

ACCESS TO HEALTHCARE FOR UNDOCUMENTED MIGRANTS IN 11 EUROPEAN COUNTRIES

“ Even as my baby was being born,
they were asking me for documents
and to pay 2,800 euros.”

F., Ugandan woman, in London

SEPTEMBER 2009 - Médecins du Monde
European Observatory on Access to Healthcare

ACCESS TO HEALTHCARE FOR UNDOCUMENTED MIGRANTS
IN 11 EUROPEAN COUNTRIES

2008 SURVEY REPORT
SEPTEMBER 2009



ACKNOWLEDGEMENTS

We are grateful to the 1,218 individuals in 11 countries who agreed to take part in our survey. This meant answering difficult questions which brought back their pain and difficult journeys. They told us about their daily lives, and the drama, fears, rejection and survival inherent within them. This report is dedicated to them.

We are also very grateful to the survey investigators (around 100 volunteers and staff) who, despite their already busy schedules, agreed to help develop the questionnaires, carry out the survey, input data, analyse data and translate texts. We thank the 11 Médecins du Monde associations for their political support in carrying out this joint project.

We thank readers for paying attention to these snapshots of lives. Together, let's fight to ensure that the fundamental rights which today are denied these children, women and men are finally recognised.

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Félix Wanga and Sara Collantes for the description of the legal situation; Nadège Drouot and Anne Tomasino throughout the survey; the European Observatory second survey working group (Marion Chenevas, Jérôme Pfaffman, Olivier Ricard, Christos Velissaropoulos, Ramon Estesó, Jose Maria Atienza); Michel Verdier for the design of the data capture tools; Juliette Poirson for finalising the report; Thérèse Benoit for proof-reading; Alejandra Garcia Paton for co-ordinating the translations; Karen Mc Coll and Johnathan Mair for the English translation (except for the questionnaire).

WITH SUPPORT FROM

the French ministry of health (Direction Générale de la Santé), the French ministry of social services (Direction Générale de l'Action Sociale), the European Commission's DG SANCO (Directorate-General for Health and Consumer Affairs) and the European Programme for Integration and Migration (EPIM).

ISBN - ISBN 978-2-918362-01-2 // Legal deposit : september 2009
CREDITS // Photos : © Jobard / SIPA // Cover art : les-eclaireurs.com // inside art : Jérôme Guibourgé // Printing : CLUMIC, contact@clumic.com



Editorial

The 14 organisations within the *Médecins du Monde* international network work with the most vulnerable populations throughout the world and in their own societies.

Through our national programmes we meet people in Europe who have fled extreme poverty, violent armies and police forces, conflict areas and disasters. A tiny minority of the children, women and men whom we try to support when we work in their countries end up coming here. After migration journeys which are very often long, dangerous and exhausting, many find themselves without permission to stay in the country, forced into the shadows of our towns and cities. At home, as abroad, *Médecins du Monde* aims to provide some support and tries to help this population protect what is often the only thing they have left—their health.

With this study, we show how undocumented migrants' living conditions are harmful to their health and prevent them from building, or rebuilding, their lives. This is despite the fact that these children, women and men are in particular need of support, given what they have lived through and the migration journeys they have undertaken.

Even worse, our own health systems often exclude them from healthcare. Serious health problems receive little medical follow-up, sometimes none at all.

Because healthcare sometimes becomes a trap—due to the fact that people are being encouraged or required to report undocumented migrants—we urge that **health policy must remain completely independent from immigration policy, respecting the obligations of health and social care professionals in terms of patient confidentiality.**

Because, in Europe, children can go untreated and women can be denied ante-natal care or be hassled until the moment of childbirth, we call on the relevant national and European authorities **to ensure the right to access healthcare for all, irrespective of immigration status.**

Because sending seriously ill undocumented migrants back to their countries of origin—even though they won't receive healthcare there—can be a death sentence, we call for **these vulnerable people to be granted regular immigration status.**

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Summary

This second European Observatory report takes another look at access to healthcare for people without a residence permit (from now on referred to as “undocumented migrants”). It combines the results of two complementary surveys. The first is a statistical survey focusing on adult undocumented migrants and the second, based on interviews, focuses on the situation of their children. These two surveys involved 1,218 adults who either participated in the quantitative survey (1,125) or provided their testimonies (93) to *Médecins du Monde* teams in 31 towns in 11 European countries. In these 11 countries—Belgium, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, Sweden, Switzerland and the United Kingdom—*Médecins du Monde* runs programmes promoting health and access to rights and healthcare among vulnerable groups, including undocumented migrants. Both surveys were carried out within these *Médecins du Monde* programmes, as well as in the premises of several partner organisations, in 2008.

1. METHODOLOGY AND NOTES ON INTERPRETATION

The **qualitative** survey was based on interviews with 32 undocumented parents in 8 countries: Belgium, France, Greece, the Netherlands, Spain, Sweden, Switzerland and the United Kingdom. This survey sheds light on how these parents sought care for their children, the problems they experienced and their reactions.

When reading the results of this survey, it is important to bear in mind that a qualitative survey enables us to identify the diversity of situations and experiences, but does not attempt to quantify the information collected.

The **quantitative** survey was based on a questionnaire devised and validated by the principal investigator in each country, the Inserm and CNRS researchers, and the *Médecins du Monde* Observatory team. This questionnaire relates to undocumented migrants’ social situation, health status and the violence they have experienced. It also covers their rights in terms of access to healthcare, their access to health coverage and treatment in practice, barriers to healthcare and experience of being denied access to care by health professionals.

As with the first *Médecins du Monde* European Observatory survey, published in 2007, the results presented here should be read as a “statistical testimony” to situations witnessed in the different centres and programmes involved in the observatory. They are not intended to paint a representative picture of problems with access to healthcare for all the undocumented migrants in Europe.

Nonetheless, because of the lack of representative surveys among undocumented migrants in general (which are very difficult to carry out due to the very nature of undocumented status), the quantitative results presented here do enable us to identify some clear trends and international differences which, despite the need for caution with their interpretation, illustrate, and provide information about, the extent of the problems in accessing healthcare which this population faces.

Finally, 61 people agreed to provide **testimonies** about their lives in their country of origin and in their host country. Excerpts from these testimonies are used to illustrate and help explain the survey results.

2. MAIN RESULTS OF THE QUALITATIVE SURVEY

- **Even the children of undocumented migrants are not protected**

Common sense would suggest that children should not be considered as undocumented because they don't choose where to live. In many countries, there is no legal obligation for children themselves to possess a residency permit and children are not required to produce identity documents on request. The protection of children—particularly the poorest and at-risk children—is a shared goal in all the countries involved, as set out in the Convention on the Rights of the Child.¹ **However, we have to point out that some countries provide no specific protection for children of undocumented parents and/or do not accept these children in the health system. Some countries go as far as to require that children, like their parents, be reported when they attend health services.**

The parents interviewed were aware—and very much regretted—that their living conditions affect their children's health. Often, the harsh realities of their lives—**having to live in unhealthy, and often overcrowded, accommodation as well as living in a permanent state of insecurity—can be harmful for children.** Situations such as being evicted or having to stay temporarily with friends or in an institution are stressful. Such problems can hinder the psychosocial development of children and can disrupt the arrangements for monitoring their health. In some interviews, the parents even reported that medical follow-up had been disrupted. Beyond the problems with money and accommodation, **the ever-present threat of being arrested, or fears of the family being broken up, also create a difficult context for child development.** Some parents commented that these issues have repercussions for the mental or physical health of their children.

The health problems of adults and children are intertwined. The parents underline their efforts to protect their children, but sometimes they are so worried and feel so helpless that it affects their own mental health and this has an impact on their children. Likewise, a child's poor health can make things more difficult for the rest of the family by, for example, making it difficult to lodge with friends or family.

Moreover, children are sometimes required to act as an **intermediary or interpreter** between their parents and the society in which they live. This may be because their parents have a poor grasp of the language in the country of residence or because of their parents' isolation. Some children provide real support for their parents and, in this way, take on **adult responsibilities.**

There are many problems with access to healthcare. Access to information is fundamental. In fact, information—which often comes from friends, public institutions or voluntary organisations—is frequently **incorrect, contradictory,** or inappropriate for the specific situation of the child. Professionals and volunteers are not always—rather, they are seldom well informed about the rights of undocumented migrants to access healthcare. Denying access to care (which signifies non-respect of the right of the child to healthcare), administrative barriers and poor information lead to delays in seeking care, or to complete abandonment of efforts to access care. The feeling of being subject to discrimination and of only receiving care “by default” affects trust in the health system in general, to the extent that some people then question doctors' diagnoses or prescriptions.

