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Welcoming refugees in Europe

Médecins du monde - Doctors of the World INTERNATIONAL NETWORK 2016 Observatory Report:

Access to healthcare for people facing multiple
vulnerabilities in health in 31 cities in 12 countries



EUROPEAN
NETWORK
TO REDUCE
VULNERABILITIES
IN HEALTH

November 2016

TABLE OF CONTENTS

3/ ACKNOWLEDGMENTS	
4/ EXECUTIVE SUMMARY	
5/ 2015 IN FIGURES	
European survey results (11 countries)	5
Key figures for Turkey	5
Focus: Pregnant women	5
Focus: Children	6
Focus: Violence	6
7/ EUROPEAN NETWORK AND INTERNATIONAL OBSERVATORY	
7/ THE SOCIAL, ECONOMIC AND POLITICAL CONTEXT IN 2015	
10/ RECENT LEGAL CHANGES, FOR BETTER OR WORSE	
France	10
Germany	10
Greece	10
Luxembourg	10
Norway	10
Spain	10
Sweden	11
Switzerland	11
Turkey	11
United Kingdom	11
12/ 2015 INTERNATIONAL OBSERVATORY SURVEY	
Methodology	12
Statistics	12
Limitations	12
Participating programmes	13
14/ DEMOGRAPHIC CHARACTERISTICS	
Sex and age	14
Nationality and geographical origin	14
Focus on nationalities in Greece	16
Reasons for migration	17
Reasons for consulting MdM and partner clinics	19
19/ ADMINISTRATIVE SITUATION	
Administrative status	19
Focus on asylum seekers	21
22/ LIVING CONDITIONS	
Housing conditions	22
Social isolation and family situation	23
Work and income	25
26/ ACCESS TO HEALTHCARE	
Coverage of healthcare charges	26
27/ BARRIERS IN ACCESS TO HEALTHCARE	
Overview	27
Giving up seeking medical advice or treatment	30
Denial of access to care by a health provider	30
Discrimination in healthcare facilities	30
Fear of being arrested	30
31/ SELF-PERCEIVED HEALTH STATUS	
32/ HEALTH STATUS	
Health problems	32
Contraception	32
Urgent care	32
Acute and chronic health conditions	33
Necessary treatment	33
Patients had received little or no care before visiting our clinics	33
Chronic conditions: no access, no continuity	34
Infectious disease screening	34
36/ FOCUS ON PREGNANT WOMEN	
Geographic origin of pregnant women	37
Administrative status	37
Living conditions	37
Isolation	37
Limiting movements	37
HIV and hepatitis screening	38
Access to healthcare	38
Pregnant women and non-access to antenatal care	38
39/ FOCUS ON CHILDREN	
Children and vaccination	40
Unaccompanied migrant children	40
42/ FOCUS ON VIOLENCE	
Global figures and consequences for health	42
Experiences of violence in medical history	42
45/ 8 NGOS IN 11 COUNTRIES TO SUPPORT MIGRANTS IN TRANSIT PROGRAMME	
Overview	46
Greece	46
Italy	46
Slovenia	47
Germany	47
48/ CONCLUSION	
49/ ACRONYMS	
49/ AUTHORS AND CONTRIBUTORS	
50/ RECOMMENDATIONS	

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“Healthy migrant” effect: not always a reality – Athens

EXECUTIVE SUMMARY

In Europe, 2015 will stay in all our memories as the year where international solidarity with migrants and refugees showed its strength and weaknesses. This strength was seen in the thousands of individuals of all nationalities responding to people’s needs and hopes, organising themselves to help; it was also seen in all the NGOs who concentrated their volunteers and staff to provide help all along the migratory route. Weaknesses were seen in the coordination between individuals and NGOs, between NGOs, between state initiatives, NGOs and individuals. Nevertheless, the solidarity of all these people and organisations worked. And it worked everywhere thanks to the strength and determination of the migrants and refugees to survive and live in a protective environment.

The real deception came from most European governments, who were unable to translate this solidarity into reality, unable to share common rules, in order to provide a positive, respectful response to the needs of the people fleeing wars, conflicts and life-threatening circumstances.

At the same time, the population in Greece is still afflicted by the social and economic crisis. And the austerity measures are harsh in their impact on everyday life. As the new president of the International Federation for Human Rights, Dimitris Christopoulos, said: *“The violation of social rights [education, health, work] resulted in my country [...] in an almost systematic violation of individual rights. The austerity policies reinforce the idea that social cohesion is not so much an obligation of the state but an act of charity”*.

The Médecins du monde (MdM) – Doctors of the World International Network’s report *Access to healthcare for people facing multiple vulnerabilities in health*, based on medical and social data collected throughout 2015 in 31 cities in 12 countries (Belgium, France, Germany, Greece, Luxembourg, the Netherlands, Norway, Spain, Sweden, Switzerland, Turkey and the United Kingdom), once more

reveals exclusion from mainstream healthcare systems.

Within the data collected in face-to-face interviews with over 30,000 patients during 89,000 consultations, we analysed “only” the full interviews, including social and medical data of 10,447 patients seen in 38,646 consultations in 12 countries.

Among those surveyed, 94.2% were foreign citizens, with 24.7% migrant EU citizens and 69.5% migrant citizens of non-EU countries.

Half of patients seen had permission to reside in the country where we met them (50.6% in Europe).

Multiple barriers to accessing healthcare were described, including lack of health coverage for 67.5%, need for interpreting for 40.8% and financial barriers for 24.3%. In the previous 12 months, 21.5% had given up seeking medical care or treatment, 9.2% had been denied care in a health facility and 39.6% of the patients without permission to reside limited their movements for fear of being arrested.

As a consequence, most health conditions had not been treated properly before arriving at MdM or a partner clinic, even if most patients had been living in the host country for a year or more. In addition, among the reasons mentioned for migration, only 3.5% said that they left their country of origin for personal health reasons, among others. These figures show that migration for health reasons is not a reality concerning the people we meet and that this myth should be erased from political discourse.

Pregnant women still do not have access to perinatal care in Europe, with 43.6% of pregnant women interviewed not able to access antenatal care before attending an MdM or partner clinic, 38.9% receiving care after the 12th week of pregnancy and 67.8% having no health coverage and having to pay.

Another example concerns children under 18 years old, as unacceptably high levels of non-vaccination were reported: 29.8% for tetanus, 35.8% for hepatitis B virus, 40.0% for

measles, mumps and rubella and 34.4% for whooping cough. Protecting children against such avoidable illnesses should be possible everywhere, for all children, all the more for those who live in high-risk environments.

Many patients reported experiences of violence, including violence perpetrated by the police or armed forces for more than 18% in Europe, sexual violence including rape for almost 15% of them, and psychological violence for 26% of the patients. Violent experiences occurred in the country of origin, but also during the journey and in the host country (particularly experiences of hunger and psychological violence). There is a significant lack of mental health support in the “host” countries. These figures show clearly the response needed in term of protection, security and access to care.

2015 IN FIGURES

MdM and partners conducted face-to-face medical and social consultations in 31 cities in Belgium, France, Germany, Greece, Luxembourg, the Netherlands, Norway, Spain, Sweden, Switzerland, the United Kingdom and Turkey.

EUROPEAN SURVEY RESULTS (11 COUNTRIES)

For the analysis in this report we used data from 9,610 patients seen during 37,012 social and medical consultations in the European countries.

41.8% women

35.9 years old is the median age, half those seen were between 27.2 and 46.9 years old

5.8% of patients were nationals: 36.7% in Greece, 9.5% in Germany, 8.0% in Luxembourg and 6.1% in France

94.2% of patients were foreign citizens:

- 63.3% migrant citizens of non-EU countries
- 24.7% migrant EU citizens
- 6.2% migrants from European countries not in the European Union

50.6% had the right to reside in Europe

36.6% were or had been involved in an asylum application

94.2% lived below the poverty line

67.8% lived in temporary accommodation, 16.9% were homeless

29.2% declared their accommodation to be harmful to their health or that of their children

22.9% never had someone they could rely on

53.1% migrated for economic reasons, 20.5% for political reasons and 13.7% migrated to escape war.

3.5% only had migrated for personal health reasons

HEALTH STATUS

40.0% required urgent or fairly urgent care

48.6% diagnosed with at least one acute health condition

47.5% diagnosed with at least one chronic health condition

73.7% required necessary treatment

51.1% had at least one chronic condition that had not received medical attention

54.7% had at least one health problem that had never been treated or followed-up

17.7% perceived their general and their physical health as poor and 19.8% perceived their mental health as poor

BARRIERS TO ACCESSING HEALTHCARE

67.5% of the people seen in Europe had no health coverage (no coverage or only access to emergency care)

40.8% required an interpreter

24.3% reported financial barriers

14.2% reported administrative problems

9.1% reported lack of knowledge or understanding of the healthcare system and of their rights

During the previous 12 months:

- **21.5% had given up seeking medical care or treatment**
- **9.2% were denied care on at least one occasion**
- **3.7% experienced discrimination based on colour or ethnic origin in a health facility**

39.6% of patients without permission to reside restricted their movement for fear of arrest

KEY FIGURES FOR TURKEY

837 patients were seen during 1,634 social and medical consultations.

30.8% were women

33.0 years old is the median age, half those seen were between 28.0 and 39.0 years old

89.4% of patients came from Sub-Saharan Africa, 4.3% from Asia and 3.2% from the Near and Middle East

21.2% had the right to reside in Turkey

8.0% were or had been involved in an asylum application

99.5% lived below the poverty line

48.3% lived in temporary accommodation

35.6% declared their accommodation to be harmful to their health or that of their children

20.0% never had someone they could rely on

60.9% migrated for economic reasons, 23.5% for political reasons and 14.7% migrated to escape war.

0.6% only had migrated for health reasons

FOCUS: PREGNANT WOMEN

Pregnant women seen in MdM and partner clinics had very limited or no access to health coverage and as a consequence to antenatal care. Many were socially isolated.

274 pregnant women were seen in the European countries, 40 in Turkey

67.8% had no health coverage in Europe (among them 19% could only access emergency care)



Fences are meant to hurt but humanity can overcome adversities – Idomeni Border Greece - FYROM

In Istanbul (40 pregnant women surveyed), 97.1% had no health coverage.

43.6% had no access to antenatal care in Europe and 38.9% had their first antenatal visit after the 12th week (62.9% in Europe and 33.3% in Istanbul).

35.8% in the European countries and 41.5% in Turkey reported they had nobody to rely on in case of need.

48.4% in Europe and 54.3% in Istanbul lived in unstable accommodation.

Among the undocumented pregnant women (52.0% of the pregnant women seen in Europe and 67.6% in Turkey), **68.2% in the European countries and 61.1% in Turkey limited their movements for fear of being arrested.**

FOCUS: CHILDREN

Children seen in MdM and partner clinics had unacceptably low levels of standard vaccines and a third of parents did not know where to go to get their children vaccinated.

1,711 children were seen at MdM and partner clinics in Europe (16.6% of the total population): 1,102 in Greece, 312 in France and 175 in Belgium.

53 children visited partner's clinic in Turkey.

771 in Europe (45.1% of the children surveyed) and 34 in Turkey were under five years old.

Of the 1,764 children seen in Europe and Turkey:

29.8% were not vaccinated against tetanus

35.8% were not vaccinated against hepatitis B (HBV)

40.0% were not vaccinated against mumps, measles and rubella (MMR)

34.4% were not vaccinated against whooping cough (pertussis)

33.0% of parents in Europe and 60.0% in Turkey did not know where to go to get their children vaccinated

FOCUS: VIOLENCE

Violence was reported by many patients, both women and men. In addition to the violent experiences lived in the country of origin, a significant amount of patients were victims of violence during the migratory journey and in the host country.

1,379 patients who had a chance to discuss this issue, faced at least one type of violence (12.8% of the total number of patients): 1277 in Europe (13.3% of the population interviewed in Europe) and 102 in Turkey (12.2% of the patients seen in Turkey).

43.2% of the patients seen in Europe had lived in a country at war, 62.7% in Turkey.

26.7% of the patients seen in Europe suffered from hunger.

26.0% interviewed in Europe and 74.5% interviewed in Turkey faced psychological violence.

18.7% seen in the European countries lived police or army violence, 30.4% seen in Turkey.

13.7% of the patients asked in Europe were victims of domestic violence.

8.7% of the patients seen in Europe and 23.5% of the ones seen in Turkey suffered sexual assault. Figures are both equal to 5.9% for rape in Europe and in Turkey.

1.8% of the patients asked in the European countries suffered genital mutilation and 2.9% in Turkey

EUROPEAN NETWORK AND INTERNATIONAL OBSERVATORY

EUROPEAN NETWORK

In January 2015 MdM created a 'European Network to reduce vulnerabilities in health', bringing together MdM organisations from the International Network, partner NGOs and academics. The Network now numbers 23 member organisations. Its main objective is to contribute to reducing EU-wide health inequalities and to support European health systems to be better equipped to deal with vulnerability factors. The Network members seek to gain greater capacity and skills through mutual learning about how to improve health service delivery, patient empowerment, common data collection and advocacy.

INTERNATIONAL OBSERVATORY

The European Network and International Network members collect the data presented in this report and the previous annual reports of the International Observatory.

All the survey reports and more information about the International Observatory on Access to Healthcare are available at: www.mdmeuroblog.wordpress.com

The International Observatory does not use the concept 'vulnerable groups' which ignores the multiple dimensions of vulnerabilities and resilience that individuals may have. The concept of 'vulnerabilities in health' is preferred as it accounts for multi-level factors and the external context.

For instance, a restrictive law can make access to healthcare very difficult for a specific population: the population did not change overnight but the law creates a context of 'vulnerabilities in health' for this group.

Understanding the multidimensionality of vulnerability in health is the only way to tailor health systems so that everyone, independently of his or her situation, can access healthcare according to his or her needs.

The MdM International Observatory on Access to Healthcare is run by the International Network and serves the following triple function:

- **To improve service quality** provided to MdM service users through use of standard questionnaires to guide the social and medical consultations.
- **To produce public health evidence** necessary to raise awareness among healthcare providers and policy makers on the social determinants of health and health status of service users. This evidence comes from the quantitative and qualitative data collected in the field.
- **To support the field teams in programme monitoring.**

THE SOCIAL, ECONOMIC AND POLITICAL CONTEXT IN 2015

In 2015, the number of migrants and asylum seekers in the world kept growing. Worldwide, more than 63 million people were forcibly displaced. Lebanon hosted the largest number of refugees in relation to its national population, with 183 refugees per 1,000 inhabitants, followed by Jordan (87). Globally, the countries who hosted most refugees were: Turkey (2.5 million), Pakistan (1.6 million), Lebanon (1.1 million), Islamic Republic of Iran (979,400), Ethiopia (736,100), Jordan (664,100)¹ and Germany (1.1 million)².

A total of 1,255,600 migrants submitted an "application for international protection" in Europe, more than double the number in 2014; Syrians accounted for nearly one third of these applications (29%)³. According to the United Nations Refugee Agency (UNHCR), over one million migrants arrived in Europe by sea in 2015, most of them from Syria, Afghanistan and Iraq. By the end of August 2016, Greece alone hosted an estimated 59,505 "persons of concern" in 47 camps on its continental territory and islands. Overall, in 2015, 3,771 migrants lost their lives in the Mediterranean Sea, and on September 8th 2016 the dead/missing toll was already 3,196 persons. In response to this disaster, the European Commission released a major "Communication" on 13 May 2015, called the European Agenda on Migration, which aims to "take immediate action to prevent more people from dying at sea".

In spite of the urgency of the situation and the need to welcome people fleeing from wars, conflicts and poverty, levels of xenophobic discourse rose in 2015. The attacks on Paris, Nice, Munich, Copenhagen and Brussels (and also many other places in the world such as Syria, Yemen, Nigeria, Egypt, Turkey and Burkina Faso), which plunged entire families into mourning, have had a major impact on public opinion and have widely paralysed discussion of migrant issues among our leaders⁴. There is no strong, united effort from European Union governments to shift to a positive narrative on migration, a fact that surely helps spark the electorate's fears⁵. A study showed that half of Europeans

1 Edwards, A. (2016) *Global forced displacement hits record high*. UNHCR [Internet] [updated 20 June 2016; cited 31 August 2016]. Available from: www.unhcr.org/news/latest/2016/6/5763b65a4/global-forced-displacement-hits-record-high.html

2 Global Migration Data Analysis Centre (2016) *Migration, asylum and refugees in Germany: Understanding the data*, IOM [Internet]. Available at: <http://iomgmdac.org/wp-content/uploads/2016/01/Data-Briefing-Migration-asylum-and-refugees-in-Germany.pdf>

3 European Migration Network (2016) *Eurostat figures show over 1.2 million first time asylum seekers registered in the EU-28 in 2015*. Dublin [Internet] [updated on 7 March 2016; cited 31 August 2016]. Available from: <http://emn.ie/index.jsp?p=100&n=105&a=2435>

4 Schleicher, A. (2016) 'Understanding the battle against extremism' In *OECD Yearbook 2016*. Paris [Internet] [updated 22 January 2016; cited 31 August 2016]. Available from: www.oecd.org/forum/oecdyearbook/understanding-the-battle-against-extremism.htm

5 European Union Agency for Fundamental Rights (FRA) (2016) *Fundamental rights report 2016*. Luxembourg: Publications Office of the European Union [Internet] [cited 31 August 2016]; 204 pp. Available from: <http://fra.europa.eu/en/publication/2016/fundamental-rights-report-2016>

believe the arrival of migrants will increase insecurity⁶ and have a negative impact on the economy and jobs. Moreover, a report by the UK National Police Chiefs' Council⁷ shows a 42% increase in hate crimes during the period immediately following the UK referendum on EU membership (Brexit). The situation in the rest of Europe is also dismal: for example, the number of incidents with right-wing activists targeting refugee housing in Germany grew nearly tenfold between 2014 and 2015 (FRA).

At the same time, European civil society has come together in large numbers in support of migrants, including the "Refugees Welcome" initiatives in all countries, as well as volunteers, organisations and local authorities.

In view of the increase of xenophobia, economists have repeatedly proved the long-term social and economic benefits of welcoming and integrating migrants⁸. The OECD, whose members feel threatened by Europe's demographic decline, reports that migration, if well managed, stimulates growth and innovation while maintaining economic competitiveness.

The entire refugee population is suffering from poorly organised reception conditions in the host and transit countries. Despite the involvement of some governments and humanitarian organisations, the reception conditions are not meeting the needs of the refugees, who often face a hostile environment (Human Rights Watch). In this context, not enough attention is being paid to the efforts being made to help the migrants, including those by local communities. Populations are under great pressure and overwhelmed, especially in the Greek islands of Lesbos and Chios. According to the UNHCR, between January 2015 and January 2016, 526,635 migrants were officially registered on Lesbos (which has a total population of around 90,000) and 154,773 migrants arrived on Chios (population 52,000).

Unaccompanied or separated children – mainly Afghans, Eritreans, Syrians, and Somalis – are a particularly vulnerable group. They lodged some 98,400 asylum applications in 2015 in 78 countries. This was the highest number on record since UNHCR started collecting such data in 2006. The issue of protecting these children rose to the surface again in January 2016 when Europol estimated that around 10,000 had disappeared⁹, possibly into the hands of human traffickers. Some migrants' rights organisations challenged these figures. But everybody agrees on the lack of reception facilities tailored to the needs of unaccompanied children, not only in the five "hot spots" of Greece but also in Italy and in detention centres throughout Europe. Detaining

6 Wike, R., Stokes, B. and Simmons, K. (2016) *Europeans fear wave of refugees will mean more terrorism, fewer jobs. Sharp ideological divides across EU on views about minorities, diversity and national identity*. Pew Research Center [Internet]. [cited 31 August 2016]; 45 pp. Available from: www.pewglobal.org/2016/07/11/europeans-fear-wave-of-refugees-will-mean-more-terrorism-fewer-jobs/

7 National Police Chiefs' Council (2016) *Hate crime undermines the diversity and tolerance we should instead be celebrating*. London [Internet] [updated 8 July 2016; cited 31 August 2016]; 1 p. Available from: <http://news.npcc.police.uk/releases/hate-crime-undermines-the-diversity-and-tolerance-we-should-instead-be-celebrating-1>

8 Dumont, J-C, Scarpetta, S. (2016) 'Europe will win from integration' in OECD *yearbook 2016* Paris [Internet] [updated 22 January 2016; cited 31 August 2016]. Available from: www.oecd.org/migration/europe-will-win-from-integration.htm

9 European Parliament (2016). *Fate of 10,000 missing refugee children debated in Civil Liberties Committee*. Strasbourg [Internet] [updated 24 April 2016; cited 31 August 2016]. Available from: www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+IM-PRES+S+20160419IPR23951+0+DOC+XML+V0//EN

minors cannot be considered as taking care of them in their best interests, as stipulated in international conventions¹⁰: alternatives to detention must be available. This situation provoked a reaction by UN Secretary-General, Ban Ki-moon, during his visit to Lesbos and the UN High Commissioner for Human Rights, Zeid Ra'ad Al Hussein, both of whom demanded that children stop being detained.

Faced with the needs of migrants and refugees arriving in European countries, a single guiding principle seems to be spreading throughout the EU: stop the "flow" by discouraging smugglers. The agreement signed by the EU Council and the Turkish government in March 2016 fits perfectly with these two goals. But the agreement also adopted measures requiring the forced return to Turkey of any migrant who "illegally" entered Europe from Turkey. In exchange for each Syrian returned to Turkey another would be resettled in Europe. The EU-Turkey deal was roundly rejected by civil society¹¹, criticised by European institutions themselves and even condemned on legal grounds¹². Its detractors denounced an idea floated by European leaders to set up asylum-processing centres in countries outside the EU. In exchange, the EU would help them control the migrant influx or, in the case of Turkey, jumpstart its bid to join the Union.

In June 2015, the Europe of the Schengen Agreement imploded. Some of the Central European States located along the migration route, including those belonging to the Visegrad Group¹³, gradually closed their borders and built walls, while others reintroduced border controls. For many months, the small Greek town of Idomeni "welcomed" up to 15,000 refugees blocked at the FYROM¹⁴ border (UNHCR).

Only in rare cases did States end up taking positive steps to welcome and take care of migrants. In Greece, for example, the law of 20 February 2016 granted free access to healthcare for uninsured patients and vulnerable groups (Law 4368/2016) (although the effectiveness of this law cannot be guaranteed given the lack of capacity in the healthcare system); the law of 18 December 2015 in Luxembourg increased access to healthcare for asylum seekers and refugees, but not undocumented migrants; and a 2015 reform in Romania expanded the minimum healthcare package for all uninsured patients.

These positive steps are limited, as the impact of the economic crisis is still being felt in terms of healthcare system investment and budgets. The health sector in Europe is one of the first to suffer from austerity policies, with consequences that have a greater effect on the most vulnerable and disadvantaged populations. According to a study by the

10 Office of the United Nations High Commissioner for Human Rights (OHCHR) (1989). Convention on the Rights of the Child. Geneva [Internet] [cited 31 August 2016]. Article 37; paragraph b. Available from: www.ohchr.org/Documents/ProfessionalInterest/crc.pdf

11 Amnesty International (2016) *EU's reckless refugee returns to Turkey illegal*. [Internet] [updated 3 June 2016; cited 31 August 2016]. Available from: www.amnesty.org/en/latest/news/2016/06/eus-reckless-refugee-returns-to-turkey-illegal/

12 This statement was a press communique with no signatures attached and was not published in the Official Journal of the European Union, the representative of the legal service told the MEPs at the Committee on Civil Liberties, Justice and Home Affairs on 09 May 2016. See the video footage of the session ([www.europarl.europa.eu/news/en/news-room/20160504IPR25801/committee-on-civil-liberties-justice-and-home-affairs-09052016-\(-pm\)](http://www.europarl.europa.eu/news/en/news-room/20160504IPR25801/committee-on-civil-liberties-justice-and-home-affairs-09052016-(-pm))). The term "agreement" was used by the EU institutions until April when it was replaced by the term "statement".

13 Hungary, Poland, Czech Republic and Slovakia.

14 The former Yugoslav Republic of Macedonia.

European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs¹⁵, access to healthcare in Europe is on the decline¹⁶. In Spain, a country with one of the world's most inclusive health systems before the financial crisis and whose law of 2012 significantly limited access to care for the uninsured and undocumented migrants, an increasing number of patients are unable to pay for treatment, while the number of hospital medical staff has fallen and many departments have closed.

