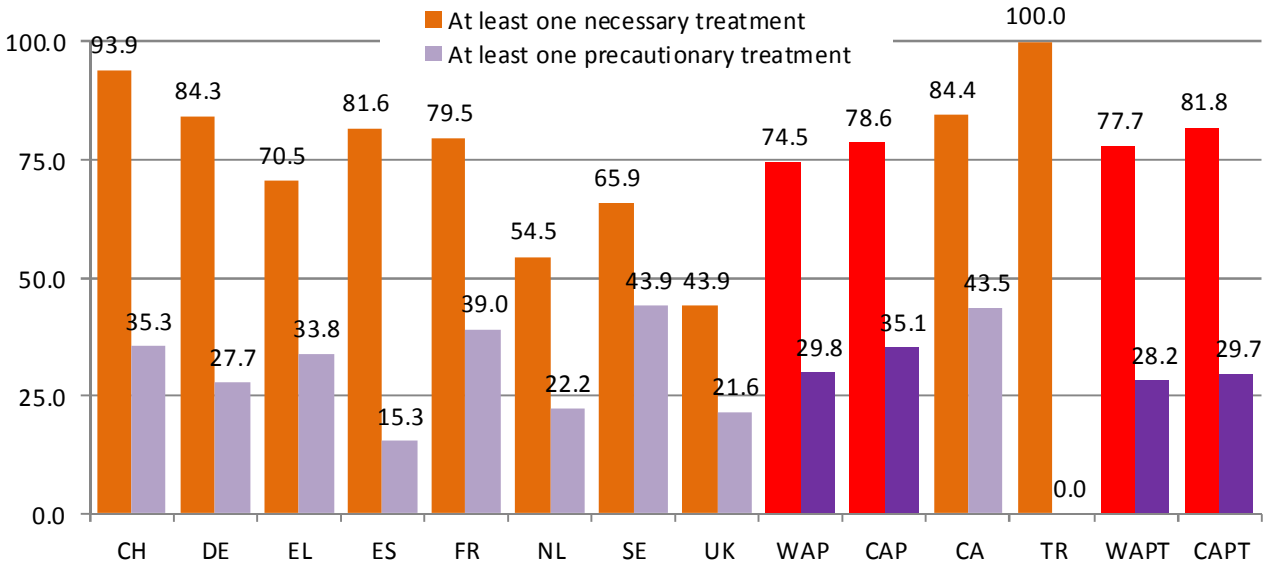
[172] Question not asked in Belgium.

[173] Missing values: respectively 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, 55.7% in CA, 4.7% in TR.

Necessary treatments

In total, three out of four patients seen by a doctor (74.5%) in the European programmes needed treatment that was judged as necessary by the doctor.[174] This percentage was significantly higher in Switzerland[175] (93.9% of patients needed at least one necessary treatment), Germany (84.3%), Spain (81.6%) and France (79.5%). In Montreal and Istanbul, 84.4% and 100.0% of patients were in this situation.

Figure 43. Proportion of patients with at least one necessary treatment or at least one precautionary treatment, by country.



Patients who 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 Montreal and Istanbul, 71.1% and almost all the patients were in this situation, respectively.

A low proportion may reflect different situations:

- **In Greece the rate was 37.8%, which may indicate frequent breaks in the continuity of healthcare:** health problems which had previously been diagnosed and treated were no longer treated, which brought patients to MdM. It should be noted that the economic crisis and subsequent austerity measures have hit the Greek healthcare system extremely hard. Cuts in spending on hospitals and pharmaceuticals have even gone beyond the targets imposed by the Troika: the most underprivileged are obviously the worst affected[176];

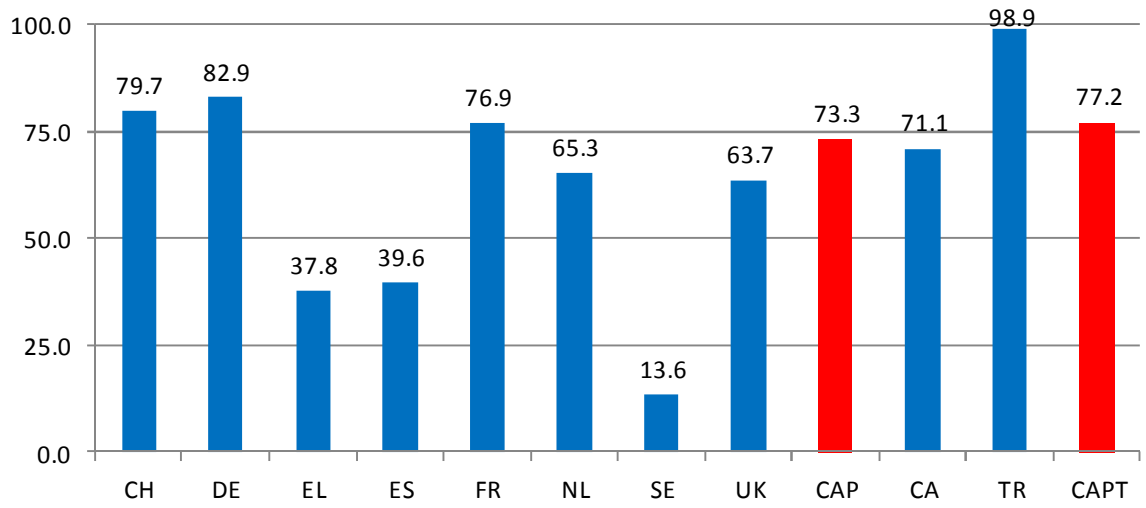
[174] Treatments were regarded as necessary if their lack would almost certainly mean deterioration in the patient's health, or a significantly poorer prognosis: in other cases they were classed as precautionary. There is no question here of *unnecessary* treatment, or of simple *comfort*.

[175] In Switzerland, patients are seen by nurses.

[176] Simou E, Koutsogeorgou E. Effects of the economic crisis on health and healthcare in Greece in the literature from 2009 to 2013: A systematic review. *Health Policy* 2014; 115: 111-9.

- **In Sweden, this rate was even lower (13.6%): for most of the patients, their disease(s) were completely neglected before but** this proportion must be interpreted cautiously (69.4% of patients were not reported).

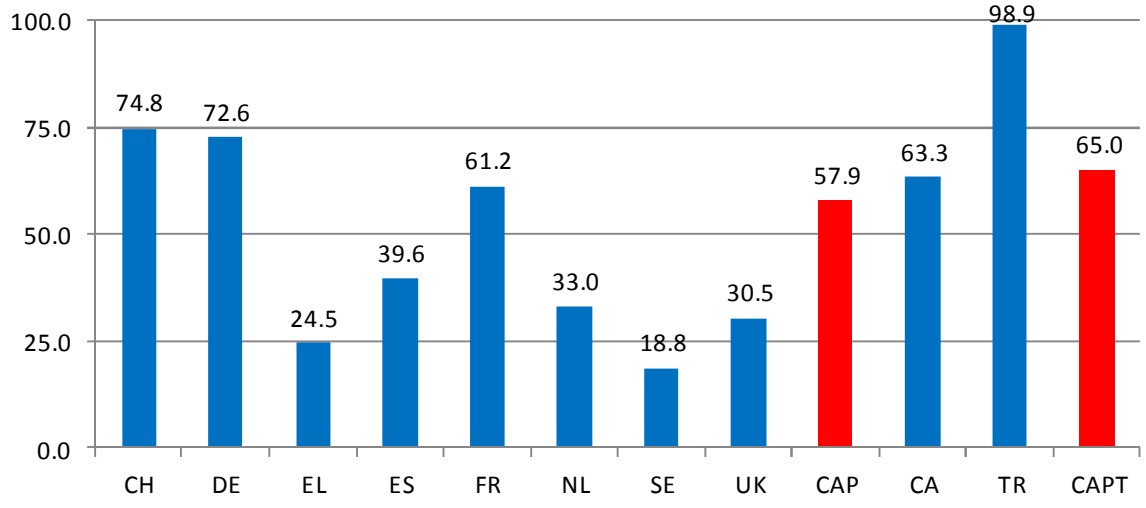
Figure 44. Proportion of patients with at least one health problem that had never been monitored or treated before consulting MdM for the first time, by country.



Altogether, 57.9% of the patients requiring treatment[177] 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%).

Here also, the Swedish data are given for information purpose only (response rate = 22.2% only[178]).

Figure 45. Proportion of patients requiring treatment who had no medical follow up before coming to MdM.

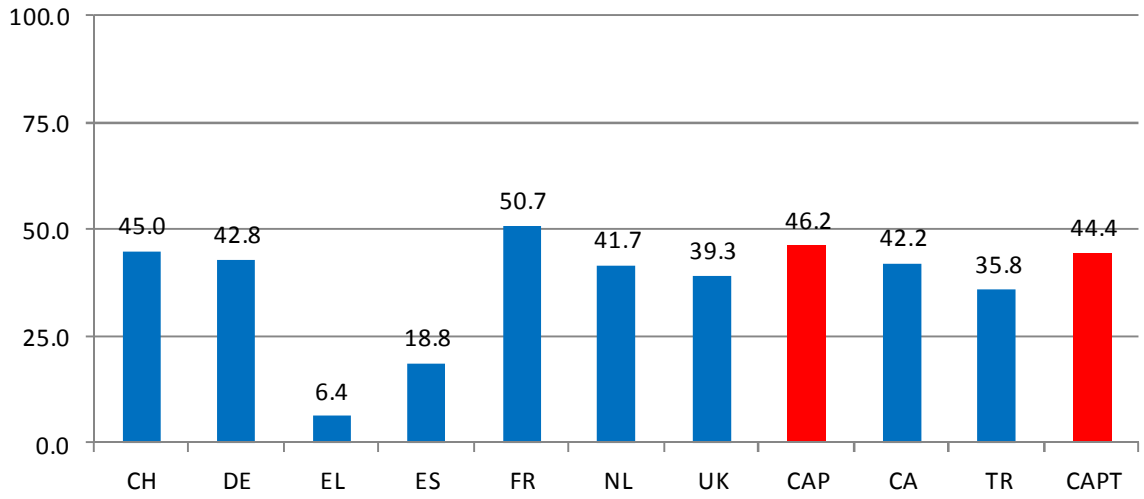


[177] Be it necessary or precautionary

[178] In Stockholm, medical consultations were not given to patients from non-EU countries. They were referred to mainstream health system, which explains the amount of missing data.

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.

Figure 46. Proportion of patients with at least one chronic health condition that had no medical follow up before coming to MdM.

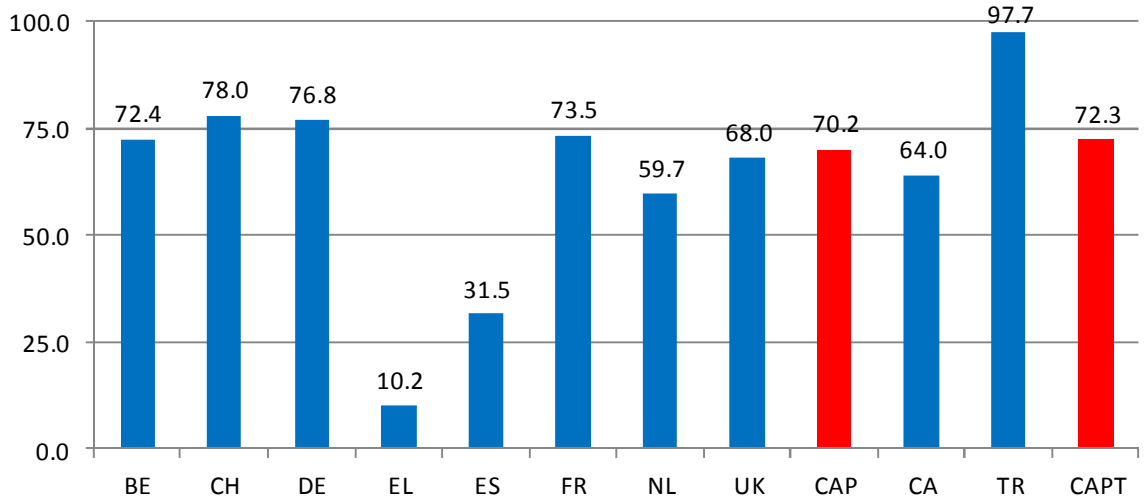


Lecture note: In Europe, 46.2% of patients with at least one chronic health condition had no medical follow-up before coming to MdM.

In other words, among the patients who suffered from one or several chronic condition(s), 70.2% hadnôt 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.

This proportion was lower in Montreal (64.0%) when, **in Istanbul, almost all patients with a chronic condition had not received care before coming to ASEM** (97.7%).

Figure 47. Proportion of patients ï among those suffering a chronic health condition ï who had not received medical follow up before coming to MdM.



Lecture note: In Europe, among patients with chronic health condition(s), 70.2% had not received medical follow-up before going to MdM for at least one of their chronic condition.

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 Montreal and Istanbul, respectively 14.2% and 31.7% of immigrants were in this situation (with 67.0% and 0.3% of missing values respectively).

Table 27. Frequency of diagnosis of chronic diseases known before migration, by sex.