Some parents manage, after a period of disorientation, to find their way around the healthcare system and to realise their children's right to healthcare. By benefiting from access to healthcare, and knowing how the healthcare system works for their children, parents become **more independent in relation to the health system.** They can then look at the health system from a different point of view, even with a critical perspective, and can choose where to seek care depending on the situation.

1. <http://www.unhchr.ch/html/menu3/b/k2crc.htm>

Parents sometimes depend on voluntary organisations—perceived to be more welcoming, less discriminatory and safer than mainstream services. Attending these voluntary sector services is often a key step in parents' dealings with the healthcare system: **these types of service, such as those offered by Médecins du Monde, play an important information and orientation role which helps people to become more autonomous in relation to the health system.**

3. KEY FINDINGS OF THE QUANTITATIVE SURVEY

Out of the 1,125 people interviewed for the quantitative survey, there were roughly as many women (49.1%) as men. The average age is 36 years. Half of the interviewees left their country just over 3 years ago, but 10% had left at least 10 years ago. In total, 97 different nationalities were recorded, with respondents coming from (in decreasing order): sub-Saharan Africa, the Americas/Caribbean, North Africa, Europe (non-EU), Asia, Near and Middle East and the European Union. The most common countries of origin for men were Morocco, Algeria, Egypt, Senegal, Brazil and Bangladesh. For women, Brazil, Bolivia, Cameroon, the Philippines, Nigeria, Albania and Romania² were the most common countries of origin.

● **Poor socio-economic conditions**

The WHO's Commission on Social Determinants of Health emphasised that "a lack of money, inadequate housing, insecure working conditions and a lack of access to healthcare are among the social determinants of health which cause inequalities within and between countries."

Respondents' housing conditions and working conditions are particularly unfavourable

Accommodation is very often insecure and unhealthy. This is, in turn, related to the poor level of financial resources: **52.4% of people surveyed live in insecure accommodation, a short-stay or medium-term shelter or are sleeping rough.** And **34% consider that these housing conditions are dangerous or harmful** for their health and/or their children's health.

Half of those interviewed (51.3%) have a regular or occasional activity to earn a living. Bear in mind that undocumented migrants cannot work legally. In particular, they work in cleaning, services for individuals and construction. They work in particularly difficult conditions: 37% work more than 10 hours per day, 22% work night shifts³ nearly every day or several times a week, especially women (26% compared to 14.7% of men). 8% have been the victim of an occupational injury since their arrival in the survey country. In addition, 9.4% of respondents said that they had been prevented from earning money or had been deprived of money earned in the host country.

Respondents live in isolated situations that make them more vulnerable

Just over half (52%) of respondents said that they feel very lonely (23%) or rather lonely (29%). This applied particularly to men, which we can link to the fact that they are more often separated from their partner and children because of their migration. In addition, **59% of parents do not live with any of their children under 18 years old.**

Only 47% of people interviewed say that they are "frequently" or "very frequently" able to count on someone for moral support or emotional support. Women interviewed benefited from this potential moral support more often than men.

2. EU citizens without financial resources nor health coverage have lost their right to stay in most EU countries since the European directive 2004/38/CE.

3. For the purposes of the survey, night shifts are considered to be between midnight and 5am.

Although this lack of emotional support can be found in all the sub-groups of the population, some groups seem particularly isolated: **38% of rough sleepers and 30% of people living in a shelter can never count on anyone for emotional support or comfort.**

- **Reasons for migration**

The findings dispel the myth of migrants immigrating to Europe wanting to take advantage of the health and welfare systems. The undocumented migrants interviewed were mainly fleeing poverty, danger or restrictions on their freedom and they wanted to ensure a future for their children.

The main motivation for migration cited was economic reasons, to be able to earn a living (56%).

In second place were political, religious, ethnic, sexual orientation reasons or to escape from war (26%) – **these are reasons that, theoretically, give the right to political asylum.**

Only 6% of people cited health as one of their reasons for coming to Europe. However, on the day of the survey 15.7%⁴ of people were suffering from a chronic health problem that they knew about before they left their country of origin (most commonly people from the European Union or North Africa). The health problems in question were mainly purely symptomatic complaints (without a precise diagnosis) or minor illnesses. We cannot seriously think that these health issues could have been a reason for migration or, even less, for moving to the precarious living conditions faced by these undocumented migrants in their destination countries.

- **In practice, health protection and access to healthcare are not always recognised as individual rights**

All the countries studied provide access to healthcare for undocumented migrants. In most cases, however, this is on condition that they pay for the care. In reality, this is impossible given the little money at their disposal. In 6 of the 11 countries studied, the law provides for the system to cover all or part of the costs for undocumented migrants who can't pay (Belgium, France, Italy, the Netherlands, Portugal and Spain). In contrast, access to healthcare is largely restricted to emergency care in four countries (Germany, Greece, Sweden and Switzerland). In these countries, there are few options for access to healthcare for common or chronic conditions. The United Kingdom has a very specific system that allows general practitioners to choose whether to accept to register undocumented migrants at their practice. If they do so this enables the migrants to access free primary healthcare. The system does not, however, provide any cover for other healthcare (secondary or tertiary care) apart from "immediately necessary treatment."

Even in those countries where access to healthcare for all is provided for in theory, access to mainstream health services in practice is limited by a number of factors: namely, differing interpretation of the law, administrative complexities (whether intentional or not), refusal to provide care, fear of being reported and poor understanding of the legal position regarding access to healthcare (on the part of patients as much as health professionals).

4. This proportion is probably higher among the people seen by the MdM teams, because they come to consult health professionals.

Undocumented migrants do not manage to benefit from the access to health coverage to which they are entitled (when such entitlement is provided for by law)

70% of people interviewed could theoretically benefit from access to health coverage (ranging from 3% in Greece to 98% in Belgium) but a quarter of them are unaware of this fact (ranging from 52% in the United Kingdom to 6% in Spain). This highlights the information deficit that renders migrants more vulnerable. Administrative difficulties are a further constraint.

These factors explain why 80% of people interviewed did not, in practice, have real access to health coverage the last time they were ill.

A series of obstacles gets in the way of undocumented migrants' access to healthcare: nearly 70% of the population surveyed had faced obstacles when seeking healthcare.

68.9% of people declaring that they had faced an obstacle cited **administrative problems** (finding documentary proof, abusive demands, unsuitable timetables, being sent from one office to another...) and **the complexity of the healthcare system**. **The cost** of consultations and treatment was mentioned by 59.4% of respondents. **Fear of being reported or arrested** was cited by 17.3% and 12.4% mentioned the **fear of discrimination, of not being welcomed or of being refused care**. 14% of interviewees report having been **refused care** the last time they were ill. In particular, this was the case for relatively serious conditions or symptoms (in 20.4% of those cases, for example, the symptoms were relevant to cardiovascular disease) and for pregnancy (18%).

Racism was also mentioned: **a third of respondents had personally been victims of racism** during the last year. For one fifth of these respondents this happened at least once in a medical establishment.

Fear—linked to the lack of authorisation to stay in the country—further distances people from health services: **60% of people say that they restrict their movements or activities because of fear of being arrested**.

As a logical consequence of these problems, people delay seeking healthcare or they give up completely. This affects children too.

According to the doctors involved in the survey, **a quarter of people seen (25%) have had treatment too late—at least once—for at least one of their health problems** since they arrived in the survey country.

29% of people interviewed **gave up on seeking healthcare for their children** at some point during the last 12 months: most commonly, this related to medical consultations and vaccinations.

41% of interviewees **gave up on seeking healthcare for themselves** during the last 12 months (representing 53% of respondents who reported at least one obstacle to healthcare). The lack of health coverage is a determinant: **people whose healthcare costs are not covered** have given up on seeking care **three times more often** than those who have access to health coverage.

● **The consequences: people who are often ill, but with very little medical care**

The socio-economic determinants of health are particularly unfavourable for the undocumented migrants seen by the Médecins du Monde teams. Their access to healthcare is very limited. As a result, the health of the survey population—both in terms of how they themselves perceive it and medical diagnoses—does not correspond to that which would be expected in such a young population (on average, in their thirties⁵).