The European Union should thus reflect on whether its recent measures to increase access to healthcare for mobile citizens in the EU should not more simply lead to an expansion of

15 Ivanković Tamamović, A., Milieu Ltd. (2015) *The impact of the crisis on fundamental rights across Members States of the EU. Comparative analysis*. European Parliament. Brussels. Available from: [www.europarl.europa.eu/RegData/etudes/STUD/2015/510021/IPOL_STU\(2015\)510021_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2015/510021/IPOL_STU(2015)510021_EN.pdf)

16 Reeves, A., McKee, M. and Stuckler, D. (2015) 'The attack on universal health coverage in Europe: recession, austerity and unmet needs' In *European Journal of Public Health*. Volume 25, Issue 3, pp. 364-365. Oxford University Press. Available from : <http://eurpub.oxfordjournals.org/content/25/3/364>

universal health coverage for all. While the EU has already set up mechanisms for patients to receive care in other EU countries, the Member States have, at the same time, decided to exclude a large portion of their own populations from their health systems. Addressing this issue must be a greater priority from the perspective of social justice and public health.

As there has been no end to the wars and conflicts in Syria and all the other countries of origin, people will continue to flee for their lives and Europe, like everywhere else in the world, will have to receive them. The challenge before us is whether we will be able to understand that this is a unique opportunity to increase the scope of human rights and benefit from migrants' experiences: country leaders should demonstrate solidarity between countries and act in solidarity towards migrants and refugees. Otherwise the logic of building useless walls, losing Schengen freedom, living as in a besieged artificial fortress, full of hatred and fears, will prevail and we will lose a substantial part of our European identity, destroying ourselves in the process.

Wisseem, 21, fled Iraq. *"I left my country because you couldn't do anything there due to Daesh. The army had been present in my city, then one day I woke up and Daesh had replaced the army in the streets. They controlled everything, including the roads. No more university. No more anything. When I told my family I wanted to leave, they told me not to do it, that it was too dangerous, but I left anyway. A man got me some clothes, like the kind Daesh wears. I disguised myself and was able to get out."*

Wisseem had to make two attempts to cross the Serbian-Hungarian border and spent several hundred euro on smugglers. *"I spent 12 hours in the woods at the Serbian-Hungarian border. A Serbian police car stopped me. The officer said, 'If you help me, I'll help you.' He wanted €300 to let me go. He gave me directions, saying I could avoid the Hungarian authorities by going a certain way. But it was a lie; after four hours, I reached a Serbian village! The police caught me and took me right back to where I started.*

"The next day, a Syrian refugee offered to help us. He had already crossed the border and knew a way to get through. He demanded €200 per person to take us across. I paid along with eight other men. But once we got to the border, the man disappeared. I suggested that we break up into two groups to be less conspicuous. We hid in the woods. A police officer shouted, 'I see you!' So we stayed hidden and waited for the right moment to make a run for it. We finally reached a village in Hungary, which was empty – a ghost village. There we found a taxi for Vienna. But the other group went to Budapest. We all ended up together in Vienna."

In Vienna, Wisseem and his companion received help: someone gave them shelter and bought them bus tickets to reach Brussels without problems.

MdM Belgium – Maximilian Park – September 2015

RECENT LEGAL CHANGES, FOR BETTER OR WORSE

A complete legal report on access to healthcare in 17 countries is available on www.mdmeuroblog.wordpress.com

FRANCE

On 1 January 2016, the PUMA (Universal Medical Protection)¹⁷ replaced the basic Universal Medical Coverage (CMU). Today anyone who works or lives legally in France continuously for over three months has the right to obtain health coverage. This development strengthens the continuity of health coverage, even during changes in situation (type of employment, studies etc.). However, the reform complicates the administrative rules of access to health coverage for migrants with a short permission to stay, who might experience long periods of time with no health coverage (between residence permits, for instance).

GERMANY

From 1 March 2015, after 15 months of having received benefits under the Asylum Seekers Benefits Act (instead of the previous 48 months), asylum seekers and refugees are entitled to welfare benefits under the same conditions that apply to German citizens. In the case of seriously ill foreign nationals, there is an asylum procedure granting a residence permit on a case-by-case basis. Yet the changes to the asylum law in 2016¹⁸, which foresee a faster asylum procedure of about three weeks, make it extremely difficult for asylum seekers to present the information in time.

GREECE

A major law concerning healthcare was adopted on 20 February 2016: Law 4368/2016¹⁹ opened access to the public health system to uninsured and vulnerable people (pregnant women, children, chronically or seriously ill individuals, etc.). The new law also introduces exceptions to the legislation prohibiting care beyond emergency treatment for adult undocumented migrants (Law 4251/2014), allowing the most vulnerable categories of people to access healthcare, including children up to 18 years old, pregnant women, chronically ill people, beneficiaries of a form of international protection, holders of a residence permit for humanitarian reasons, asylum seekers and their families, persons accommodated in mental healthcare units, victims of certain crimes, people with severe disabilities, seriously ill people and prison inmates.

However, Greece is witnessing an unprecedented increase in the inflow of refugees and migrants to its territory and, even though the Greek State and population have showed great solidarity towards them, the ability of the Greek health system to provide adequate healthcare to migrants upon entry is severely stretched. Practically speaking, access to healthcare is therefore still limited, particularly affecting the most vulnerable individuals.

17 www.legifrance.gouv.fr/eli/loi/2015/12/21/FCPX1523191L/jo/texte

18 www.bgbl.de/xaver/bgbl/start.xav?startbk=BundesanzeigerBGBl&jumpTo=bgbl116s0390.pdf

19 Law 4368/2016 (2016): www.minedu.gov.gr/publications/docs2016/%CE%A6%CE%95%CE%9A.pdf

Regarding unaccompanied children, Greek law enjoins authorities to avoid detaining them. Yet detentions for periods ranging from a few hours to several days or months are common. There is no institutionalised procedure for determining the best interests of the child, a guiding principle of the protection of children, according to international standards and Greece's obligations.

LUXEMBOURG

Asylum seekers and refugees can benefit from medical care (with an income threshold for asylum seekers), based on the Law on the Reception of Applicants for International Protection and Temporary Protection²⁰ and the Law on International and Temporary Protection (December 2015).

Nevertheless, undocumented migrants and their children have no access to healthcare²¹. Only unaccompanied children have access to healthcare. Luxembourg's legislation and practice do not guarantee that all foreign nationals in an irregular situation can benefit from emergency care for as long as they may need to.

NORWAY²²

All citizens and authorised residents in Norway are entitled to public healthcare. Everyone residing in the country is a mandatory member of the National Insurance Scheme (NIS).

As authorised residents, asylum seekers and refugees are entitled to the same access to healthcare as Norwegian citizens²³.

Undocumented migrants are only entitled to emergency healthcare and to the "most necessary" healthcare. Otherwise, they have to pay for all the healthcare goods and services they receive. The price is a significant barrier to healthcare for undocumented migrants, who can rarely afford healthcare and thus often forgo medical treatment. Pregnant women are entitled to prenatal care and children have entitlements.

SPAIN

Royal Decree 16/2012, adopted on 20 April 2012, removed the previous universal access to healthcare²⁴, impacting on the population's health (even more for undocumented migrants), "*Such changes could have serious consequences for population health, especially with regard to tuberculosis*

20 Law on the Reception of Applicants for International Protection and Temporary Protection [cited 7 September 2016]. Available from: <http://eli.legilux.public.lu/eli/etat/leg/loi/2015/12/18/n16>

21 Rechel, B. et al (eds.). (2011) *Migration and health in the European Union*. European Observatory on Health Systems and Policies, Berkshire: McGraw-Hill. [Internet] [cited 7 September 2016]. Available from: www.euro.who.int/_data/assets/pdf_file/0019/161560/e96458.pdf

22 Even though no new law was passed in 2015/2016 in Norway, we have described the system here, as this is the first time we have published results for this country.

23 Ordinance on Insurance Coverage for Asylum Seekers and their Family Members (2008). Available from: <https://lovdata.no/dokument/SF/forskrift/2008-05-14-460>

24 Doctors of the World – Médecins du Monde ES (2014), *Dos años de reforma sanitaria: más vidas humanas en riesgo* [Two years of healthcare reform: more human lives at risk]. Available at: www.medicosdelmundo.org/index.php/mod.documentos/mem.descargar/fichero.documentos.Impacto-Reforma-Sanitaria-Medicos-del-Mundo_3ec0bdf9%232E%23pdf

and HIV infections, and could threaten access to mental health, addiction, and chronic care services for vulnerable populations, such as the homeless”²⁵.

In 2012 the Decree was challenged by the Parliament of Navarra in the Constitutional Court. However this appeal was rejected in early August 2016, strengthening the exclusion from healthcare of the most vulnerable. However, 14 autonomous regions have implemented regulations to improve the access to healthcare for undocumented migrants.

SWEDEN

On 1 June 2016, the amendments made to the Reception of Asylum Seekers’ Act (LMA) entered into effect. Asylum seekers whose claim and appeal have been denied will no longer be entitled to stay in Swedish Migration Agency accommodation and will have to return their LMA card granting them access to healthcare²⁶. In theory, children will not be affected by this reform until they reach the age of 18.

The National Board of Health and Welfare announced in April 2015 that EU citizens who stay longer than three months may in certain cases have access to healthcare on the basis of the 2013 law (Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act).

SWITZERLAND

On 5 June 2016 a major modification of the Asylum Act was put to the vote through a referendum²⁷. The new law was adopted by a large majority (73.5% of the voters). This reform may shorten the asylum procedure and the timetable for appeals by rejected asylum seekers, which would toughen the current asylum legislation. However, it also includes the obligation for the authorities to provide free legal counselling for all asylum seekers and to take into account the specific needs of unaccompanied children, families with children and “particularly vulnerable individuals”.

TURKEY

In March 2016²⁸, Turkey adopted the regulation implementing and precisising the 2013 Law on Foreigners and International Protection. This law introduced some positive changes to the asylum system in Turkey. It still keeps geographical criteria: Europeans (Council of Europe), Syrians and others.

In order to access healthcare, asylum seekers must prove their lack of resources. To initiate the procedure for fee

25 Legido-Quigley, H. (2013) “Erosion of universal health coverage in Spain” in *The Lancet*. Available from: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62649-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62649-5/fulltext)

26 Migrationsverket (2016), frequently asked questions about the new laws [Internet]. Available from: www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/Frequently-asked-questions-.html

27 Referendum on modifications to the asylum law (2016). Available from: www.admin.ch/gov/fr/accueil/documentation/votations/20160605/modification-de-la-loi-sur-asile.html

28 Regulation on the Implementation of the Law on Foreigners and International Protection <http://www.resmigazete.gov.tr/eski-ler/2016/03/20160317-11.htm>

exemption before the Social Aid and Solidarity Foundation, they need a kind of residence permit (“ikamet”) which most of them do not obtain²⁹. Therefore, in practice, access to healthcare for asylum seekers is denied or takes too long to be really effective. This means they usually have to pay out-of-pocket for all kinds of health services.

A Directive on Healthcare Services to be provided to Temporary Protection Beneficiaries was adopted on 4 November 2015, in relation to refugees from Syria, whose numbers in Turkey are gradually increasing. Under this arrangement, introduced by the Temporary Protection Regulation, hospital-based medical examinations, treatment bills and medicine cost-sharing by refugees from Syria are covered by the Prime Minister’s Disaster and Emergency Management Authority. However, since this agency takes a long time to make payments, pharmacists refuse to supply free medicine to refugees. This arrangement excludes refugees from all other countries.

Undocumented migrants do not have access to healthcare through the General Health Insurance System and have to pay 100% of costs to access healthcare, even for emergency consultations in public hospitals³⁰ (“tourist fee”). In some cases, they are also refused treatment or reported to the police by medical and administrative staff.

UNITED KINGDOM

Since 6 April 2015, when the provisions of the Immigration Act 2014 came into force, nationals of countries from outside the EEA coming to the UK for longer than six months are required to pay a “health surcharge” when they make their immigration application³¹ (236€ per year, 177€ for students). This entitles the payer to NHS-funded healthcare on the same basis as those who are ordinarily residents.

The following categories of the population are exempt from charges: refugees, asylum seekers, those whose application for asylum was rejected but who are supported by the Home Office or a local authority, children looked after by a local authority, victims of human trafficking and modern slavery, those receiving compulsory treatment under the Mental Health Act, prisoners and immigration detainees.

Any treatment which is considered to be immediately necessary by clinicians (including all maternity care), whilst chargeable, must in theory be provided without waiting for payment or even a deposit. However, the patient is still billed during or after treatment. Hospitals are required to inform the Home Office of patients who owe the NHS more than €585 and such people may be refused visa renewals or regularisation of their immigration status until the debt is paid.

29 Amnesty International (2009), *Stranded. Refugees in Turkey denied protection*, United Kingdom. Available from: www.amnesty.org/download/Documents/48000/eur440012009en.pdf

30 Blézat, M. and Burtin, J. (2012) ‘Soigner le mal par le rien’, in *Plein droit*, June 2012, No 93.

31 <https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations/summary-of-changes-made-to-the-way-the-nhs-charges-overseas-visitors-for-nhs-hospital-care>

2015 INTERNATIONAL OBSERVATORY SURVEY

Since 2006, the six reports produced by the International Observatory have seen a gradual expansion in the geographical coverage of the data collection, as well as in the focus – from undocumented migrants to all patients who attended MdM health centres and those run by partners.

All the reports are aimed at health professionals and stakeholders. The reports published for a broader public produced by the MdM International Network Observatory on Access to Healthcare are available at: www.mdmeuroblog.wordpress.com

METHODOLOGY

The Observatory analyses data collected in face-to-face social and medical consultations, thanks mostly to volunteer doctors, nurses and support workers. Specific components address social determinants of health such as living conditions, activities and resources, administrative situation, isolation, health coverage and barriers to accessing healthcare, perceived health, vaccination, women’s sexual and reproductive health, health state and experiences of violence.

The data were collected throughout 2015 (except in Norway, where data collection began on 8 October 2015).

In approximately half the clinics, 100% of patients were interviewed. In the other clinics, only some patients were interviewed, mostly for practical reasons (lack of time for data collection). For instance, in Athens, one in 20 patients were sampled, while one in 10 patients were selected at the five other Greek sites. In the Netherlands, they selected the first patient of the day at each facility. In Spain three kinds of sampling were used in the six sites. In Belgium one in seven patients was interviewed fully.

(10,447 for 38,646 consultations) than the total amount of patients who visited MdM and partner clinics (approximately 30,000 patients for 89,000 consultations).

STATISTICS

Univariable analyses and data are presented in three different types of proportions:

1) crude proportion: proportions by country; this includes all the survey sites (irrespective of the number of cities or programmes³²);

2) weighted average proportions (WAP): proportions calculated for the European countries which, unless otherwise indicated, include 11 countries; this minimises the differences in the number of patients seen per country, as each country has the same weight in the overall total; **proportions presented throughout the report for the 11 European countries are based on the WAP – unless otherwise noted.**

3) crude average proportions (CAP): proportions calculated for the European countries which, unless otherwise indicated, include 11 countries; they contribute proportionally to the calculation based on the number of patients seen per country. In the event of low numbers of respondents or when subgroups of populations were examined, the CAP is provided.

Standard univariable statistical tests were used, mainly the Chi-square test or Fisher’s exact test when numbers were low. Statistical significance was denoted by $p < 0.05$. When missing data is above 20%, the level is presented in footnotes.

LIMITATIONS

Healthcare and social services provided vary across sites and countries. Legal frameworks establishing access to mainstream healthcare also vary. This is the reason why we chose to publish a description of each legal system with indications on the reality of access to care for each country.

The populations visiting the organisations’ clinics should not be considered as a representative sampling of the overall population facing multiple vulnerabilities in health in the 12 countries of the study. Results should be approached as a social epidemiological picture of people facing multiple vulnerabilities in health finding their way to MdM’s and partners’ free clinics, because they cannot reach mainstream clinics for many reasons. This underserved population needs to be highlighted for policy makers to improve access to care until it becomes really universal.

Despite growing awareness and literature on health inequalities, the populations encountered at MdM and partner clinics, particularly undocumented migrants, are mostly not included in official population-wide surveys. Consequently, critical data from

these populations are not included in official health information systems. The annual analysis produced by the International Observatory provides a description of the populations seen at MdM and partner clinics which is complementary to official population-wide surveys which do not include these populations.

³² 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.

Figure 1 / Extract from the International Observatory medical form 2015

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

5. **Interpreter / interprète:** No need / pas besoin Present By phone / par téléphone No

If interpreter needed, which language? / Si besoin d'interprète, quelle langue?

6. Actual state of children vaccinations (on arrival before vaccination by MdM) / Etat des vaccinations enfants (à l'arrivée avant vaccination par MdM)	7. Fait ici ce jour / Done here today	Brand, batch, 1 st , 2 nd , 3 rd , booster / Marque, lot, 1 ^{er} , 2 ^e , 3 ^e , rappel
Tetanus / Tétanos <input type="checkbox"/> Yes/Oui <input type="checkbox"/> Probable <input type="checkbox"/> No <input type="checkbox"/> Doesn't know/Ne sait pas	<input type="checkbox"/> Yes	
Hepatitis B* <input type="checkbox"/> Yes/Oui <input type="checkbox"/> Probable <input type="checkbox"/> No <input type="checkbox"/> Doesn't know/Ne sait pas	<input type="checkbox"/> Yes	
MMR / ROR <input type="checkbox"/> Yes/Oui <input type="checkbox"/> Probable <input type="checkbox"/> No <input type="checkbox"/> Doesn't know/Ne sait pas	<input type="checkbox"/> Yes	
Whooping cough / Coqueluche <input type="checkbox"/> Yes/Oui <input type="checkbox"/> Probable <input type="checkbox"/> No <input type="checkbox"/> Doesn't know/Ne sait pas	<input type="checkbox"/> Yes	

*If not all dates given please tick No. / Si pas toutes les dates cocher Non

8. **Patient knows where to receive vaccination (before you tell her/him) / Le patient sait où se faire vacciner (avant de le lui dire)** Yes/oui No

Please don't forget to give information about where to receive vaccination or do it / Penser à informer sur les lieux de vaccination ou à vacciner

Before analysing the database obtained by merging the 12 national databases, the information within the database must be reviewed and the data must be cleaned to remove inconsistencies and mistakes from the raw data. To carry out the analysis, we kept only patients who had had a medical consultation and who had answered a minimum amount of standard questions: we kept the consultations with at least one answer to Questions 8-27 on the social form, and/or one answer to Questions 9-23 on the medical form. This is the reason the database contains fewer patients

PARTICIPATING PROGRAMMES

MdM and partner programmes are run mainly by volunteers with a few salaried staff. The teams include a range of health professionals including nurses, medical doctors, midwives, dentists, psychologists and medical specialists, and of support workers including social workers, and administrators.

Table 1 / Programmes in the 2015 survey

Country code	Country / Number of patients	Sites in survey / Number of patients	All programmes provide free primary healthcare (unless specified), social support and information services – specific details are given for each programme.
BE	Belgium (2,264)	Antwerp (1,054) Brussels (1,210)	MdM. The Belgian centres also provide psychological support and access to screening.
CH	Switzerland (577)	La Chaux de Fonds (97) Canton of Neuchâtel (480)	MdM. The Swiss programme has two types of intervention. In the Canton of Neuchâtel nurse-led consultations are provided in asylum seeker centres. In La Chaux de Fonds a fixed centre provides nurse consultation and social advice mostly serving migrant populations.
DE	Germany (531)	Hamburg (101) Munich (430)	MdM. The German programmes also provide specialised paediatric, gynaecological, psychiatric and psychological consultations. The Hamburg programme is run in cooperation with partner organisation Hoffnungsorte. The Munich programme is the 'open.med' clinic which also provides legal counselling in cooperation with partner organisation Café 104. Specific women's and children's clinics are run twice a month.
EL	Greece (2,503)	Athens (520) Chania (64) Lesbos (61) Patras (946) Perama (144) Thessaloniki (768)	MdM. The six Greek programmes also provide vaccinations, antenatal care and specialist consultations. Psychological support is provided in some programmes. Specific action is provided for unaccompanied children in Lesbos.
ES	Spain (261)	Alicante (17) Bilbao (62) Malaga (78) Sevilla (15) Tenerife (16) Valencia (27) Zaragoza (46)	MdM. The Spanish programmes do not provide direct care, but social and referral services, campaigns in awareness-raising and health promotion, trainings, intercultural mediation between professionals and programme users, peer education courses, HIV rapid testing and awareness-raising for professionals working in public facilities.
FR	France (2,357)	Nancy (435) Nice (1,197) Rouen (725)	MdM. The three French centres also provide specialist consultations, including psychiatry, and referral to the mainstream healthcare system.
LU	Luxembourg (177)	Esch sur Alzette (17) Luxembourg (160)	MdM. The Luxembourg centres provide social and medical services to people with no access to care.
NL	The Netherlands (83)	Amsterdam (28) The Hague (55)	MdM. The two Dutch programmes provide social support and referral to general practitioners for undocumented third-country migrants. The programmes provide over-the-counter medication but do not provide direct care.
NO	Norway (71)	Oslo (71)	The Norwegian programme, the Health Centre for Undocumented Migrants, is run by Foundation Oslo Church City Mission and the Norwegian Red Cross Oslo. The centre provides primary care, mental health and psycho-social support and activities.
SE	Sweden (59)	Stockholm (59)	MdM. The Swedish team also provides legal consultations for asylum seekers. The programme mainly serves European citizens but third-country migrants also visit the centre.
TR	Turkey (837)	Istanbul (837)	The Turkish programme is run by ASEM (Association of Mutual Aid and Solidarity for Migrants) and mainly serves asylum seekers, refugees and undocumented migrants.
UK	United Kingdom (727)	Brighton (12) London Hackney (19) London Bethnal Green (696)	MdM. The clinic in East London also provides assistance with GP registration, the entry point to mainstream primary healthcare. The family clinic provides services to pregnant women and children. The Hackney programme helped excluded people access primary care. The Brighton clinic opened in October 2015.

Figure 2 / Map of the sites surveyed in 2015



DEMOGRAPHIC CHARACTERISTICS

SEX AND AGE

In Europe 41.8% of the patients seen were women and in Istanbul this figure was 30.8%. MdM in London and Munich offer family clinics (pregnant women and children), twice a month. In Spain, the MdM teams are mobilised on gender equality and have a proactive approach towards women, including programmes against female genital mutilation and other gender violence. In Switzerland, 28.2% of patients were women, due to the higher proportion of men among asylum seekers. In Luxembourg only 14.6% of patients seen were women, as the team worked mainly with homeless people.

The mean age was 35.9 years old, with half between 27 and 47. In Istanbul the mean age was slightly younger, at 33, with half between 28 and 39.

Overall, in 2015, 1,711 children under 18 years old were received at MdM and partner clinics in Europe, representing 16.6% of all patients. Among these children, 771 were under five years old. In Turkey, 53 children visited the ASEM clinic.

Across the 11 European countries 60 unaccompanied migrant children³³ came to the clinics, representing 3.4% of

all children seen. As MdM carries out programmes targeting unaccompanied children (e.g. at the Moria Reception Centre in Lesbos (Greece) and in Caen and Paris (France)), most of these children are seen within these specific programmes and not at the clinics which collect the data.

NATIONALITY AND GEOGRAPHICAL ORIGIN

In the 11 European countries, the patients surveyed mostly originated from the European Union (30.5%, including 5.8% nationals), followed by sub-Saharan Africa at 24.6%, the Maghreb at 12.6%, Asia at 10.9%, and the Near and Middle East³⁴ at 9.2%. Istanbul predominantly received patients from Sub-Saharan Africa (89.4%). Foreign European citizens represented the majority of people seen in Sweden (76.9%), Germany (67.3%) and Luxembourg (57.7%). Nationals (5.8% of all people received) were mainly seen in Greece (36.7%), Germany (9.5%), Luxembourg (8%) and France (6%).

The nationalities most frequently recorded varied from one location to another: Africa, including the Maghreb, remains the main continent of origin for patients seen in Belgium, France, the Netherlands, Norway, Turkey and Switzerland, while the majority of patients seen in the UK come from Asia. As written above, in Germany, Luxembourg and Sweden, EU migrants were the majority of patients seen.