	No. Total	% Total	No. men	% men	No. women	% women
Hypertension	90	11,4%	38	8,3%	52	15,6%
Digestive S/C	86	10,9%	59	12,9%	27	8,1%
Diabetes (insulin dependent and non-insulin dependent)	69	8,7%	35	7,7%	34	10,2%
Teeth-gum complaints	47	5,9%	28	6,1%	19	5,7%
Other musculoskeletal S/C	33	4,2%	16	3,5%	17	5,1%
Asthma	29	3,7%	16	3,5%	13	3,9%
Eye S/C	28	3,5%	17	3,7%	11	3,3%
Other respiratory diagnosis	24	3,0%	18	3,9%	6	1,8%
Back syndrom	23	2,9%	16	3,5%	7	2,1%
Other eye diagnosis	22	2,8%	12	2,6%	10	3,0%
Rachis S/C	19	2,4%	8	1,8%	11	3,3%
Other cardiovascular diagnosis	18	2,3%	7	1,5%	11	3,3%
Other skin pathology	18	2,3%	11	2,4%	7	2,1%
Neurological S/C	18	2,3%	9	2,0%	9	2,7%
Other digestive diagnosis	17	2,1%	16	3,5%	1	0,3%

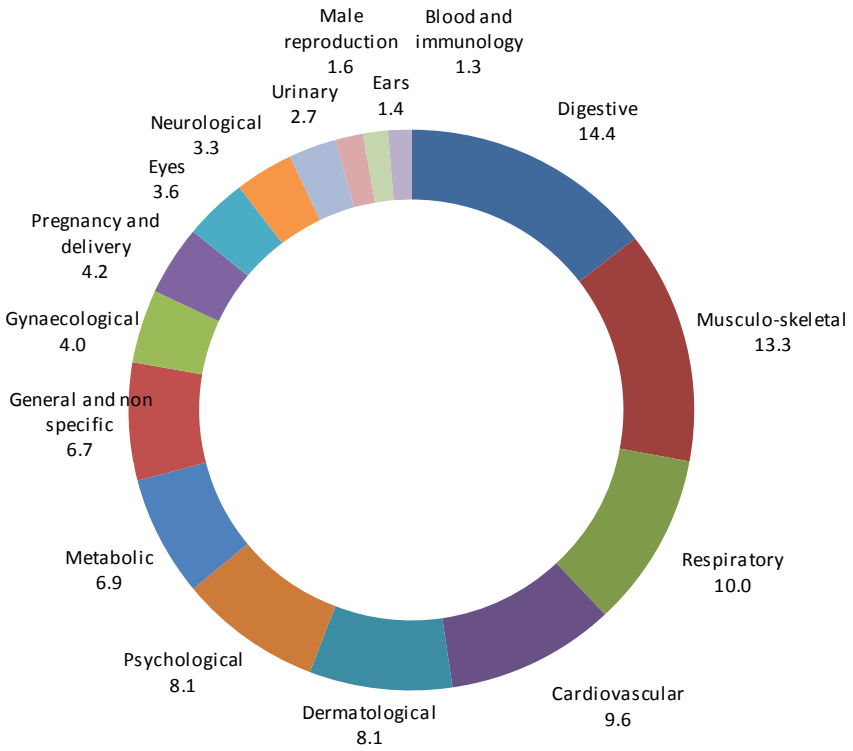
Depressive syndrome	17	2,1%	7	1,5%	10	3,0%
Other metabolic diagnosis	15	1,9%	7	1,5%	8	2,4%
Other respiratory S/C	15	1,9%	9	2,0%	6	1,8%
Other locomotor diagnosis	14	1,8%	5	1,1%	9	2,7%
Heart disease, Disorders heart rate	14	1,8%	3	0,7%	11	3,3%
Period disorder	14	1,8%	-	-	14	4,2%
Anxiety-Stress-Somatic disorders	13	1,6%	8	1,8%	5	1,5%
Skin S/C	13	1,6%	10	2,2%	3	0,9%
Urological S/C	12	1,5%	5	1,1%	6	1,8%
Injuries	12	1,5%	7	1,5%	5	1,5%
Other female genital diagnosis	11	1,4%	-	-	11	3,3%
Viral Hepatitis	**10**	**1,3%**	**5**	**1,1%**	**5**	**1,5%**
Skin infections	10	1,3%	10	2,2%	-	
Rash skin / Lumps	9	1,1%	7	1,5%	2	0,6%
Epilepsy	8	1,0%	6	1,3%	2	0,6%
General S/C	8	1,0%	6	1,3%	2	0,6%
Ear S/C	8	1,0%	7	1,5%	1	0,3%
Female genital S/C	8	1,0%	-		7	2,1%
Other neurological diagnosis	7	0,9%	4	0,9%	3	0,9%
Ulcerous Pathology	7	0,9%	6	1,3%	1	0,3%
Male genital S/C	7	0,9%	7	1,5%	-	
Other psychological problems	6	0,8%	3	0,7%	3	0,9%
Overweight-Obesity	6	0,8%	1	0,2%	5	1,5%
Vascular pathology	6	0,8%	4	0,9%	2	0,6%
Cardiovascular S/C	6	0,8%	3	0,7%	3	0,9%
Sexually Transmitted Infections - H	5	0,6%	5	1,1%	-	
Use of psychoactive substances (drugs)	5	0,6%	4	0,9%	-	
Diagnosis NOS	4	0,5%	2	0,4%	2	0,6%
Upper infections respiratory	4	0,5%	2	0,4%	2	0,6%
Infectious disease NOS	4	0,5%	4	0,9%	-	
Anaemia	3	0,4%	-		2	0,6%
Other male genital diagnosis	3	0,4%	3	0,7%	-	
Cancers	**3**	**0,4%**	**-**		**3**	**0,9%**
Dermatitis atopic and contact	3	0,4%	2	0,4%	1	0,3%
Pregnancy and non-pathological childbirth	3	0,4%	-		3	0,9%
Eye infections	3	0,4%	3	0,7%	-	
Gastrointestinal infection	3	0,4%	2	0,4%	1	0,3%
Ear infections	3	0,4%	3	0,7%	-	
Disease caused by a parasite / Candida	3	0,4%	3	0,7%	-	
Use of psychoactive substances (alcohol)	3	0,4%	3	0,7%	-	
Use of psychoactive substances (tobacco-drugs)	3	0,4%	3	0,7%	-	
Other urological and renal diagnosis	2	0,3%	2	0,4%	-	
Contraception	2	0,3%	-		2	0,6%
Pregnancy and pathological childbirth	2	0,3%	-		2	0,6%
HIV	**2**	**0,3%**	**2**		**-**	
Lower infections respiratory	2	0,3%	2	0,4%	-	

Sexually Transmitted Infections - F	2	0,3%	-		2	0,6%
Urological / renal infections	2	0,3%	1	0,2%	1	0,3%
Psychosis	2	0,3%	2	0,4%	-	
Metabolic S/C	2	0,3%	1	0,2%	1	0,3%
Tuberculosis	**2**	**0,3%**	**2**	**0,4%**	**-**	
Administrative	1	0,1%	-		1	0,3%
Other ear diagnosis	1	0,1%	-		1	0,3%
Eye NS	1	0,1%	1	0,2%	-	
Pregnancy, Childbearing, Family Planning S/C	1	0,1%	-		1	0,3%
Nose-Sinus S/C	1	0,1%	-		1	0,3%
Total	896		499		393	

Health problems by organ system

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

Figure 48. Distribution of diagnoses by biological system.



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%).

Table 28. Frequencies of psychological disorders by gender (as a % of medical consultations)

	Women		Men		Total	
	n	%	n	%	n	%
Anxiety/stress/psychosomatic problems	396	5.8	608	5.9	1009	5.8
Other psychological problems	66	1.0	110	1.1	178	1
Psychoses	22	0.3	64	0.6**	86	0.5
Depressive syndromes	259	3.8	240	2.3*	500	2.9
Use of psychoactive substances	9	0.1	58	0.6**	68	0.4
Total	752	10.9	1080	10.4	1841	10.6

All the differences between women and men were not significant except *p<0.05 and **p<0.01

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 Peterôs 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: ñ*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 ó*from a list of people with illegal status who had to be arrestedôò. 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.

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Emmanuel, a 39 year old man fled from Ivory Coast due to political violence. He arrived in Spain in 2006 where he applied for asylum. In this period he lived on the streets where he suffered verbal, physical and emotional abuse. ñ*I left Ivory Coast [é] I applied for asylum in Spain, but was harassed by the police. They humiliated me. I felt tortured. In the end I left Spain for the Netherlands*.ò In 2010 Emmanuel arrived in the Netherlands where he eventually joined the mobile group of ex-asylum seekers ñ*We are Here*ò in 2012. Being undocumented, Emmanuel cannot get health coverage. Emmanuel is now living in a squatted garage (the ñrefugee garageò). In the garage, there is continuous unrest, tension and there are frequent conflicts and fights between the 130 occupants. In situations where incidents require immediate medical assistance, such as ambulance or GP care, a problem arises as healthcare providers would not enter the building without police assistance. This is how Emmanuel was taken to a police station and placed in a cell (bearing in mind that Emmanuel was traumatized as a result of his dealings with police in Spain). In the fall of 2014, MdM got aware of Emmanuelôs mental problems. He was therefore referred to a psychiatrist who diagnosed PTSD (Post Traumatic Stress Disorder) and a major depression with suicidal tendencies. Although Emmanuel had had contact with a number of care givers since arriving in the Netherlands, he was never previously referred to a mental healthcare specialist. An MdM volunteer is also in charge of close follow up. Emmanuel contacts him when he is acutely suicidal: ñ*Can I ever be a normal person again? Will I ever be able to speak to you again in a normal manner?*ò

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Overall, around half of all medical consultations concerned seven health problems. These were: gastrointestinal symptoms (9.6%), hypertension (8.1%), non-specific musculoskeletal symptoms (7.4%), diabetes (insulin-dependent and non-insulin-dependent, 7.4%), anxiety, stress or psychosomatic problems (5.8%), pregnancy (4.4%), upper and lower back problems (4.4%). Added to these nine problems, the following nine concerned 75% of medical consultations and the next seven, 90% of consultations.

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%).

Viral forms of hepatitis related to 1.8% of consultations (2.3 % for men), HIV infection 0.4% of consultations for men as for women, and tuberculosis 0.1% of consultations.

Table 29. Diagnoses recorded in decreasing order (as % of the medical consultations).

	No. total	%	%cum	No. men	%	%cum	No. women	%	%cum
Digestive S/C	1660	9.6	9.6	1003	9.7	9.7	647	9.4	9.4
Hypertension	1405	8.1	17.7	647	6.2	15.9	753	10.9	20.3
Other musculoskeletal S/C	1289	7.4	25.1	860	8.3	24.2	415	6	26.3
Diabetes (insulin dependent and non-insulin dependent)	1288	7.4	32.5	756	7.3	31.5	527	7.7	34
Anxiety-Stress-Somatic disorders	1009	5.8	38.3	608	5.9	37.4	396	5.8	39.8
Pregnancy and non-pathological childbirth	767	4.4	42.7	0	0	37.4	760	11.0	50.8
Rachis S/C	758	4.4	47.1	500	4.8	42.2	255	3.7	54.5
Teeth-gum complaints	669	3.9	51.0	452	4.4	46.6	210	3.1	57.6
Other digestive diagnosis	656	3.8	54.8	410	4	50.6	240	3.5	61.1
Upper infections respiratory	604	3.5	58.3	364	3.5	54.1	236	3.4	64.5
Back syndrom	596	3.4	61.7	415	4	58.1	181	2.6	67.1
Depressive syndrome	500	2.9	64.6	240	2.3	60.4	259	3.8	70.9
Neurological S/C	471	2.7	67.3	274	2.6	63	188	2.7	73.6
Other locomotor diagnosis	467	2.7	70	252	2.4	65.4	214	3.1	76.7
Skin S/C	431	2.5	72.5	309	3	68.4	120	1.7	78.4
General S/C	430	2.5	75	272	2.6	71	155	2.3	80.7
Disease caused by a parasite / Candida	384	2.2	77.2	298	2.9	73.9	84	1.2	81.9
Injuries	383	2.2	79.4	292	2.8	76.7	88	1.3	83.2
Other respiratory diagnosis	380	2.2	81.6	286	2.8	79.5	94	1.4	84.6
Cough	361	2.1	83.7	221	2.1	81.6	133	1.9	86.5
Female genital S/C	360	2.1	85.8	0	0	81.6	357	5.2	91.7
Other skin pathology	348	2	87.8	257	2.5	84.1	89	1.3	93
Administrative	345	2	89.8	248	2.4	86.5	96	1.4	94.4
Lower infections respiratory	343	2	91.8	234	2.3	88.8	105	1.5	95.9
Eye S/C	341	2	93.8	222	2.1	90.9	113	1.6	97.5
Urological S/C	325	1.9	95.7	232	2.2	93.1	90	1.3	98.8
Medicinal treatment	321	1.8	97.5	211	2	95.1	110	1.6	100.4
Viral Hepatitis	320	1.8	99.3	238	2.3	97.4	81	1.2	101.6
Other respiratory S/C	311	1.8	101.1	210	2	99.4	99	1.4	103
Other cardiovascular diagnosis	303	1.7	102.8	166	1.6	101	133	1.9	104.9
Other eye diagnosis	300	1.7	104.5	189	1.8	102.8	110	1.6	106.5
Period disorder	297	1.7	106.2	5	0	102.8	291	4.2	110.7
Rash skin / Lumps	296	1.7	107.9	217	2.1	104.9	76	1.1	111.8
Asthma	295	1.7	109.6	184	1.8	106.7	110	1.6	113.4
Heart disease, Disorders heart rate	292	1.7	111.3	184	1.8	108.5	108	1.6	115
Other metabolic diagnosis	238	1.4	112.7	91	0.9	109.4	146	2.1	117.1
Skin infections	237	1.4	114.1	185	1.8	111.2	51	0.7	117.8
Other neurological diagnosis	228	1.3	115.4	122	1.2	112.4	104	1.5	119.3
Male genital S/C	223	1.3	116.7	222	2.1	114.5	0	0	119.3
Follow-up	222	1.3	118	180	1.7	116.2	41	0.6	119.9
Urological / renal infections	213	1.2	119.2	75	0.7	116.9	136	2	121.9