5. This average age is higher than that of the entire population seen in *Médecins du Monde* programmes because this survey only relates to adults.

The health status of the people surveyed is worrying.

Among the respondents, a third of men (34%) and a quarter of women (23%) perceive their health as “bad” or “very bad”. Most studies show a good general correlation between this indicator and objective (and/or medical) indicators of health. This is 3 times higher⁶ than for the population of the 25 European Union countries.

Among the youngest respondents (18-25 years), 27% of men and 12% of women already say that their health is “bad” or “very bad”.

32% of people surveyed are affected by at least one chronic health problem. This is more common among men than women. These people often live in insecure accommodation (35%) and are relatively isolated (half of them feel lonely and 17% cannot count on anybody for emotional support).

They need medical treatment: two thirds of respondents (65%) have at least one health problem for which treatment is considered by the doctors as preferable, necessary (29%) or indispensable (21%). 8% of those who are suffering from a condition for which treatment is considered indispensable are rough sleepers and 7% live in a short-term or medium-term shelter.

Many people also suffer from more than one health problem: 24% of people interviewed present with at least 2 health problems for which treatment is considered to be preferable. This high rate, in such a young population, is indicative of delayed access to healthcare.

Thus, according to the doctors, 16% of the population present with a **vital prognosis that is possibly, probably or certainly bad unless they receive treatment.**

Only 8% present with only one health problem for which treatment is judged to be optional. Contrary to the widespread pre-conception that foreigners would abuse European health systems, the impoverished survey population hardly seeks any care for minor health problems.

Unsuitable and largely inadequate medical follow-up, irrespective of the severity of the health problem.

Under half of pregnant women (48%) received ante-natal monitoring during their pregnancy.

Of the 1,371 health problems identified in the survey population, only a quarter (26%) were comprehensively treated or monitored. A quarter (27%) received partial treatment and **nearly half (45%) were not being treated or followed-up at all on the day of the survey.**

Even when the health problems are serious, they receive very little treatment or follow-up: **among the health problems for which treatment is judged by the doctors to be indispensable, less than half (43%) received comprehensive follow-up, one fifth were partially followed up or treated (21%) and a third (34%) did not receive any follow-up at all.** When the treatment was “only” considered to be necessary, nearly half of the problems (44%) did not receive any follow-up either.

Treatment of less serious health problems is also problematic: **only 13% of less serious health problems—for which treatment is nonetheless preferable—received comprehensive medical follow-up.**

6. It is important to bear in mind that the survey mostly took place in programmes of a medical organisation.

Many of the interviewees live with, or have experienced, violent situations. Logically, this means that they should, in fact, have more protection.

59% of the population reports having been subjected to at least one type of violence (for 41% of respondents this was in their own country). **Very often, they have suffered several instances of violence** (for 40% of respondents).

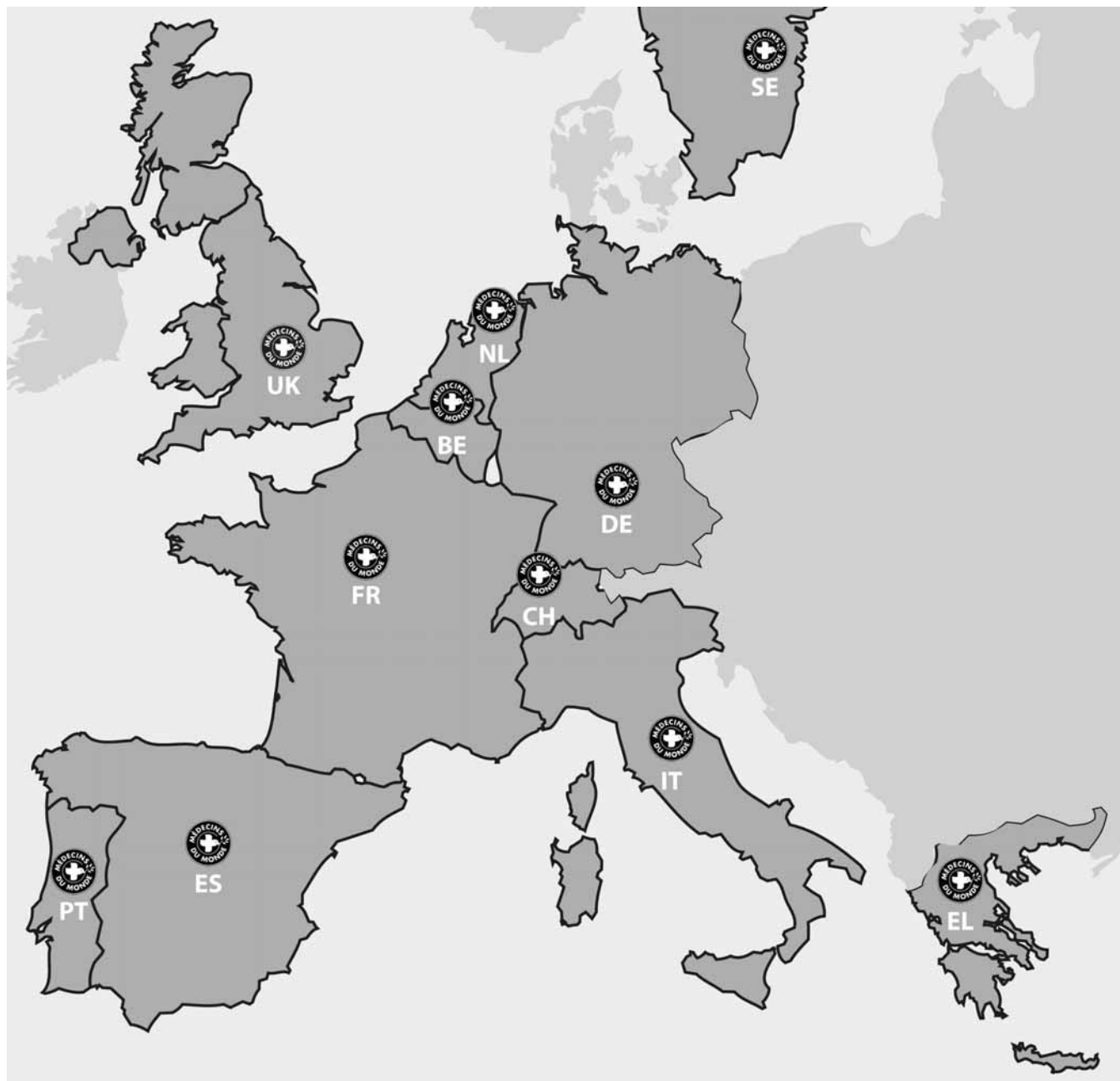
The types of violence most commonly experienced are (in decreasing order): suffering from hunger or lacking enough to eat, living in a country at war, physical violence (including domestic violence), being prohibited from earning a living or denied access to money earned, violence by police or armed forces, being subject to surveillance or restriction on activities, being threatened or imprisoned for their ideas, torture and sexual assault.

The numerous instances of insecurity that undocumented migrants have to deal with from the moment of their arrival in the "host" country prevent them from rebuilding their lives. **A quarter of respondents (24%) say they have been subjected to violence since they arrived in Europe.** Thus, we have a duty to protect them.

Part 1:
Statistical survey among undocumented migrants attending services run by Médecins du Monde and some of its partners

- **European observatory on access to healthcare - Survey 2008**

1,125 adults in 31 cities in 11 European countries participated in the 2008 survey.



BE	BELGIUM = 112 – Brussels	IT	ITALY= 99 - Milan
CH	SWITZERLAND = 11 - Fribourg	NL	NETHERLANDS = 103 - Amsterdam (n=62) - Arnhem (n=1) – The Hague (n=6) - Eindhoven (n=10) - Haarlem (n=3) - Leiden (n=1) - Leidschendam (n=2) - Rotterdam (n=6) - Tilburg (n=2) – Utrecht (n=10)
DE	GERMANY = 24 - Munich		
EL	GREECE = 118 – Thessalonica (n=68) - Athens (n=50)	PT	PORTUGAL = 32 - Lisbon (n=21) - Loures (n=11)
ES	SPAIN = 216 - Alicante (n=21) - Balearics (n=23) - Bilbao (n=21) – Canary Islands (=39) - Galicia (=25) - Madrid (=21) - Toledo (n=30) - Valencia (n=36)	SE	SWEDEN = 103 - Stockholm
		UK	UK = 108 - London
FR	FRANCE = 199 - Lyon (n=56) - Paris (n=71) - Saint-Denis (n=72)		

INTRODUCTION

This is the second report of *Médecins du Monde's* European Observatory on access to healthcare. It relates to the living conditions, health status and access to healthcare of some of the most vulnerable people in our countries: undocumented migrants. The testimonies collected during this survey are damning. Europe creates undocumented migrants then casts them—people who, more than anything, need security and humanity—into obscurity in our cities. These victims have become pariahs.