³³ It should be noted that this figure comes from the final database used for the analysis in this report, which does not include all the patients seen. Therefore the actual number of unaccompanied children who visited the MdM and partner clinics is probably higher.

³⁴ In this report, the Near and Middle East comprises Afghanistan, Egypt, Iran, Iraq, Jordan, Kazakhstan, Kurdistan, Kuwait, Lebanon, Pakistan, Palestine, Syria, the United Arab Emirates and Yemen.

Figure 3 / Geographical origins of patients by country surveyed

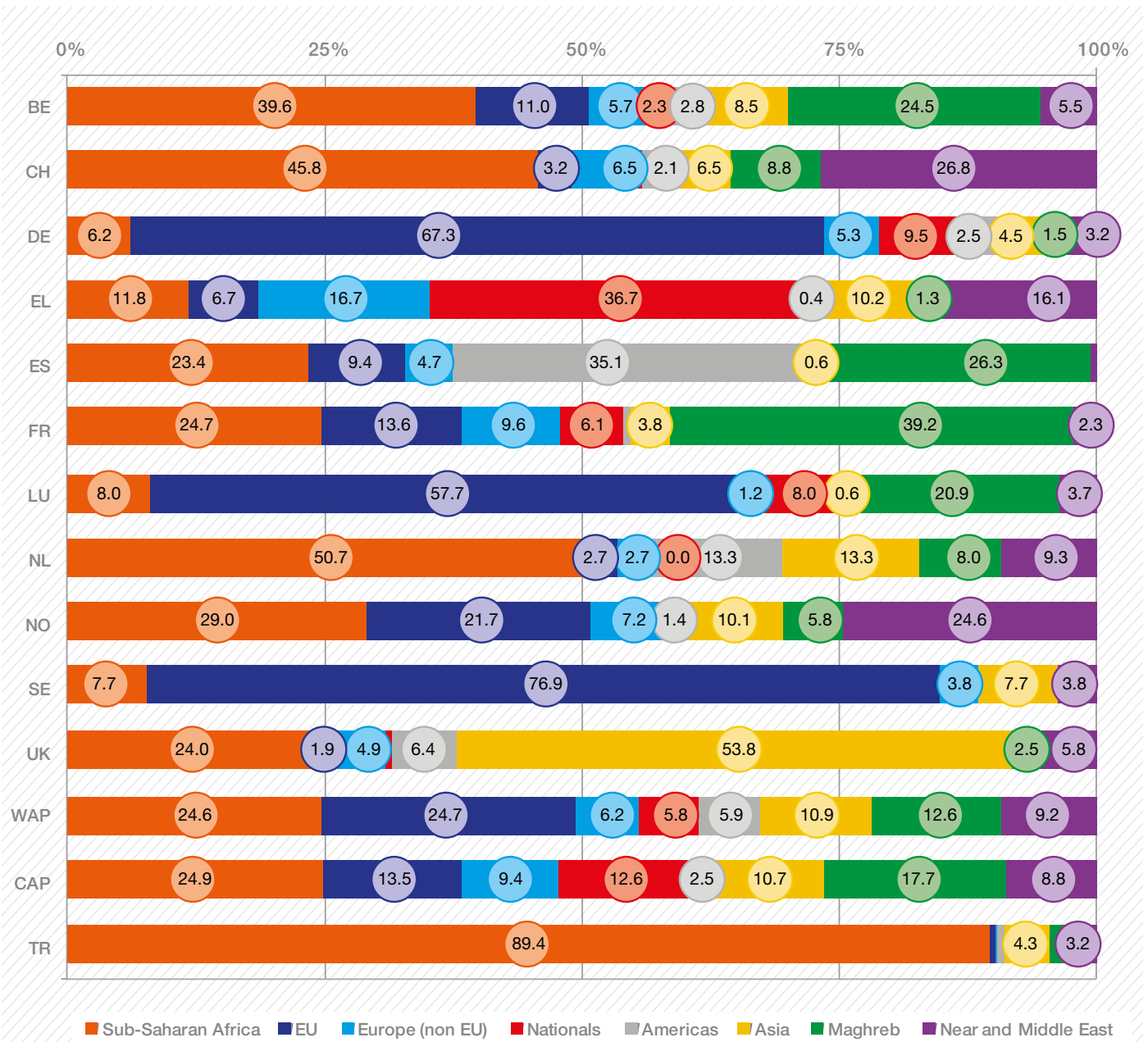


Table 2 / Top five nationalities, by country

BELGIUM

Nationality	N
Morocco	427
Congo (DRC)	191
Guinea	131
Cameroon	119
Nigeria	87

FRANCE

Nationality	N
Algeria	390
Morocco	282
Tunisia	211
France	144
Romania	128

GERMANY

Nationality	N
Bulgaria	209
Romania	56
Germany	50
Serbia	18
Vietnam	14

LUXEMBOURG

Nationality	N
Romania	46
Portugal	18
Morocco	14
Luxembourg	13
Algeria	13

NETHERLANDS

Nationality	N
Ghana	14
Nigeria	9
Suriname	6
Morocco	5
Somalia	5

NORWAY

Nationality	N
Romania	14
Somalia	13
Iraq	6
Iran	6
Albania	5

SPAIN

Nationality	N
Morocco	39
Nigeria	16
Romania	12
Nicaragua	8
Argentina	8

SWEDEN

Nationality	N
Romania	17
Kyrgyzstan	1
Ghana	1
Greece	1
Russia	1

SWITZERLAND

Nationality	N
Eritrea	133
Afghanistan	71
Syria	45
Iraq	30
Algeria	27

UNITED KINGDOM

Nationality	N
Philippines	49
Bangladesh	43
China	41
India	37
Uganda	33
Albania	5

TURKEY

Nationality	N
Senegal	158
Congo (DRC)	112
Nigeria	104
Cameroon	84
Guinea	47

FOCUS ON NATIONALITIES IN GREECE

Greece faces a double crisis, both socio-economic and migratory, which affects health and social needs in many parts of the country. MdM Greece has developed many new programmes (mobile units and free clinics) to tackle them. Indeed, since the beginning of the social and financial crisis, many Greek citizens have been severely affected by austerity measures and have fallen into poverty and/or lost their health coverage (in the context of a dramatic decrease in the budgets dedicated to public healthcare services). More recently, the same country (and, locally, often the same communities facing vulnerabilities) has faced the arrival of high numbers of refugees fleeing the armed conflicts in the Middle East.

On average, Greek citizens represent a quarter of the patients. They are the main nationality at all the sites but Lesbos and represent up to 65% in Perama (a city in the suburbs of Athens where the docks industry collapsed with the crisis). In contrast, Middle Eastern migrants account for nine out of 10 patients in Lesbos (MdM runs clinics in the migrant camps) and a third of them in Athens.

Iannis is Greek and 58 years old. He is unemployed and has several serious health problems, such as heart palpitations, hypertension, urological problems and hernia. Because he has no health coverage, he has almost no access to healthcare. His wife left him a few months ago and he has no children or close relatives to take care of him. He used to be a wealthy businessman but lost almost everything during the financial crisis of the last eight years.

During the past 13 months he has been trying to get his heart and urological problems treated in the public hospitals of Thessaloniki, with no success. In some cases he did not manage to attend because of bad weather conditions and no money to take a bus. He became disillusioned, thinking that he would die without any help and *“without anybody knowing that I had died...”* He stopped any attempt to find doctors or deal with his health problems, he was depressed.

Then he heard of the MdM polyclinic. He asked for an appointment with the pathologist and the urologist. *“I was really surprised that both appointments were arranged so quickly, for the next two days... the doctors were kind and smiling and I finally got medicine!”*

Some visits afterwards, he accepted that he was in need of psychological help. Surgery for his hernia will be arranged for free in a public hospital in a few months. Then he might be able to look for work again, or at least hope.

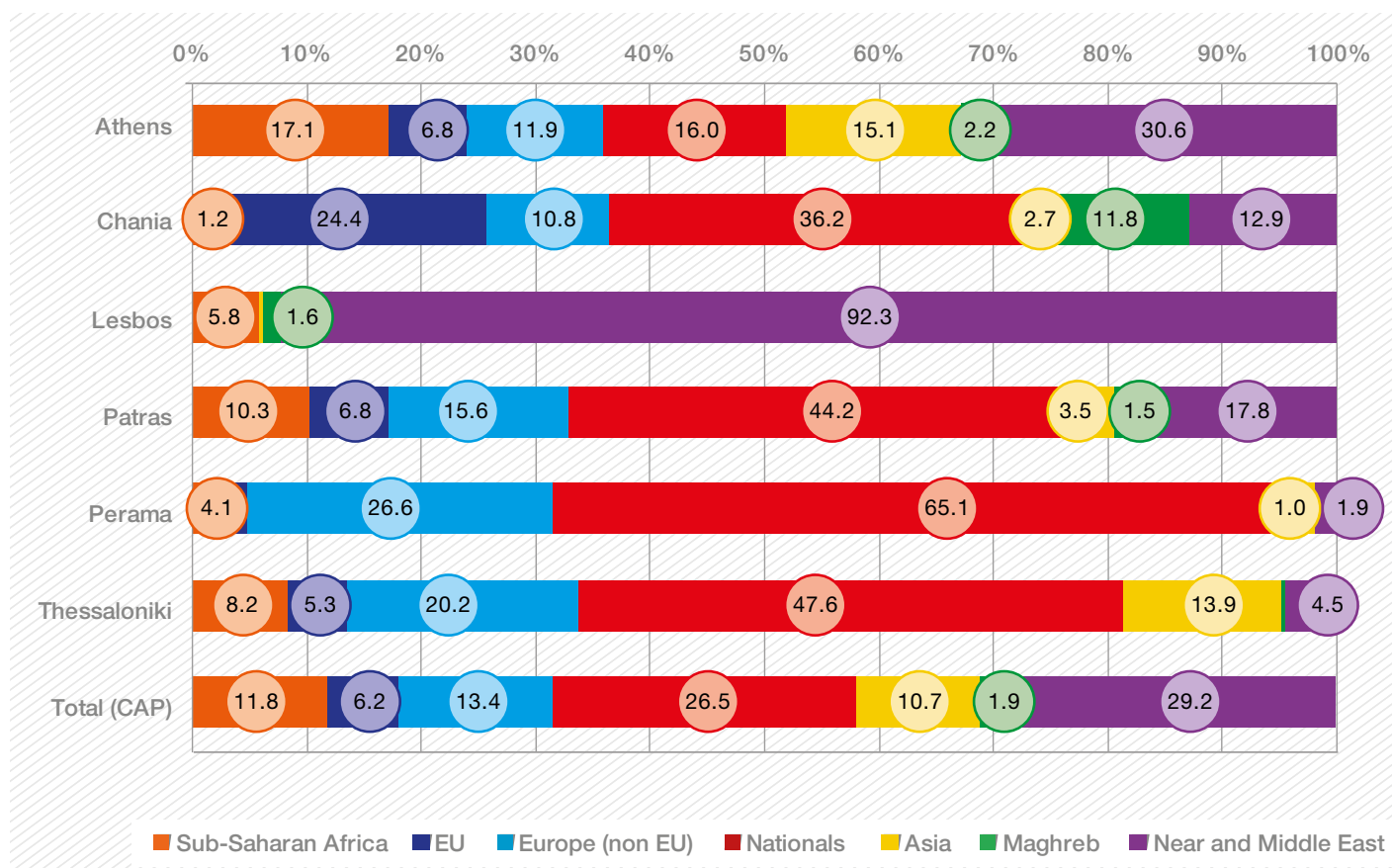
MdM Greece – Thessaloniki – December 2015

Table 3 / Top five nationalities at the six Greek sites

ATHENS		CHANIA		LESBOS		PATRAS	
Nationality	Numbers	Nationality	Numbers	Nationality	Numbers	Nationality	Numbers
Greece	1,770	Greece	301	Afghanistan	1,477	Greece	707
Afghanistan	1,570	Bulgaria	145	Syria	444	Albania	235
Bangladesh	1,214	Albania	85	Iraq	159	Afghanistan	198
Albania	1,145	Morocco	82	Pakistan	92	Sudan	100
Nigeria	643	Syria	58	Nigeria	51	Bulgaria	73

PERAMA		THESSALONIKI		TOTAL GREECE	
Nationality	Numbers	Nationality	Numbers	Nationality	Numbers
Greece	1,140	Greece	1,739	Greece	5,657
Albania	434	Albania	671	Afghanistan	3,336
Bulgaria	31	Georgia	360	Albania	2,570
Romania	21	Nigeria	216	Bangladesh	1,294
Syria	17	Bulgaria	121	Syria	1,208

Figure 4 / Patients' geographical origins by site in Greece and overall (CAP)



REASONS FOR MIGRATION

As in 2013 and 2014, in the European countries, **the reasons most often cited for migration were economic (53.1%) and political (20.5%), as well as escaping from war (13.7%)**. Since last year, this latter reason has notably increased in Greece (21.6% in 2015 versus 14.4% in 2014) and is frequently reported in Norway (23.2%).

As every year, personal health reasons were extremely rare (CAP=3.0%³⁵ in Europe, which is a similar rate to that reported in 2008, 2012, 2013 and 2014³⁶, 0.6% in Turkey).

There is no correlation between the number of people who migrate for health reasons, among others, and the level of legal restrictions and barriers to accessing healthcare in the “host” country. These results are part of the evidence base showing that migration for health reasons is a myth (among people seen in our clinics).

35 For these answers, we have been using the Crude Average Proportion, first because it reflects the individual reasons and, secondly, because we used the CAP in the last four Observatory reports so we can compare the figures.

36 In 2008, 2012, 2013 and 2014, 6.0%, 1.6%, 2.3% and 3.0% respectively of people cited personal health as one of their reasons for migration.

In the Netherlands, 10.3% of the reasons for migration were linked with health, although it is very complicated for undocumented migrants to access care there, especially if they are EU citizens. Spain follows with 4.8%, where, since 2012 there is no access for undocumented migrants to the mainstream health system. In Germany, where access to healthcare is particularly difficult for people with no permission to reside, the rate of migration for health reasons, although still very low (4.3%), is still the third highest compared with the other countries analysed. In the UK also, only 2.2% of people cited health as a reason for migration (the figure was 2.6% in 2014), demonstrating once again that the discourse against migrants, stating that they come to take advantage of the British healthcare system, is unfounded.

No significant association was observed between reporting a reason for migration being related to health and the length of residence in the host country (both means were around 12 to 14 months, $p=0.40$); in other words: **people declaring they had moved for a health reason were not those who had most recently arrived**. In almost all the surveyed countries the average length of stay is above or equal to one year. In the United Kingdom and the Netherlands, patients had been in the country for the longest time, an average of five and six years respectively.



“Migration is not a crime” – Mdm France, Calais

Table 4 / Reasons for migration by country (%)

	BE	CH	DE	EL	ES	LU	NL	NO	SE	UK	WAP	CAP	TR
Economic reasons	35.0	14.9	69.6	52.0	69.9	84.0	42.3	36.2	86.4	40.5	53.1	51.4	60.9
Political, religious, ethnic, sexual orientation	27.8	37.2	5.6	25.8	10.8	4.7	16.7	43.5	9.1	24.0	20.5	21.6	23.5
To escape from war	6.3	54.5	4.9	21.6	0.0	9.4	11.5	23.2	0.0	5.4	13.7	14.9	8.4
To join or follow someone	8.6	11.6	21.8	14.1	14.5	2.8	9.0	2.9	9.1	11.5	10.6	13.4	14.7
Family conflicts	14.6	5.0	5.1	6.2	7.2	0.9	14.1	1.4	4.5	12.2	7.1	7.6	1.0
To ensure your children's future	2.3	1.7	5.1	3.6	4.8	0.9	5.1	4.3	36.4	2.2	6.6	3.7	0.4
Personal health reasons	4.6	2.5	4.3	1.8	4.8	1.9	10.3	2.9	0.0	2.2	3.5	3.0	0.6
To study	2.3	0.8	2.8	0.8	3.6	1.9	1.3	0.0	9.1	4.3	2.7	1.9	1.7
Others	10.0	2.5	14.6	3.7	4.8	1.9	7.7	7.2	0.0	21.9	7.4	8.4	6.5
Missing data	83.9	78.7	12.8	77.2	67.9	39.9	6.0	13.5	45.0	61.1	48.6	64.5	3.4

* Multiple responses were possible. In France the question was not asked.

Amin is a 17-year-old Somali. “I have been in Europe for five months. I left from Somalia. There: no security, Boko Haram, Daesh, terrorism. You know... From Somalia, I passed through Kenya, Uganda, South Sudan, Sudan, Libya, Italy, Switzerland, Germany, Holland and Belgium. It's been two months that I've been in Belgium. But because they took my fingerprints in Italy first, I was deported there. I just got back. I do not want to live in Italy.”

Between February and April 2015, Amin was locked up in a detention camp in Libya. “It was overcrowded. We were 600 or 700 people in the same room. We slept on the floor. And they gave you a loaf of bread a day. It is managed by private militias. Not by the government. There are women and children. And no medical help. I was beaten, yes. Above all, do not say you're sick. Otherwise you will be taken outside and killed. They do it outside. You can die every day. I don't have a home anymore. And I am without hope for my future. My life is not going to get better here.”

Mdm Belgium – Maximilian Park – September 2015

Sami, a 33-year-old Iraqi, left his country to flee Daesh. *“The militias make the law, the army is everywhere, and the Iranian secret services too. We hid on a boat between Turkey and Greece for six hours with 55 people before the Turkish smugglers allowed us to set foot on land on a Greek island. They abandoned us there, so we called for help after a few hours. We had no water or food and I waited three days for help with my other travel companions, including women and children. When the police arrived on the third day, I was weak and dehydrated.”* Sami’s back problems grew worse during the trip and he only got limited care at the makeshift “camp” where he and his companions were taken. *“Forced to leave by the police the next day, I reached Athens, where I went directly to a pharmacy. I didn’t want to go to a hospital out of fear of being arrested. The pharmacist wouldn’t let me pay.”*

MdM Belgium – Maximilian Park – September 2015

REASONS FOR CONSULTING MDM AND PARTNER CLINICS

Most patients in Europe visited MdM and partner programmes for medical care³⁷ (90.8%) and in Istanbul the figure was 99.8%. In Turkey, people with no health coverage cannot access care. In the UK, seeking help registering with a GP was recorded as an administrative reason for consultation, however, this reveals the patient’s main concern was accessing healthcare. One person in four in Europe visited the programme for an administrative, legal or social reason. Only 4.3% of the people said they had come for mental health issues.

Tarik and Manel, an Iraqi couple in their 30s, fled the violence of war. Manel: *“Daesh killed my little brother. He was 26 years old. My brother was very handsome. My father died from grief after his death.”*

It took them two months to reach Maximilian Park after travelling through Turkey, Greece, FYROM, Serbia, Hungary, Austria and Germany. The boat they took between Turkey and Greece sank.

Tarik: *“My wife doesn’t know how to swim. I had to hold her up so I swallowed large amounts of seawater. After we were saved by the Greek police, we went to Athens, where I was refused medical care when I went to hospital because I didn’t have the necessary papers. I did, however, have serious kidney problems from the boat sinking and drinking salty water. Here in Belgium, I’m too afraid to go to the health facilities because I don’t know how much it’s going to cost.”*

MdM Belgium – Maximilian Park – September 2015

ADMINISTRATIVE SITUATION

ADMINISTRATIVE STATUS

A small majority of the people surveyed in 2015 at the MdM and partner clinics in the 11 European countries (50.6%) had permission to reside in the country. In Istanbul the majority had no permission to reside (77.8%).

In the 11 European countries, not having permission to reside was reported by 36.7% of patients seen who were citizens of non-EU countries and 10% of patients who were EU citizens residing in the country for more than three months and without adequate financial resources and/or valid health coverage.

Seen from a different angle, **38.9% of EU citizens and 49.6% of non-European citizens did not have permission to reside in the country** where they were interviewed ($p < 0.001$).

EU nationals without adequate financial resources and/or health coverage lost the right to reside in an EU country other than their own upon the adoption of [European Directive 2004/38/EC](#) (transposed mostly in 2008) on the right of citizens of the EU and their family members to move and reside freely. The Directive’s Article 7 states *“All Union citizens shall have the right of residence on the territory of another Member State for a period of longer than three months if they [...] have sufficient resources for themselves and their family members not to become a burden on the social assistance system of the host Member State during their period of residence and have comprehensive sickness insurance cover in the host Member State.”*

As a consequence of Directive 2004/38/EC, EU citizens staying for more than three months in a host Member State without sufficient resources and/or health 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 even though the legal framework for EU citizens is more protective than for citizens of non-EU countries.

³⁷ It should be noted here that the database analysed concerns only people who had both medical and social consultations.



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Despair in Idomeni

Yordi, aged 32, came to Norway eight years ago. She left Ethiopia after she was raped and her brother was arrested. *“When my asylum application was rejected and I was sick someone recommended me a doctor. The doctor said, ‘No, you don’t have any right to healthcare nowhere in this country, you are illegal here’”*. Yordi felt depressed, stressed and had menstruation problems. She went to an asylum organisation who directed her to another hospital. *“I went to that hospital to check my depression but they told me I didn’t have any rights”*.

She then found out about the Health Centre for Undocumented Migrants (HCUM). *“Everywhere you go you are illegal, like a non-human. Everywhere is closed to us. When I came to the HCUM I felt like a human being. I got help for my depression. HCUM makes us feel at home. Here is where I remember I am a human being”*.

Yordi explains that she is engaged in political work and how she often faces threats and harassments from other political or ethnic groups. After an attack she went to the accident and emergency department where she got help. *“But when I got a prescription for medicine I couldn’t pay for it. I didn’t want to ask to my friends about it. You feel down and useless. Everything is charity. I always have to beg for bread, a place to sleep, for a shower... sometimes I walk outside the whole night. When I feel good I want to help others, give something back, produce something for others. That is why I do volunteer work.”*

Health Centre for Undocumented Migrants – Norway – Oslo – August 2015

- Undocumented migrants were a majority in Belgium and the Netherlands³⁸.
- Switzerland saw the smallest proportion of undocumented migrants due to its specific programme with asylum seekers: 82.4% were in the process of seeking asylum.
- In Greece also, few people had no residence permit (11.4%), since 36.7% were nationals, 16.8% asylum seekers and 10.3% were foreigners who had stayed less than three months.
- In France, Spain and Norway half of patients seen in the programmes had no residence permit³⁹.
- In Germany, 36.9% of patients were EU nationals who had lost their permission to reside (compared with an average rate under 10% in the other countries). This was also the situation of 25% of patients seen in Sweden.

Overall, 10% of patients included in the 2015 survey at MdM and partner clinics in Europe were EU citizens who had arrived in the country less than three months before visiting the programme. The clinics receiving the highest proportions of newly arrived EU nationals were Sweden with 58.3%, Germany with 22.6%, Norway with 21.1% and Luxembourg with 15.7%.