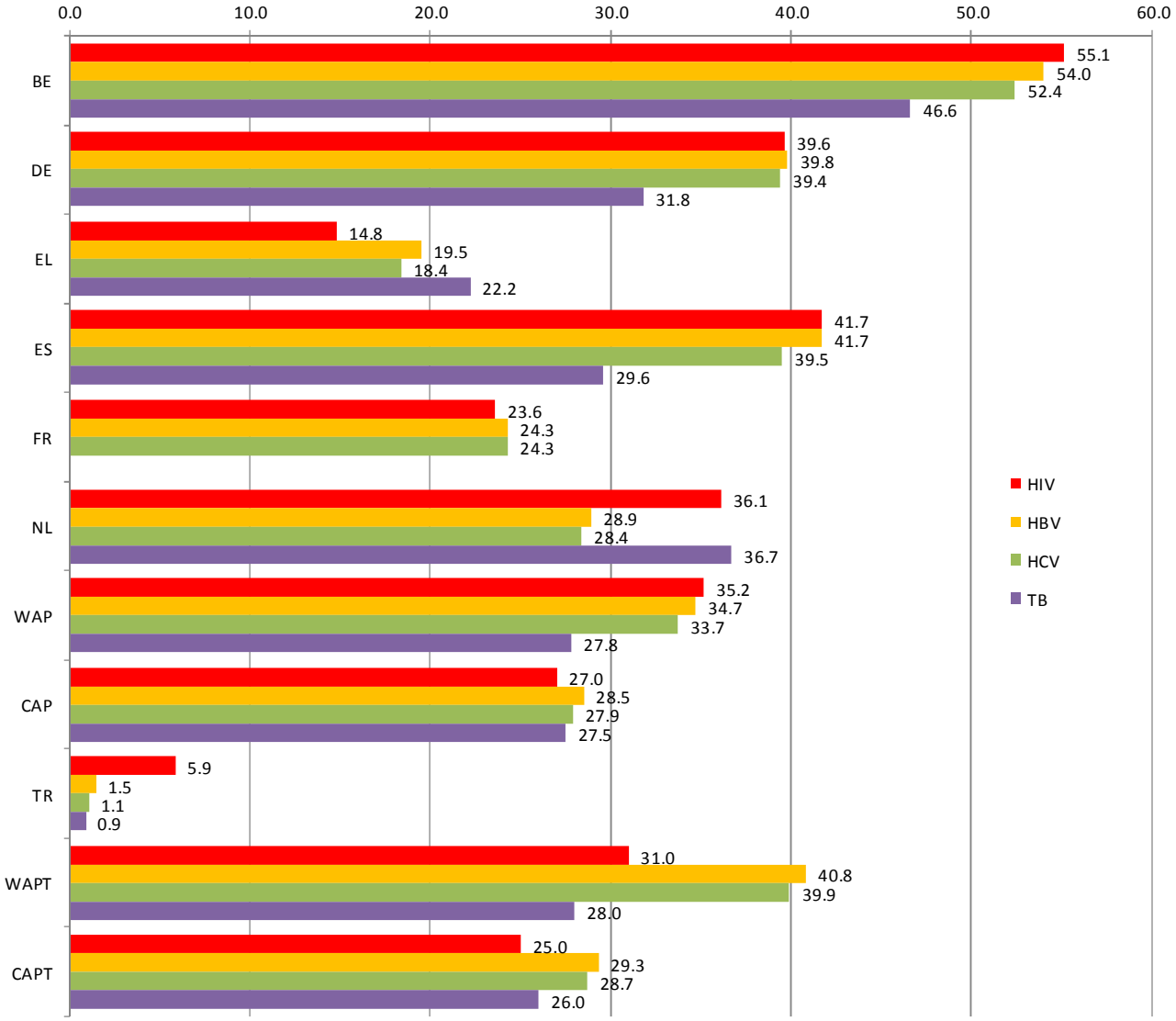
Nose-Sinus S/C	204	1.2	120.4	142	1.4	118.3	61	0.9	122.8
Vascular pathology	198	1.1	121.5	127	1.2	119.5	68	1	123.8
Results	194	1.1	122.6	134	1.3	120.8	59	0.9	124.7
Dermatitis atopic and contact	191	1.1	123.7	138	1.3	122.1	50	0.7	125.4
Other procedures	187	1.1	124.8	141	1.4	123.5	46	0.7	126.1
Other psychological problems	176	1	125.8	109	1.1	124.6	65	0.9	127
Cardiovascular S/C	169	1	126.8	106	1	125.6	63	0.9	127.9
Medical examination	167	1	127.8	106	1	126.6	61	0.9	128.8
Eye infections	163	0.9	128.7	116	1.1	127.7	47	0.7	129.5
Diagnosis NOS	141	0.8	129.5	93	0.9	128.6	48	0.7	130.2
Fears of/Concern	137	0.8	130.3	77	0.7	129.3	60	0.9	131.1
Ear S/C	136	0.8	131.1	92	0.9	130.2	43	0.6	131.7
Advice / Counselling, Listening	131	0.8	131.9	76	0.7	130.9	55	0.8	132.5
Complementary examination	122	0.7	132.6	69	0.7	131.6	53	0.8	133.3
Contraception	120	0.7	133.3	0	0	131.6	119	1.7	135
Other urological and renal diagnosis	108	0.6	133.9	71	0.7	132.3	35	0.5	135.5
Overweight-Obesity	108	0.6	134.5	37	0.4	132.7	71	1	136.5
Ear infections	105	0.6	135.1	62	0.6	133.3	40	0.6	137.1
Gastrointestinal infection	104	0.6	135.7	65	0.6	133.9	38	0.6	137.7
Anaemia	98	0.6	136.3	12	0.1	134	85	1.2	138.9
Medical Care	91	0.5	136.8	69	0.7	134.7	21	0.3	139.2
Psychosis	86	0.5	137.3	64	0.6	135.3	22	0.3	139.5
Infectious disease NOS	82	0.5	137.8	53	0.5	135.8	29	0.4	139.9
Cancers	80	0.5	138.3	42	0.4	136.2	38	0.6	140.5
Epilepsy	78	0.4	138.7	48	0.5	136.7	30	0.4	140.9
Vaccination / Other preventive procedures	76	0.4	139.1	37	0.4	137.1	37	0.5	141.4
Other ear diagnosis	74	0.4	139.5	56	0.5	137.6	17	0.2	141.6
HIV	73	0.4	139.9	37	0.4	138	36	0.5	142.1
Ulcerous Pathology	69	0.4	140.3	49	0.5	138.5	19	0.3	142.4
Metabolic S/C	62	0.4	140.7	34	0.3	138.8	28	0.4	142.8
Other diagnosis blood forming organs and immune mechanism	47	0.3	141	27	0.3	139.1	20	0.3	143.1
Glasses-Contact lens	40	0.2	141.2	29	0.3	139.4	11	0.2	143.3
Use of psychoactive substances (alcohol)	33	0.2	141.4	29	0.3	139.7	4	0.1	143.4
Tuberculosis	25	0.1	141.5	20	0.2	139.9	5	0.1	143.5
Psychological NS	22	0.1	141.6	8	0.1	140	14	0.2	143.7
Pregnancy, Childbearing, Family Planning NS	20	0.1	141.7	0	0	140	18	0.3	144
Use of psychoactive substances (drugs)	19	0.1	141.8	15	0.1	140.1	3	0	144
Use of psychoactive substances (tobacco-drugs)	16	0.1	141.9	14	0.1	140.2	2	0	144
S/C Blood forming organs and immune mechanism	15	0.1	142	8	0.1	140.3	7	0.1	144.1
Eye NS	7	0	142	6	0.1	140.4	1	0	144.1
Skin NS	3	0	142	2	0	140.4	1	0	144.1
Urological NS	3	0	142	2	0	140.4	1	0	144.1
Total	25410	146.3		14807	142.7		10452	151.8	

Screening

Questions on serology were inconsistently asked across the countries. All the following results only cover six European countries (Belgium, Germany, Greece, Spain, France and the Netherlands[179]) and Istanbul (not asked in Montreal). The response rate for past history of testing is very low in Belgium (24.8%), and Greece (30.6%); so data are given here for illustrative purposes only.[180]

In average, not more (and often much less) than a third of the patients interviewed had been tested for HIV, HBV, HCV or tuberculosis in the past. These proportions were even lower in Greece (between 14.8% and 22.2% according to the disease screened), in France (less than a quarter of patients reported having been screened for HIV, HBV or HVC[181]) and in the Netherlands (between 28.4% and 36.1%). In Istanbul, such past history of testing was exceptional.

Figure 49. Past history of testing by country.



[179] Questions were not asked in Canada, Switzerland, Sweden and the UK.

[180] In the other countries, the rates of missing values are respectively: 33.8% in DE, 13.0% in ES, 55.0% in France, 22.8% in NL, 3.7% in TR.

[181] TB screening not asked in France.

HIV infection

Regarding HIV, this proportion is especially worrying, in light of the particular vulnerability of migrants (and their partners) to HIV, as highlighted in particular by the European Centre for Disease Control (ECDC)[182]. Migrants represented two-fifths of reported HIV cases in the EU/EEA between 2007 and 2011. The number of HIV cases reported among migrants increased slightly over the period, with an increased trend among migrants from Latin America up to 2010; an increased trend throughout the period in Central and Eastern Europe; and a sustained decreasing trend among migrants from sub-Saharan Africa.[183] For instance, in a recent report[184], ECDC recalls that:

- In Germany, between 2001 and 2012, 58% of new HIV diagnoses were among people from Germany, 25% were among people from other countries and in 17% the country of origin was unknown. Of all new HIV diagnoses among people originating from outside Germany, 40% were in people from sub-Saharan Africa. During the same period, 46% of those known to have acquired HIV heterosexually were from sub-Saharan Africa;
- In the Netherlands, in 2012, people from sub-Saharan Africa accounted for 28% of all new diagnoses of heterosexually acquired HIV;
- In Spain, in 2011, the percentage of people born outside Spain among those newly diagnosed with HIV was 37%. Among those born outside Spain, 57% originated from Latin America and 19% from sub-Saharan Africa;

Migrants account for the majority of cases due to heterosexual transmission, but also for more than 20% of cases attributed to sex between men and injecting drug users. For the past ten years an increasing number of women infected by HIV amongst migrants was observed. Women are more vulnerable to the virus, both biologically and socially. The Council of Europe Committee on migration, refugees and displaced persons report[185] highlights that ñ*evidence suggests that migrants from countries with a high HIV/AIDS prevalence, particularly in sub-Saharan Africa, are disproportionately affected by HIV. [...] On the other hand, the levels of HIV amongst migrants to Europe are in general significantly below HIV levels in their countries of origin. This can be explained by what migration specialists call the* **ñ***healthy migrant effect***ò ï** *a process of self-selection where only the healthiest in a society migrate*ò.

Late diagnosis of HIV infection is more frequent among migrants (from non-EU countries and non North-American) than among native-born cases. ECDC recalls also that:

- In Belgium, the percentage of migrants from sub-Saharan Africa diagnosed late (CD4 < 350) between 1998 and 2011 ranged from 50ȩ70% (51% in 2011);
- In France, 43% of HIV+ immigrant men and 30% of HIV+ women infected heterosexually were reported to have CD4 <200 or AIDS at the time of diagnosis. Rates of late diagnosis are particularly high among those diagnosed within one year of migration to France. Due to late diagnosis, it is estimated that there may be still 9,000 migrants with undiagnosed HIV in France;
- In Greece, rates of late diagnosis (CD4 <350) or advanced disease (CD4 <200) were higher among those of African origin (72% and 50% respectively) than those of Greek origin (51% and 29% respectively).

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[182] ECDC. Migrant health: HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA/EFTA member States. Stockholm: ECDC (Technical reports), 2011.

[183] ECDC. *Migrant health: Epidemiology of HIV and AIDS in migrant communities and ethnic minorities in EU/EEA countries*. Stockholm: ECDC (Technical reports), 2010.

[184] ECDC. *Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA*. Stockholm: ECDC (Technical reports), 2014.

[185] Committee on migration, refugees and displaced persons. *Migrants and refugees and the fight against AIDS*. Strasbourg: Council of Europe, January 2014.

- In the Netherlands, from 1996 to 2012, percentages of late diagnosis (CD4 <350) ranged from 60% to 80% among non-Dutch heterosexuals and from 40% to 60% among Dutch heterosexuals.
- In Spain, migrants from most regions were more likely to be diagnosed late (CD4 <350) or with advanced disease (CD4 <200) than people born in Spain. Migrants from sub-Saharan Africa were the most likely to be diagnosed late.

Current studies and data do not reveal precisely if migrants mainly contract HIV in their country of origin or afterwards, in the country they have migrated to. A study by the ECDC in 2013 showed **major differences between destination countries for the proportion of post-migratory infections**[186]. This percentage ranged from 2% for sub-Saharan Africans in Switzerland, while it had reached 62% among black Caribbean men who were having sex with men in the United Kingdom[187]. The report cited earlier states that ñ***migrant workers who live alone, far from their spouse or usual sexual partners, can be more exposed to the virus***. *This is due to the fact that they seek out other casual partners, increasing their own risk of exposure to HIV and that of their sexual partners*.ò

- Data for 2010 indicate that 46% of heterosexually acquired HIV infections reported among people born abroad were likely to have been acquired in the UK ҫan increase from 24% in 2004.[188]
- The proportion of migrants that probably acquired HIV heterosexually in Germany between 2003 and 2012 is higher among those from other countries of Europe (53%) and the Americas (33%) than among those from Asia (15%) or sub-Saharan Africa (14%).
- In France, data suggest that in 2011, at least one quarter of new HIV infections diagnosed among people born in sub-Saharan Africa were likely to have been acquired in France.[189] This is higher than the figure for the same year based on cliniciansô reports. It confirms the findings from UK saying that clinicians underestimate the proportion of sub-Saharan migrants who have been infected in the country to which they have migrated.