It is not a crime to flee one's country. Yet, these children, women and men live in constant fear of being identified, reported, separated and deported. People flee from torture and from violence (sexual, domestic, police or military violence). They also flee from destitution and in order to ensure that their children have a future. We all hope that we would be strong and brave enough to do the same.

Little is known about the situation of undocumented migrants living in Europe. We know that their social and economic situation is highly precarious. Various testimonies also attest to the problems that they have with realising their right to healthcare and with obtaining support from the health system. In general, national healthcare programmes often discriminate against:

- temporary migrants (considered as temporary because they entered the country with a tourist visa, as is often the case);
- asylum seekers⁷ who don't always have the same rights as nationals;
- people who do not have authorisation to stay in the country—either since their first arrival or at a later stage (for example, when their provisional visas or documents expired, or they were refused refugee status).^{8,9}

At the same time, we know that policies that—intentionally or not—exclude certain groups of migrants (particularly those without residency permits but also, more generally, temporary migrants) from healthcare, contribute to the deterioration in migrants' health and in public health within these host countries.¹⁰

For these migrants, there are many, sizeable obstacles to good health. These are mainly linked to discrimination, their legal status, language or cultural differences, various social and economic problems, and their very difficult living conditions in general.¹¹

There have been various estimates, with different degrees of accuracy, of the numbers of undocumented migrants in different European countries (and particularly in the countries in this study). In most countries the maximum estimates are 1% to 2% of the total population, except in countries such as Greece where the percentage is higher (3.4%).¹² Against a general backdrop of tightening border controls, there are currently considerable variations between countries in terms of openness to immigration. In relation to population size, France is the most restrictive of the survey countries (receiving 2.9 foreign nationals per 1,000 inhabitants in 2006). Switzerland and Spain have the most proportionally (14.3 and 18.1 foreign nationals per 1,000 inhabitants respectively in 2006).

7. On the subject of restrictions on access to healthcare for asylum seekers in the EU see a 2004 Danish study which concluded that real restrictions existed in 10 countries (including Germany, Spain and Sweden): Norredam M, Mygind A, Krasnik A, "Access to healthcare for asylum seekers in the European Union: a comparative study of country policies", *Eur J Public Health*, 2005, 16 : 285-89.

In relation to asylum seeker health see, for example, the recent Swiss epidemiological study: Bischoff A., Schneider M., Denhaerynck K, Battegay E., "Health and ill health of asylum seekers in Switzerland: an epidemiological study", *Eur J Public Health*, 2009, 19 : 59-64.

8. Verbruggen N. ed., "Health Care for Undocumented Migrants: Germany, Belgium, the Netherlands, United Kingdom", Brussels, Platform for International Cooperation in Undocumented Migrants (PICUM), 2001.

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10. Carballo M, Mboup M, "International migration and health, a paper prepared for the Policy analysis and research programme of the GCIM", Geneva, Global Commission on International Migration, 2005.

11. World Health Organization "International Migration, Health and Human Rights", Geneva, WHO, 2005.

12. Source: French parliamentary report on irregular immigration.

Since the great majority of national surveys do not include undocumented migrants, there is a lack of statistical information on the living conditions, health status and access to healthcare of this population which is generally estimated to number between 5 million and 8 million people (10 to 15% of migrants in Europe).¹³

This lack of information and data contrasts with increasing attempts to use restrictions on access to healthcare for undocumented migrants as an arm of immigration control—against all principles¹⁴ and with little effect.¹⁵

The *Médecins du Monde* European Observatory on Access to Healthcare carried out a first survey among undocumented migrants attending *Médecins du Monde* health programmes in 2005-6 in seven European countries.¹⁶ Following this first study, *Médecins du Monde* decided to carry out another survey, in more countries and with more comprehensive systematic data collection on respondents' social situation and health status.

As with the first survey, the results presented here must be read as “statistical testimony” of situations witnessed in the European Observatory's different centres and programmes.

The results are not intended to paint a representative picture of the problems with access to healthcare experienced by all the undocumented migrants in Europe. When reading this document, it is important to bear this last point in mind, for at least four reasons:

- The people interviewed in this survey have been able, by definition, to have contact with the healthcare services where the survey took place at the very least. No doubt, there will be other undocumented migrants in worse health and living in even worse social conditions and, since they are even further removed from health and welfare support services, who are “invisible” in this survey;
- On the other hand, there will be undocumented migrants living in slightly better conditions than those interviewed here, and who do not seek support services. Clearly more and more restrictive immigration policies are increasingly pushing people into irregular status, and this prevents most undocumented migrants from living a decent life. There are, however, some in this group who—mainly because of the support they receive from family and friends—do not need to access the types of support services included in the European Observatory. Of course, it is also possible that undocumented migrants do not attend health services because they do not have any health problems, or because they do not feel any need (which is not the same thing);
- The health programmes associated with this survey in 11 countries, do not constitute a representative or exhaustive sample of the health services which undocumented migrants may attend in each country or area (town or region). Hospital emergency services, public healthcare centres, general practices and other voluntary sector services, for example, also see people in this group;¹⁷
- Finally, in each of the 11 countries where the survey took place, there is considerable variation in the number of survey “sites” (the places, centres or programmes where the survey was carried out). In some countries, the survey took place in one town, while in others it was carried out simultaneously in several regions. It is particularly

13. Report by the Global Commission on International Migration (OECD) in “Access to healthcare for undocumented migrants in Europe”, PICUM, Brussels, 2007.

Huber M, Stanciole A., Bremner J., Wahlbeck K. eds. “Quality in and equality of access to healthcare services”, Brussels, European Commission, DG Employment, Social Affairs & Equal Opportunities, March 2008, pp. 196-201.

14. WHO. “International migration, health and human rights”. Geneva, WHO (Health and human rights publication series), 2008, no. 4.

15. Editorial. “Access to healthcare for undocumented migrants in Europe.” *The Lancet*, 2007, 370: 2070.

16. European observatory on access to healthcare. “European survey on undocumented migrants' access to healthcare”. Paris, *Médecins du Monde*, 2007.

17. Representative surveys studying hard-to-reach populations (or numerically very small groups within the general population—such as homeless people, undocumented migrants, sex workers etc.) often rely on random samples within facilities frequented by the target group. We found one such survey carried out among undocumented migrants in Chicago in 2002. Mehta C., Theodore N., Mora I., Wade J., “Chicago's undocumented immigrants: an analysis of wages, working conditions, and economic contributions”, Chicago, University of Illinois, Center for Urban Economic Development, 2002). This type of study unfortunately only partially removes the bias in terms of representativeness, particularly when all types of services are not included in the survey field (as is often the case in practice).

important to bear this in mind for countries with devolved administrations (Germany, the United Kingdom and Spain, in particular). In cases where the law and provision of services for undocumented migrants varies from one region to another, these results clearly only relate to the geographical area where the survey took place.

Nonetheless, there are currently no randomised, representative surveys conducted amongst the general undocumented migrant population (such surveys are, because of their very nature, extremely difficult to carry out). This is why the quantitative results presented here do enable us to identify key trends and international differences that, despite the need for caution in their interpretation, do illustrate the extent of the problems this population experiences with access to healthcare.

1. THE POPULATION STUDIED AND LEGISLATION ON ACCESS TO HEALTHCARE IN EACH COUNTRY

The population studied is composed of people aged 18 or over, living without residence permits in one of the European countries surveyed, and attending a service provided by *Médecins du Monde* or one of its partner organisations. **In total, 1,125 adults were interviewed in 11 countries: Belgium, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, Sweden, Switzerland and the United Kingdom.**

The final sample is broken down as follows (in decreasing order of number of participants per country): Spain (216), France (199), Greece (118), Belgium (112), United Kingdom (108), Netherlands and Sweden (103 in each), Italy (99), Portugal (32), Germany (24) and Switzerland (11).