38 In the Netherlands, the programme is specifically meant for undocumented migrants from outside the EU.

39 49.7%, 51.7% and 49.3% respectively

Table 5 / Administrative status of patients, by country (%)

	BE	CH	DE	EL	ES	FR	LU	NL	NO	SE	UK	% in the 11 European countries*	TR
Citizen of non-EU country without permission to reside	74.4	10.7	9.1	11.4	49.5	44.2	8.6	84.8	43.7	4.2	63.1	36.7	77.3
EU citizen with no permission to reside ¹	9.9	0.7	36.9	6.0	2.2	5.5	13.6	3.8	5.6	25.0	1.0	10.0	0.5
<i>Total without permission to reside</i>	84.3	11.4	46.0	17.4	51.7	49.7	22.2	88.6	49.3	29.2	64.1	46.7	77.8
No residence permit required (nationals) ²	2.5	0.4	10.3	39.6	0.0	14.3	31.4	0.0	0.0	0.0	1.4	9.1	1.1
EU citizen staying for less than three months (no permit required) ²	1.6	1.6	22.6	1.8	0.0	2.7	15.7	0.0	21.1	58.3	0.7	11.5	2.7
Asylum seeker (application or appeal ongoing)	2.9	82.4	2.1	16.8	14.3	9.3	6.4	5.1	16.9	0.0	11.6	15.3	8.0
Valid residence permit	2.1	2.2	3.7	14.9	15.4	9.0	1.4	2.5	0.0	0.0	2.3	4.9	7.3
Visas of all types ³	1.2	1.1	6.3	2.2	8.7	11.4	0.0	-0.1	7.1	0.0	12.0	4.4	1.8
EU citizen with permission to reside ⁴	2.7	0.2	4.3	3.8	6.6	1.5	4.3	1.3	2.8	4.2	0.4	2.9	0.1
Residence permit from another EU country	1.8	0.0	3.5	1.0	0.0	2.1	4.3	0.0	1.4	8.3	0.6	2.1	0.0
Specific situation conferring right to remain ⁵	0.5	0.5	0.4	0.0	0.0	0.0	0.0	1.3	0.0	0.0	2.0	0.4	0.2
<i>Total with permission to reside</i>	15.3	88.4	53.2	80.1	45.0	50.3	63.5	10.1	49.3	70.8	31.0	50.6	21.2
Unable to define	0.4	0.2	0.8	2.5	3.3	0.0	14.3	1.3	1.4	0.0	4.9	2.6	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Missing data	4.5	4.5	2.6	7.9	65.1	3.5	20.9	4.8	0.0	59.3	4.1	16.1	3.3

* WAP

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 health coverage

5 Including subsidiary/humanitarian protection

FOCUS ON ASYLUM SEEKERS

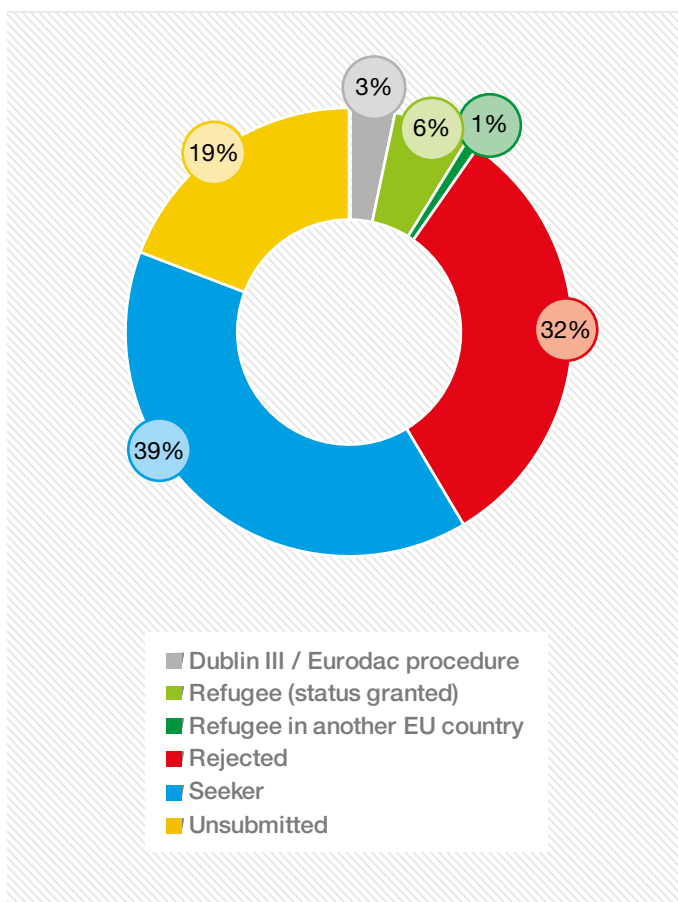
Overall, in the 11 European countries, 36.6% of patients were or had been involved in an asylum application⁴⁰.

As reported above, asylum seekers were particularly numerous in Switzerland (88.3%), but also in Norway (56.5%), Germany (52.1%), and Greece (49.8%). These proportions have notably decreased in the UK since last year (73.3% in 2014 and 18% in 2015), and also in Sweden (31.3% in 2014 and 4.3% in 2015).

Only a very small minority of asylum seekers were granted refugee status (CAP=4.8%), while 36.7% had already been rejected at the time of their first visit to an MdM or partner programme. As in 2014, the proportion of those rejected was the highest in Belgium (81.0%) and in the Netherlands (71.0%).

40 Unfortunately, the level of missing data was on average 71.2%.

Figure 5 / Situation of asylum seekers (at first visit to MdM and partners) in Europe (% WAP)



LIVING CONDITIONS

HOUSING CONDITIONS

When patients were asked to report their perception of their accommodation as either 'stable' or 'temporary' the vast majority, 67.8%⁴¹ in 10 European countries⁴² said it was temporary⁴³, (this was particularly common in Switzerland, Luxembourg, the Netherlands and Sweden). Living in unstable or temporary accommodation was reported by 48.3% of patients in Istanbul.

Temporary housing most often means that people are always worrying about where they live, adding one more vulnerability in health.

Living with family members or friends was reported by 46.3% of patients surveyed in Europe and was the most frequently reported living situation across Europe, especially in the UK (76.1%).

Across 10 European countries only 17.9% of patients rented (or owned) a personal flat or house: only in Belgium and Spain were over 40% of patients in this situation. In Istanbul 58.9% of patients rented a personal flat or house.

Across Europe 16.9% of patients were homeless, with a peak in Luxembourg (56.6%) and Sweden (33.3%). Another 3% reported living in makeshift camps or slums, but this concerned 25.9% of patients seen in Sweden. So in Sweden, with harsh winters, 59.2% of patients seen were living outside or in non-adapted shelters.

14.4% reported being housed by an organisation or charity or hotel for more than 15 days: due to the specific situation of one of the Swiss programmes, 86.9% of patients were in this situation, mostly in asylum seeker centres.

In Istanbul, 58.9% were living in their own flat or house. As in 2013 and 2014, homelessness was very rarely reported in Istanbul.

Table 6 / Housing condition by country

	BE	CH	DE	ES	FR	LU	NL	NO	SE	UK	WAP	CAP	TR
Friends/family	40.9	8.3	55.9	48.9	58.8	20.2	58.0	66.2	29.6	76.1	46.3	49.2	38.0
Personal	46.6	3.6	14.2	42.0	15.3	10.4	17.3	8.5	7.4	13.2	17.9	24.3	58.9
Rough sleeper	8.9	1.1	20.2	4.5	16.5	56.6	9.9	14.1	33.3	4.2	16.9	12.5	0.7
Organisation	2.2	86.9	7.5	2.3	7.5	10.4	9.9	11.3	3.7	2.7	14.4	12.1	0.2
Camp/slums	0.1	0.0	1.0	0.0	0.8	1.2	1.2	0.0	25.9	0.0	3.0	0.5	0.6
Workplace	0.1	0.0	1.2	2.3	0.0	0.6	1.2	0.0	0.0	3.1	0.8	0.5	1.1
Squat	1.2	0.2	0.2	0.0	1.2	0.6	2.5	0.0	0.0	0.7	0.7	0.9	0.4
Total	100.0	100.1	100.2	100.0	100.1	100.0	100.0	100.1	99.9	100.0	100.0	100.0	99.9
Missing data	5.3	2.4	1.9	66.3	5.1	2.3	2.4	0.0	54.2	2.1	14.2	6.0	1.1

41 Missing data accounted for 21.4%.

42 The question was not asked in Greece.

43 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.



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Bathtime, kids! – Idomeni

A Chechen family wanting to seek asylum arrived at the Healthcare, Advice and Referral Clinic (CASO) with their luggage: a couple, three young children and a grandmother. The local Directorate for Social Cohesion (DDCS) agreed to provide shelter for the parents and children but not the grandmother.

MdM France – Nice – March 2015

Artemis, 21 years old, is a single Greek mother of a 10-month-old girl. She visited the MdM polyclinic in Perama in order for her daughter to be examined by the paediatrician and receive vaccination. Artemis is unemployed and has had no health coverage for over a year, since she closed the shop she owned. She was forced to return to her parents' house so she and her daughter could get their help. *"I tried to start a beautiful family and I failed, and now I can't take care of my daughter, even less of myself."*

MdM Greece – Perama – 2015

Physical and mental health are affected by unstable housing: not only because of the dwelling itself (harmful materials, inadequate heating, etc.) but also because of less tangible factors (psychological, cultural and social dimensions of "home")⁴⁴.

When asked about their housing, **29.2% of patients surveyed in Europe deemed their accommodation to be harmful to their health or the health of their children**⁴⁵ with a peak in Luxembourg (61.9%) as patients interviewed there were mostly homeless. In Norway, where accommodation

44 Braubach M, Jacobs DE, Ormandy D. Environmental burden of disease associated with inadequate housing. A method guide to the quantification of health effects of selected housing risks in the WHO European Region. WHO Regional Office for Europe [Internet]. 2011 [cited 2016 May 24]; [16 pages]. Available from: http://www.euro.who.int/_data/assets/pdf_file/0017/145511/e95004sum.pdf?ua=1

45 33.5% missing data.

was deemed harmful by 47.8% of patients, even though they live with friends or family, housing is so expensive that this often means living in overcrowded places. In Istanbul 35.6% of patients said their accommodation was harmful.

SOCIAL ISOLATION AND FAMILY SITUATION

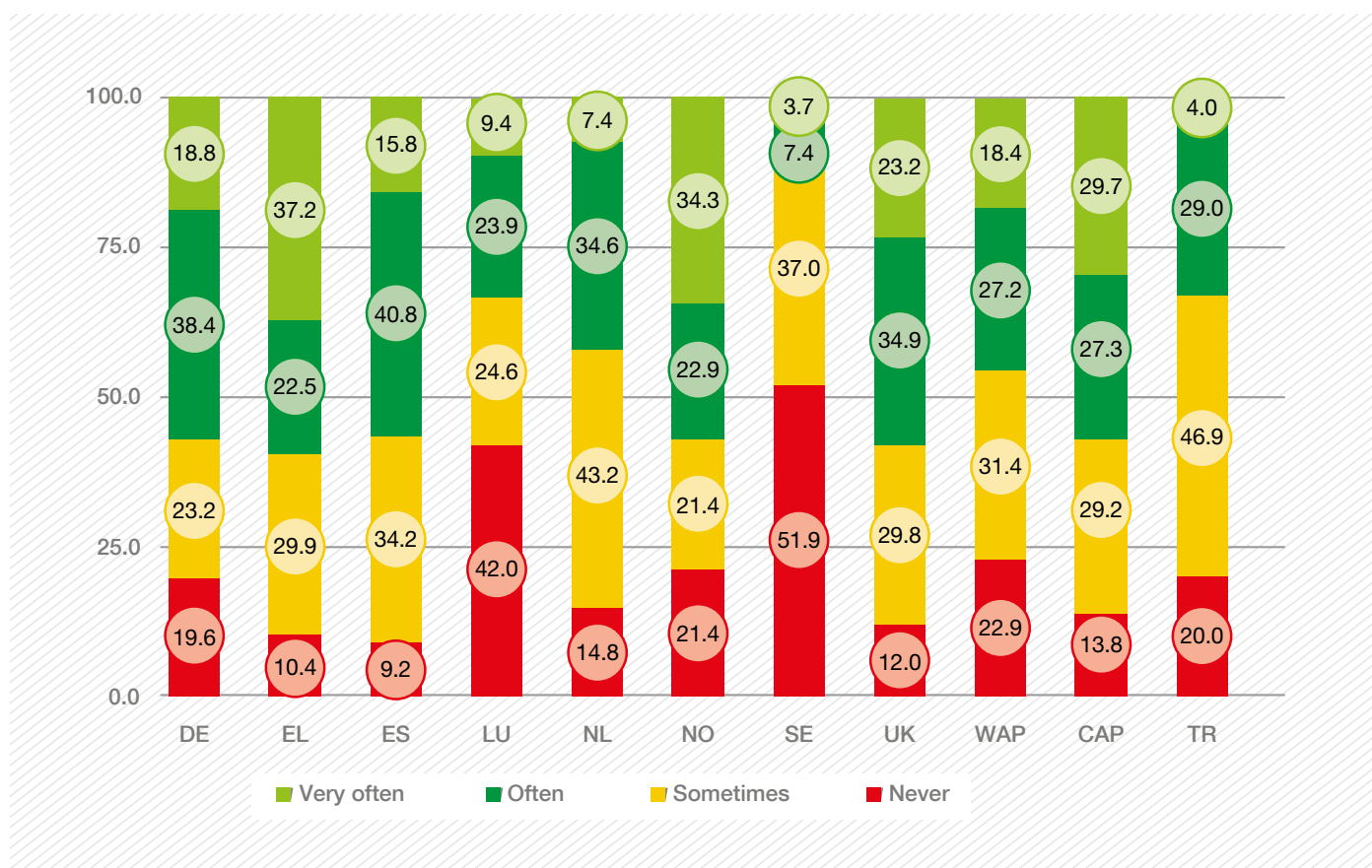
Patients lacking social support may require more assistance from MdM and partners, as referring them to the mainstream health system is even more of a challenge and accompaniment must sometimes be set up for urgent cases.

When asked if they could rely on someone if needed, 54.3% of patients seen in eight⁴⁶ European countries said they could rarely (31.4%) or never (22.9%) rely on someone if needed.

Sweden and Luxembourg are the two countries where patients most frequently reported being completely isolated: respectively 51.9% and 42% said that they could never rely on someone when needed. In Sweden, most people live with others who are just as destitute as they are. Although they stick together, most feel vulnerable and there is no-one they can rely on for support. In Greece, 37.2% of patients said that they could very often rely on someone for support: this could be linked to the high proportion of Greek patients who have family and friends nearby. In Norway, 34.3% said that they could very often rely on someone for support, maybe thanks to migrants' self-support organisations in Oslo.

46 Unfortunately, the question was not asked in Belgium, France and Switzerland.

Figure 6 / Availability of someone to rely on, when needed, by country (%)



Petre, Romanian, 41 years old, came to Norway two years ago. He struggles with severe pain in his leg. *“I have felt pain for 26 years. My health is bad and gets worse and worse. No medicine is good for me. I have pain everywhere. Particularly my leg. And no hospital provides me with surgery. I am denied access. They said it’s because I am unemployed, but no one gives me a work contract. I also needed to have a permanent place to live, a registered address for six months. But it is very difficult for me. I can’t work physically. I went to the welfare office but they told me I must have a work contract before they could help me to get any accommodation.”*

Once he fell in the street and a lady helped him reach the hospital. He was there for three days and was supposed to receive surgery but was denied it. The Romanian embassy told him that the Romanian state didn’t want to pay for the surgery. After that he went to the Health Centre for Undocumented Migrants. He got medicine and a wheelchair.

Then the church where he stayed shut down. *“I am always outside. It is a problem for me because I need to avoid cold and rain. In March someone stole my wheelchair. I walk very badly now. And I live outside in the forest. This spring was very bad. I had a lot of pain, particularly during the night. Sometimes I couldn’t feel my legs. I had to spend 20-30 minutes every morning to warm up.”*

Petre explain that social support helps him handle the situation. *“I have many friends. I like to talk a lot. Everything I do I do it for others. Everybody trusts me. They come to me to ask for help and advice, particularly the Romanian people. And I also work voluntarily in an organisation providing counselling for women from different backgrounds.”*

Petre came back to the Health Centre the day after the interview. He asked for opportunities to do voluntary work.

Health Centre for Undocumented Migrants – Oslo – Norway – September 2015

Nearly 38% of patients in the 11 European countries had children under 18 years old. This proportion was the highest in Sweden (60.9%) and the lowest in Spain (20.9%).

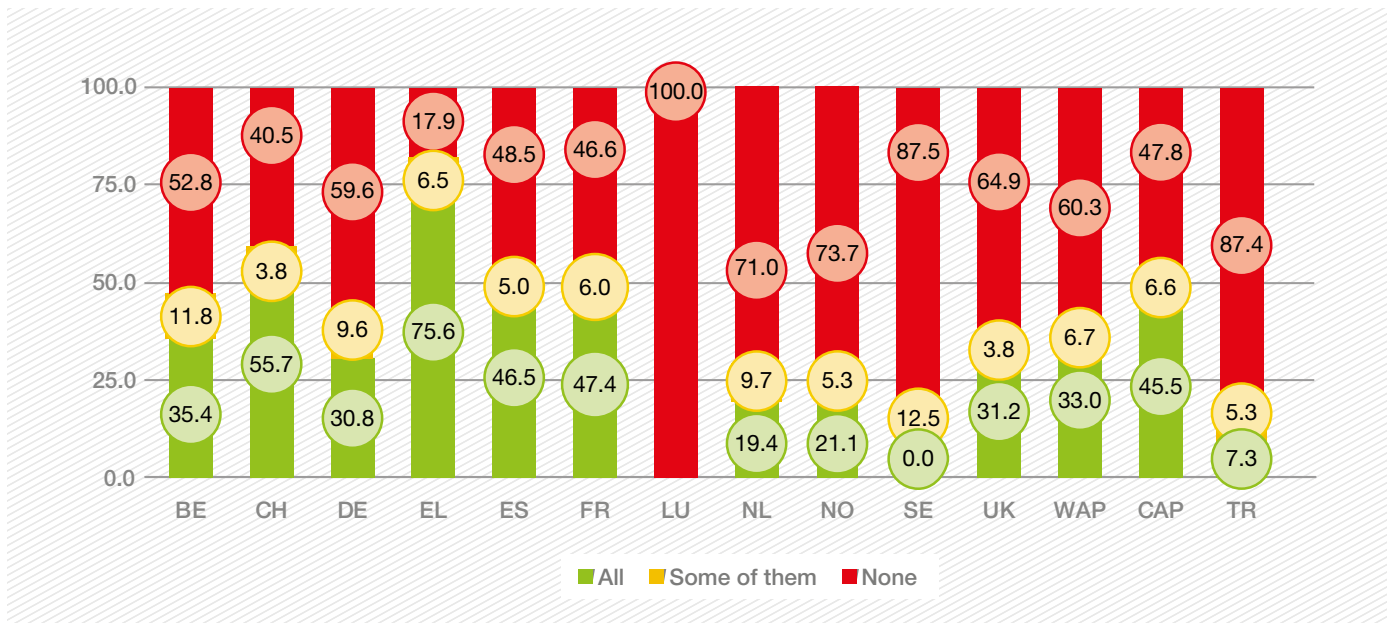
Among the people who had children under 18, only 33.0% were living with all of them in Europe. **Parents separated from their children are under considerable emotional strain which constitutes one more negative determinant of health.**



© Kristof Vadino

Homeless in Brussels

Figure 7 / Proportion of patients living with their children by country surveyed (%)



WORK AND INCOME

Near half of the people (46.7%) attending MdM and partner centres in Europe had no permission to reside and consequently did not have permission to work. As a consequence only 18.3% of patients surveyed across the 11 European countries reported having the means to earn a living.

As in 2013 and 2014, this proportion is the highest in the UK (31.3%) and, like last year, in Istanbul (57.5%) but it is noticeably low in France (where the Paris area is no longer included in the survey). Overall, these proportions may reflect the opportunities for access to the non-declared labour market in big cities.

Almost all the people⁴⁷ in the European countries (94.2%) and in Istanbul (99.5%) were living below the poverty line⁴⁸.

47 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 100% of the patients seen by MdM and partners.

48 The poverty threshold was given for each country at the beginning of 2015, on the basis of official figures in the country.

ACCESS TO HEALTHCARE

Universal health coverage (UHC) intends to avoid catastrophic expenditure on health which would drag people into poverty and discourage them from seeking healthcare when needed⁴⁹.

It helps reduce inequities in access to healthcare: all the people living in a country should benefit from health coverage independently of their administrative status.

COVERAGE OF HEALTHCARE CHARGES

The issue of the coverage of healthcare charges is an essential aspect of the path towards UHC. Having good

coverage is crucial to be able to access appropriate healthcare, especially for destitute people. In fact, substantial variation in access to health services exists across EU countries as access can be restricted or conditional.

Having personal health coverage helps a person to feel comfortable seeking care when needed. In some countries, patients have to rely on individual health professionals to grant them access to care. This means they have to find the right doctor at the right time, which is not always feasible when ill.

Two thirds, 67.5%, of patients surveyed at the MdM and partner clinics across Europe reported having no coverage of healthcare charges when they first came to the clinic, this figure includes both the 54.2% with no health coverage and the 13.3% who could only access emergency care.

49 United Nations. Sustainable Development Goals [Internet]; 2015. Goal 3: Ensure healthy lives and promote well-being for all at all ages [cited 2016 August 23]; [1 screen]. Available from: <http://www.un.org/sustainabledevelopment/health/>

Table 7 / Coverage of healthcare charges* by country

	BE	CH	DE	EL	ES	FR	LU	NL	NO	SE	UK	WAP	CAP	TR
No coverage at all	93.0	11.3	78.1	17.3	1.2	97.7	67.3	14.3	45.6	87.0	82.9	54.2	64.2	97.9
Only emergency care	0.0	4.2	11.5	42.7	50.4	0.0	0.7	0.0	36.8	0.0	0.0	13.3	13.2	0.0
Sub-total	93.0	15.5	89.6	60.0	51.6	97.7	68.0	14.3	82.4	87.0	82.9	67.5	77.4	97.9
Full coverage	4.1	80.9	4.6	25.9	40.0	2.4	0.0	4.3	2.9	0.0	7.8	15.7	15.7	0.9
Partial coverage	0.2	3.2	15.0	17.6	2.8	0.0	21.8	81.4	1.5	8.7	0.0	13.8	6.8	0.9
Free access to GP	0.0	0.0	0.0	0.0	1.6	0.0	2.0	0.0	0.0	0.0	7.0	1.0	0.3	0.2
Coverage in another EU country	2.1	0.5	10.9	0.4	0.4	0.0	8.2	0.0	10.3	4.3	0.0	3.4	1.7	0.0
Others**	1.9	0.4	42.2	0.3	3.6	0.0	0.0	0.0	2.9	0.0	3.9	5.0	3.7	0.1
Total***	101.3	100.5	162.3	104.2	100.0	100.1	100.0	100.0	100.0	100.0	101.6	106.4	105.6	100.0
Missing data	11.0	1.9	1.9	27.1	4.2	17.3	16.9	15.7	4.2	61.0	64.5	20.5	17.9	2.3

* To the extent that it exists in the country, meaning that care may still require out-of-pocket payments.

** Access to GP with out-of-pocket payment; Access to secondary care but no GP; Case by case basis; Insurance included in visa.

*** People could give more than one answer, which explains why the total may be over 100%.

The proportion of patients with no health coverage was very high in France and Belgium at 97.7% and 93% respectively. In fact, the clinics there redirect those with health coverage to the mainstream healthcare system. **Theoretically, undocumented migrants in both countries should be able to access specific full health coverage, however, administrative and language barriers limit access in practice.**

In Germany, 89.6% of patients reported no health coverage. Some migrant EU citizens and Nationals cannot afford health coverage.

In the UK, a very high proportion of patients, 82.9%, did not have access to the NHS, meaning they were not able to register with a GP, the entry point to the UK healthcare system. **In Greece, 60% of patients did not have health coverage.** Until the law changed in 2016, undocumented migrants had no access to care ; nationals or migrants with permission to reside lost their rights to health coverage after two years of unemployment. **In Norway, 82.4% of patients did not have access to the health system.**

“When I arrived in Madrid in 2008, I had no problems getting a health card. I must say that I was very well treated as regards my illness. They did some very costly tests on me.” Fabiola, 46, is a Paraguayan woman who has been living in Spain since 2008. She is employed as a carer and her administrative situation is irregular. For many years, she has been suffering from lupus erythematosus.

In 2011, Fabiola fell ill with shingles and began going often to the clinic. *“One day – Royal Decree 16/2012 had already come into force – I went to the outpatient clinic, and at the front desk they asked for my TIS (Individual Health Card) – as always – and, for the first time, my residence permit. When I replied that I did not have a residence permit, it wasn't the administrative assistant who was serving me, but another one beside her, who said: ‘Get it, take her card’. They snatched it from me.”*

Fabiola was no longer able to register, as the family she was living with had left; she could not therefore apply for a new TIS. Her doctor decided to continue treating her regardless of her situation. *“Since I was not registered, the TIS I got when I arrived here and which had been valid for ten years was useless. It's a bit sad, because they gave it to me and they themselves took it away.”*

Fabiola was persistent and managed to register again, obtaining a TIS at the end of 2014.