Elsa, a 55-year-old Ivorian, has been living in Turkey for five years. She has obtained the status of asylum seeker and as such has health coverage. HIV positive, she has a uterine fibroma of 25 cm long. Alerted by her bleeding, ASEM refers her to the gynaecological department of the Austrian hospital Saint Georges. When discovering her HIV + status, the surgeon refused to operate. Based on the same argument, three other hospitals also refused to proceed with her surgery. Up-to-date, Elsa is still expecting to be properly treated.

ASEM Turkey ï Istanbul ï December 2014.

HBV infection

Regarding HBV, the prevalence of hepatitis B is highest in sub-Saharan Africa and East Asia. The hepatitis B virus infects most of those living in these regions during their childhood (the hepatitis B virus is generally transmitted at birth, from mother to child, or during early childhood, from one child to another) and five to 10% of the adult population is chronically infected. High levels of chronic infection in the Amazonia and in southern parts of Central and Eastern Europe were reported. In the Middle East and the Indian sub-continent, it is estimated that the chronic carriers represent 2-5% of the general population. Not to speak of China that counted one third of the total number of worldwide infected people, with 130 million carriers and 30 million chronically infected.

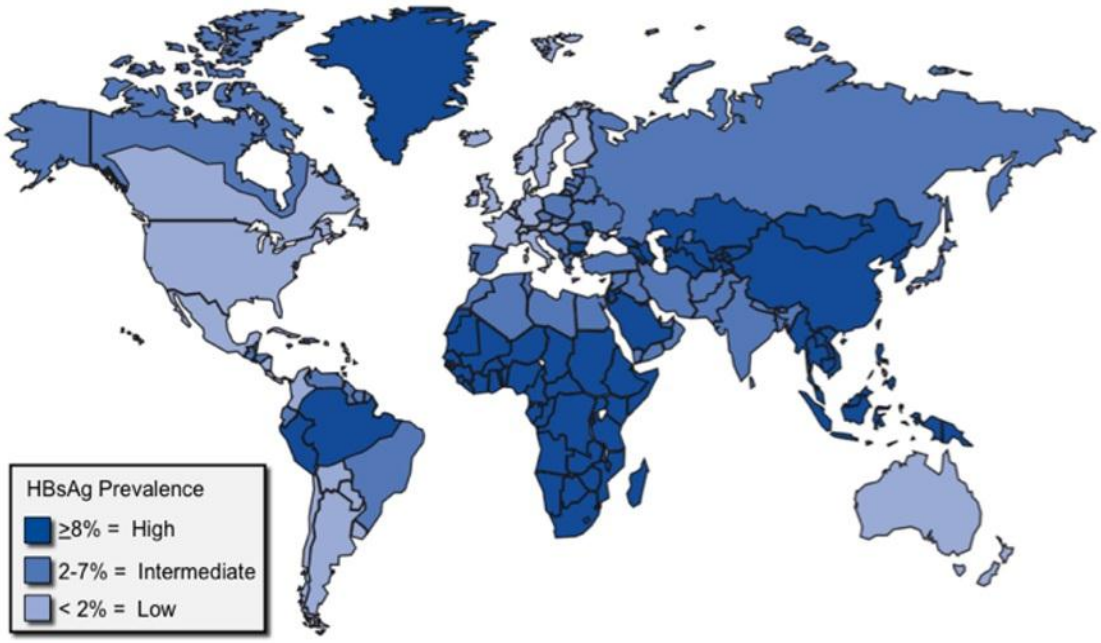
[186] ECDC. Migrant health: *Sexual transmission of HIV within migrant groups in the EU/EEA and implications for effective interventions*. Stockholm: ECDC (Technical reports), 2013.

[187] Dougan S, Payne LJ, Brown AE, Fenton KA, Logan L, Evans BG, et al. Black Caribbean adults with HIV in England, Wales, and Northern Ireland: an emerging epidemic? *Sex Transm Infect* 2004; 80(1): 18-23.

[188] Rice BD, Elford J, Yin Z, Delpech VC. A new method to assign country of HIV infection among heterosexuals born abroad and diagnosed with HIV. *AIDS* 2012; 26(15): 1961-6.

[189] Lucas E, Cazein F, Brunet S, et al. Types, groupes et sous-types de VIH diagnostiqués depuis 2003: données de huit années de surveillance. Bull Epidémiol Hebd 2012; 46-47: 533-7.

Figure 50. Worldwide geographic distribution of chronic HBV infection



Source: Hwang EW, Cheung R. Global epidemiology of Hepatitis B Virus (HBV) infection. *N A J Med Sci* 2011; 4(1): 7-13.

Migrants from high prevalence areas represent a particularly at-risk population group: for themselves (liver complications, including oncologic, chronic HBV carrier) and for others (virus transmission, including mother to child).

In most European countries[190], HBV screening (and vaccination for those who test negative) is recommended for migrants from those areas of high endemicity.

- In France, for the first time in 2014 (before 2014, it was only a usual clinical practice), systematic screening proposal for HBV is **officially recommended** for ñall people born or coming from high endemicity countries (Asia, Sub-Saharan Africa) and from middle endemicity countries (overseas French regions, Eastern Europe, North Africa, Middle East, Indian sub-continent and Latin America)ò[191]

HCV infection

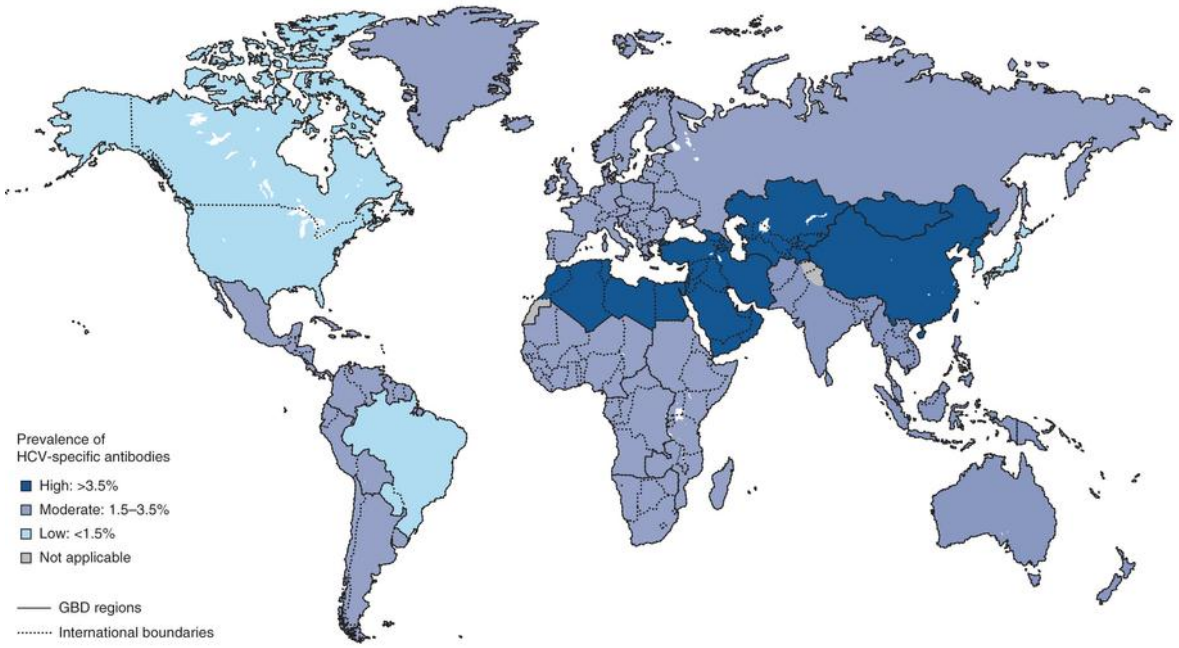
Regarding HCV, its screening is recommended (among other situations) for people who come from (or have received medical care) in South-East Asia, Middle East, North and Sub-Saharan Africa, and Latin America.

- Indeed HCV prevalence is estimated to be 1.7% in people born in middle endemicity countries, up to 10.2% in Middle East (a high endemicity area), comparing to 0.84% for those born in France, for instance. Of course, any past or present drug use is also an indication for HCV testing (intravenous use, sniff, crack pipesé).

[190] ECDC. *Hepatitis B and C in the EU neighborhood: prevalence, burden of disease and screening policies*. Stockholm: ECDC (Technical reports), 2010.
Niesslein S. *Chronic hepatitis B and C among migrants and at-risk groups: a systematic literature review of screening practices and approaches to minimize morbidity and mortality in Europe*. Hamburg: Hochschule für Angewandte Wissenschaften, Fakultät Life Sciences, MSc thesis, 2013.

[191] Dhumeaux D, ed. *Prise en charge des personnes infectées par les virus de l'hépatite B ou de l'hépatite C*. Paris : Ministère des Affaires sociales et de la Santé, 2014

Figure 51. Worldwide geographic distribution of HCV infection



Source: Thomas DL. Global control of Hepatitis C: where challenge meets opportunity. *Nature Medicine* 2013; 19: 850-8.

Box 10. 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. ú41,000 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.

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[192].

Tuberculosis

Regarding tuberculosis (TB), less than half of the patients seen in EU countries reported a past history of screening[193] when migrants are supposed to be systematically and actively screened at their entrance in many EU countries for decades[194].

Tuberculosis (TB) remains a major global public health concern. Worldwide, most TB cases occur in low-income settings, predominantly Asia (59%) and Africa (26%) - 80% of tuberculosis cases being

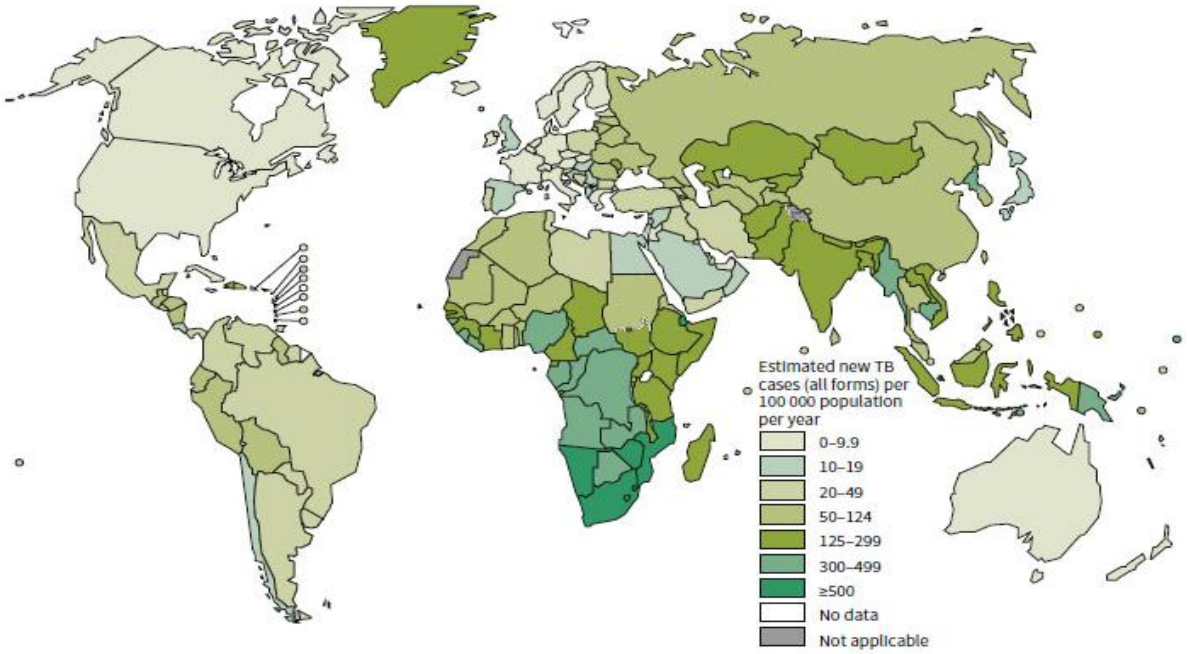
[192] Available in French at http://www.medecinsdumonde.org/Presse/Hepatite-C-Medecins-du-Monde-s-oppose-au-brevet-sur-le-sofosbuvir (last access 01/04/2015)

[193] It is suggested that the question about TB screening precises "*since your arrival in this country*?"

[194] Rieder HL, Zellweger JP, Raviglione MC, Keizer ST, Migliori GB. Tuberculosis control in Europe and international migration. *Eur Respir J* 1994; 7: 1545-53.

concentrated in 22 high-burden countries - but TB prevention and control remains a challenge in all countries.

Figure 52. Worldwide geographic distribution of TB incidence



Source: WHO, TB incidence by country in 2013.

WHO estimates that 4.3% of all TB cases in 2011 occurred in the European Region, with eastern Europe particularly affected (18 eastern European countries are defined by WHO as ó*high-priority countries*ô and are targeted with specific TB control programmes; five of these countries ï Bulgaria, Estonia, Latvia, Lithuania and Romania ï being EU Member State). **In 2010, the proportion of foreign-origin cases (i.e. among immigrants and/or foreign-born, depending of the national TB surveillance system) among all TB notifications in the EU/EEA was 25.1%, slightly higher than in 2008 (22.4%) and in 2007 (21%).** One out of five cases was among children under 15. In 2010, this proportion was 54.6% in Belgium, 48.3% in Germany, 47.2% in Greece, 32.0% in Spain, 48.3% in France, 73.5% in the Netherlands, and 68.6% in the UK. Only Belgium and Germany reported a decrease of the absolute number of TB cases in their immigrant populations.[195]

- It should be noted also that the **average percentage of extra-pulmonary TB was 14.4% in natives and 31.1% among migrants** (in half of the cases, from Southern Asia: as a consequence 54% of foreign-born TB cases had extra-pulmonary TB in UK in 2010, according to ECDC).