• **Survey sites and legal context, by country**

IN SPAIN (ES),

216 people were interviewed in *Médecins du Monde* projects. Interviews were carried out in eight locations in total in order to obtain a diverse sample in terms of place of residence and type of health facility attended.¹⁸ The breakdown is as follows:

- in the Canary islands, 39 people were interviewed in a socio-medical centre for migrants (CASSIM¹⁹) in Tenerife;
- in Valencia, 36 people were interviewed in a CASSIM;
- in Toledo and the surrounding area 30 people participating in an intercultural health mediation programme were interviewed;
- in Galicia (in Vigo and La Coruña), 25 people were surveyed in a mobile outreach unit working mainly with drug users and sex workers,²⁰
- in the Balearics (mainly in Palma de Majorca and the surrounding villages), 15 people were surveyed in a medico-psycho-social support centre for sex workers (CASSPEP²¹) and in 8 "*Dones del Mon*"²² projects;
- in Bilbao, 21 people were interviewed in a CASSIM;
- in Madrid, 17 people were surveyed in a mobile unit for sex workers and 4 people were interviewed in a socio-medical centre for transgender individuals;
- in Alicante, 16 people were surveyed in a CASSIM and 5 in a CASSPEP.

Twenty eight percent of respondents in Spain were working in prostitution (62 individuals). In total, 47% of those approached did not participate in the survey. The most common reasons given were that respondents did not have the time or because they did not speak the languages spoken by the interviewers.

18. In Alicante, Madrid and Palma de Majorca, the different programmes were not identified at the time of data capture.

19. Cassim refers to a "Centro de Atención Socio Sanitaria a Inmigrantes".

20. The Spanish programmes use the term "personas en situación de prostitución" that can be translated as "people in situation of prostitution".

21. Casspep refers to a "Centros de Atención Socio Sanitaria a Personas En situación de Prostitución".

22. *Dones del Mon* ("Women of the world"): Capacity building programme for migrant women to enable them to improve their health.

The **CASSIM** programmes aim to reduce health inequalities affecting vulnerable migrants and to facilitate migrants' access to mainstream health services. Multi-disciplinary teams provide medical consultations, nursing care, advice sessions and psychological consultations. Migrants can benefit from these services until they are integrated into mainstream services.

The **CASSPEP programmes, and the mobile outreach units**, aim to improve the health of sex workers (men, women, transgender individuals). The teams carry out harm reduction work, provide information on sexually transmitted infections, inform people about their rights, and help people access mainstream services. The vast majority of service users are migrants (the most vulnerable).

The **programme for excluded transgender individuals in Madrid** aims to improve the target group's health. The teams offer medical and advice consultations and provide information on mainstream services.

The **"Dones del Mon" programme in Palma de Majorca** aims to promote the integration of migrant women into society. The team carries out health promotion activities to build up women's skills and enable them to be as healthy as possible.

The **intercultural health mediation project in Toledo** aims to promote mutual understanding and awareness between health professionals and migrants. The team provides mediation services to reduce the conflicts that can arise as a result of cultural, linguistic and social differences. In this way the project facilitates relationships between health professionals and migrants.

Access to healthcare in Spain

The "right to health for all" is recognised in Spanish law (article 43 of the 1978 Spanish constitution). The general preamble to the 1986 general law on health lays out that "all Spanish citizens, as well as foreign citizens residing in the country, have the right to health and to healthcare."

The national health system is funded by tax and access is free for the great majority of Spaniards.

Patients are required to pay 40% of the costs for medication (10% for treatments for some chronic diseases, for retired people and people who are temporarily incapacitated) except in some regions, such as the Valencian Community (where medication is free for people with no economic means- including undocumented migrants).

Social security cards, given to all workers and their immediate families, are progressively being replaced by individual health cards. All residents who do not have social security and who have a low income (in 2009, not more than the minimum wage of 624 euros) can benefit from the individual health card.

There are major differences between the regions (autonomous communities) in terms of how long they take to respond to requests for health cards and in relation to the user charges for medicines.

Undocumented migrants

The individual health card is given to those who cannot register for social security through their work. This includes undocumented migrants. Cardholders have the same access to healthcare as Spanish citizens and have access to free HIV testing and treatment throughout the national health system.

To be able to obtain the individual health card a person must:

- possess an identity document;
- register with the local town hall (*Padrón*)—pregnant women and children are exempt;
- have limited financial resources (in most regions).

Despite the apparent simplicity of the system, there are major obstacles. Some people, for example, no longer possess any identity documents. Others are afraid to register at the local town hall because, since 2003, police have had the right to access the register.

Another problem is that the system for dealing with health cards for undocumented migrants varies considerably from one region to another. In some regions people obtain a card in less than two months, while in other regions people have to wait more than seven months. Some regions have created an alternative system for undocumented migrants to be able to access the health card without having to declare themselves on the local register (Andalusia, the Valencian Community and Murcia).

Children of undocumented migrants

The children (under 18 year olds) of undocumented migrants, do not themselves have to be declared on the local register to obtain a health card. They have the same access to healthcare as Spanish nationals (free access across the national health system).

School attendance up to the age of 16 is compulsory, irrespective of immigration status.

European citizens with inadequate means and without health insurance

European Union citizens living long-term in Spain and who have neither sufficient financial resources nor health insurance can have access to health coverage if they have an individual health card (with the same requirements as for nationals or undocumented migrants). In general, a signed statement on oath will suffice to be able to prove poor financial status. Some regions, such as the Valencian Community and the region of Castilla La Mancha, require European Union citizens to present an official document from their country of origin certifying that they do not have any health insurance and that this is not a voluntary decision (i.e. that they have not refused an offer of health insurance). After three months in Spain, EU citizens have to enter themselves on the central register of foreign nationals.

Protection of seriously ill foreigners (who do not have real access to treatment in their country of origin)

Spanish legislation (article 45-4 B of royal decree 2393/2004, of 30 December 2004) sets out the possibility of granting one-year temporary residence permits (renewable annually) for humanitarian reasons to foreigners *"suffering from a serious illness which has appeared in Spain, and which requires specialist help that is not accessible in their country of origin, where a disruption in, or absence of, treatment would pose a serious risk to their health or their life."*

In order to prove that this medical help is necessary, a certificate from the local health authorities (including details of the lack of access to this treatment in the country of origin) is required. However, it is often difficult to prove that there is no access to treatment in the country of origin and the procedures to obtain this protection are complex (excerpts from police records are requested...), which can make obtaining a residence permit problematic. Pregnant women, however, are protected from being deported if it would damage their health or that of the foetus.

IN FRANCE (FR)

The survey included 199 individuals interviewed in 3 major *Médecins du Monde* healthcare and advice clinics (*Centres d'accueil, de soins et d'orientation* or CASOs):

- 72 people interviewed in Saint-Denis (with an 18% refusal rate);
- 71 people interviewed in Paris (with a refusal rate of only 9%);
- 56 people interviewed in Lyon (with a refusal rate of 47%).

In total, the refusal rate among people contacted in France was 26%. The main reasons for refusal were language barriers (for 55% of those who refused), a lack of time (28%) or because they didn't want to participate (7%).

The CASOs are open to anyone who has problems accessing healthcare. The centres aim to relieve suffering and to help people access mainstream services as soon as possible. Multi-disciplinary teams welcome patients (without any restrictions) and work with them to help them realise their rights to access the public health system. General practitioners and medical specialists provide medical consultations. Nurses provide care and also carry out some health promotion activities. Social workers and those welcoming the patients at the centres ensure that everyone gets access to their rights. The centres also run activities—including testing—to prevent transmission of HIV, hepatitis and tuberculosis. The CASOs are often the first place of contact for people who are excluded and who do not know their rights to access healthcare or how the health system works.

Access to healthcare in France

The French health system is funded by tax and social security payments. Social security and healthcare cover is based on a system where “everyone pays according to their means and receives care according to their needs.” The system covers around 65% of healthcare costs. All long-term residents (with residence permits) are entitled to access this system—for people with low incomes care is free (universal health insurance or “basic CMU”). For the remaining 35% of the costs, complementary private health insurance schemes exist, and some of these are non-profit making (*mutuelles*).