Today, Fabiola has to self-inject her medication once a week, although her hands are not steady enough to allow her to inject on her own. However, each time she goes to the health centre for the injection, they *“give me hassle. And the other problem is the cost: it's €100. If it weren't for ANESVAD, I would not be able to get it... One thing that seems sad to me is that the very same people who employ us deny us access to our rights: I mean no registration and no work contract. I weigh up who is worse, the government changing the law or the people who don't allow us to register so that we can access our rights.”*

MdM Spain – Bilbao – December 2015

Although undocumented migrants in Spain should be able to access emergency care under equal conditions and free of charge, in practice some have been billed for this care as witnessed by both MdM Spain and the Ombudsman in Spain⁵⁰. The REDER network⁵¹ also published many cases where pregnant women were denied temporary health coverage, as well as many children who should have the same access as nationals until the age of 18.

A very high proportion of patients surveyed in Sweden (87%), had no national identification number to allow them access to the mainstream health system.

In Switzerland the vast majority (80.9%) of patients surveyed had health coverage as asylum seekers.

Nearly all of the patients (97.9%) surveyed in Istanbul had no health coverage.

When we compare access to care for EU citizens and third-country nationals in Europe, we can see that both groups have almost no access to health coverage (over 70% do not). In practice, in some countries, it might be even more difficult to obtain health coverage for an EU citizen than for other nationalities, as we see in the field mainly in France, Belgium, Spain and the Netherlands, because of administrative hurdles.

50 Report from the Ombudsmen: “Daily practices in health centres (e.g. invoicing and charging costs) uncover problems in emergency care for undocumented migrants, which should be provided under equal conditions and free of charge”. Las urgencias hospitalarias en el Sistema nacional de salud: derechos y garantías de los pacientes, Madrid, January 2015.

51 The Network to Denounce and Resist the Spanish Royal Decree 16/2012 (Red de Denuncia y Resistencia al RDL 16/2012).

BARRIERS IN ACCESS TO HEALTHCARE

OVERVIEW

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

- **Financial barriers (24.0%)**, a combination of charges for consultations and treatment, upfront payments and the prohibitive cost of health coverage contributions. Financial barriers, including costs of consultations or treatments, were three times more frequently cited in Germany, at 67.4%, than the average of the nine European countries⁵².
- **Administrative problems (14.2%)**, including restrictive legislation and difficulties in collecting all the documentation needed to obtain any kind of health coverage, as well as administrative malfunctioning. Administrative problems were frequently reported in Spain (41.7%), France (25.7%) and in Norway (26.3%).
- **Lack of knowledge or understanding of the healthcare system and of their rights (9.1%)**.
- Even though language barriers were cited spontaneously only by 6.9% of patients, **40.8% of all consultations in the European clinics required an interpreter. So we should probably consider language barrier as one of the main issues.**

The interpreting need is high and should be met in all mainstream health structures. At MdM and partners' clinics, the language barriers were addressed by providing interpreting services as often as possible, on site or by phone. Unfortunately, professional interpreting was not always available or was prohibitively expensive.

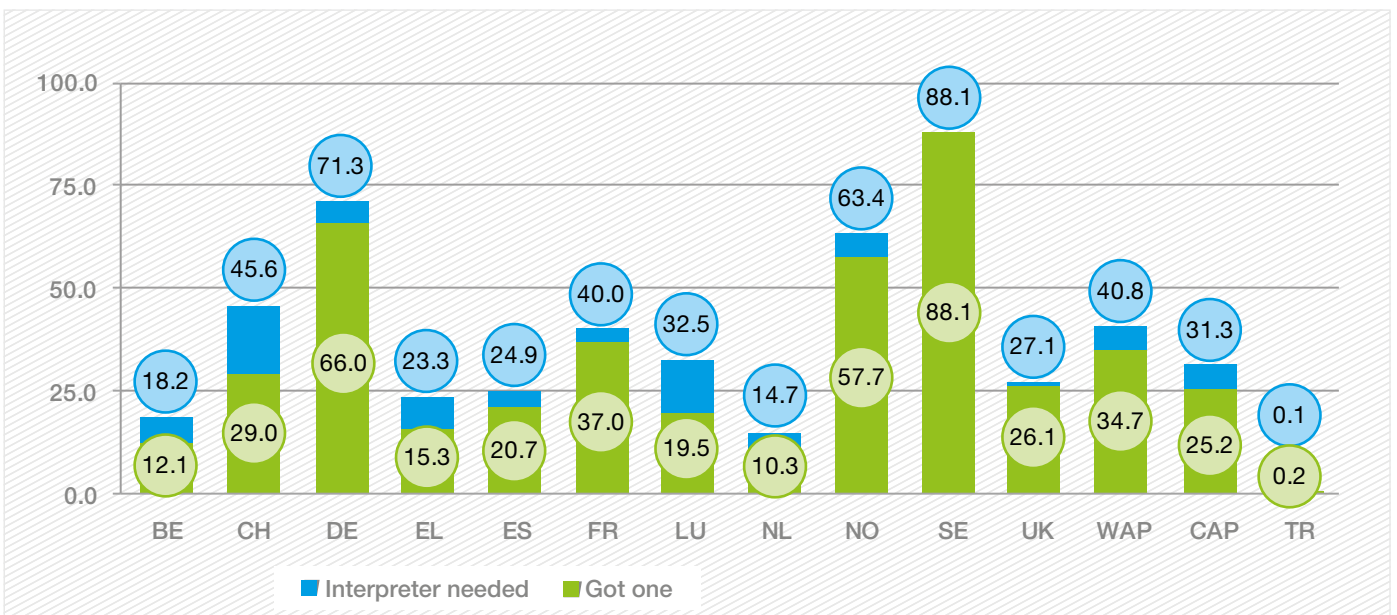
52 Belgium and Switzerland did not answer the question on the barriers in access to healthcare.



© Mike YOUSAF

Welcome to open.med in Munich

Figure 8 / Interpreters needed and provided, by country



Habeeba comes from Nigeria and is 27 years old. “When I arrived in Belgium, I discovered I had been walking around with a tumour in my uterus for two years. It had got so big that the doctors initially thought I was pregnant. I tried to get financial coverage for an operation through the Public Social Action Center (CPAS), but they refused to help me because I couldn’t prove that I lived in Antwerp. I postponed medical care, and in the end, things got so bad that I had to be admitted to the accident and emergency department for an immediate operation. Afterwards, I got a gigantic bill but, fortunately, the people from Doctors of the World mediated with the CPAS and I finally got the medical coverage that I was entitled to. It’s three years later now and I’m still tumour free. I almost lost my uterus, luck was on my side.”

MdM Belgium – Antwerp – July 2015

In Germany, asylum seekers, refugees and undocumented migrants must request a health voucher from the municipal social welfare office in order to access free healthcare. However, civil servants including healthcare providers are required to report undocumented migrants to the police, except in emergency rooms in hospitals (and in schools). This creates a major barrier for undocumented migrants and their children to access healthcare, as they fear being arrested.

Health coverage in another EU country was extremely rare, except in Germany (11.9%), the Netherlands (7.0%) and Sweden (9.1%). We consider it as a barrier, since in reality, having the right to care in another country makes it virtually impossible to access that right in the country of residence.

In Spain, 65.9% of respondents had administrative barriers, including denial of health coverage, as a consequence of the 16/2012 RDL (Real Decreto-Ley – Royal Decree-Law).

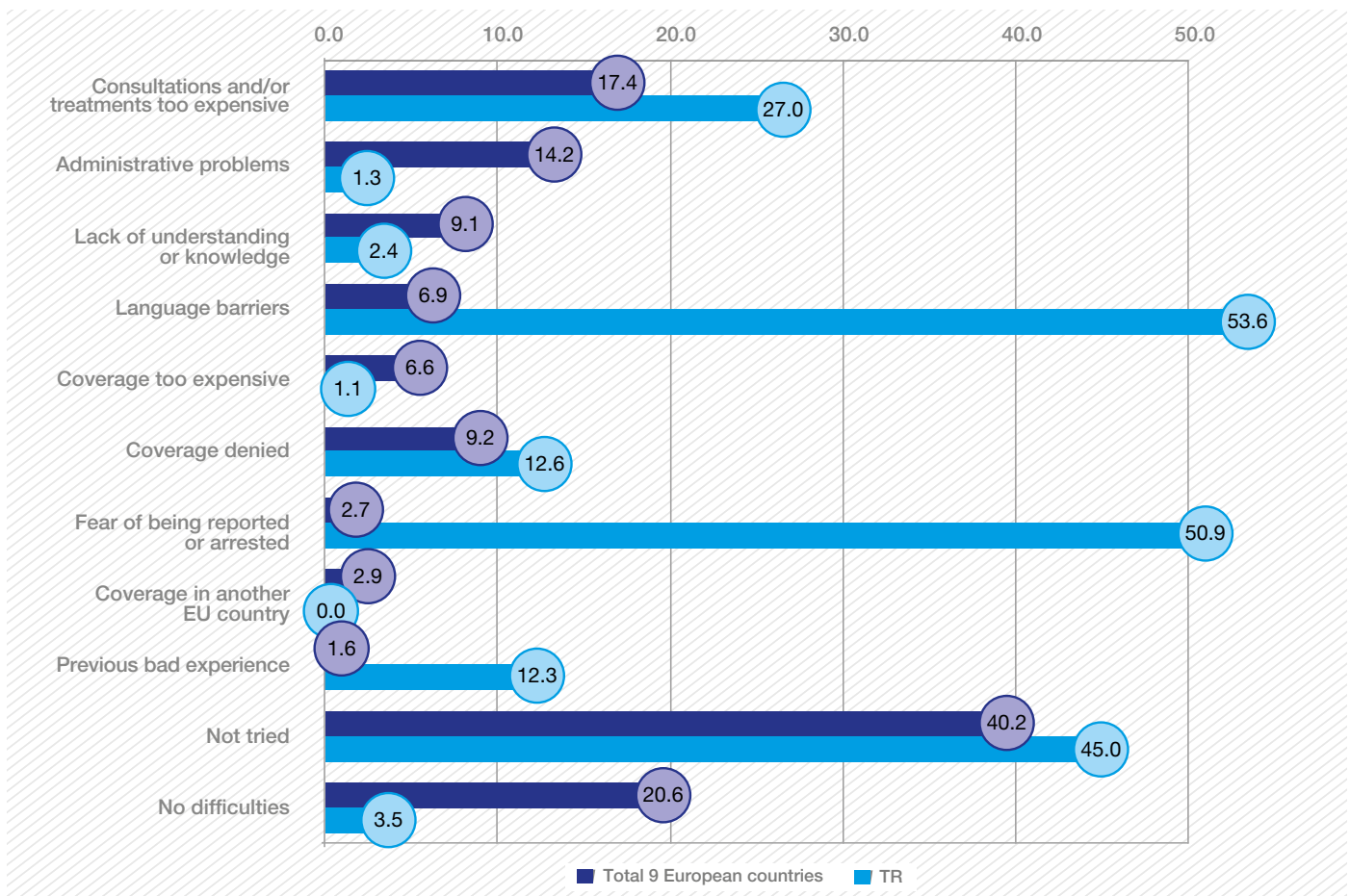
The situation is very different in Istanbul, where barriers cited are language barriers (53.6%), fear of being reported or arrested

(50.9%) and financial (28.1%). It is also the country where the proportion of patients reporting a bad previous experience at health facilities is the highest (at 12.3%) compared with 1.6% in all other countries ($p < 0.001$). Only 3.5% of patients said that they had no difficulties when seeking care versus 20.6% in Europe ($p < 0.001$). All these differences reflect the limited access to healthcare in Turkey for migrants, particularly undocumented migrants.

The fact that 40.2% of patients in Europe⁵³ had not tried to access care before arriving at MdM and partners' free clinics shows once again how the mainstream health system is perceived as inaccessible. While some may not have required medical attention before their first visit to an MdM or partner clinic, it is likely that others did not seek care as they had internalised the barriers or perceived more significant barriers than exist in reality, due to their lack of knowledge about their rights to healthcare in the few countries where they have any.

⁵³ Missing data average in Europe: 52.9%.

Figure 9 / Barriers to access healthcare in nine European countries and Turkey



The Nasris are undocumented migrants from Morocco who have been living in Belgium since 2009. Their youngest daughter has severe mental and physical disabilities. Despite the fact that she is entitled to receive care through the Urgent Medical Coverage (AMU) procedure, the local authorities are denying this access.

“Djamila is eight years old. She’s not able to walk or talk. Screaming and pulling her hair are her main means of expression. The doctors [MdM Antwerp] told us she needs to see a neurologist and a psychiatrist and needs different scans. But the CPAS refuses to pay for the medical examinations, claiming we don’t cooperate enough with the social investigation.” Regularisation on medical grounds was refused, with the argument that Djamila was already disabled before she came to Belgium. *“Our daughter needs professional help. Help that we can’t provide. Help that is being refused again and again by the authorities. My husband has become suicidal, he says we should all just jump under a train, that there is no future for us anymore. I’m scared for my family, scared for my child.”*

MdM Belgium – Antwerp – May 2015

GIVING UP SEEKING MEDICAL ADVICE OR TREATMENT

In the previous 12 months, 21.5% of the patients had given up seeking medical advice or treatment, the figure was up to 39.8% in Germany⁵⁴.

DENIAL OF ACCESS TO CARE BY A HEALTH PROVIDER

Mehdi is Egyptian, 31 years old and has been living in Chania for the last seven years. In February 2015, he went to a private clinic with a fever: he was diagnosed with HIV. He went to the hospital in Heraklion where he had a blood test at the HIV unit to confirm the diagnosis. Yet he was refused access to treatment by the hospital pharmacy, based on the fact that he was undocumented. The doctors at the hospital suggested that he contacts the Mdm polyclinic in Chania. Mehdi booked an appointment with the social workers of the polyclinic to find a way to access the drugs. *“Why don’t they give me any treatment? How am I supposed to buy the drugs? I am going to die, I have no money to buy the drugs.”*

The social workers booked an appointment with the NGO Thetiki Foni (Positive Voice) so that Mehdi could get his medicines for free for one month. They also helped in the asylum application process. In April 2015, Mehdi became an asylum seeker and started receiving his medication from the HIV unit of Heraklion hospital.

MdM Greece – Chania – 2015

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 care in the previous 12 months by a health provider was reported by 9.2% of patients seen in Europe (with higher figures for Spain, the Netherlands and the UK) and 12.6% of those seen in Istanbul⁵⁵. These figures show how health providers’ practices can really make a difference.

Hamza, aged 24, is an undocumented migrant from Morocco. He was denied to access healthcare because of his administrative situation: *“I went to the clinic and waited my turn. Then I saw a doctor or a nurse, I don’t know. What I know is that I didn’t receive any medical care for my problems. They just sent me to a pharmacy to buy some over-the-counter pills. I feel sad that I did not receive any help.”*

MdM Sweden – Stockholm – May 2015

DISCRIMINATION IN HEALTHCARE FACILITIES

Among the patients interviewed, 3.7% faced racism (discrimination based on colour or ethnic origin) in a healthcare facility in Europe (in the eight countries where the question was asked⁵⁶).

Over a third of patients in Istanbul (38.7%) faced discrimination from a healthcare provider⁵⁷.

FEAR OF BEING ARRESTED

Migrants who are either undocumented or whose residence status is precarious were asked if they limited their movements for fear of being arrested. Restricting movement constitutes a well-known barrier in seeking access to healthcare, as more important issues will be prioritised, like getting food or looking for a place to sleep.

In Europe, 39.6% of the patients reported limiting their movements due to fear of being arrested, which included limiting their movement sometimes, frequently or very frequently⁵⁸. As in past years, this figure, surprisingly, was the highest in the UK (80.0%).

Kodjo is Togolese and is 35 years old. He lives in a squatted former office building in Amsterdam, together with approximately 80 other undocumented migrants. Food and money are scarce.

He had to flee his country because of his sexual orientation. In the Netherlands he applied for asylum, stating that he feared for his life and freedom in Togo due to his homosexuality. He was refused asylum because he was told that he could not prove that he was homosexual: there were no photos of him or any written documentation of him showing he was.

Kodjo came to MdM because of a persistent pain in his foot. At a violent strike and demonstration in Togo a couple of years ago, he was hit by a metal object on his left foot. The injury was so serious that a forefoot amputation was performed in the hospital. Since then he has experienced a lot of pain related to the cutting of nerves, which is very common in amputations. He was taking strong medication for this, but because of his uncertain financial situation he has not been able to import medication from his home country for the last six months. *“I was afraid that doctors would tell the police that I was here without papers; so that is why I did not go to them for new medication.”*

Through the MdM network we explained to him that we could safely arrange a doctor’s appointment for him, without any risk of being reported to the police. This way he could get a prescription for the medication and not have to import it from other (unsafe) sources.

MdM Netherlands – Amsterdam – 2015

54 This question was not asked in Belgium and Switzerland and the missing data rate was 53.1% in Greece, 59.0% in the UK, 63.8% in Luxembourg and 62.7% in Sweden.

55 This question was not asked in Belgium and Switzerland and the missing data rate was 61.0% in Greece, 61.1% in the UK and 76.1% in Spain.

56 This question was not asked in Belgium, France and Switzerland. Missing values were frequent in Luxembourg (87.1%) and Sweden (57.6%). In all the other countries, this question is asked far more frequently since its formulation was changed; so we recommend keeping it in future surveys.

57 The missing data rate was 29.8% in Europe and 22.5% in Istanbul.

58 Missing data: 60.3%.

SELF-PERCEIVED HEALTH STATUS

The self-assessment of a person's own health is based on the individual's perception and may include various factors that are difficult to capture clinically, such as incipient disease, disease severity, physiological and psychological reserves and social functioning. Scientific studies have demonstrated that self-perceived health status is a valid measure, at population level⁵⁹.

The questions on perceived health are included on the social form, they are deliberately asked by non-medical staff (in order to let the patient express his/her own perception). **A majority (58.4%) of patients seen by MdM and its partners in nine countries in Europe⁶⁰ perceived their general health status as poor (i.e. very bad, bad or fair) and 24.1% perceived it as very bad or bad (3.6% in Turkey).**

59 De Salvo K, Bloser N, Reynolds K, He J, Muntner P. Mortality prediction with a single general self-rated health question. A meta-analysis. *J Gen Intern Med* 2006; 21: 267-76.

60 In nine European countries, as the questions were not asked in France and the rate of missing data was very high in Belgium (> 95%)

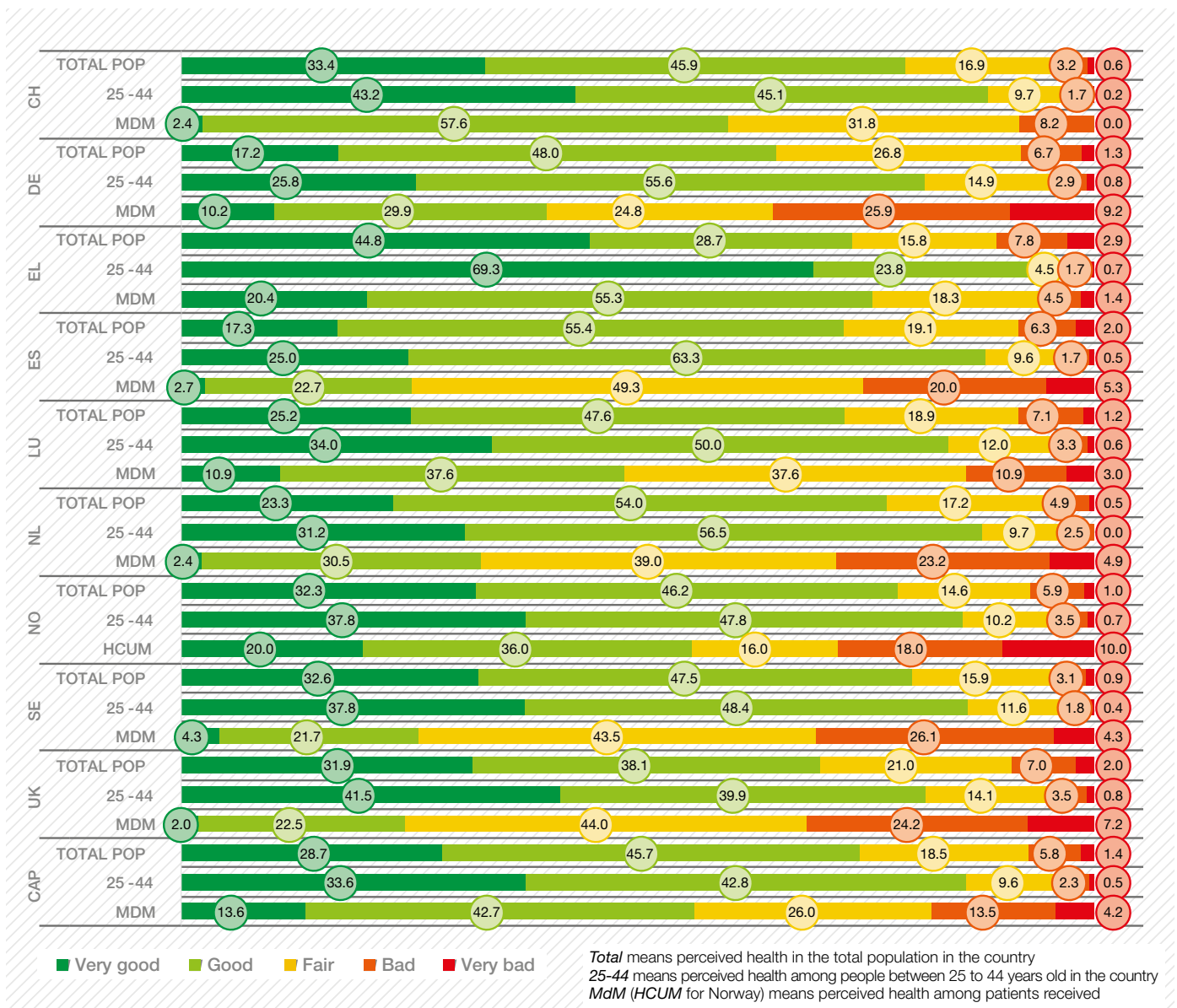
Furthermore, 23.7% of patients perceived their physical health as bad or very bad (4.4% in Turkey), **and this goes up to 24.7% for their mental health** (11.3% in Turkey).

The figure below shows the perceived general health of MdM and partners' patients, along with data from the general population of the host countries⁶¹. Given that most of the people going to MdM or partners' clinics have a health issue, the purpose of this figure is not a strict comparison with the general population's perceived health status.

Altogether, 13.5% and 4.2% of MdM patients reported a bad or very bad health status respectively, against 2.3% and 0.5% of the adults aged 25-44 in the general population of these nine countries (this age group is close to the age distribution of MdM and partners' patients).

61 Eurostat [Internet]. 2014. Self-perceived health statistics [cited 2016 September 5]. Available from: http://ec.europa.eu/eurostat/statistics-explained/index.php/Self-perceived_health_statistics

Figure 10 / Perceived general health: adults aged 25-44 visiting MdM and partner clinics and the general population in the host country, by country in Europe



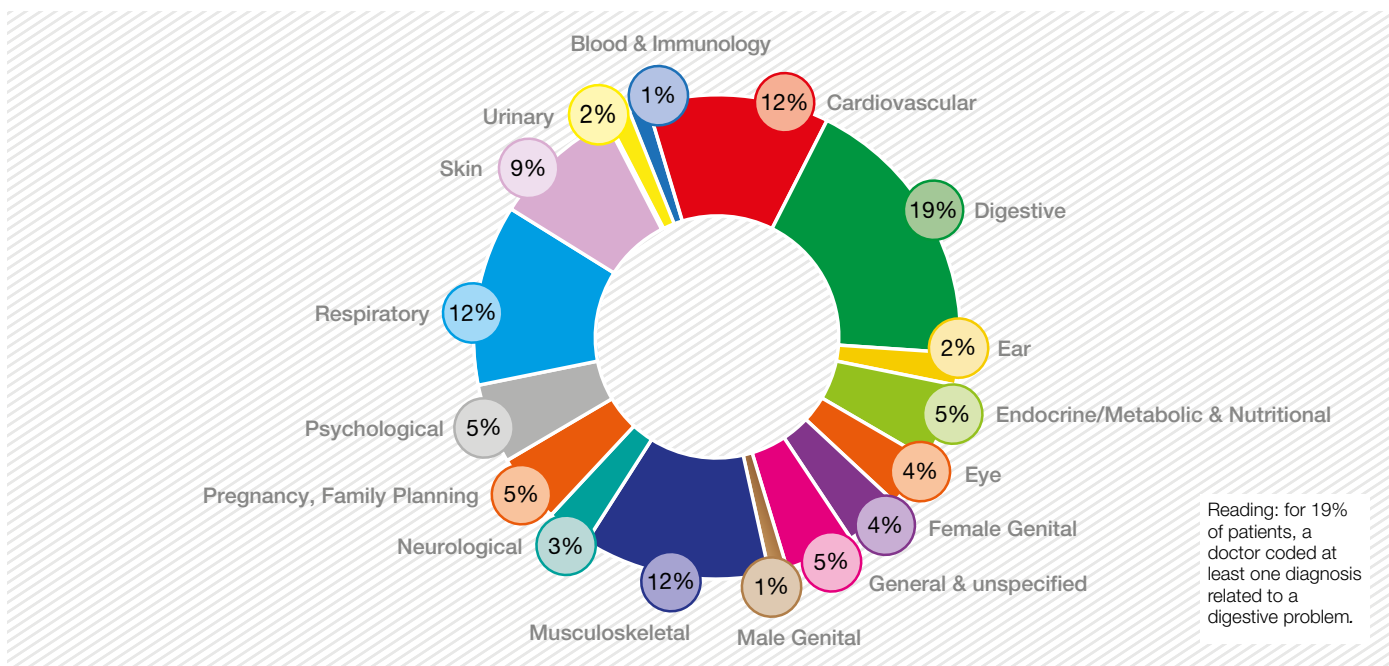
HEALTH STATUS

HEALTH PROBLEMS

Half of the health issues encountered concerned four organ systems: 19.0% of patients were diagnosed with a digestive problem, 12.0% with a musculoskeletal issue, 12.0% with a cardiovascular problem and 12.0% with respiratory problems.