- Active TB disease in migrants can be the result of: i) reactivation of infection acquired previously in the country of origin (many studies have shown that migrantsô risk of active TB lasts for years ï between one and five years ï after their arrival, **so a single screening at entry is not effective**); ii) recent infection acquired in the host country (especially among destitute, underserved migrants) ; or iii) recent infection during travel to country of origin.

[195] ECDC. *Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA*. Stockholm: ECDC (Technical reports), 2014.

Patients seen in MdM and ASEM free clinics were also asked if they wish to have one of these tests (HIV, HBV, HCV) in Germany, Greece, Spain, the Netherlands and Istanbul.[196]

For instance, half of the patients seen in Munich (and asked about it) wished to be tested and almost the total number of patients seen in Istanbul. In this city, only 1% of patients knew where to go to be tested: the need for information and/or orientation is crucial when, in Munich, less than half of the patients knew where to go to be tested.[197]

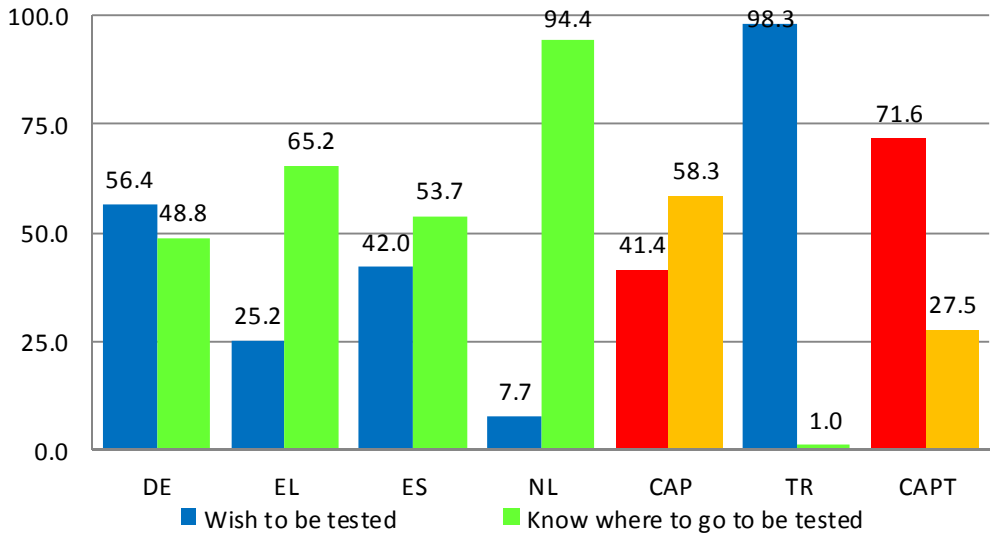
In the Netherlands, the results were relatively opposed to the other countries: a close cooperation with municipal public health services offering rapid testing services could have contributed to an increased knowledge on where to have a test. This could also explain the small number of respondents willing to get tested as many had reported having been already tested for some of the diseases. Additionally, TB testing is systematically performed at arrival for asylum seekers.

Globally, in the six European countries, **6.2% of patients who were interviewed about it and who knew their serological status were HIV+, 14.5% were HBV+, 7.5% were HCV+ and 6.0% had had a positive TB test at one moment or another.**

Harriet was diagnosed with TB in 2010. She explains how for eight years she wasnôt once sick and hadnôt so much as taken a paracetamol before contracting TB. ñ*It suddenly came on and I started sweating, my breathing was bad and I fell ill on the street [é] I was diagnosed with tuberculosis but in the first place I didnôt know. I couldnôt breathe. I couldnôt talk fluently. It took the doctor from Barnet hospital six months to diagnose me. She referred me to UCL in central London to check me. So I went there and had one night there. Straight away they put me on medication. I am still under observation because I was having severe pain. Iôm no longer on medication. When I came here I came with a visitorôs visa. I didnôt know exactly what to do*ò

MdM United Kingdom ï London ï September 2014.

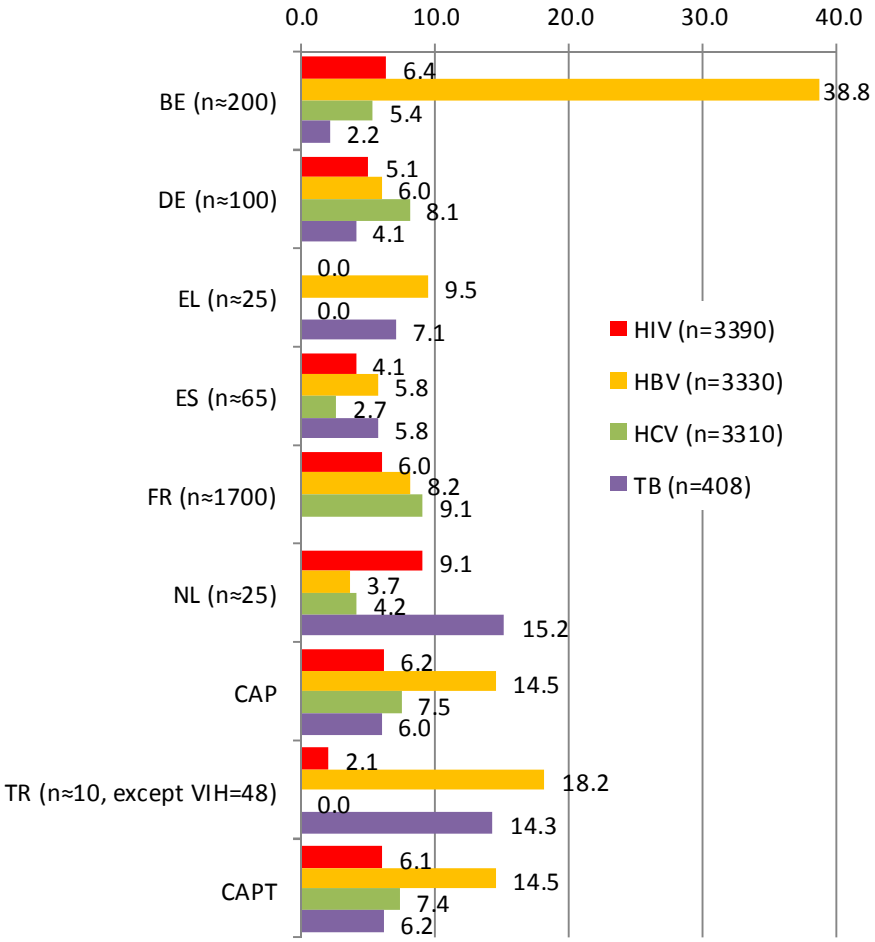
Figure 53. Proportion of patients who wished to be tested for one virus or the other (HIV, HBV, HCV), and of patients who knew where to go to be tested



[196] Missing values: respectively 42.0% in DE, 77.0% in EL, 21.8% in ES, 47.2% in NL, 3.9% in TR.

[197] Missing values: respectively 45.8% in DE, 77.0% in EL, 23.3% in ES, 42.3% in NL, 3.7% in TR.

Figure 54. Proportion of patients who knew their positive status for the different tests (in % of patients interviewed and who reported a history of screening and declared that they know their status).



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: *ñI was born in Uganda. I grew up in a tough situation. I didnôt have parents to look after me and was raised by an aunt who wasnôt often in the country. So growing up was tough and I didnôt 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 itôs tough growing up in such an environment. I managed to get out of the country and came to the UK.*

ñWhen I first came to the UK I thought life would be so easy. I thought I would be free. But it turned out that wasnôt the case. In the UK I had to live with a person close to my family and so it wasnôt 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 didnôt 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.ò

Trenton was directed to the MdM UK clinic by a friend. He relates his first contact: *ñThat 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 Iôd 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.ò*

On his arrival Trenton had had a GP, *ñBut 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, óEveryone is entitled to medical care no matter what their visa status isô. The MdM volunteer immediately started searching for all the GPs in the area. She asked whether I had been registered at their practices. Iôll 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.ò*

Trenton was diagnosed with severe depression. *ñThe 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 didnôt have valid documents. Although Iôd taken my medication in the morning, the following day I wasnôt able to take it and didnôt know who to talk to in the detention centre. I kept mentioning it to the officers and I kept telling them, óI need my medicationô. It is a 30-day treatment and you cannot skip a day.ò*

Trenton explains that he kept in contact with MdM UK and the GP so that he could get medication on a daily basis. *ñStaying 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 ï 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.ò* (Trenton means the support from MdM-UK GP.)

ñNot everyone was able to get information about what was happening around them. Some people didnôt 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. Iôm now free to live. I have the freedom to be who I am without any fear because Iôm 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. Iôm totally free and Iôm 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 Iôm 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. Iôm looking forward to starting work and Iôm looking forward to having a place of my own.ò

MdM UK ï London ï 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[198], both the Commission[199] and the Council[200] 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 consequences of the crisis and austerity policies are still having negative consequences on peopleôs health. In addition, as the Council notes, ñ*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*ò.

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 (ñ*the Council acknowledges that universal access to healthcare is of paramount importance in addressing health inequalities*ò) have not been accompanied by any real improvements in access to healthcare for groups already facing 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 ósoftô recommendations into óhardô 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 mythsé

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[201], the ECDC warns that ñ*poor access to healthcare is an important proximal risk factor for poorer health outcomes*ò and that more needs to be done to ensure equal access to healthcare for migrants, especially for asylum seekers and undocumented migrants. National governments

[198] 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))

[199] European Commission Communication on effective, accessible and resilient health systems. Op. cit.

[200] Council conclusions on the economic crisis and healthcare, Luxembourg, 20 June 2014: www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/143283.pdf

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

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 ó*quick win***ô** in terms of human rights by protecting this small group. The Member States who have done so have not seen any significant rise in the number of seriously ill migrants seeking protection. In doing so, these States are following the Parliamentary Assembly of the Council of Europe, which considered that a migrant living, for example, with HIV, ñ*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*ò[202]. 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 ñ*strong and unequivocal opposition to the death penalty in all times and in all circumstances*ò[203]. 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[204] developed by its members from 36 European countries, regarding obstetric, neonatal and gynaecology services. The Board highlights that, ñ*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*ò. The economic and societal impact of such inequitable access shows the ñ*compelling need to improve delivery of care*ò. EBCOG recommends that ñ*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***ô***s language*ò.

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[205]. It states that, ñ*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.*ò The declaration calls for better protection of migrantsô 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 Associationôs 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 whatever their administrative status and whatever legal barriers exist.**

[202] PACE Resolution 1997. *Migrants and refugees and the fight against Aids*. 2014.

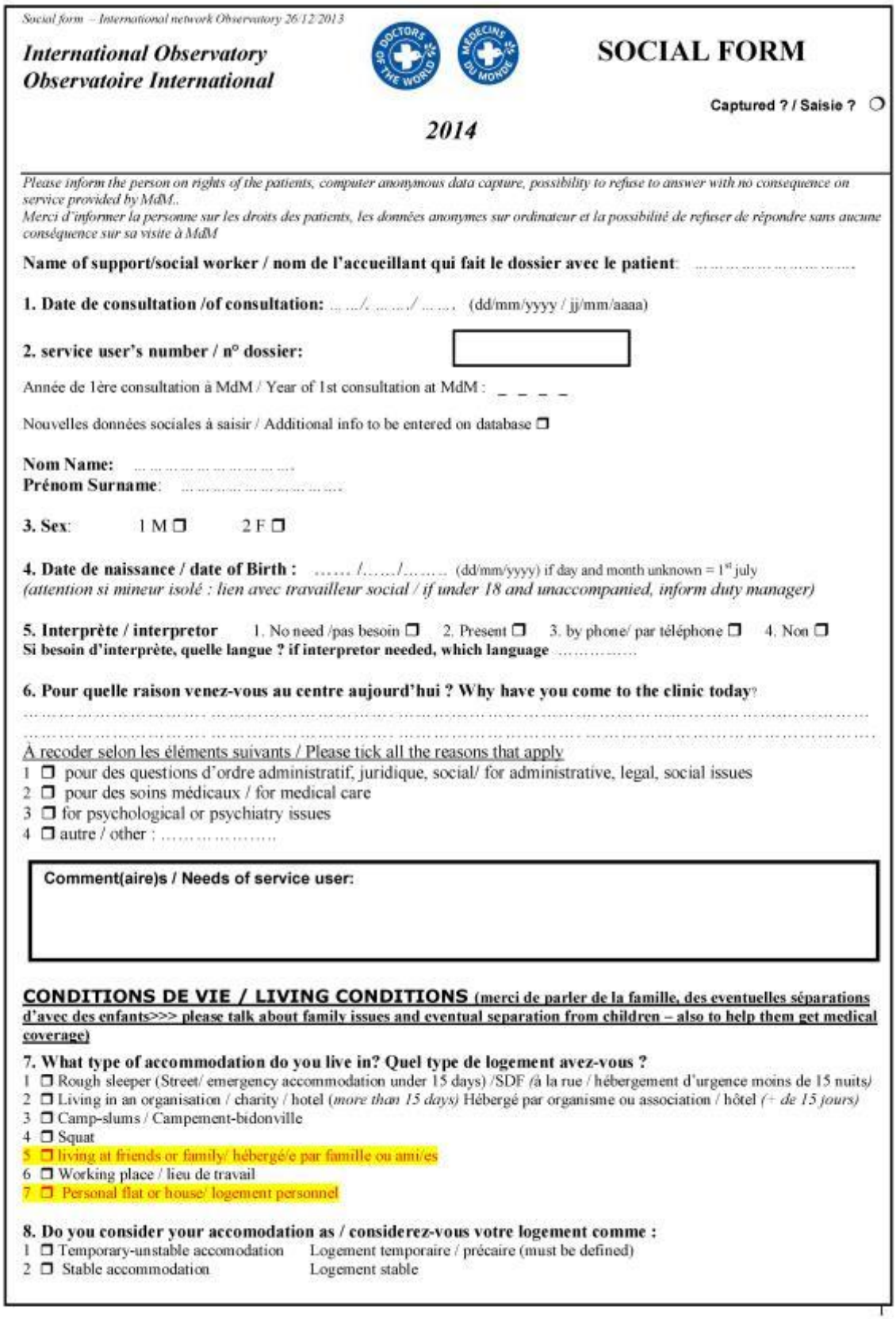
[203] EU guidelines on the death penalty. www.eeas.europa.eu/human_rights/guidelines/death_penalty/docs/guidelines_death_penalty_st08416_en.pdf