People on low incomes (below 621 euros/month) are entitled to have 100% of their healthcare costs covered by the enhanced “complementary CMU”.

Asylum seekers can have access to social security from when they arrive in the country and, depending on their means, are entitled to the complementary CMU.

Although the overseas departments benefit from the same laws, they are applied to varying degrees. In French Guiana, for example, access to healthcare for undocumented migrants and the protection of seriously ill foreign nationals is poor.

In the overseas communities, such as Mayotte, it is difficult to know which laws apply and it is clear that some fundamental rights are not respected, particularly the right to an official identity and the protection of the right to family life (parents are deported, while their children remain on the island without them). Until 2005, when the social security system was introduced, access to healthcare was free for all. Since then, the system has created a distinction between the “affiliated”, who have access to free care, and the “non-affiliated” who have to pay a fee. Children also have to pay these fees.

In both cases—French Guiana and Mayotte—we also see people living in destitution and dangerous conditions in shantytowns, despite the recommendations of the national health institute for combating dengue fever and chikungunya fever.

Undocumented migrants

Anyone who has been living in France with a residence permit for more than 3 months, and who has income below 621 euros per month, has a right to state medical aid (*aide médicale d'Etat* or AME). This means access to healthcare with 100% of the costs covered and without having to make payments in advance—the coverage is known to be inadequate for all prostheses and aids (false teeth, glasses etc). The AME is valid for one year and has to be renewed annually—this means that the same documents have to be presented for renewal. Undocumented migrants who cannot prove that they have been living in the country for more than three months are entitled to free hospital care for urgent care (e.g. pregnancy, abortion).

Undocumented migrants' children and unaccompanied minors

Children (under 18) of undocumented migrants (children cannot be considered as undocumented) are exempt from the requirement to be resident for at least three months (thanks to a complaint by voluntary organisations). Unaccompanied minors must be placed under the protection of a judge and child social services (*Aide sociale à l'enfance* or ASE) – then they have access to social security and the complementary CMU (with 100% of costs covered).

European citizens with low income and without health insurance

Citizens from within the EU, according to European directive 2004/38/CE on “the right to freedom of movement and residency of European citizens” and “the requirements for entry and residency for foreign nationals and the right to asylum”, have a right to residency which is linked to their social group (workers, students, economically inactive). The right to residency is limited to three months for EU citizens who are not working and students. People in these groups are only considered to be in a regular situation if they have valid health insurance and have adequate financial resources so as not to place an “unreasonable” burden on the welfare system. EU citizens on low incomes and without health insurance, therefore, lose their right to residency after three months and can, from then on, obtain the AME insurance like other undocumented migrants.

Protection of seriously ill foreigners (who do not have real access to healthcare in their country of origin)

A “private and family life” residence permit for one year, renewable, is granted to “foreigners normally living in France who risk exceptionally serious damage to their health if they do not receive medical care, provided that they cannot, in practice, benefit from suitable treatment in their country of origin” (article L313-11 11th paragraph of the Code on entry and residency of foreign nationals and the right to asylum).

The decision to grant this type of permit is taken by the administrative authorities, following advice from a public health inspector.

The ill foreign national must obtain a full medical report on his or her health from a hospital practitioner or an approved doctor. In addition, any information concerning the lack of access to treatment in the country of origin is useful.

The Ministry of Immigration, Integration, National Identity and Development published information files on their intranet for local officials and medical inspectors. These files give information—which is often incomplete or erroneous—on medical treatments in 28 countries.

The two main problems are:

- breach of confidentiality—in order to check whether a person can be deported or not, officials ask doctors to indicate the type of treatment necessary;
- the new system does not take into account, the accessibility of the treatment in practice—the country files only indicate whether the treatment exists (even though, for example, treatment for a specific illness only exists in one hospital or private clinic and is only accessible to dignitaries).

This law protecting seriously ill foreign nationals since 1998 has, however, enabled many lives to be saved and remains a model at the European level, having demonstrated that there was no sudden influx of ill foreigners in France because of this law. In fact, the regular increase in the number of permits granted relates to the fact that the permits for chronic conditions are renewed from one year to the next.

IN GREECE (EL)

118 people attending two *Médecins du Monde* independent clinics (policlinics) were interviewed:

- 68 people interviewed in Thessalonica;

- 50 people interviewed in Athens.

The undocumented migrants who did not respond to the survey were mainly people who could not be interviewed because of language barriers.

Within the policlinics, teams of doctors, nurses, receptionists and psychologists provide healthcare and social support to anyone who does not have access to the national health system, people with no income or health insurance, homeless people, Roma migrants, asylum seekers, undocumented migrants etc.

Access to healthcare in Greece

The national health service was established in 1983. All salaries are covered by compulsory health insurance.

The healthcare system is decentralised to primary healthcare centres, district and regional hospitals. The health service is funded by private sources and government grants. Access to consultations is free within the national health system, but patients must pay 25% of medication costs.

The welfare system covers Greeks who are in poverty (income less than 300 euros per month), are unemployed or who are 29 years old or more and do not have health insurance. It also covers people aged over 65 (who have not worked or have not worked enough to be covered) and people with special needs or disabilities. People who have access to identity documents can obtain a health leaflet enabling access to health coverage and treatment.

Asylum seekers have the same rights as nationals as long as they can prove their status, which is difficult to do at the very start of the process.

People who enter Greece illegally are most often confined to centres where they are not informed of their rights. This group, therefore, has major problems submitting asylum requests. The rate of granting refugee status in Greece is the lowest in Europe (0.04% in the first instance and 2.05% on appeal in 2007, according to UNHCR, compared to 34%, for example, on the first application and 24% on appeal in the United Kingdom).

Undocumented migrants

Undocumented migrants can only access healthcare in emergencies, and only until their condition can be stabilised. Since 2001, a law has forbidden public institutions from helping those who cannot prove that they have authorisation to live in Greece. This does not apply, however, to hospitals and clinics when it relates to children or to undocumented migrants who must be hospitalised.

HIV and other infectious diseases, as well as childbirth, are normally considered as emergencies.

The children of undocumented migrants

In theory, there is a law to ensure that children can receive healthcare and be hospitalised free of charge. In practice, however, this remains very difficult.

European citizens with low income and without health insurance

EU citizens who have been residing in Greece for less than three months can receive healthcare through the European health insurance card. If they have no health insurance, they will have to pay for the services that they receive. If they obtain a residence permit even if they are poor and without health insurance, they can ask for a "health pass" which gives access to free care on the health system.

Protection for seriously ill foreign nationals (who do not have real access to treatment in their country of origin)

All undocumented migrants in the country, and who cannot be deported for medical reasons, can benefit from a temporary residence permit (Art. 37(4) (a) of the law 2910/2001). In the same way, undocumented pregnant women cannot be removed from the territory during their pregnancy or for six months after delivery (Art. 79(1) of the law 3386/2005).

Greek law provides for provision of one-year renewable humanitarian visas for undocumented migrants who are seriously ill, provided that they have previously had a visa. A medical certificate must be supplied by a public or social security fund hospital, confirming the serious health problems and indicating the treatment duration.

In practice, people are not always deported, but nor do they obtain a residence permit.

IN BELGIUM (BE)

112 people were interviewed in *Médecins du Monde's* healthcare and advice clinic (CASO) in Brussels. This represents 44% of the undocumented migrants who attended the clinic during the survey days. The reasons for non-response were predominantly language barriers (16%) or a lack of time (12%). The refusal rate for people contacted was only 10%.

The Brussels clinic supports anyone who does not have access to healthcare by explaining and facilitating the necessary administrative processes to obtain health coverage. Multi-disciplinary teams—including receptionists, doctors, psychologists and social workers—provide healthcare while these administrative processes are ongoing. The team also provides long-term care for people who cannot access healthcare in Belgium.

Access to healthcare in Belgium

Belgium has a compulsory national health insurance system that is managed by six not-for-profit health insurance funds. Responsibilities are shared between the federal government (for example, responsible for the compulsory insurance) and the different states.

In general, people have to pay up front and are then reimbursed for the proportion of the costs covered by sickness and invalidity insurance (55 to 75%). Medicines are broken down into six categories according to their therapeutic effectiveness, and this dictates the level of reimbursement. The costs of some medicines—such as HIV/AIDS treatment drugs—are covered 100%.