Among female patients, problems related to pregnancy or delivery were cited in 12.2% of consultations and gynaecological problems were cited in 8.4% of consultations.

Figure 11 / Distribution of diagnoses by clinical system (as % of patients)



One or more mental health problems were diagnosed in 5.0% of patients, with 2.5% diagnosed with anxiety and related problems and 1.0% diagnosed with depression. Mental health issues clearly remain under-reported and under-diagnosed among patients visiting MdM and partner clinics, considering their elevated burden in migrant populations⁶², particularly among refugees or people who fled a country at war⁶³.

Mental health problems should be systematically and more carefully explored beyond the main reasons for consultation that are given by patients at first sight.

CONTRACEPTION

Overall, 13.4% of women in Europe were using contraception and 7.8% in Istanbul⁶⁴. Among women not using contraception, 15.1% in Europe reported that they would like to benefit from contraception⁶⁵. The provision of information about birth control should be increased in European programmes.

62 Carta MG, Bernal M, Hardoy MC, Haro-Abad JM. Migration and mental health in Europe (the state of the mental health in Europe working group: appendix 1). *Clin Pract Epidemiol Mental Health* 2005;1:13.

63 Bogic M, Ajdukovic D, Bremner S, Franciskovic T, Galeazzi GM, Kucukalic A, Lecic-Tosevski D, Morina N, Popovski M, Schützwohl M, Wang D, Priebe S. Factors associated with mental disorders in long-settled war refugees: refugees from the former Yugoslavia in Germany, Italy and the UK. *Br J Psychiatry* 2012;200:216-23.

64 Missing data: 69.3% and 63.2% respectively.

65 Missing data: 67.7%.

Lili comes from South East Asia and is 35 years old. She has been living for several years in Munich without papers, working as a nanny for a family from her country of origin. She has a child of her own whom she had to leave behind and hasn't seen for many years.

The first time we saw her, she was very shy and fearful. She told us that she hadn't seen a doctor in the last five years and had pain in her whole body: abdominal pain, dental pain and headaches. We arranged several appointments with a dentist and a gynaecologist and enabled her health situation to improve. By chance, she also met another patient from her home country with a similar story.

Having a place to turn to and knowing that she is not the only one in this situation has helped Lili to build up her confidence. She is currently intending to obtain a residence permit with the help of our partner organisation, Café 104.

MdM Germany – Munich – August 2015

URGENT CARE

In total, more than 40% of patients needed urgent or fairly urgent care when they visited the programmes in ten European countries⁶⁶. As in 2014, this proportion was notably the highest in Munich, at 49.0%, and the UK, at 33.8%. These results show once more that patients wait before seeking care and that they arrive late at our free clinics.

66 Belgium did not collect these data. Missing data: 37.0%.



An MdM mobile unit in Athens

ACUTE AND CHRONIC HEALTH CONDITIONS

Across the European countries, 48.6% of patients were diagnosed with at least one acute health condition, up to 82.2% of patients in Istanbul.

In the European countries, 47.5% of patients had at least one chronic health condition, 17.8% in Istanbul. For people with no proper access to health coverage (the people we see in our clinics), one of the main issues is the lack of continuity of care, which is even worse for chronic pathologies.

NECESSARY TREATMENT

Across the European programmes⁶⁷, 73.7% of patients required treatment that was judged 'necessary' by the doctor⁶⁸. Treatment was considered necessary if, without treatment, the patient's health would deteriorate or the patient would have a significantly poorer prognosis. Treatment was considered precautionary in all other cases.

The proportion of patients requiring necessary treatment was very high everywhere (except in the UK), showing that patients consult the MdM and partners' free clinics for serious health issues.

PATIENTS HAD RECEIVED LITTLE OR NO CARE BEFORE VISITING OUR CLINICS

In ten European countries⁶⁹, 65.9% of patients had not

been treated properly before arriving at our clinics. 54.7% of patients had at least one health problem that had never been monitored or treated before coming to the MdM or partners' clinics and 11.2% had only been partially treated. This percentage was significantly higher in Switzerland (71.5%), France (67.5%) and Norway (67.2%). In Istanbul, no patient at all had benefited from treatment before attending the free clinic.

In Greece, 46.4% of patients reported having no previous follow-up or treatment before their first consultation at MdM Greece, a substantial increase from last year's 37.8%. This may indicate frequent breaks in the continuity of healthcare: health problems which had previously been diagnosed and treated were no longer treated, consequently, patients came to MdM Greece. The effect of the economic crisis, with subsequent austerity measures and the far-reaching reorganisation of the whole health system should be noted⁷⁰.

Ayan is a 5-year-old child from Jordan. He lives with his undocumented parents in Greece. He has been diagnosed with chronic bronchial asthma by the doctors at our polyclinic. Before MdM, he couldn't access healthcare because he was not entitled to free medical care in any public hospital. He needs certain medicines every month which are provided by MdM Greece. The treatment is monitored by the paediatrician at the polyclinic.

MdM Greece – Patras – 2015

67 Belgium is not included due to missing data.

68 Missing data: 39.6%.

69 Belgian records were not analysed due to 96.1% missing data. The missing data average was 42.6%.

70 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.

Jawad, aged 42, comes from Pakistan and is currently living as an undocumented migrant in Greece. He only has a “voluntary return” card from the IOM (International Organization for Migration).

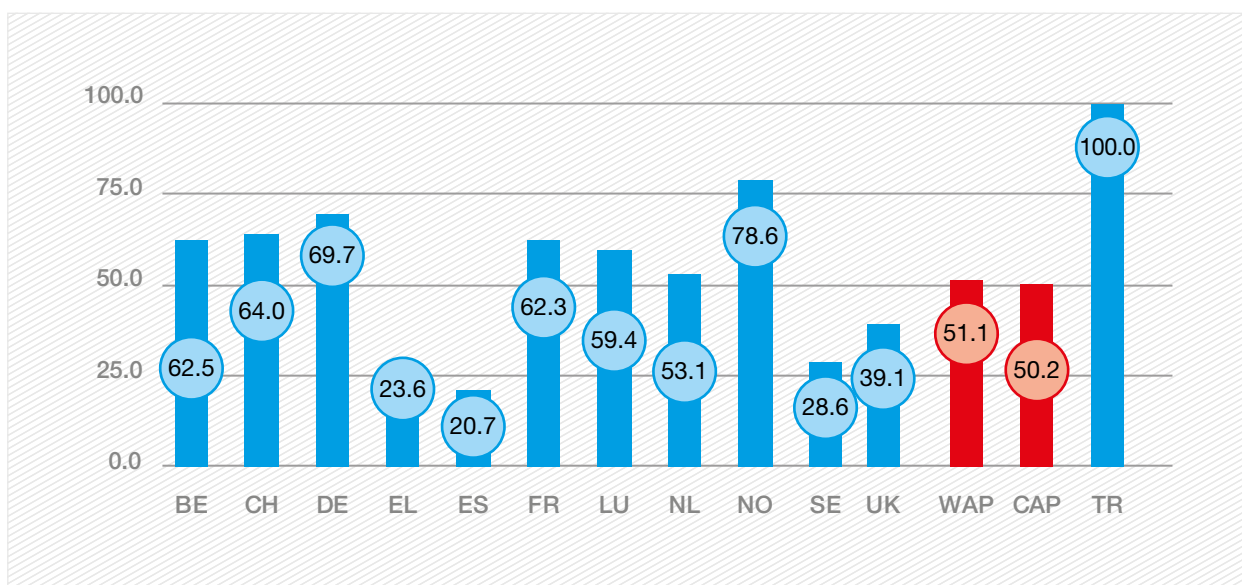
Jawad came to the MdM polyclinic in Perama with intense chest pain and said that he was denied treatment at the public hospital after having been asked for money in order to be treated. Our doctor asked immediately for him to be taken to hospital, since his condition was critical: he was diagnosed with acute myocardial infarction. Jawad was eventually transferred to the cardiology department of the Thrasio General Hospital.

MdM Greece – Perama – December 2015

CHRONIC CONDITIONS: NO ACCESS, NO CONTINUITY

Half of the patients in Europe (51.1%) seen by a medical doctor at MdM or partner clinics had at least one chronic condition that had never been checked or monitored by a doctor before. No patient in Istanbul had accessed care before reaching the ASEM clinic.

Figure 12 / Proportion of patients with one or more chronic health condition that had not been treated before visiting an MdM or partner facility, by country



Substantial proportions of patients living with chronic health conditions should have accessed treatment for their conditions earlier. Across the European countries, **44.8% of patients had at least one chronic condition that medical doctors indicated should have been treated earlier.** These proportions went up to 81.0% in Greece, 71.0% in Germany and 64.0% in Norway.

In Istanbul, all patients should have accessed follow-up or treatment earlier as assessed by medical doctors.

Two thirds of the patients (68.7%) did not know about their chronic disease before arriving in the host

country, showing once more that migration for health is not the reality for the patients we see.

INFECTIOUS DISEASE SCREENING

People facing multiple vulnerabilities in health are also those who generally have less access to preventive medicine. So screening is essential. Asking the patients if they wish to be tested for HIV, HBV and HCV is also a way to discuss prevention more widely.

Table 8 / Wish to be tested (HIV, HBV and HCV) and knowing where to be tested, by country

	DE	EL	ES	NL	NO	SE	UK	% in the 7 European countries*	TR	% in the 8 countries surveyed*
Wish to be tested	55.8	18.8	43.5	45.8	74.4	27.8	2.4	43.5	98.7	48.7
Missing data	44.6	41.4	9.2	42.2	45.1	69.5	43.5	59.0	0.4	57.5
Know where to be tested	39.1	49.0	63.6	51.0	55.6	0.0	2.2	50.0	0.6	45.5
Missing data	46.5	41.2	11.5	41.0	62.0	71.2	43.5		0.4	

*WAP. No data in BE, CH, FR, LU.

Access to treatment is essential in order for people to get screened; medical teams are reluctant to refer patients for screening when no treatment option is possible.

For example, access to new HCV treatment is made impossible because of the very high cost. Most countries have considerably limited the access to new treatments in

order to preserve their health systems monetary balance. Only full access to infectious disease treatments will help in detecting them, avoiding further infections and preserving people's health.

Ricardo, 39, is from Colombia and arrived in Spain ten years ago. He is a victim of a trafficking network for purposes of sexual exploitation. His family is in Cali. MdM Galicia found him living in a flat used for prostitution. His health situation was very worrying.

"I was too afraid to go to the doctor because I have no health card, my passport is no longer valid and I am in an irregular situation. I know this is not going to end well if I don't see a doctor. So, well, the shame of it, male prostitute, homosexual, and on top of that if I have AIDS... I don't need to tell you, something more to be afraid of."

MdM accompanied him to the hospital where he stayed for two months. The barriers to accessing the health system are endless, even though during his stay he was diagnosed with acquired immune deficiency syndrome (stage C3), active HBV infection, latent syphilis and oral oesophageal candidiasis associated with oesophageal ulcers caused by cytomegalovirus.

After a lot of paperwork, he was admitted to the Epidemiological Surveillance Programme in Galicia. He was taken to an anti-AIDS committee apartment for people living with HIV where he is recovering.

Subsequently he has been attended to by the MdM team in Bilbao as he needs anti-retroviral treatment. The Basque health service is offering a treatment different from the one he was used to, which is the reason why he has decided to go back to Galicia.

MdM Spain – A Coruña province / Bilbao – December 2015

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 "direct-acting antiviral" drugs brings new hope as they are better tolerated by patients and the cure rate exceeds 90%!

However, the first drug of its kind, Sofosbuvir, is sold at exorbitant prices – for example, in France it costs €41,000 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 medical innovation but abusive pricing, driven by profit, is never acceptable for necessary health products. Such profiteering jeopardises the very existence of our public health model, which is based on solidarity and equity. Consequently, in February 2015, MdM opposed the patent for Sofosbuvir at the European Patent Office. MdM wants affordable hepatitis C medicines for all.

To mark the significance of World Hepatitis Day (28 July 2016), MdM and Treatment Action Group published the report "Dying at these prices: generic HCV cure denied" based on crowd-sourced hepatitis C data from over 40 countries, available at mapcrowd.org⁷¹. As Dr Françoise Sivignon, president of MdM France, notes, *"The online platform mapCrowd confirms that we are on an uneven road toward eliminating hepatitis C for the 80 million chronically infected people around the world— largely due to high prices. Generics are safe, effective superheroes ready to act. They require stronger political efforts to become available on domestic markets."*

71 Map Crowd. Report #2. Dying at these prices: generic HCV cure denied [Internet]. 2016 July [cited 2016 August 25]; [24 p.]. Available from: http://mapcrowd.org/public/pdf/EN_mapCrowd_Report2.pdf



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Let's make their dreams come true – Athens

FOCUS ON PREGNANT WOMEN

Nehla is a 34-year-old undocumented Tunisian in France. In 2009, she and her husband Farid arrived from Italy after he lost his job. Farid started his own crafts business in France, which enabled him to obtain health coverage that also includes his wife and children. Because the family still doesn't have a residence permit, the administration blocked their social benefits.

Nehla is diabetic and pregnant with her third child. At first, she received antenatal care for high-risk pregnancies at the hospital. We met her in her seventh month of pregnancy because the hospital admissions office required her to pay for consultations and check-ups and denied her access to care providers without prior payment.

We submitted a request for State Medical Aid (AME) in emergency for Nehla. We also contacted the hospital, reminding them that lack of care would endanger the lives of both Nehla and her unborn baby. They still wanted to deny her care if she didn't pay. We asked our doctor to contact the hospital's medical staff. Finally, after two weeks of anxiety, consultations were again scheduled for Nehla.

One week later, State Medical Aid was granted, with retroactive effect. Nehla can now receive the care she needs.

MdM France – Nice – March 2015

Salome is 33 and is Portuguese. She has been living in Spain for two months and therefore does not need a residence permit. She is pregnant and does not have a health card.

She went to a health centre to request healthcare: it was denied, although she was 35 weeks pregnant, because she did not have health coverage. She was told to go to the emergency unit on condition that she signed an agreement to pay in advance. However, once there, since they did not consider being pregnant as an emergency, she was told to come back only for the final antenatal consultation, just before delivery.

She arrived at MdM to obtain information on her rights to access healthcare and future billing arrangements. Without the help of the organisation, the only option open to her would be a health card at patient's cost, even though all pregnant women are theoretically entitled to free access to care.

MdM Spain – Tenerife – May 2015

A total of 274 pregnant women in Europe were included in this survey, mainly in Belgium (53), Germany (79) and the UK (55), with 40 in Turkey.

The average age of the pregnant women who visited our clinics was 30 (standard deviation 6.5 years).

GEOGRAPHIC ORIGIN OF PREGNANT WOMEN

Nearly all pregnant women seen in the 11 European countries were foreign nationals. EU citizens were the first group (33.8% including 8.1% nationals).

ADMINISTRATIVE STATUS

Of the pregnant women surveyed in Europe, 18.1% were in the process of claiming asylum and 52% had no permission to reside.

LIVING CONDITIONS

Most pregnant women (55.6%) were staying with friends or lived with their family, but 8.1% were homeless (rough sleepers). In Turkey and Europe, nearly half of the pregnant women (48.4%) considered their housing to be temporary or unstable, meaning they could not be sure of having a roof over their head when they delivered. This adds greatly to antenatal anxiety.

Table 9 / Housing situation of pregnant women

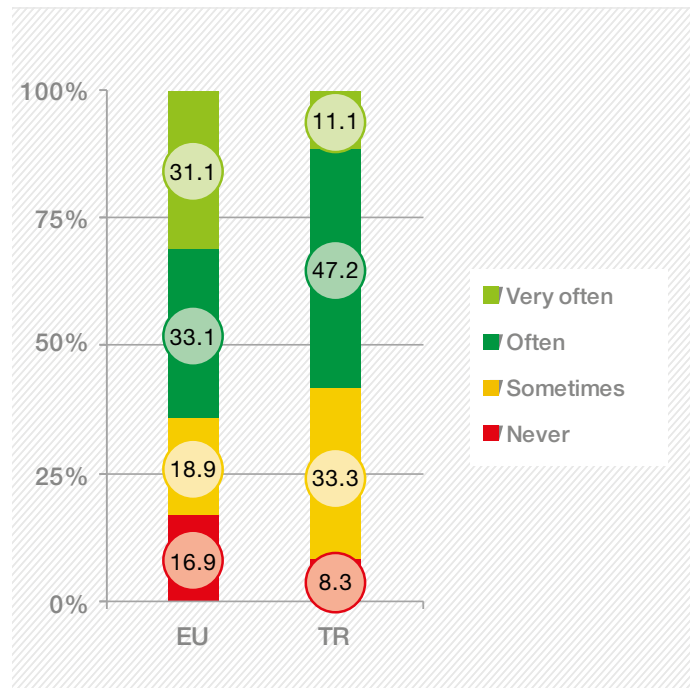
	% in EU (n=280)	% in Istanbul (n=35)
Friends/family	55.6	41.7
Personal	26.1	58.3
Rough sleeper	8.1	0.0
Organisation	8.5	0.0
Camp/slums	0.0	0.0
Workplace	1.3	0.0
Squat	0.4	0.0
Missing data	5.1	0.0
Unstable housing	48.4	54.3
Missing data	18.9	2.8

ISOLATION

The levels of social isolation reported by pregnant women were very high and occurred at a time when moral support is most necessary.

In Europe, 16.9% of pregnant women never had anybody to rely on if needed, and 18.9% had sometimes only someone to rely on, so in total 35.8% of pregnant women were isolated (it was the case for 41.5% in Istanbul). Social isolation constitutes an additional barrier to accessing healthcare.

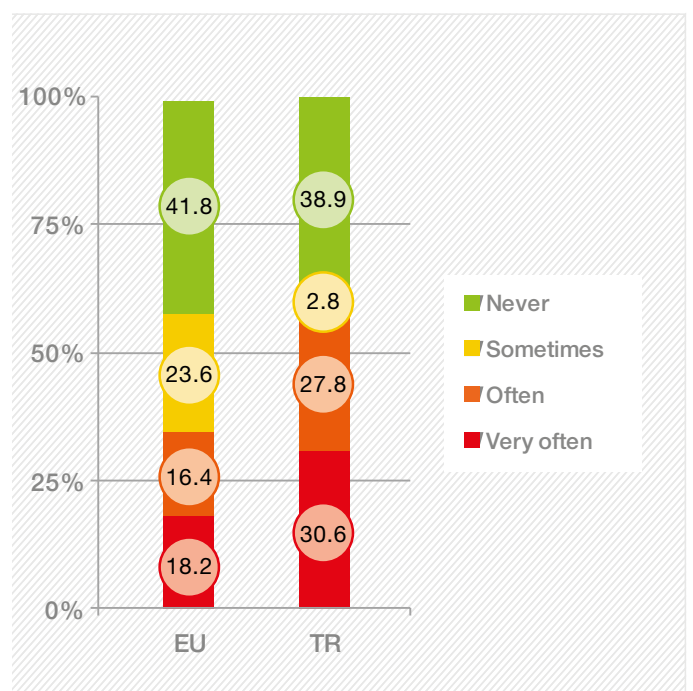
Figure 13 / Isolation: having someone to rely on when needed



LIMITING MOVEMENTS

High proportions of pregnant women⁷² limited their movements because of the fear of being arrested. In Europe, 58.2% of them limited their movements sometimes or (very) often. The situation was even worse in Turkey (61.1%). Pregnant women who are limiting their movements will prioritise looking for food or shelter before seeking antenatal care.

Figure 14 / Fear of being arrested, pregnant women



⁷² This question was asked to undocumented migrants or those whose status was precarious.

HIV AND HEPATITIS SCREENING

In Europe, only 42.3% of pregnant women reported that they had previously been tested for HIV, 48.1% for HBV and 42.9% for HVC. In Istanbul only 2.9% reported a previous HIV test and none had had an HBV or HCV test.

Only 42.7% of pregnant women knew where to be tested in Europe and none knew where to be tested in Istanbul⁷³.

Due to the impact of HIV, HBV and HCV on both the health and care of pregnant women and their babies, 100% of pregnant women should receive information on STIs and have immediate access to screening.

ACCESS TO HEALTHCARE

Despite the need for mothers and babies, access to healthcare and antenatal care was extremely limited for the pregnant women attending Mdm and partner clinics, as 67.8% had no access to health coverage⁷⁴, meaning that they mostly had to pay all the costs of care.

Table 10 / Health coverage for pregnant women

	% in EU (n=280)	% in Istanbul (n=35)
No coverage / all charges must be paid	48.8	97.1
Access to emergency services only	19.0	0
Access on a case-by-case basis	4.4	0
Partial health coverage	18.8	0
Open rights in another European country	4.5	0
Full health coverage	11.9	2.9
Health costs covered by visa	0.1	0

73 36.5% and 0% missing data respectively

74 This figure includes women with no health coverage and those who only have access to emergency services.

PREGNANT WOMEN AND NON-ACCESS TO ANTENATAL CARE

Only 56.4% of pregnant women seen in Europe had access to antenatal care before their visit to our programmes. This proportion was notably lower in Istanbul (37.1%).

Altogether, 38.9% of pregnant women had access to antenatal care after the 12th week of pregnancy at the time of their first visit to our programmes in the eight European countries. This figure was 33.3% in Istanbul.

Table 11 / Proportion of pregnant women who had no access and access after 12th week to antenatal care at the time of their first visit in our programmes

	% in Europe*	% in Istanbul
No access	43.6	62.9
Access after 12th week	38.9	33.3
Missing data	17.4-49.1	0.0-40.0

* No pregnant women in LU, no response for late antenatal care in CH and SE.

When she was still in Bulgaria, Ioana, a 35 years old Bulgarian Turkish Roma, noticed a knot in her breast. She did not see a doctor, hoping that it was not serious. "I went to school, then I worked in a factory. Due to the crisis the company stopped and I lost my job and health coverage." She then worked on and off. "I worried about the knot, but did not have the courage to go to a doctor, I was so afraid to hear a negative diagnosis". The knot developed into an open bleeding wound on the outside of the breast.

Ioana came to Germany in 2015 to look for a real job and stayed with her brother's family. When they saw the wound, they took her to the Hoffnungsorte and Mdm clinic in Hamburg: she was diagnosed with breast cancer, with a high risk of metastasis. The team took time for her to see the need to be treated and organized the operation and reimbursement. Ioana told us: "After [the operation] I want to find a job so that I can finance a health coverage again."

Hoffnungsorte - Mdm Germany - Hamburg - December 2015



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Near the tent camp in Piraeus - Greece

Bernaldo is Brazilian and is four years old. He has been living in Spain with his family for two years. They are undocumented.