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

[205] www.eupha-migranthealthconference.com/?page_id=1766

Table of figures, tables and boxes

Appendix 1. Questionnaires (in red highlighted in yellow: the new questions or answers in 2014)



Social form – International network Observatory 26/12/2013

International Observatory
Observatoire International

SOCIAL FORM

Captured ? / Saisie ? ❍

2014

Please inform the person on rights of the patients, computer anonymous data capture, possibility to refuse to answer with no consequence on service provided by MdM..
Merci d'informer la personne sur les droits des patients, les données anonymes sur ordinateur et la possibilité de refuser de répondre sans aucune conséquence sur sa visite à MdM

Name of support/social worker / nom de l'accueillant qui fait le dossier avec le patient: ……

1. Date de consultation /of consultation: …/…/…… (dd/mm/yyyy / jj/mm/aaaa)

2. service user's number / n° dossier:

Année de 1ère consultation à MdM / Year of 1st consultation at MdM : _ _ _ _

Nouvelles données sociales à saisir / Additional info to be entered on database ❒

Nom Name: ……
Prénom Surname: ……

3. Sex: 1 M ❒ 2 F ❒

4. Date de naissance / date of Birth : ……/……/…… (dd/mm/yyyy) if day and month unknown = 1st july
(attention si mineur isolé : lien avec travailleur social / if under 18 and unaccompanied, inform duty manager)

5. Interprète / interpretor 1. No need /pas besoin ❒ 2. Present ❒ 3. by phone/ par téléphone ❒ 4. Non ❒
Si besoin d'interprète, quelle langue ? if interpretor needed, which language ……

6. Pour quelle raison venez-vous au centre aujourd'hui ? Why have you come to the clinic today?
……
……
À recoder selon les éléments suivants / Please tick all the reasons that apply
1 ❒ pour des questions d'ordre administratif, juridique, social/ for administrative, legal, social issues
2 ❒ pour des soins médicaux / for medical care
3 ❒ for psychological or psychiatry issues
4 ❒ autre / other : ……

Comment(aire)s / Needs of service user:

CONDITIONS DE VIE / LIVING CONDITIONS (merci de parler de la famille, des eventuelles séparations d'avec des enfants>>> please talk about family issues and eventual separation from children – also to help them get medical coverage)

7. What type of accommodation do you live in? Quel type de logement avez-vous ?
1 ❒ Rough sleeper (Street/ emergency accommodation under 15 days) /SDF *(*à la rue / hébergement d'urgence moins de 15 nuits*)*
2 ❒ Living in an organisation / charity / hotel (*more than 15 days)* Hébergé par organisme ou association / hôtel *(+ de 15 jours)*
3 ❒ Camp-slums / Campement-bidonville
4 ❒ Squat
5 ❒ living at friends or family/ hébergé/e par famille ou ami/es
6 ❒ Working place / lieu de travail
7 ❒ Personal flat or house/ logement personnel

8. Do you consider your accomodation as / considerez-vous votre logement comme :
1 ❒ Temporary-unstable accomodation Logement temporaire / précaire (must be defined)
2 ❒ Stable accommodation Logement stable

9. A votre avis, ce logement est-il néfaste pour votre santé ou pour celle des enfants qui y vivent ? Do you believe your accommodation is affecting your health and/or children's health??

(*peeling paint, damp, non access to water, no heating, domestic accident risks)*

1. Yes-Oui ❒ 2. No ❒

If yes please see why / si oui, merci de voir les raisons

10. Do you have children under 18 years old ? 1. Yes ❒ 2. No ❒

11. If yes: do you live with / si oui : vivez vous avec

11.1 ❒ all of them (how many) / tous (combien)
11.2 ❒ only part of them (how many) / une partie d'entre eux (combien)
11.3 ❒ with none of them / sans aucun

12. Comment est votre état de santé général ?/ How is your general health?

1 ❒ very good / très bon
2 ❒ good / bon
3 ❒ fair / moyen
4 ❒ bad / mauvais
5 ❒ very bad / très mauvais

13. Comment est votre état de santé physique? How is your physical health?

1 ❒ very good / très bon
2 ❒ good / bon
3 ❒ fair / moyen
4 ❒ bad / mauvais
5 ❒ very bad / très mauvais

14. Comment est votre état de santé psychologique et émotionnel ? How is your psychological and emotional health?

1 ❒ very good / très bon
2 ❒ good / bon
3 ❒ fair / moyen
4 ❒ bad / mauvais
5 ❒ very bad / très mauvais

15. Dans cette ville, pouvez-vous compter sur quelqu'un pour vous soutenir moralement, vous réconforter en cas de besoin? / In this town, can you rely on someone to support you emotionally, to comfort you, if needed?

1 ❒ Very frequently / très souvent
2 ❒ Frequently / souvent
3 ❒ Sometimes / parfois
4 ❒ Never / jamais

ACTIVITES ET RESSOURCES

16. Exercez-vous une activité pour gagner votre vie ? Do you have a job or another activity to earn a living?

1. Yes ❒ 2. No ❒

17. With or without a job, how much money did you have on average to live with, each month in the past 3 months: over poverty threshold or under / Avec ou sans boulot, avec combien d'argent vivez-vous par mois en moyenne sur les 3 derniers mois : au-dessus ou au dessous du seuil de pauvreté

1. Over – au-dessus > ❒ 2. Under - below < ❒ *attention: look at poverty threshold in your country*

NL= 938€; SE = 921€; DE = 912€; FR= 903€; BE= 900€; UK = 860€; ES= 645€; EL = 574€; CA = 900$

SITUATION ADMINISTRATIVE / ADMINISTRATIVE SITUATION

18. Quelle est votre nationalité ? What is your nationality ?

.....

communauté si déclarée/ ethnic group if declared .....

19. Dernière date d'entrée ici / Date of your last entry to this country? _ _ /_ _ / _ _ _ _ (jj/mm/aaaa - dd/mm/yyyy)

1 ❒ Non concerné (né et resté ici) /Not applicable (was born and stayed here)

20. Au total (tous séjours confondus), combien de temps avez-vous séjourné ici? /In total (including every time you have been here), how long have you lived here?

1 ❒ _ _ _ _ mois / months
2 ❒ _ _ _ _ années / years

21. Quelle est votre situation administrative ici? What is your immigration status at the moment? (Tick only one/ ne cochez qu'une réponse)

1 ❒ N'a pas besoin de titre de séjour (national, mineur) / residency permit not applicable (national...)

➔ Pour les citoyens UE / For EU citizens

2 ❒ n'a pas besoin de titre de séjour car ici depuis moins de 3 mois/Doesn't require a residency permit: here for less than 3 months
3 ❒ est autorisé à rester : a des ressources suffisantes « officielles » et une assurance maladie valable (ici ou dans pays d'origine)
Can stay: has adequate « official » means and health insurance (here or in country of origin)
4 ❒ n'est pas autorisé à rester ici : ici depuis + de 3 mois, sans ressources suffisantes « officielles » et sans assurance maladie
Doesn't have leave to remain: has stayed over 3 months, doesn't have enough official financial means and no health insurance

➔ Pour les citoyens hors UE	**For non EU citizens**
5 ❒ A un titre de séjour valide + date validité	Has a valid residency permit + permit end date
6 ❒ Demandeur d'asile (demande ou recours en cours)	Asylum seeker (Has processed a claim or appealing still in process)
7 ❒ Visa tourisme, étudiant, court séjour	Tourist, student, short stay visa
8 ❒ Visa travail	Work visa
9 ❒ Protection subsidiaire / humanitaire	Humanitarian Protection/ Discretionary Leave
10 ❒ Sans autorisation de séjour/	Undocumented
11 ❒ Titre de séjour dans un autre pays européen	Permit to stay in another EU country

12 ❒ Situations spécifiques donnant un droit au séjour (à compléter selon les pays) : demande de régularisation en cours, Duldung (DE)/ Specific situations giving a right to stay (complete for countries) : Under process for sorting out papers ...
13 ❒ ne sait pas / unable to define status

22. Etes-vous ou avez-vous été concerné/e par l'asile ? Have you ever claimed asylum or do you plan to claim asylum?
1. Yes -Oui ❒ 2. No ❒

23. Si oui, quelle est votre situation à ce jour ?	**If yes, what is your situation today?**
1 ❒ Débouté(e) du droit d'asile	Claimed asylum but refused
2 ❒ Procédure Dublin II/Eurodac	Dublin II/Eurodac procedure
3 ❒ N'a pas encore déposé la demande d'asile	Hasn't submitted yet the asylum request
4 ❒ Demandeur d'asile (demande ou recours en cours)	Asylum seeker (Has processed a claim or appealing still in process)
5 ❒ Refugié	Refugee

Commentaires/ Commentaries

Pour les personnes sans autorisation de séjour ou sejour precaire / For undocumented/ precarious migrants

24. En ce moment, vous arrive-t-il de limiter vos déplacements de peur d'être arrêté/e ? / Do you currently limit your movements for fear of being arrested?

1 ❒ Very frequently / très souvent
2 ❒ Frequently / souvent
3 ❒ Sometimes / parfois
4 ❒ Never / jamais

25. Pour quelle(s) raison(s) avez-vous quitté votre pays ? Why did you leave your country? (plusieurs réponses possibles / several answers possible)

1 ❒ Pour des raisons politiques, religieuses, ethniques, d'orientation sexuelle / For political, religious, ethnic reasons or sexual orientation
2 ❒ pour fuir la guerre / to escape from war,
3 ❒ For economic reasons, to earn a living, because had no perspectives/ no way to earn a living in his own country / Pour des raisons économiques, pour gagner votre vie, parce que n'avait pas de perspectives / ne pouvait pas gagner sa vie dans son pays
4 ❒ Because of family conflict(s) / A cause de conflits familiaux
5 ❒ For personal health reasons / Pour des raisons personnelles de santé : ……
6 ❒ To join or follow someone / Pour retrouver ou suivre quelqu'un
7 ❒ To study / Pour faire des études
8 ❒ To ensure the future of your children / Pour assurer l'avenir de vos enfants
9 ❒ Other / Autre - specify: ……

COUVERTURE MALADIE, OBSTACLES A L'ACCES ET A LA CONTINUITE DES SOINS/ HEALTH COVERAGE AND OBSTACLES TO ACCESS TO HEALTHCARE

26. Couverture des frais de sante ? Healthcare costs chargeable or not (2 answers possible)

1 ❒ A une couverture maladie totale (autant qu'elle existe dans le pays)/ has full medical coverage, not chargeable (as much as possible in the country)	
2 ❒ A une couverture maladie partielle	Has medical coverage only for part of costs
3 ❒ Aucune prise en charge/ doit tout payer	No health cover at all / fully chargeable
4 ❒ Accès gratuit médecine générale	Free access to GP
5 ❒ Accès médecine générale avec participation	Access to GP but must pay a part
6 ❒ Accès soins 2ème ligne sans MG	Access to secondary care but no GP yet
7 ❒ Accès soin par soin	Access on case by case basis
8 ❒ Accès seulement aux urgences	Access only in Emergency room
9 ❒ Droits ouverts dans un autre pays européen	Healthcare coverage in another European country

27. Au cours de l'année écoulée, avez-vous rencontré des problèmes pour accéder aux soins ou à un professionnel de santé ? / In the past 12 months, have you faced problems in accessing healthcare or healthcare providers? *(4 réponses possibles - Il s'agit d'obstacles cités par le patient ou repérés lors de l'entretien par l'accueillant ou travailleur social/ 4 possible answers ; obstacles quoted by the patient or that you could notice*

01 ❒ Did not try to access healthcare services / n'a pas essayé d'aller dans une structure médicale
02 ❒ No difficulties/ Pas d'obstacles
03 ❒ administrative problems and issues with documentation in order to obtain non chargeable costs/ problèmes concernant des justificatifs ou preuves à apporter pour obtenir une prise en charge des frais
04 ❒ Lack of understanding or knowledge of the system and rights / Ne connait pas ou ne comprend pas le système ni ses droits
05 ❒ Was denied health coverage / N'a pas obtenu de couverture maladie
06 ❒ Medical consultation, treatment or deposit too expensive / Consultation ou traitement ou avance trop cher
07 ❒ Language barrier / Barrière linguistique
08 ❒ Fear of being reported or arrested / peur d'être dénoncé et/ou arrêté
09 ❒ Previous bad experience within the health system / mauvaise expérience dans le système de santé
10 ❒ Healthcare coverage too expensive / couverture santé trop chère
11 ❒ Health coverage open in another EU country / couverture maladie ouverte dans un autres pays européen
12 ❒ Other reasons expressed / Autre raison : ……

28. Est-ce que vous avez déjà renoncé à des soins pour vous-même au cours des 12 derniers mois ? / Have you given up seeking medical advice/treatment for yourself in the past 12 months?
1. Yes - Oui ❒ 2. No ❒

29. Depuis 1 an, est-ce qu'on a refusé de vous soigner dans une structure de santé ? / In the past 12 months have you been denied access to healthcare in this country by any healthcare provider?
1. Yes - Oui ❒ 2. No ❒