When a patient is covered by the *mutuelle* (compulsory health insurance), payments and reimbursements are carried out as follows:

- charges for medical consultations are either paid in total and the proportion covered by social security is reimbursed, or the patient need only pay a reduced rate ("*tiers payant*") set by the doctor;
- for medicines, the patient usually only pays the reduced rate ("*tiers payant*"), but there are several levels of reimbursement (beyond the six categories) depending on the individual's status—the standard level and a "higher" level of reimbursement for disabled persons or people depending on social services (i.e. CPAS – *centre public d'action sociale*);
- for hospitalisation, patients receive an invoice for the proportion of the costs that they have to pay.

Complementary health insurance schemes exist in Belgium. The most common are insurance policies for hospitalisation, which reduce the invoice by covering the inpatient charges. Such insurance is not compulsory.

There are several types of complementary insurance scheme that cover all the health charges not covered by the basic *mutuelle* (consultations, extra tests, hospitalisation, medicines, dental care etc.). These schemes, however, are rare, very expensive and are often provided by foreign countries—such as France—for expatriates living in Belgium who are not used to paying a proportion of health charges.

In relation to prevention and screening for STIs and HIV, there are only two free, anonymous testing centres in Belgium (in Brussels and Antwerp).

Asylum seekers

Asylum seekers have the right to free social, legal, medical and psychological support.

But *Fedasil*, the federal organisation in charge of asylum seeker reception and support is currently unable to provide a welcome to all asylum seekers in centres at the start of the process. Asylum seekers are referred instead to homelessness organisations, which are not adapted to the needs of this target group. People living outside an open centre can choose which services to use. In principle, the only requirement to be able to access healthcare is to show the service provider an official document concerning the request for asylum. The service provider must then contact the *Fedasil* “medical charges” unit to obtain approval for the costs to be covered (a form guaranteeing payment for the care provided is supplied). The service provider then sends an invoice to *Fedasil* to claim reimbursement.

Undocumented migrants

Since 1996 “destitute” undocumented migrants living in Belgium who need medical care can request urgent medical help (*Aide médicale urgente* or AMU) from a social services centre (i.e. a CPAS) where they are registered.

Poor understanding of the administrative system is aggravated by the fact that each CPAS, as an organisation under the auspices of local government, is free to pursue its own policy in relation to the AMU and to implement different administrative processes. This causes particular problems around Brussels, where 19 CPAS facilities are concentrated into a relatively small, but densely populated, area. Each CPAS has its own emergency medical aid declaration for doctors to complete and applies specific criteria to decide whether someone is entitled to this care or not. Most service providers, however, require patients to have proof that the CPAS will pay for the care. This creates a vicious circle that can only be broken at the behest of at least one of the two parties.

Each CPAS also has its own criteria to define whether a person is destitute (e.g. maximum monthly income, the fact that they are paying rent). Furthermore, each official has his or her own interpretation. To obtain emergency medical aid (AMU), an individual must:

- obtain a medical declaration stating that AMU is required;
- know where to go and how to get an appointment;
- be able to have a home inspection visit (accommodation and destitution) from a CPAS employee (this is particularly difficult for anyone lodging with others).

The time taken to be able to access the AMU, as well as the period for which the AMU is valid, varies from one CPAS to another. This means that people are required to renew their AMU often and this, in turn, hinders any prevention efforts and can deter people from seeking any healthcare at all.

Children of undocumented migrants and unaccompanied minors

All children up to the age of six have access to free preventive care (including vaccinations) at the Office of Birth and Childhood.

Children of undocumented migrants have the same rights as adults to healthcare via the AMU, and they are also subjected to the same requirements (medical certificate and home inspection).

Since 2008, unaccompanied foreign children have access to the same health insurance rights as nationals, provided that they have been registered at an educational establishment for at least three months (unless they are exempt from the requirement to attend school).

European citizens on low incomes and without health insurance

After three months, EU citizens with inadequate financial resources and without health insurance will not be considered to be lawfully resident. Thus, they are only able to obtain emergency care. They can request access to the AMU. The CPAS, after checking in the relevant country, only considers that a person does not have access to insurance in their country of origin after the person has been in Belgium for more than a year.

Protection for seriously ill foreign nationals (who do not have real access to treatment in their country of origin)

“Foreigners staying in Belgium who have an identity document and who suffer from an illness that poses a real risk to his or her life or physical integrity, or which poses a real risk of inhumane or degrading treatment, while adequate treatment does not exist in their country of origin or the country where they reside, can apply for a residence permit” which allows them to stay in Belgium for more than three months. They are required to provide a medical certificate and proof of address. If the request is accepted for submission and is judged to be well founded, the person is granted a residence permit of up to one year, which is renewable and which enables access to the same rights as people who are lawfully resident (social services etc).

During the submission process, the foreigners’ office decides on the basis of the request. A person may, for example, receive permission to stay for a fortnight or two months depending on the medical needs. Certificates for one year are only granted for chronic diseases (such as HIV, diabetes and schizophrenia). After five years’ residency on medical grounds, the person receives unlimited permission to stay in the country.

IN THE UNITED KINGDOM (UK)

108 people were interviewed in London. The survey took place in *Médecins du Monde*'s healthcare and advice clinic which is mainly aimed at migrants. Seven interviews were also conducted at the New North London Synagogue (NNLS). Of all those contacted, 25% refused to participate in the survey – the main reason given was lack of time.

Médecins du Monde's free clinic—known as Project: London—aims to improve access to healthcare for vulnerable groups and to promote access to the national health service (NHS). Multidisciplinary teams provide medical consultations, nursing care, advice consultations and help people to register with a general practitioner (the entry point to the whole system).

The NNLS is a drop-in centre for destitute asylum seekers. Sessions offering meetings with lawyers, as well as food and clothing, are organised one Sunday per month. There are no medical consultations.

Access to healthcare in the United Kingdom

The UK health system is largely funded by taxation and is based on the principle of free access to healthcare for all. Access to the system is based on residency and not on nationality—everyone ordinarily resident in the UK, therefore, has the right to access medical care. Anyone should be able to register with a general practitioner near his or her home.

General practitioners and hospital emergency departments are the entry points for secondary care. It is, however, sometimes difficult to register with a general practitioner because of the administrative requirements (proof of address, passport etc.). Both public hospitals and private services exist.

Some health services provide free care to everyone (irrespective of their immigration status): accident and emergency departments, family planning centres and walk-in centres for care similar to that provided in emergency departments.

Care relating to some health problems—such as sexually transmitted infections, infectious diseases (apart from HIV/AIDS), mental health problems where the patient may pose a danger to themselves or others, as well as a list of 35 illnesses (hepatitis, meningitis, SARS etc)—is completely free.

For other conditions, although the medical consultation is free, there is a charge of 7.3 euros for prescribed medication.

Asylum seekers have the same rights to access the National Health Service as nationals.

Undocumented migrants

Since the 1977 law on medical services was amended on 1 April 2004, the definition of “ordinarily resident” has been restricted to “lawfully resident” and new rules have stipulated that undocumented migrants are no longer entitled to free hospital treatment.

Registration with a general practitioner is still possible, at the discretion of the doctor. On the other hand, all tests and secondary care in hospital are chargeable and overseas payments officers pursue, and sometimes harass, patients for the fees.

Ante-natal care and maternity services are chargeable, which often results in people not seeking care. Payment is often demanded before care is provided. Finally, although treatment for infectious diseases is completely free, it is important to note that HIV is a particular exception, which has been removed from the list of conditions for which treatment is free.

Children of undocumented migrants

There is no specific protection for children, who are therefore subject to the same restrictions as their parents. To register a child with a general practitioner, the parents must first be registered – which can be an extra problem. As a result, children have access to free primary care (if they are registered with a general practitioner) and have to pay for secondary care.

Protection for seriously ill foreign nationals (who do not have real access to treatment in their country of origin)

The 1971 law on immigration (art.3-1 b) provides for the possibility that discretionary or exceptional residence permits can be granted. These can be issued on medical grounds, provided that the non-existence (*not* the inaccessibility) of treatment in the country of origin has been shown.