Concerned about Bernaldo's vaccinations, his parents went to the health centre for the second time (they had already tried the previous year) to apply for a health card for their son, which was again denied. When they asked for the vaccination schedule, they were told that the matter was irrelevant since the child had no right to the health card. Someone then spoke to them about MdM: they came to us, in order to get our help with the vaccination procedure. According to the law, all children have free access to care in Spain.

MdM Spain – May 2015

Paola is 13 and comes from Argentina. She has been in Spain for three years with her family in an irregular situation. She used to go to her health centre as she had a health card. Recently they told her that her health card was no longer valid because of Royal Decree-Law 16/2012. They redirected her to the National Institute of Social Security (INSS). There they informed her that, because she did not have a residence permit, they could not issue the document entitling her to social security. They then redirected her to her health centre. There they sent her back again to the INSS.

The text of the 2012 Decree-Law is ambiguous about what is the responsibility of the INSS or of the health centres with regard to recognising the social security status of minors. In Malaga we have come across many cases in which a child is left without health coverage for this reason. Families eventually give up and only go to MdM when children need urgent care.

MdM Spain – February 2015

FOCUS ON CHILDREN

Children have always been only a minority of the patients who attend MdM and our partners' programmes, except in Greece where they accounted for 44.0% of the population. Nevertheless, with 1,772 children in the total number analysed (1,711 in Europe), it was possible to give details about their vaccination status. Nearly half of the children (805) were under the age of five (771 in Europe).

In Greece, we saw 1,102 children (545 under five). In France, 312 children visited MdM's clinics (98 were under five) and in Belgium it was 175 (68 under five).

In 2015, in the European countries, 37.8% were European citizens (including 9.3% nationals) and 21.6% were from the Near and Middle East.

- In Belgium, the most numerous group of children came from Sub-Saharan Africa;
- In Greece, 41.3% of children were nationals;
- In France, 48.5% of children were European (from within or outside the EU).

CHILDREN AND VACCINATION

Vaccination is specifically important for children facing multiple vulnerabilities, as they are more frequently exposed to infectious disease risk factors, including unhealthy living conditions and malnutrition. Paradoxically, these children have fewer opportunities to be vaccinated, largely due to legal and financial barriers to care.

In September 2014, the Member States of the WHO European Region unanimously adopted the European Vaccine Action Plan 2015-2020⁷⁵, pledging to ensure long-term domestic funding and political commitment to immunisation, with particular attention on ensuring the benefits of vaccination are equitably extended to all (objective 3).

Despite the health protection that vaccination provides to the individual and their community, an unacceptably high proportion of children seen in MdM and partner programmes⁷⁶ were not vaccinated⁷⁷ (meaning that they were not able to present a vaccination booklet for several basic vaccinations).

Among children under five years old seen in Europe and Turkey, high proportions were not vaccinated and/or not able to present a vaccination booklet: 31.6% were not vaccinated against tetanus, 53.9% against MMR, 38.4% against HBV and 37.2% against whooping cough⁷⁸.

Among minors under 18 years old, vaccination coverage was a little better but still worrying, since 29.8% (tetanus), 40.0% (MMR), 35.8% (HBV) and 34.4% (whooping cough) required vaccination.

Providing adequate and recommended vaccination to all children, particularly those living in the most precarious environments, should be an absolute priority. Their parents' administrative status should obviously not interfere with children's protection against avoidable diseases.

In total, 33.0% of people did not know where to go to have their children vaccinated in seven European countries⁷⁹. This proportion rose to 60.0% in Istanbul.

75 European Vaccine Action Plan 2015-2020. WHO. Regional office for Europe. 2014. Denmark, Copenhagen.

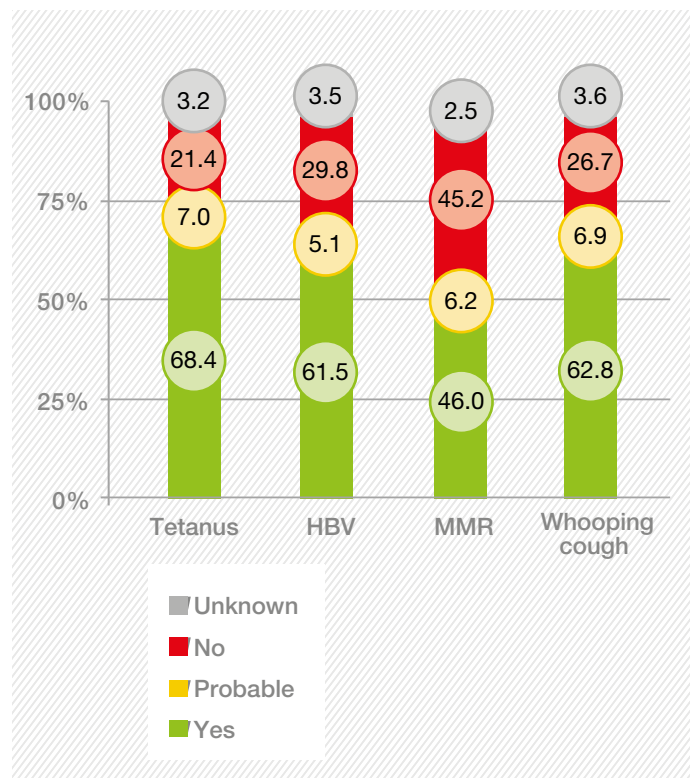
76 The rate of children seen in MdM clinics for whom vaccination status was not documented is much too high. All children's vaccination status should be checked, even if they may subsequently be referred to specific vaccination centres.

77 Proportions given are CAP.

78 Missing data were: BE 94.1%, CH 84.5%, DE 58.5%, EL 4.2%, FR 33.3%, SE 39.2%, UK 28.2%, TR 39.4%.

79 57.0% missing data. The seven countries are: BE, CH, DE, EL, FR, NL, NO.

Figure 15 / Vaccination status of children < 5 (CAP)



UNACCOMPANIED MIGRANT CHILDREN

The increasing number of unaccompanied migrant children⁸⁰ in Europe is an urgent humanitarian issue. Unaccompanied children need assistance: states have the responsibility of ensuring their protection in suitable facilities (not prisons or detention centres).

Across the 11 European countries, MdM and partner programmes saw 60 unaccompanied migrant children in 2015, representing 3.4% of all children seen. Given the high level of missing data related to unaccompanied children, results are not presented here. Efforts are being made in the data collection procedure of the Observatory to ensure, for the future, the gathering of robust and more extensive data related to unaccompanied children.

Specific programmes with unaccompanied children take place in France (Caen and Paris) and in Greece (Moria in Lesbos and Peania near Athens).

80 An unaccompanied child is a person who is under the age of 18 (unless, under the law applicable to the child, majority is attained earlier) and who is "separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so". <http://www.unhcr.org/3d4f91cf4.pdf>

“Although lately there has been a slight increase in the number of accommodation places in Lesbos, nevertheless, around 140 unaccompanied children remain in custody in Moria, some of them over a time period that exceeds four months. At the same time, more newcomers belonging to this multiply vulnerable category are gradually being added. Despite continued efforts to include more recreational activities in the unaccompanied children’s programme, the prolonged stay in confinement conditions have caused a significant deterioration in mental health and psychological state. Indicative is the increase of cases where children suffer from panic attacks. MdM Greece repeats that restriction of personal freedom of children should at the most take place for a minimum period of time and only for their registration, so they can be referred to appropriate accommodation facilities. Migrant and refugee children arriving in Europe after difficult and dangerous journeys should first of all be treated as children – with their rights – and not as violators of immigration law.”

MdM Greece – 6 September 2016

Unaccompanied children in France: difficulties in accessing child protection measures

While the majority of minors seen in the Healthcare, Advice and Referral Clinics (CASOs) are living in France with one or both parents, nearly 16% (359) are by themselves in the country and considered as unaccompanied children on their first visit.

The unaccompanied children seen in the CASOs are mainly boys aged between 15 and 17. Among them, 78% come from Sub-Saharan Africa and 7% from the Near and Middle East. 61% of them have been in France for less than three months. Over half of them (52%) are homeless and 11% are living in squats or camps. Only 6% have an effective health coverage even though all children should benefit from direct, immediate registration for health coverage.

Most of them are on the streets and extremely vulnerable, unable to benefit from the protection measures to which they are entitled.

In order to determine eligibility for child protection, the local authorities assess the situation to decide whether they are indeed underage and unaccompanied. During this assessment process, children are rarely able to produce identity documents proving their age, as such documents are particularly difficult to obtain in their countries of origin⁸¹.

An unaccompanied child may also have to undergo a medical assessment in order to determine whether s/he is indeed under 18 via a dental examination, an examination of puberty or even x-rays to examine bone structure. These examinations are inadequate, degrading and offer no guarantee of reliability. However, they are widely used and, on this basis, many children are refused access to child protection.

Already deeply shaken by their migration journeys and vulnerable situation, these types of assessment constitute an act of institutional violence against these children.

MdM France, Observatory Report 2015

Farhan is a 17-year-old child from Pakistan. “One week after my arrival, I had an evaluation at the local centre for children and families (CDEF). It took 30 minutes. An interpreter was there. I was a bit confused at that time. I had problems with dates. [...] The lady took my birth certificate and gave me a copy. A month and a half later, the CDEF gave me a hospital appointment. They told me it was for a medical test, no more precise information. [...] Someone came to the hotel to get me. Two other boys were in the car. [...] In the hospital, a woman came to do hand and teeth x-rays on me. Then they looked at my head. Then I went to the Doctor. He asked if I had any specific problems. I said no. Then he asked me: ‘Can you unzip?’ So I opened my trousers zip and he looked at my penis. I had to take my T shirt off. He checked my height and weight. I was once again very confused and when he looked at my body I felt very embarrassed. [...] Then he told me I could go. He gave a report to the man who had taken me there, but I was never able to see it. I had to go home alone. [...] A month later, they told me I was not a minor, that I was a man, and that I had to leave the hotel. [...] Today, I live in a squat.”

MdM France – Nantes – 2015

In September 2015, the MdM International Network wrote a policy paper on the age assessment for unaccompanied children, analysing the accuracy of the techniques used and the legal frameworks related to their use. Alongside international institutions, MdM states that current practices go against the best interest of the children.

“Medical procedures for age assessment are unanimously considered as unreliable and disproportionately intrusive by the UN, the institutions of the Council of Europe, healthcare providers, and even by EU institutions such as the FRA (European Union Agency for Fundamental Rights) or EASO (European Asylum Support Office). Having recourse to a holistic approach is recommended, but despite this, X-rays are still widely used by EU Member States.

“As health professionals, MdM refuses the use of medical examinations which have no therapeutic benefit and are purely requested for migration control purposes. The only foreseeable outcome of such unreliable methodologies is the wrongful exclusion of minors on a regular basis.”⁸²

81 230 million children worldwide are apparently not registered at birth [UNICEF 2013].

82 Feltz V. Age assessment for unaccompanied minors. When European countries deny children their childhood. MdM International Network Head Office [Internet]; 2015 August 28 [cited 2016 September 01]; [18 pages]. p.17. Available from: <https://mdmeuroblog.files.wordpress.com/2014/01/age-determination-def.pdf>

FOCUS ON VIOLENCE

GLOBAL FIGURES AND CONSEQUENCES FOR HEALTH

More than 1.3 million people worldwide die each year as a result of violence in all its forms (self-directed, interpersonal and collective), accounting for 2.5% of global mortality. For people aged 15-44 years, violence is the fourth leading cause of death worldwide.⁸³

People who have suffered violent experiences may endure multiple consequences for their physical and mental health over the years. These consequences may be aggravated by poor living conditions, unsafe administrative status and social isolation:

- Injuries (including tympanic, internal ear, genital, perineal, dysuria);
- Peripheral neuropathy, epilepsy, memory problems, attention deficit;
- Distress, shame, guilt, withdrawal (inward-looking attitude);
- Self-neglect;
- Depression, anxiety, suicidal ideation, phobia, post-traumatic stress disorder (PTSD);
- Addictions, eating and sleeping disorders;
- HIV, other STIs, sexual disorders, unintended pregnancy, unsafe abortion, chronic pelvic pain;
- Cancers, cardiovascular disorders, diabetes, arthritis and asthma, other chronic conditions;
- Psychosomatic symptoms: fatigue, headache, stomach and digestive pain, back pain, etc.

It should be noted that refugees, asylum seekers and undocumented migrants are particularly vulnerable to the consequences of violence because of their unstable administrative and social status. They are more likely to face social isolation and barriers in accessing continuing and adequate care⁸⁴.

EXPERIENCES OF VIOLENCE IN MEDICAL HISTORY

Corneliu is a 40-year-old Romanian. He has been living in Sweden for about one and a half years and has only been home to see his family once in that time. He is in Sweden to try to support his family by begging and collecting recycling cans which can be exchanged for cash in Swedish grocery shops.

When he came to our clinic, Corneliu had no teeth left after having been kicked in the face by a stranger. "This Swedish man came and without provocation hit me so hard that my teeth fell out." The patient is very depressed, "I have no hope, I don't know what to do." MdM Sweden is following up this case. Because it is a hate crime, Corneliu is entitled to economic compensation and should be able to get his teeth fixed for free – or at a very low cost.

MdM Sweden – Stockholm – November 2015

Daba, a 35-year-old Sudanese woman, has applied for asylum in Sweden three times but has been refused on all occasions. She is in the country with her husband and two sons. Daba suffers from infibulation (female genital mutilation combining excision and sewing). After she had her first child, her aunt and a midwife from the area came to sew her up again. Daba has now had her second child and fears that if she is sent back to Sudan she will be sewn up once again. She states that she has suffered from severe complications after the mutilation.

Daba contacted us to get our support for another asylum application. In her previous interviews she was

too scared to tell the interviewer about her fears: her husband was in the room, which made it impossible for her to speak about FGM, given that this issue is taboo. "I am so happy that I have two sons, if I had a daughter she would also have been a victim of FGM and suffered the same way as I do". MdM is now looking into the possibilities for Daba to make a new claim for asylum. An appointment is planned with one of our gynaecologists specialising in FGM.

MdM Sweden – Stockholm – December 2015

Lisy, 28, arrived in Switzerland from the Democratic Republic of Congo (DRC) in September. She was kidnapped by soldiers and held from late May to late August. "They put me in a small windowless room and constantly raped me, sometimes several soldiers at a time, with my hands bound." She said that on the day of her kidnapping, her mother was raped and killed right in front of her and her father executed.

Overcome by extreme sorrow, Lisy cries continuously during the consultation. She demonstrates the clinical manifestations of trauma, but expresses difficulty with following a specialised treatment routine: "I have nightmares and the feeling that I'm reliving all of that... I avoid talking about it because they ask a lot of questions to find out if I can get asylum but I draw blanks... Do you believe me?"

MdM Switzerland – Neuchâtel – December 2015

83 WHO. Global Status Report on Violence Prevention 2014. [Internet]. Geneva; 2014 [cited 2016 September 3]. p.2. Available from: http://apps.who.int/iris/bitstream/10665/145086/1/9789241564793_eng.pdf?ua=1&ua=1

84 Keygnaert I, Temmerman M, Vettenburg N. Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Culture, Health & Sexuality [Internet]. 2012 [cited 2016 September 3]. 14(5): 505-520. Available from: <http://www.tandfonline.com/doi/pdf/10.1080/13691058.2012.671961?needAccess=true>



Children Travel Diaries – Lesbos

MdM and partner organisations ask patients about their experiences of violence as part of taking the medical history. The violent events may have happened in the country of origin, during the migration journey and/or in the host country. Identifying violent experiences in the patients' history helps medical teams better understand and respond to patients' needs. Asking about experiences of violence helps reduce misdiagnosis and diagnostic errors when faced with unexplained physical disorders⁸⁵ and can help detect sexually transmitted infections following sexual violence, as well as genital mutilation and domestic violence⁸⁶.

Remarks on methodology

In 2015 the questions about violence were not often asked and this severely limits data interpretation. In addition, when the issue of violence was discussed, not all the topics were covered. So the results presented in this report are not representative of the prevalence of violence among the patients seen or among migrant populations. When asked why they do not speak about violence with their patients, health providers mostly reply that they prefer to wait for a second consultation, in order to develop greater trust and confidence.

Many primary healthcare professionals are in favour of a systematic questioning of all patients about their history of violence for the reasons mentioned above. For 2016, the medical questionnaires include an additional question on violence in the medical history.

85 Weinstein HM, Dnasky L, Lacopino V. Torture and war trauma survivors in primary care practice. *West J Med* 1996; 165 (3): 112-118.

86 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.

In 2015, among patients who spoke about violence, **1,379 patients said that they had faced violence at one time or another.** They represent 12.8% of all patients seen. In Europe, 1,277 patients discussed the violence they had experienced (13.3%) with the health provider. While this is an increase compared with 2014, violence remains insufficiently screened, despite the medical justifications for systematic screening at MdM and partners' clinics. The proportions of patients who faced violence may be significantly under-reported and figures should be interpreted with caution⁸⁷. In Turkey, 102 patients (12.2%) responded.

When medical staff talked about violence with the patients, many types of violence came out. Sexual assault and rape were discussed as frequently with men and women, in more than 95% of cases, which is good practice.

Many patients had lived in a country at war: 43.2% seen in Europe and 62.7% in Turkey. The rate of psychological violence was very high, as this kind of violence was endured by 26.0% of the patients interviewed in Europe and 74.5% interviewed in Turkey.

In the European countries, 18.7% of patients had experienced police or army violence (in their country of origin, during migration or in the host country) and this applied to 30.4% of the patients seen in Turkey.

87 Regarding violence against women, for instance, global estimates indicate that "1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime." (WHO [Internet]. Geneva; 2016. Violence against women. Intimate partner and sexual violence against women [updated 2016 September; cited 2016 September 3]. Available from <http://www.who.int/mediacentre/factsheets/fs239/en/>)

Domestic violence was mentioned by 13.7% of the patients asked in Europe.

Many patients reported suffering from hunger: 26.7% in Europe. It is common to observe more hunger among vulnerable women than men, either because of their particularly precarious conditions if they are single or because, in a

context of food insecurity, mothers may starve to prioritise their children's food intake or also because, in some countries, meals are taken separately, men eat together, children eat in a circle and women eat the leftovers.

Table 12 / Distribution of violence by country (%)

	BE	CH	DE	EL	ES	FR	LU	NL	NO	SE	UK	CAP	TR	CAPT
War (N= 695)	31.0	72.5	19.4	75.0	34.5	47.8	0.0	50.0	73.3	0.0	9.5	43.2	62.7	44.6
Threat/prison/torture for ideas (N= 372)	26.8	13.2	0.0	20.7	17.2	34.8	0.0	25.0	60.0	0.0	12.9	17.8	23.5	18.2
Police/army violence (N= 401)	40.8	21.7	1.6	22.6	18.4	30.4	50.0	28.6	40.0	0.0	8.6	18.7	30.4	19.6
Domestic violence (N= 301)	12.7	2.9	10.9	13.4	24.1	0.0	0.0	28.6	20.0	25.0	14.3	13.7	4.9	13.0
Beaten/injured (N= 121)	8.5	14.5	5.4	11.0	14.9	65.2	0.0	17.9	46.7	12.5	0.0	9.8	19.6	10.5
Sexual assault (N= 287)	15.5	5.8	4.3	4.3	12.6	26.1	50.0	32.1	13.3	0.0	8.8	8.7	23.5	9.8
Rape (N= 245)	12.7	7.2	2.9	2.7	10.3	0.0	50.0	21.4	6.7	0.0	6.3	5.9	5.9	5.9
Psychological violence (N= 505)	39.4	20.3	11.8	31.7	43.7	0.0	50.0	50.0	33.3	0.0	16.7	26.0	74.5	29.6
Confiscation (N= 312)	15.5	4.3	11.1	8.3	20.7	0.0	0.0	39.3	13.3	50.0	4.3	9.2	30.4	10.7
Hunger (N= 479)	25.4	1.4	6.0	43.8	50.6	21.7	0.0	57.1	46.7	37.5	7.9	26.7	19.6	26.1
Genital mutilation (N= 212)	0.0	0.0	0.0	2.4	4.6	17.4	0.0	0.0	6.7	0.0	0.2	1.8	2.9	1.9
Other violence (N= 306)	23.9	13.0	23.2	3.0	9.2	8.7	0.0	32.1	13.3	0.0	5.2	8.4	36.3	10.5



Where 15,000 people ended up living – Idomeni – Greece

8 NGOS IN 11 COUNTRIES TO SUPPORT MIGRANTS IN TRANSIT PROGRAMME

The 8 NGOs for migrants/refugees' health in 11 countries programme is run by six members of the MdM International Network and two partners from the European Network to reduce vulnerabilities in health. Its main objective is to make sure that migrants in transit access prevention and care all along the migratory route, from the arrival countries of Greece, Italy and Spain, through Croatia, Bulgaria and Slovenia, to Germany, Norway, Sweden, France and Belgium (although these five countries are not always the final destination).

The needs of migrants in transit are different from those of migrants who have been living in a host country for years, as they do not know the local language, do not have people to rely on and do not understand the system.

The network wanted to document the specific vulnerabilities of people encountered along the migratory route in order, as always, to highlight needs, determinants of health and health status, with the hope of ensuring that an increased level of appropriate services would be offered to the migrants/refugees in each country.

The situation of migrants in transit is particularly precarious, following experiences in their home countries, the trauma of the journey to Europe and the inadequate reception conditions in the countries of arrival or transit. Issues of concern include a high level of isolation, a large proportion of women and girls travelling alone, large numbers of unaccompanied children, dangerous migration routes, no access to healthcare, etc.⁸⁸.

88 Simonnot N, Vanbiervliet F. MdM position on migrants in transit. Position paper [Internet]. 2016 January 20 [cited 2016 September 5]; [4 p.]. Available from: <https://mdmeuroblog.files.wordpress.com/2016/07/en-mdm-network-position-paper-on-migrant-reception-crisis.pdf>

A Médecins sans frontières report published in July 2016 showed that a large number of migrants and asylum seekers are suffering from mental health disorders following experiences in their home countries, the trauma of the journey to Europe and the inadequate reception conditions in Italy. Of the 387 people interviewed, 60% presented mental health disorders and 87% of them stated that the reception system was making their suffering worse⁸⁹.

Data collection started in January 2016 in Chios and Athens (Elliniko) in Greece, while other sites started collecting data during spring and summer 2016. Depending on the sites, migrants were interviewed at mobile clinics, camps, reception or accommodation centres or at fixed clinics. Approximately 18,000 patients were interviewed for this survey in Italy, Germany, Norway and Greece. Most of them were seen in Greece on two islands receiving arrivals from Turkey (Lesbos and Chios) and in the Attica region.

The data presented here was collected between January and the end of June 2016.

Note

A report on the project 8 NGOs for migrants/refugees' health in 11 countries will be published in 2017. The elements presented here are based on only part of the data collected between January and June 2016. They only provide a snapshot of some of the issues the network teams have been encountering.

89 <http://www.msf.org/en/article/italy-mental-health-disorders-asylum-seekers-and-migrants-overlooked-inadequate-reception>

OVERVIEW

Between January and the end of August 2016 around 290,000 people arrived in Europe by sea, landing in Greece, Spain and Italy. Among them, 29 % were children, 18% women and 53% men. The countries of origin differ between the central Mediterranean route (from Libya to Italy) and the eastern route (from Turkey to Greece). Migrants arriving in Greece are mainly from Syria, Afghanistan, Pakistan and Iraq. In Italy, the main countries of origin are Nigeria, Eritrea, Gambia, Ivory Coast, Sudan, Guinea, Somalia, Mali and Senegal (data from UNHCR).

Many migrants and asylum seekers have been victims of torture, violence and other forms of degrading treatment and trauma, with physical and psychological consequences. Such traumatic experiences can lead to serious psychiatric conditions, including post-traumatic stress disorder, severe anxiety, clinical depression, problems with concentration, thinking and memory, somatoform disorders and risk of suicide⁹⁰.

Although around 29% of migrants arriving in Europe by sea were women, they represented 47% of patients seen by medical teams. Women are at particular risk of violence, abuse and exploitation, notably from the smugglers they rely on to get to Europe.

GREECE

Between January and June more than 17,000 patients visited some of the mobile and fixed clinics included in this survey run by MdM in Greece.

Approximately 55% of these patients were men and 45% were women. Children under 18 represented 25% of the total number of patients. Few unaccompanied children were seen. In Chios and Lesbos, we saw 202 pregnant women.