30. Au cours de l'année écoulée, avez-vous été personnellement victime de racisme (couleur ou origine ethnique) dans une structure de santé ? / In the past year have you personally been a victim of racism (color or ethnic origin) by a healthcare provider?
1. Yes - Oui ❒ 2. No ❒

Notes / case studies / testimonies

Merci de vérifier que vous avez donné toutes les informations nécessaires au patient pour qu'il elle accède à ses droits en matière de prise en charge financière des soins ET connaisse le système d'accès aux soins dans votre pays.
Please make sure you have given all relevant information so that the service user can obtain all possible health coverage and knows the health system in your country

International Observatory
Observatoire International

MEDICAL FORM

2014

Captured ? / Saisie ? ❍

Please inform the person on rights of the patients, computer anonymous data capture, possibility to refuse to answer with no consequence on service provided by MdM..
Merci d'informer la personne sur les droits des patients, les données anonymes sur ordinateur et la possibilité de refuser de répondre sans aucune conséquence sur sa visite à MdM

Nom du médecin / infirmier(e) / Name of doctor / nurse : ……

1. Patient's number / Numéro de dossier :

2. Date de consultation / Date of consultation : _ _ / _ _ / _ _ _ _ (jj/mm/aaaa_dd/mm/yyyy)

- Nom / Surname : ……
- Prénom/ First name : ……

3. Sex : 1 M ❒ 2 F ❒ **4. Date de Naissance / Birthdate** : ….. /…… /…… (jj/mm/aaaa - dd/mm/yyyy)
if day and month unknown = 1st july

⚠ Merci de regarder le dossier social / Please read the social form

5. Interprète / interpretor 1. No need /pas besoin ❒ 2. Present ❒ 3. by phone/ par téléphone ❒ 4. Non ❒

- Langue parlée, si problème de langue ou interprète/ language required if interpreter needed: ……

6. ETAT DES VACCINATIONS ENFANTS/ ACTUAL STATE OF CHILDREN VACCINATIONS

		6'. Fait ce jour /Done the day of consultation *(Marque, lot, 1ère, 2ème, 3ème injection, rappel*
a) Tétanos /Tetanus	1 ❒Oui 2 ❒ probable 3 ❒Non 4 ❒ sait pas/ doesnt know	1 ❒ Oui _
b) Hépatite B*	1 ❒Oui 2 ❒ probable 3 ❒Non 4 ❒ sait pas/ doesnt know	1 ❒ Oui** _
c) ROR /MMR	1 ❒Oui 2 ❒ probable 3 ❒Non 4 ❒ sait pas/ doesnt know	1 ❒ Oui _
d) Coqueluche/ Whooping cough	1 ❒Oui 2 ❒ probable 3 ❒Non 4 ❒ sait pas/ doesnt know	1 ❒ Oui _
		1 ❒ Oui _

** si pas toutes les doses cocher non if not all doses given please tick No*
***only after blood test results / à ne faire qu'après avoir vu des résultats de test sanguin*

7. Le patient sait où se faire vacciner (avant de le lui dire) / Patient knows where to receive vaccination (before you tell her/him) 1. Yes-Oui ❒ 2. No ❒

➔ Penser à orienter ou à vacciner - Please don't forget to give information about where to receive vaccination or do it

Women specific

8. Women : how many previous pregnancies/ Femmes : combien de grossesses antérieures: ….
9. Age 1st pregnancy / Age de la 1ère grossesse : …..
10. Do you have a contraception today/ avez-vous une contraception à ce jour 1. Yes-Oui ❒ 2. No ❒
11. If no, do you want one / si non, en voulez-vous? 1. Yes-Oui ❒ 2. No ❒

12. Femme enceinte / Pregnant woman 1 ❒ Oui Yes W78 2 ❒ Non No
12.1. Nombre de semaines de la grossesse / weeks of pregnancy _ _ semaines /weeks
12.2. A accès aux soins prénataux /has access to antenatal care 1. Yes-Oui ❒ 2. No ❒
12.3. Si pas de suivi, motif de non suivi / If has no follow up, reasons for no access to antenatal care:
……
……
……
12.4. Retard de suivi de grossesse >12 semaines / antenatal care received late >12weeks : 1. Yes-Oui ❒ 2. No ❒
12.5. Demande d'IVG / Wants a Termination of pregnancy W79 1. Yes-Oui ❒ 2. No ❒

1

ANTECEDENTS / ALLERGIES / CONTRE INDICATIONS / FACTEURS DE RISQUES// MEDICAL HISTORY/ ALLERGIES/ CONTRAINDICATIONS/ RISKS FACTORS :

EXAMEN MEDICAL / MEDICAL EXAMINATION

Traitement habituel / en cours (Classe / posologie / durée)/ **Usual treatment /ongoing treatment** (class, dosage, time):
Contraception

TA / Blood pressure: _ _ _ _ _
Fréquence cardiaque / Pulse: _ _ _ _ _

Poids /Weight: _ _ _ _ **kg**
Taille /Height : _ _ _ _ **cm**
IMC BMI: _ _ _ _

13- PROBLEME(S) DE SANTE ou résultat(s) de la consult. HEALTH PROBLEM or result of consultation: ***diagnostic(s) OU symptômes et plaintes si pas de diagnostics /diagnosis or symptoms and complaints if no diagnosis***

13.1 ❒ Aucun problème de santé / no health problem

	1er pb/diagnostic	**2ème pb/diagnostic**	**3ème pb/diagnostic**
Diagnostic (ou symptômes si inconnu)			
13.2 Code CISP **ICPC code**	_ _ _	_ _ _	_ _ _
13.3 : waiting for diagnosis **Diagnostic en attente**	1 ❒ diagnostic en attente	1 ❒ diagnostic en attente	1 ❒ diagnostic en attente
13.4 La pathologie est-elle aigue ou chronique ? **Is the pathology acute or chronic?**	1 ❒ aigüe /acute 2 ❒ chronique /chronic 3 ❒ ne sait pas/ doesn't know	1 ❒ aigüe /acute 2 ❒ chronique /chronic 3 ❒ ne sait pas/ doesn't know	1 ❒ aigüe /acute 2 ❒ chronique /chronic 3 ❒ ne sait pas/ doesn't know
13.5 Un traitement ou un suivi serait-il… **Treatment or follow-up would be**	1 ❒ nécessaire/ necessary 2 ❒ accessoire- de précaution/ precautionary	1 ❒ nécessaire/ necessary 2 ❒ accessoire- de précaution/ precautionary	1 ❒ nécessaire/ necessary 2 ❒ accessoire- de précaution/ precautionary
Si traitement/suivi nécessaire If treatment of follow up is necessary : **13.6. le problème était-il traité ou suivi avant la 1ère consultation à MdM ?** **Did this problem have a follow up or a treatment before 1st consultation in MdM ?**	1 ❒ oui / yes 2 ❒ oui partiellement-irrégulièrement/ yes partially or only on and off 3 ❒ non / no 4 ❒ ne sait pas / doesn't know	1 ❒ oui / yes 2 ❒ partiellement-irrégulièrement/ yes partially or only on and off 3 ❒ non / no 4 ❒ ne sait pas / doesn't know	1 ❒ oui / yes 2 ❒ partiellement-irrégulièrement/ yes partially or only on and off 3 ❒ non / no 4 ❒ ne sait pas / doesn't know
Please ask the patient /	*SVP demandez au patient*	*For Chronic pathologies*	*Pour pathos chroniques*
13.7. Connaissiez-vous ce problème de santé avant votre départ pour l'Europe ? **Did you know about this health problem before coming to Europe ?**	1 ❒ oui /yes 2 ❒ non /no 3 ❒ non concerné(e) / not applicable	1 ❒ oui /yes 2 ❒ non /no 3 ❒ non concerné(e) / not applicable	1 ❒ oui /yes 2 ❒ non /no 3 ❒ non concerné(e) / not applicable
13.8 Should this health problem have been treated earlier? **Ce problème de santé aurait-il dû être traité plus tôt ?**	1 ❒ oui /yes 2 ❒ non /no	1 ❒ oui /yes 2 ❒ non /no	1 ❒ oui /yes 2 ❒ non /no

➔ Attention, en cas de pathologie grave, merci d'informer le patient sur les possibilités de régularisation et de l'accompagner dans la démarche. If seriously ill, please help with obtaining humanitarian protection (foreigners) 2

TRAITEMENTS PRESCRITS *(forme, posologie, durée, quantité remise)*
PRESCRIBED TREATMENTS (precise dosage and quantity)

…… ❒ Remis Given ❒ Non remis Not given
…… ❒ Remis Given ❒ Non remis Not given
…… ❒ Remis Given ❒ Non remis Not given
…… ❒ Remis Given ❒ Non remis Not given

14 - VIOLENCES (it is easier to start with violence the person might have witnessed, do not ask the questions on the paper but give each patient an opportunity to speak freely about the violence s/he has been victim of or has witnessed)

	Non Yes	Oui No	Si oui, chronologie par rapport à l'arrivée If yes, when was it ?		
			Avt Before	Pdt le trajet During journey	Ici Here
14.01. a vécu dans un pays en guerre - has lived in a country at war					
14.02. a été menacé(e) physiquement ou emprisonné(e) pour ses idées ou a été torturé/e Has been physically threatened or imprisoned for ideas or has been tortured					
14.03. a été victime de violences de la part de forces de l'ordre (police, armée) - Has been the victim of violence by police or army forces					
14.04. A été battu(e) ou blessé(e) dans votre famille ou ailleurs - has been beaten up or injured as a result of domestic violence or by other people					
14.05. a subi une agression ou des attouchements sexuels - has been sexually assaulted or molested					
14.06. a été violé/e – has been raped					
14.07. a été victime de violences psychologiques / has been victim of psychological violence					
14.08. L'argent gagné ou les papiers ont été confisqués- earned money or identity documents have been confiscated					
14.09. A souffert de la faim - has suffered from hunger ?					
14.10. a subi des mutilations génitales / has been genitally mutilated					
14.11. A été exposé(e) à un autre événement violent non évoqué dans les questions précédentes ? Has suffered from any other type of exposure to violence that has not been mentioned in the questions above?					
14.12. Précisez éventuellement / Explain further : _ _ _ _ _ _ _ _					
14.13. ❒ Sujet non abordé lors de la consultation / Question was not asked during consultation					

Commentaires

HIV – HBV - + TUBERCULOSE - SEROLOGY + TUBERCULOSIS

❒ **Items sur VIH-VHB-VHC et TB non abordés / HIV-HBV-HCV and TB were NOT discussed**

15. Avez-vous été testé / have you had a test ? - Si oui, résultats du test

a) HCV-VHC 1. Yes ❒ 2. No ❒ 3. Positif + ❒ 4. Négatif - ❒ 5. Ne sait pas/ Doesn't know ❒ */Date of test :*

b) HBV-VHB 1. Yes ❒ 2. No ❒ Un médecin a-t-il déclaré que vous aviez le VHB ? /Did a doctor tell you that you had HBV? 3.Yes ❒ 4.Non ❒ 5. Ne sait pas/ Doesn't know ❒ */Date :*

c) VIH/HIV 1. Yes ❒ 2. No ❒ 3. Positif + ❒ 4. Négatif -❒ 5. Ne sait pas/ Doesn't know ❒ / *Date of test*

d) Tuberculose 1. Yes ❒ 2. No ❒ Un médecin a-t-il déclaré que vous aviez la TB ? /Did a doctor tell you that you had TB? 3.Yes❒ 4.Non❒ 5. Ne sait pas/ Doesn't know❒ */Date :*

16. Do you wish to have one or all of these tests – voulez-vous être dépisté pour l'un ou tous HIV/HBV/HCV: 1. Yes-Oui ❒ 2. No ❒

17. Do you know where to go to get tested / savez-vous où aller pour être testé: 1. Yes-Oui ❒ 2. No ❒

3

Notes for Doctors

18. Is this patient's case urgent? Le cas de ce patient est-il urgent ?
1 ☐ Urgent 2 ☐ Fairly urgent / assez urgent 3 ☐ Non-urgent

19. Does this patient require close follow-up? e.g accompaniment or more contact? Ce patient a-t 'il besoin d'un suivi rapproché, d'accompagnement, de plus de contacts
1 ❒ Oui Yes 2 ❒ Non No

EXAMENS COMPLEMENTAIRES – DEPISTAGE ORIENTATION / COMPLEMENTARY TESTS AND ORIENTATIONS seulement pour le suivi local = only for monitoring

20. Orientation vers quelles structures ? Where have you referred the patient and for what?
01 ❒ Différents tests / examens (laboratoire, échographie, …) Tests, exams (laboratory, echography)
1. ❒ Frottis cervico vaginal / vaginal exam, ……
2. ❒ Mammographie / mammography ……
3. ❒ Autre examen ou dépistage, précisez / Other exams or tests : specify: ……
02 ❒ Test maladies infectieuses / Tests for infectious diseases
1. ❒ HIV
2. ❒ VHB
3. ❒ VHC
03 ❒ Radio pulmonaire / Pulmonary X ray : Tuberculosis
04 ❒ Structures publiques de santé / privées pour soins (dont urgences et spécialistes) Public or private healthcare services (including emergencies and specialists)
1. ❒ consultations spéciales pour public précaire / special consultation for people in precarious situation ……
2. ❒ Urgences / Accident and Emergencies ……
3. ❒ Autres consultations hospitalières / Other consultations at the hospital……
4. ❒ Autre (médecin généraliste, spécialiste…)/ other (GP, specialist…)
05 ❒ Suivi de grossesse / antenatal follow up
06 ❒ Consultation psychologiques ou psychiatriques / Psychological or psychiatric consultation ……
07 ❒ Centres de prévention (enfants, planning) / Prevention centres (children, family planning)
08 ❒ Centre de vaccination (vaccination centre)……
09 ❒ Addressed / advice on regularization for medical reasons / Orientation pour régularisation pour raisons médicales
10 ❒ Orientation interne à MDM, précisez / referral within MdM, specify……
11 ❒ Autres, précisez / Other, specify ……

MEDICAL RECONSULTATION FORM

International Observatory 2014 **Captured ? / Saisie ?** ❍

Please inform the person on rights of the patients, computer anonymous data capture, possibility to refuse to answer with no consequence on service provided by MdM.. / Merci d'informer la personne sur les droits des patients, les données anonymes sur ordinateur et la possibilité de refuser de répondre sans aucune conséquence sur sa visite à MdM

Nom du médecin / infirmier(e) / Name of doctor / nurse : ……

1. Patient's number / Numéro de dossier :

2. Date de consultation / Date of consultation : _ _ / _ _ / _ _ _ _ (jj/mm/aaaa_dd/mm/yyyy)

- Nom / Surname : ……

- Prénom/ First name : ……

3. Sex : 1 ❒ M 2 ❒ F **4. Date de Naissance / Birthdate** : …. /…. /…… (jj/mm/aaaa - dd/mm/yyyy)
if day and month unknown = 1st july

5. Interprète / interpretor 1. No need /pas besoin ❒ 2. Present ❒ 3. by phone/ par téléphone ❒ 4. Non ❒

New information on vaccination, violence, HIV/HBV/HCV : ❒ (pour la saisie / for data capture)

TA / Blood pressure: _ _ _ _ _
Fréquence cardiaque / Pulse: _ _ _ _ _

Poids /Weight: _ _ _ _ kg
Taille /Height : _ _ _ _ cm
IMC BMI: _ _ _ _

13- PROBLEME(S) DE SANTE ou résultat(s) de la consult. HEALTH PROBLEM or result of consultation:
diagnostic(s) OU symptômes et plaintes si pas de diagnostics /diagnosis or symptoms and complaints if no diagnosis

13.1 ❒ Aucun problème de santé / no health problem

	1er pb/diagnostic	2ème pb/diagnostic	3ème pb/diagnostic
Diagnostic (ou symptômes si inconnu)			
13.2 Code CISP ICPC code	_ _ _	_ _ _	_ _ _
13.3 : waiting for diagnosis Diagnostic en attente	1 ❒ diagnostic en attente	1 ❒ diagnostic en attente	1 ❒ diagnostic en attente
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➔ En cas de pathologie grave, merci d'informer le patient sur les possibilités de régularisation et de l'accompagner dans la démarche.
If seriously ill, please help with obtaining humanitarian protection (foreigners)

1

TRAITEMENTS PRESCRITS *(forme, posologie, durée, quantité remise)*
PRESCRIBED TREATMENTS (precise dosage and quantity)

..... ❒ Remis Given ❒ Non remis Not given
..... ❒ Remis Given ❒ Non remis Not given
..... ❒ Remis Given ❒ Non remis Not given
..... ❒ Remis Given ❒ Non remis Not given

Notes for Doctors

12. Femme enceinte / Pregnant woman 1 ❒ Oui Yes W78 2 ❒ Non No
12.1. Nombre de semaines de la grossesse / weeks of pregnancy _ _ semaines /weeks
12.2. A accès aux soins prénataux /has access to antenatal care 1. Yes-Oui ❒ 2. No ❒
12.3. Si pas de suivi, motif de non suivi / If has no follow up, reasons for no access to antenatal care:
.....
.....
.....
12.4. Retard de suivi de grossesse >12 semaines / antenatal care received late >12weeks : 1. Yes-Oui ❒ 2. No ❒
12.5. Demande d'IVG / Wants a Termination of pregnancy W79 1. Yes-Oui ❒ 2. No ❒

18. Is this patient's case urgent? Le cas de ce patient est-il urgent ?
1 ☐ Urgent 2 ☐ Fairly urgent / assez urgent 3 ☐ Non-urgent

19. Does this patient require close follow-up? e.g accompaniment or more contact? Ce patient a-t'il besoin d'un suivi rapproché, d'accompagnement, de plus de contacts
1 ❒ Oui Yes 2 ❒ Non No

EXAMENS COMPLEMENTAIRES – DEPISTAGE ORIENTATION / COMPLEMENTARY TESTS AND ORIENTATIONS seulement pour le suivi local = only for monitoring

20. Orientation vers quelles structures ? Where have you referred the patient and for what?
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1. ❒ Frottis cervico vaginal / vaginal exam, ...
2. ❒ Mammographie / mammography .....
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1. ❒ HIV
2. ❒ VHB
3. ❒ VHC
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1. ❒ consultations spéciales pour public précaire / special consultation for people in precarious situation .....
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4. ❒ Autre (médecin généraliste, spécialiste...)/ other (GP, specialist...)
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08 ❒ Centre de vaccination (vaccination centre).....
09 ❒ Addressed / advice on regularization for medical reasons / Orientation pour régularisation pour raisons médicales
10 ❒ Orientation interne à MDM, précisez / referral within MdM, specify.....
11 ❒ Autres, précisez / Other, specify .....

Appendix 2. Missing data per country (selection)

Sex

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	2.3	1	0.2	1.6	0	0.3	0.8	1	0.4	0.8	0.7	2.4	0.2	0.9	0.7

Initial reason for consultation

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	2.5	0.3	0	1.8	0.4	12.2	0	2	3.9	2.6	7.6	2.7	0	2.3	7.7

Type of accommodation

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	4.3	10.6	3	100	0	33.1	12.2	3.1	8.6	19.4	24.7	15.2	2.5	17.5	25.1

Accommodation stability

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	95.3	14.7	4.2	100	1.5	34.7	13	4.1	8.8	30.7	39.2	17.9	3.2	27	39.8

Accommodation harmful

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	95.6	65.1	22.8	18.5	1.1	100	8.9	13.3	58.3	42.6	78.6	23	4.3	37.4	79.2

Children < 18

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	59.3	65.3	22.1	25.7	7.3	37.4	35	3.1	42.5	33.1	37.3	23	4.8	29.6	38

Living with children

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	85.4	88.6	75.9	75.2	57.6	76.7	86.2	57.1	66.1	74.3	71.3	72.3	61.5	73	76

General health status

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	96	76.5	18.8	20.5	0.8	100	5.7	3.1	13.2	37.2	74.8	36.1	5	34.2	75.8

Physical health status

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	100	78.2	20	20.5	0	100	4.9	3.1	13.2	37.8	75.5	33.1	5	34.4	76.4

Psychological health status

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	100	78	21.5	20.9	0	100	5.7	6.1	13	38.4	75.5	33.1	5.8	34.9	76.5

Support

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	100	80	24.1	21.8	0.8	100	5.7	7.1	13.2	39.2	75.8	40.2	7.1	36.4	76.9

Job/activity

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	95.3	62.8	7	17.7	0.4	47.7	26	6.1	36.3	33.3	46.9	20.6	4.2	29.5	47.5

Income

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	95.5	67.3	15.4	20.8	3.1	64.8	4.9	9.2	13.3	32.7	54.8	32.8	8.4	30.5	55.9

Nationality

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	1.5	0.3	1.1	2.2	0	9.7	3.3	1	9	3.1	6.6	14.5	2	4.1	7

Administrative situation

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	7.1	9.4	4.8	100	2.7	32.6	1.6	7.1	8.8	19.3	24.8	20.6	4.3	18.1	25.4

AMONG NON NATIONALS

Asylum seeker

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	20.9	5.6	80	68.4	3.5	31	4.2	30.9	25	29.9	27.5	16	8.6	26.7	28.2

Last year of entry

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	34.2	31.3	53.7	100	3.1	24.9	12.6	18.6	12.6	32.3	25.8	13.2	7.4	28.3	26.4

Total length of stay (months)

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	100	39.4	73.7	100	30.4	100	88.2	17.5	80.1	69.9	86.1	80	55.4	69.5	90.8

Total length of stay (years)

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	100	89.8	84.2	100	71.2	100	13.4	90.7	32.4	75.7	84.2	74.8	76.6	75.7	90.1

Reasons for migration

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	95.2	60.1	2.6	26.5	1.5	100	6.7	41.2	6.8	37.8	74.4	31.2	6.1	34.4	75.3

Among asylum seeker: Asylum situation

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	13.9	0.7	21.7	14.6	14.3	0	1.8	9.5	0.9	8.6	4	4.4	4.9	7.9	4.4

Fear to be arrested

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	100	82.3	92.6	76.4	29.4	68.2	17.9	73.5	31.5	63.5	65.2	65.5	6.9	58.6	66.8

Health coverage

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	6.9	4.3	2.9	52.2	2.7	33.7	7.3	18.4	17.1	16.2	24	19.9	9.5	15.9	24.9

Access Barriers

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	96.1	93.4	1.7	42.4	3.1	43.7	9.8	17.3	31.5	37.7	45.9	33.4	20.2	35.7	47.7

Medical advice or treatment given up

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	96.7	93.9	29.3	43.3	0.8	40.5	8.1	16.3	65.5	43.8	48.1	42.9	22.4	41.8	50.1

Access Denied

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	96.7	93.7	30.4	43.3	0.8	58.6	11.4	17.3	62	46	58	43.2	22.4	43.6	60

Racism healthcare service

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	100	93.9	34.8	45.3	0.8	100	23.6	19.4	68.7	54.1	82.5	42.2	22.5	50.1	84.6

VIOLENCE

Country at war

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98	91.4	90.5	84.7	25.6	98.8	74.8	100	89	83.6	88.2	100	3.7	77.9	90.2

Physically threatened or imprisoned

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98.1	93.4	92.8	84.9	26.7	99	74.8	100	89.2	84.3	88.5	100	3.9	78.4	90.6

Security forces

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	97.9	93.4	92.2	84.9	27.5	99.3	77.2	100	90.4	84.8	88.7	100	3.7	78.8	90.8

Domestic or other violence

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98	92.2	93	84.9	25.2	99.1	76.4	100	90.7	84.4	88.6	99.7	3.7	78.4	90.7

Sexual assault

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98.9	95.2	92.6	85	27.5	99.7	74.8	100	90.9	85	89.2	100	3.7	78.9	91.2

Rape

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98.7	95.7	93.2	84.9	28.2	100	76.4	100	91.2	85.4	89.4	100	3.7	79.3	91.5

Psychological

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98.3	92.2	93	84.9	27.5	100	76.4	100	88.7	84.6	89	100	3.7	78.6	91.1

Paper or money confiscated

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98.8	95.2	93.3	84.9	29	100	78	100	91.1	85.6	89.4	100	3.9	79.5	91.5

Hunger

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98.7	95.7	92.6	84.9	30.2	98.9	77.2	100	91.4	85.5	88.8	100	3.7	79.4	90.9

Pregnant women among women

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	54.3	41	0	86.7	20.6	0	31	87.5	81.8	44.8	25	36	3.4	40.2	26.4

AMONG PREGNANT WOMEN

Pregnancy follow-up

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	38	23.8	16.5	33.3	0	48.5	11.1	66.7	24	29.1	21.5	21.2	0	25.7	24.7

Late ante natal care

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	64.8	90.5	65.9	66.7	50	45.5	55.6	100	72	67.9	45.3	50	24.6	62.3	56.3

Termination of pregnancy

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	100	100	100	100	100	42.4	100	100	100	93.6	62.2	100	100	94.8	91.3

AMONG NON PREGNANT ADULT WOMEN

Contraception

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	77.3	64.9	41.1	84.3	10.9	79.5	62.5	96.4	89.9	67.4	71.5	80.6	4.1	62.9	73.7

Contraception wish

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	84.9	75.3	67.5	91.8	48.4	89.7	70.8	96.4	92	79.6	80.7	96	10.4	74.8	83.6

AMONG MINORS

Tetanus vaccine

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	93.7	77.5	29.3	61.2	0	63.3	0	100	92.9	57.5	63.5	100	3.4	56.5	64.5

HBV vaccine

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	94.6	77.5	29.3	61.2	9.1	66.3	0	100	96.4	59.4	65.5	100	3.4	58	66.5

MMP vaccine

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	93.7	77.5	31.7	61.2	9.1	67.4	0	100	96.4	59.7	66.1	100	3.4	58.2	67.1

Pertussis vaccine

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	93.7	77.5	29.3	61.2	9.1	67.4	0	100	92.9	59	65.9	100	3.4	57.7	66.9

Vaccination where to go

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	89.2	77.5	73.2	76.5	36.4	90	0	100	100	71.4	82.2	71.4	3.4	65.2	82.9

AMONG ALL

HCV test

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	75.2	91.1	33.8	69.4	13	100	22.8	100	97.8	67	83.1	98.6	3.7	64.1	85.1

HBV test

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	75	91.4	34	69.6	13	100	21.1	100	97.7	66.9	83	98.6	4	64	85.1

HIV test

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	74.3	90.1	33.3	69.9	12.2	100	21.1	100	97.1	66.4	82.8	98.6	3.7	63.7	84.9

TB Test

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	72.3	90.4	37.8	69.9	18.7	100	26.8	100	97.5	68.2	82.9	99.3	4	65.2	84.9

Test wish

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	97.4	94.9	42	77	21.8	100	47.2	100	94.2	74.9	87.1	99.3	3.9	70.7	89.1

Test where to go

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	97.7	92.9	45.8	77	23.3	100	42.3	100	93.2	74.7	87.1	100	3.7	70.5	89.2

Urgent case

Variables	BE	CH	DE	EL	ES	FR	NL	SE	UK	WAP	CAP	CA	TR	WAPT	CAPT
Missing Data	98.3	32.2	46.6	72.7	24	73	35.8	100	70.4	61.4	68.4	67.9	8.4	57.2	70.1

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All the reports of the Doctors of the World International Network and other documents and information about the European programme can be found at: www.mdmeuroblog.wordpress.com