Nationalities varied significantly from one site to another but tended to be homogeneous at each site.

In Elliniko (Athens suburbs), 98% of the patients interviewed were Afghans and 2% were Iraqis. During June (Ramadan time), the medical consultations were mainly offered to exhausted and dehydrated people, in need of immediate intravenous fluid administration. Moreover, we came across self-inflicted injuries, in the context of suicide attempts, mainly by males between 17 and 28 years old. The lack of prospects in terms of their destination since all borders have been closed and impoverishment after months without being able to work lead to despair.

In Lesbos, the patients seen by our teams were 85% Syrian and 11% Afghan. From March 2016, we noticed a diversification in the nationalities of the people arriving in Greece. However, the proportion of migrants from Sub-Saharan Africa did not increase in the survey sites (Karatepe, and other sites served as needed by the mobile unit). We suppose that Sub-Saharan Africans were directly transferred to the Moria camp which became a closed hotspot in Lesbos. As the first asylum appointments in Athens are set for December 2016, no migrant/refugee can leave the island. Thus, the Karatepe Camp has started being adapted to meet the needs of the people staying there. Tents are being replaced by wooden shelters, shaded areas are being

90 <http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues>

installed, as are water coolers (in June, knowing that heating might soon be needed...). In addition, some work has begun on the supply of electricity.

In Chios, 62% of patients were Syrians, 21% Afghans, 6% Iraqis and 2% were from the Maghreb. The most common symptoms were related to stress anxiety disorders, panic attacks and psychiatric problems. In spring 2016, the numbers of referrals made by both the medical team and social services to the hospital in Chios for psychiatric and child psychiatric assessments increased. The referrals are regularly monitored by psychologists and psychiatrists from the hospital, with whom our team has been collaborating closely.

ITALY

Around 122,300 migrants/refugees arrived in Italy by sea in 2016 (to 4 September, UNHCR data).

About 14% of new arrivals are women and 16% are children, and these percentages have been steadily increasing during 2016. Almost 14,000 women (mostly from Nigeria, Eritrea and Somalia) and over 13,300 unaccompanied children, more than double the figure for 2015, (from Egypt, Eritrea, Somalia, Gambia and Guinea) have landed in Italy since the beginning of 2016⁹¹. MdM has been present in Reggio Calabria since the beginning of 2016, improving access to primary healthcare, mental healthcare and psychosocial support at disembarkation in the port of Reggio Calabria, in emergency centres for unaccompanied children and in secondary reception centres for asylum seekers. During May and June, 203 consultations were carried out by our teams in Calabria.

70% of the patients were under 18 years old: 30% were under 16 and the youngest was 11 years old. Most of the children came from African countries (19 different nationalities in total).

One of the main physical health problems was scabies. Even if migrants were in good health when they left their home country, the dangerous travelling conditions and very poor living conditions, mainly in Libya and during the long voyage at sea, have a major impact on their health.

In Ventimiglia, volunteer teams gave 654 consultations in 2015, mainly to Sub-Saharan men (99%). For 46% of them, the migratory route had lasted over six months.

“My boat sank somewhere between Turkey and Greece and we stayed in the water for an hour, including families with young children, before being rescued. The police took us back to Turkey and we had to start over. I saved my friend’s life who didn’t know how to swim.” Faiz, 20, left everything behind to travel from Iraq to Belgium, except for his mobile phone and some money that he hid in his underwear. “When you are on the road, the only thing you want is to arrive as soon as possible. You don’t care about where you sleep, how you sleep, what you eat and whether you eat or not. You’ll have time to rest later. You need to move forward. It took me 17 days to get here.”

MdM Belgium – Maximilian Park – September 2015

91 <https://www.iom.int/news/mediterranean-migrant-arrivals-2016-160547-deaths-488>

SLOVENIA

In Slovenia, most of the patients were single men between 19 and 59 years old. In total, Slovene Philanthropy and MDM teams saw 291 people (193 men and 98 women). Some children were seen (18 under five years old and 43 under 18).

Most of the patients came from the Near and Middle East (245), 19 came from Africa and 18 from Eastern Europe.

We saw 11 unaccompanied children (10 from Afghanistan and one from Iraq).

Among the patients seen, 39 (15%) reported poor general health, 52 (20%) perceived their mental health as bad or very bad and 51 (20%) perceived their physical health as poor.

In Ljubljana, the main accommodation facility had 155 migrants/refugees (on 1 July 2016). It is composed of six premises: for families, single men, unaccompanied minors, single women, people with special needs and one for people with restrained movement. The facility is run by the Ministry of the Interior. The main nationalities accommodated there are Syrians, Afghans, Iraqis, Iranians and Pakistanis but a lot of other nationalities from Africa and Eastern Europe are also present. The migrants and refugees accommodated there have access to Slovenian language classes, sports activities, creative workshops for children and adults etc. There are also psychosocial activities implemented by the Department of Asylum and various NGOs. Legal counselling is offered by a specialised NGO, PIC – Legal-information Centre. Slovene Philanthropy, is present daily with volunteers and staff to provide help with social integration, activities for children and to provide (legal) information on asylum procedures and activities with unaccompanied children, as well as information on the national health system and migrants' rights to access healthcare.

GERMANY

In 2015, Germany received over one million refugees. Most of them used the Aegean and Balkan route, crossing the Austrian-German border, aiming to apply for asylum in Germany or elsewhere. In Munich, a city which served as a transit zone and destination for migrants in transit, between September 2015 and March 2016, the project provided newly arrived refugees (mainly unregistered) with first response and immediate relief through medical consultations and psycho-social counselling at the central bus and railway stations. The main nationalities of the refugees were Syrian and Afghan.

Following the closure of the Balkan route, more refugees were housed in asylum centres and the focus of the project changed. Since then the team has been operating with a mobile unit, providing medical care in asylum accommodation centres, where access to medical care is difficult or not fully implemented, and facilitating the integration of asylum seekers into the mainstream healthcare system. Medical consultations are offered by volunteers.

Of the patients seen, 47% were women and 53% men. The main nationalities were Afghans, Syrians, Somalis, Nigerians, Pakistanis and Iraqis. 30% of patients were children.

With regard to perceived health, 84% of patients who responded considered their general and physical health to be bad or very bad, and up to 86% declared bad or very bad mental health. These figures are much higher than at all the other sites around Europe where we ask these questions.

Figure 16 / Main countries of origin: patients seen in Germany, Greece, Italy and Slovenia

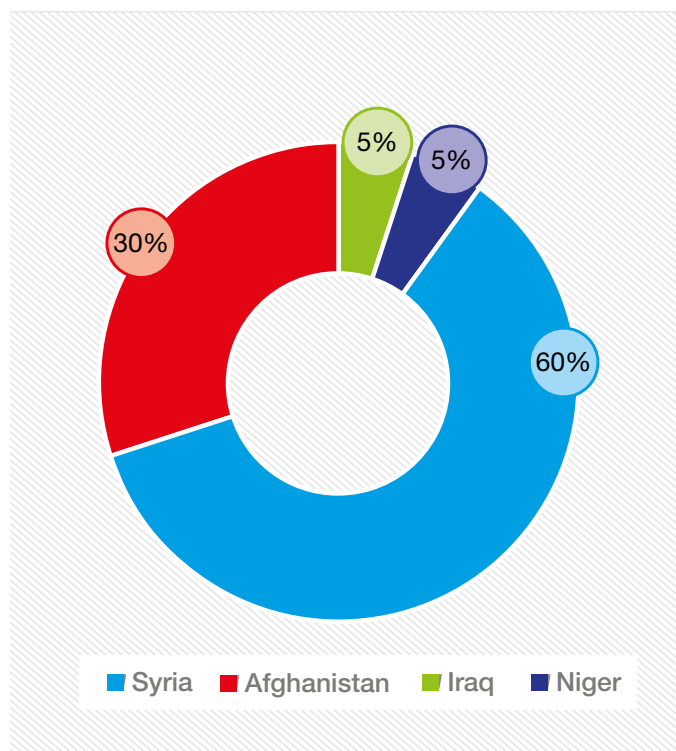
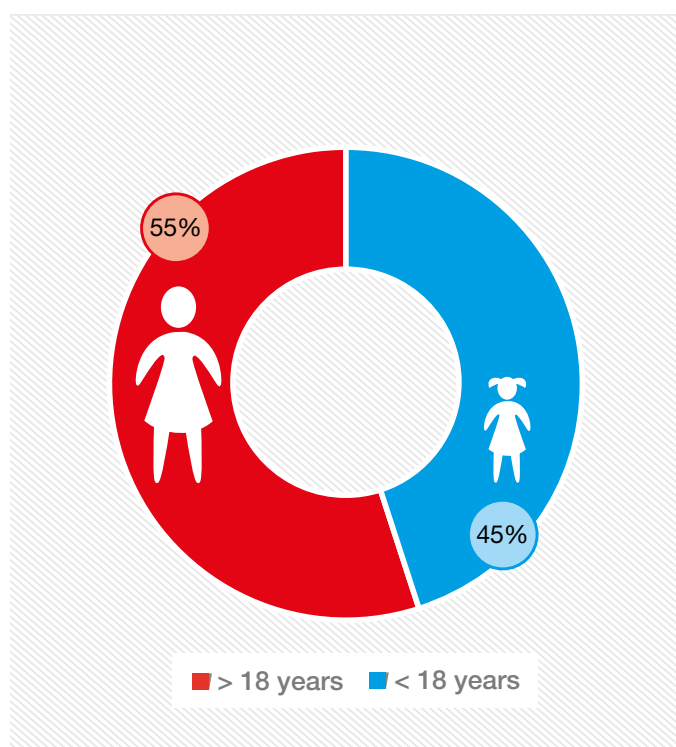


Figure 17 / Proportions of adults and children: patients seen in Germany, Greece, Italy and Slovenia



85% of Syrians were in family groups - 65% of Afghans were in family groups (overall results for Germany, Greece and Slovenia).



© Kristof VADINO

Laughter was still possible before all the borders were closed and the migrants were trapped – Lesbos

CONCLUSION

This sixth report of the International Observatory on access to healthcare, in addition to showing again how inequitable access to health care remains in Europe for people facing multiple vulnerability factors, bears a double responsibility in terms of effectiveness and power to convince.

Our broad network, with its 23 organisations all across Europe, produces evidence-based arguments in order for policy makers to improve laws and health providers to improve practices. Will they read our report? Will they push for solidarity or exclusion?

2016 has seen the UK vote to leave the EU, an increase in hate crime, hate speech and the scapegoating of migrants and other groups on the margins for purely political, and mostly individual, interests. Yet this year has also seen the further development of the greatest solidarity movement in Europe, which began in 2015 and has drawn people from all parts of our societies. These are the people we want to rely on, the people whose actions we want to highlight, the ones who dare to stand up for what they believe in, the ones who refuse to close their eyes and who stand in solidarity with the people who dare to cross the sea, who are able to sleep in tents in the mud for months at Idomeni or Calais and still smile on life, take care of one another and fight for their human rights.

We are a strong network because we react immediately, like Slovene Philanthropy did when, in the space of just a few days, they mobilised over 2,000 volunteers to take care of migrants. And similar actions took place in Greece, Germany, Sweden, Norway and everywhere where migrants/refugees arrived.

We are a strong network because we never give up fighting for respect, human rights, access to care and solidarity – and surely also because we know how enjoyable it is to be together.

Inequity is neither inevitable, insurmountable, nor acceptable.

Samuel is 27 years old and is Ugandan. He had to flee Uganda after being 'outed' as a gay man, and chased by a mob. Someone arranged his flight and he arrived in the UK. After a few days, Samuel was dropped off at a local church and had no contacts in the UK. He did not claim asylum.

In the church he met a woman who also happened to be from Uganda and spoke his language. Upon telling her his situation and showing his passport, she agreed to let him stay with her until he could establish himself. The woman put him in contact with someone associated with Out and Proud Diamond Group, an LGBT support group for those of African origins.

At Out and Proud, he was encouraged many times to go and have his health assessed: *"In my country I had lived 27 years without visiting a doctor, not anything"*. He was reluctant to do so as he had no funds and was wary of the negative reception he may receive: *"In my country when it comes to doctors ... and when you're so poor, the moment you are going to access something for free, you are not taken care of. So I was fretting over that and whether I should go. But [my friend] told me this is a very nice place."*

Doctors of the World was able to register Samuel with a GP. He was very happy with the respect and engagement shown by the staff at MdM. *"I remember one question I asked the lady who received me: how do you manage to smile throughout the session? Ever since you picked me from there you've been smiling. That in itself is just enough to cure me, if I'm sick. It was so amazing."*

Samuel has been granted 6 months leave to remain in the UK. He is awaiting his national insurance number so he can start working. Although he is still adjusting to London, he is happy to see his dream come true.

MdM United Kingdom – London – December 2015

ACRONYMS

AME	State Medical Aid (Aide Médicale d'Etat) (France)
AMU	Urgent Medical Aid (Aide Médicale Urgente) (Belgium)
ASEM	Association of Mutual Aid and Solidarity for Migrants
BE	Belgium
CAP	Crude average proportion
CAPT	Crude average proportion including Turkey
CASO	Healthcare, Advice and Referral Clinic (Centre d'accueil, de soins et d'orientation)
CH	Switzerland
CMU	Universal Medical Coverage (Couverture maladie universelle)
CPAS	Public Social Action Centre (Centre public d'action sociale)
DDCS	Directorate for Social Cohesion (Direction Départementale de la Cohésion Sociale)
DE	Germany
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EL	Greece
ES	Spain
EU	European Union
FR	France
FRA	European Union Agency for Fundamental Rights
FYROM	Former Yugoslav Republic of Macedonia
GP	General practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
INSERM	French National Institute of Health and Medical Research (Institut National de la Santé et de la Recherche Médicale)
LFIP	Law on Foreigners and International Protection (Turkey)
LMA	Reception of Asylum Seekers' Act (Sweden)
LU	Luxembourg
MdM	Doctors of the World (Médecins du monde)
MMR	Mumps, measles and rubella
NIS	National Insurance Scheme (Norway)
NHS	National Health Service (UK)
NL	Netherlands
NO	Norway
OECD	Organisation for Economic Co-operation and Development
PUMA	Universal Medical Protection (Protection Universelle Maladie) (France)
SE	Sweden
STI	Sexually transmitted infection
TB	Tuberculosis
TR	Turkey
UK	United Kingdom
UHC	Universal Health Coverage
UNHCR	United Nations Refugee Agency
WAP	Weighted average proportion (each country accounts for the same weight)
WAPT	Weighted average proportion including Turkey

AUTHORS

Reference for quotations:

Simonnot N¹, Rodriguez A¹, Nuernberg M¹, Fille F¹, Aranda-Fernández P.E², Chauvin P². Access to healthcare for people facing multiple vulnerabilities in health in 31 cities in 12 countries. Report on social and medical data gathered in 2015 in 11 European countries and Turkey.

1. Doctors of the World International Network, Paris, France
2. Pierre Louis Institute of Epidemiology and Public Health, Department of social epidemiology, INSERM, Sorbonne Universités (UPMC), Paris, France

CONTRIBUTORS

- BE** Nel VANDEVANNET, Sofie MANANTSOA, Stéphane HEYMANS, Emmy DESCHUTTERE, Jonathan HARDENNE
- CH** Janine DERRON, Manon RAMSEYER, Sinda EL KATEB, Stéphanie EMONET, Raquel GERMANO, Anne Lise TUPIN, Aline CATZEFLIS
- DE** Suzanne BRUINS, Claudia ROKITTA, Sabine FÜRST, Melanie MÜCHER, Caroline DWORZAK, Johanna OFFE
- EL** Efstratios KLADIS, Vasia FLOUROPOULOU, Mina FLOUROPOULOU, Stefanos SALEVOURAKIS, Eva TATSIDOU, Evi TZIVELEKI, Konstantina KYRIAKOPOULOU, Eleftheria ANDRIANOPOULOU, Efi SAMANTA, Aggeliki TSAGRI
- ES** Miguel PÉREZ-LOZAO, José ATIENZA, Ramòn ESTESO, David MORALES
- FR** Marielle CHAPPUIS, Nadège DROUOT, Cécile GABORET, Agnès GILLINO, Elise JOISEL, Paula LAKROUT, Anne-Sophie MARIE, Anne TOMASINO
- LU** Sylvie MARTIN, Serge DEPOTTER, Ruth SMILEY, Maggy GUILLEAUME, Dominique PÉRILLEUX, Catherine CONVIÉ
- NL** Linda JANMAAT, Gerianne SMITS
- NO** Frode EICK, Monica FALCK, Linnea NÄSHOLM
- SE** Eliot WIESLANDER, Linnea SANDSTRÖM LANGE
- TR** Lerzan CANE, Bass N'DIAYE, Sékouba CONDE
- UK** Lucy JONES, Phil MURWILL, Clare SHORTALL, Charnele NUNES, Sarah DICKSON, Katie TURNER, Joy CLARKE, Amy KIMBANGI, Maddie GUERLAIN, Anna MILLER, Karen LAU, Mohmooda MIAN, Nadeem SAUMTALLY, Abigail BENTLEY, Luc PERIERA

MdM International Network:

Dagna FRYDRYSZAK, Lucile GUIEU, Romain GILLIOTTE, Sophie ISSA

Pierre Louis Institute of Epidemiology and Public Health:

Cécile Vuillermoz

Editing: Heather Stacey Language Services

Graphic design: Maud Lanctuit

Printing: Clumic Arts Graphiques

Contact: Nathalie Simonnot

Médecins du monde – Doctors of the World International Network:

nathalie.simonnot@medecinsdumonde.net

+33 1 44 92 14 37

www.mdmeuroblog.wordpress.com

RECOMMENDATIONS

1. Today hundreds of millions of people live outside their country of origin and have migrated for numerous reasons, including conflict, natural disasters or environmental degradation, political persecution, poverty, discrimination and lack of access to basic services. These migrants may be subjected to multiple discrimination, violence and exploitation, all of these experiences often directly affect their physical and mental health. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health has long been established in international human rights law, as have principles of equality and non-discrimination. It is therefore critical for mainstream healthcare systems and policies to address migrants' right to health, regardless of their legal status.

Our Network urges EU Member States and institutions to offer universal public health systems built on solidarity and equity, open to everyone living in the EU. All people living in the EU, irrespective of their migration status, should have access to appropriate mainstream healthcare.

2. Violence has frequently been reported on migration routes. Migrants are exposed to criminal and dangerous smuggling schemes. Rapes have been reported on the routes. The journey is particularly dangerous for children, pregnant women, the elderly or people with chronic health conditions or disabilities. Many women are in the initial or advanced stages of pregnancy or have recently given birth. A significant number of women and girls are travelling alone and are exposed to increased risks of gender-based violence or exploitation. **Our Network urges governments to ensure safe migration channels to Europe, free from violence, for all migrants regardless of their nationality. Our Network also asks for specific measures to ensure protection for girls and women travelling alone or as single parents. Women and girls travelling alone should be accommodated in safe shelters. All children, including unaccompanied children, also need specific and high-level protection.**

In addition, many European countries have built or are building barbed wire fences, some equipped with razor wire. **Fences intended to inflict injuries must be dismantled.**

3. More than 32,000 people have already perished in the Mediterranean Sea since 2000 whilst trying to reach Europe. 2015 saw 3,700 die in a single year. Yet, there is a simple solution to end the ordeal that refugees must endure to get to Europe and that would have many benefits for the host countries. Issuing humanitarian visas to those who are fleeing war will create real humanitarian corridors so that refugees can find the protection to which they are legitimately and legally entitled. It will allow refugees to arrive alive and in a dignified manner and allow the most vulnerable to find protection, as has already been put in place in some countries. **Our Network supports the action of the European Parliament in its move to amend the Commission's proposal for a recast Visa Code that should give asylum seekers the possibility of requesting a European humanitarian visa directly at the consulates and embassies of Member States.**

4. States and aid organisations on the ground should abide by the Humanitarian Charter and Minimum Standards in Humanitarian Response, as developed by the Sphere project. It is one of the most widely known and internationally recognised sets of common principles and universal minimum standards in life-saving areas of humanitarian response.

Our Network urges governments to ensure adequate reception conditions (shelter, hygiene facilities, health-care, access to information, etc.) in accordance with the Minimum Standards in Humanitarian Response.

5. Under the Dublin III regulation, people who are able to reach Europe and wish to lodge an asylum application can only do so in the EU country where they first arrived. This regulation, together with the whole Common European asylum system, is about to be reformed at the end of 2016. Nevertheless, under the new regulations, migrants will still not be able to choose where to live and will continue to be separated from their families. This unwanted separation leads to significant consequences for the migrants' well-being and mental health. Another consequence of the Dublin III regulation is that countries with accessible Mediterranean coasts, or countries accepting their responsibility such as Germany, end up hosting the majority of migrants. The resulting lack of appropriate reception and care facilities leads to a worsening of asylum seekers' health.

Our Network urges EU Member States to allow asylum seekers to submit their application in the EU country of their choice, under the reform of the Dublin regulation. In the meantime, we urge all Member States to ensure that the family reunification entitlement afforded to asylum seekers under the Regulation is enforced in an active and timely manner.

6. Although some European states, such as Italy and Greece, bear the responsibility for a high number of refugee arrivals, the current relocation and resettlement plans of the European Council are far from sufficient to ensure adequate reception conditions.

Our Network urges the EU Member States to significantly increase their relocation and resettlement quotas and accept a higher number of relocated refugees.

7. Certain social and health services available to migrants may not be sensitive to key issues for migrant populations, may not be culturally appropriate and may not provide sufficient interpreting services. This needs to be fully and appropriately addressed.

Our network asks EU Member States and institutions to promote active collaboration across the different sectors and close cooperation between governments and the many non-state actors involved in the migration process. Such developments should bear in mind the short, mid and long-term perspectives.

8. The right of children to health and care is one of the most basic, universal and essential human rights. It is time to fully uphold the United Nation's 1989 Convention on the Rights of the Child and to respect its core principle of the superior interests of the child.

Our Network urges EU Member States and institutions to stop child detention (which is never in the best interest of the child) immediately and to provide suitable facilities for unaccompanied children. Furthermore, they should ensure that all children residing in the EU have full access to national immunisation programmes and to paediatric care. As health professionals, we denounce the use of medical examinations which have no therapeutic benefit and are performed only for migration control purposes. Children need to be protected!

9. Pregnancy-related care is essential to the health of mothers and their babies, reduces the adverse effects of poverty in vulnerable communities and is critical to improving the health of current and future generations. Pregnant women must have access to perinatal care.

Every woman should have access to termination of pregnancy, if it is her wish.

In light of the Charter of Fundamental Rights of the European Union of 2000 (Article 34 on social security and social assistance), our Network urges EU Member States and institutions to ensure pregnant women have access to effective and high-quality antenatal and postnatal care and safe delivery.

10. No-one should be subjected to inhuman or degrading treatment or punishment. It is time to fully respect Article 3 of the 1950 European Convention on Human Rights.

Our Network urges EU Member States and institutions to protect seriously ill foreign nationals and ensure their access to appropriate care - never to expel them to a country where effective access to adequate healthcare cannot be guaranteed.

11. Medicines must be accessible and affordable for all. Today European public health systems are directly threatened by price-gouging on medicines which is both unethical and unsustainable. For specific diseases, overpricing policies lead to treatment rationing and endanger public health systems.

Our Network urges EU Member States and institutions to enforce public-health-focused pricing policies rather than allow profit-driven pricing.

Germany / Ärzte der Welt

www.aerztederwelt.org

Belgium / Dokters van de Wereld

www.doktersvandewereld.be

Belgium / Médecins du monde

www.medecinsdumonde.be

France / Médecins du monde

www.medecinsdumonde.org

Spain / Médicos del Mundo

www.medicosdelmundo.org

Greece / Giatri tou Kosmou

www.mdmgreece.gr

Luxembourg / Médecins du monde

www.medecinsdumonde.lu

Netherlands / Dokters van de Wereld

www.doktersvandewereld.org

Norway / Health Centre for Undocumented Migrants

www.bymisjon.no

Sweden / Läkare i Världen

www.lakareivarlden.se

Switzerland / Médecins du monde

www.medecinsdumonde.ch

Turkey / Association de solidarité et d'entraide aux migrants

www.asemistanbul.org

United Kingdom / Doctors of the World

www.doctorsoftheworld.org.uk



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