IN THE NETHERLANDS (NL)

103 interviews were conducted in 10 towns and in 21 services provided by *Médecins du Monde's* partner organisations. This enabled a wider diversity of respondents to be interviewed:

- in Amsterdam (62 interviews), in the following facilities: Filipino UM DWsNL, Het Kerkhuis, Stichting Sikaman, ASKV, De Open Deur, Centrum 45, Casa Migrante, Wereldpand, Het Wereldhuis;
- in the Hague (6 interviews): Paardenberg programme, Oase Stek programme;
- in Rotterdam (6 interviews): ROS programme;
- in Haarlem (3 interviews): Stem in de Stad programme, De Huiskamer programme;
- in Utrecht (10 interviews): STIL programme, Huize Agnes programme;
- in Leidschendam (2 interviews): Stichting Noodopvang programme;
- in Tilburg (2 interviews): VLOT programme;
- in Eindhoven (10 interviews): Vluchtelingen in de Knel programme;
- in Arnhem (1 interview): Blankenspoor general practitioner;
- in Leiden (1 interview): Fabel van de Illegaal programme.

The vast majority of facilities where the survey took place do not provide any medical services, but provide social support services (language courses, internet, a meeting place and café, food, spiritual support etc.) for any migrant (whether documented or undocumented) who wants them. There are a few specificities to note: Het Kerkhuis and Het Wereldhuis in Amsterdam work particularly with West African migrants; Filipino UMDWs NL works with migrants from the Philippines; *Huize Agnes* in Utrecht works with women who have been victims of domestic violence or trafficking.

The survey was carried out within the framework of *Médecins du Monde's* MEDOC project, which aims to improve access to healthcare for undocumented migrants. The programme provides consultations by medical volunteers in order to be able to give migrants personalised information on their rights and the Dutch health system. MDM gives these migrants a MEDOC (a health booklet that contains information on their medical history and care received) and helps in cases where people have difficulties accessing healthcare. The MEDOC document can be given to any health professional the next time that the person seeks care, thereby facilitating access to consultations. The team works in collaboration with partner services and visits their facilities.

Access to healthcare in the Netherlands

Since reforms in January 2006, health insurance has been compulsory for everyone living in the Netherlands. This insurance covers a standard healthcare package. The insured person pays approximately 90 euros per month and the insurer reimburses healthcare expenses. Children (under 18) have free insurance.

People on low incomes can obtain a monthly health allowance to help them to pay their insurance premium. The law allows for people to opt for a “deductible personal risk”, which enables people to pay reduced premiums although they have to pay a higher level of excess payment for any care provided. Those who do not use health services (apart from general practitioner consultations, ante-natal monitoring, dental care for young people aged under 22 years, or care for chronic diseases) have part of the insurance premium reimbursed.

For other treatment not included in the healthcare package—such as adult dental care—the insured can take out complementary insurance or can pay the entire costs. Some insurers have organised healthcare networks—if the patient does not use these networks he or she will not receive the same level of reimbursement. Other, more expensive, insurance policies leave it up to the patient to choose which health professional to consult.

General practitioners are the gateway to the health system.

Since these reforms in 2006, more people without health insurance have begun to appear in the Netherlands. Also, a 1998 law linked the right to health insurance to lawful residency. Everyone within the Dutch borders, however, continues to have the right to “medically necessary care” as a minimum.

Asylum seekers

Health coverage for asylum seekers is more or less the same as the ordinary basic health insurance (with exceptions such as assisted conception, sex-change operations etc.). Asylum seekers cannot insure themselves for their healthcare, since the government is responsible for their welfare. Since 1 January 2009, the organisation dealing with care for asylum seekers in the ministry of justice (the COA) has signed a contract with *Menzis* (to provide treatment) and with the Netherlands national health system (for public health services).

Undocumented migrants

Undocumented migrants have not had the right to health insurance since 1998. They are entitled to medically necessary treatment and this includes treatment for infectious diseases. The term “medically necessary” relates to:

- life-threatening conditions;
- situations involving the permanent loss of essential functions;
- infectious diseases and psychological problems that could lead to aggressive behaviour;
- ante- and post-natal monitoring;
- preventive services and child immunisation;
- situations where a health professional considers that treatment is medically necessary and appropriate. Normally this reflects the healthcare package associated with the compulsory health insurance.

Until the end of 2008 (during the period when the survey presented here was carried out), the Dutch government had established a special fund (*Koppelingsfonds*) for undocumented migrants who were unable to pay for the care they received. This fund reimbursed general practitioners, midwives, pharmacists and dentists who made compensation claims (provided that they knew about the fund’s existence). For secondary care, hospitals could use a special budget line reserved for “bad debts.” In all cases (both primary and secondary care) patients were asked to pay part of the costs. It was only when payment was not possible that the health professionals (such as general practitioners, dentists, midwives) could send their invoices to the *Koppelingsfonds*. Concerning secondary care, the hospitals had to decide whether or not to use the bad debts mechanism. How the bill would be handled often depended on an individual doctor or hospital.

Since January 2009, the Dutch government has implemented a new financial rule within the health insurance law. The principle remains that undocumented migrants are responsible for paying for the care that they receive. When they cannot pay, healthcare professionals and institutions can receive partial compensation for unrecoverable costs. This law applies to primary, secondary and tertiary care. The financial system replaces the special fund, *Koppelingsfonds*, as well as the hospitals’ bad debtors funds (only for undocumented migrants). In this new system, health professionals receive less compensation for their costs, with the exception of midwives – who continue to be reimbursed 100%. In each region (26 in total), only one hospital and one pharmacy have contracts with the institution responsible for implementing the new law that relates to all care for undocumented migrants.

Since this new law came into force, *Médecins du Monde* has seen an increase in problems, particularly with access to adult dental care and the accessibility of pharmacies (only one per region).

Children of undocumented migrants

Like their parents, children of undocumented migrants are only entitled to medically necessary treatment. In relation to vaccinations and preventive care, on the other hand, they have the same free access as children who are Dutch nationals.

Protection of seriously ill foreign nationals (who do not have real access to treatment in their country of origin)

Undocumented migrants suffering from tuberculosis can delay their departure. This is also the case for pregnant women (no deportation by air six weeks prior to, or after, giving birth) and people who are too ill to travel (or have a member of their family who is too ill to travel). Medical certificates are required to demonstrate these conditions.

Seriously ill foreign nationals can obtain a temporary residence permit for a maximum of five years, depending on the length of the treatment. The request must be sent to the immigration authorities which, in turn, ask for a medical report on the patient from the office of the medical council. This report establishes the urgency of the medical situation and whether treatment can be obtained in the country of origin (in fact, it is usually the issue of whether treatment exists, rather than accessibility in practice, which is considered). The fees for requesting a permit can be as high as 331 euros. In addition, a passport and a temporary visa can be required. Successive demands can be submitted if it is shown that ongoing treatment is necessary and that it is more appropriate and necessary to stay in the Netherlands.

IN SWEDEN (SE)

The sample includes 103 people interviewed in Stockholm in *Médecins du Monde's* healthcare and advice clinic. This centre is open one evening a week for undocumented migrants. Only 20% of people contacted refused to answer the questionnaire—the main reasons were a lack of interest and language barriers.

The programme aims to improve awareness among the general public and the authorities about the poor access to healthcare for undocumented migrants. It also seeks to encourage the Swedish government to permit access to healthcare for everyone living in the country, irrespective of immigration status.

The team—composed of doctors, nurses, midwives, dentists, psychologists, physiotherapists and lawyers—responds to the needs of undocumented migrants by providing medical consultations and treatment, monitoring and referrals for pregnant women, and legal advice.

Access to healthcare in Sweden

Sweden has a national health system that covers the entire population, based on the principles of free choice of health professional and equal access to care. It is funded by taxation. Responsibility for health in Sweden is split between the government, the 21 regional councils and town councils.

For adults, healthcare is subject to an annual charge for medical consultations (around 100 euros), as well as for medicines (around 200 euros).

Child asylum seekers have the same rights to access healthcare as national children.

Adult asylum seekers are only entitled to care which cannot be postponed. This is interpreted in a very restrictive way and in most cases only urgent care is provided. Follow-up of chronic conditions—which one might expect to be included—is excluded. This is why today some regions examine individual circumstances on a case-by-case basis.

An identification number is needed to obtain access to health services.

Undocumented migrants

Undocumented migrants were not referred to in health legislation until May 2008, when they were cited in the preparation texts. Since then, they have been explicitly excluded from access to healthcare, unless they pay the entire costs—impossible for the vast majority of them. Civil society pressure (from voluntary organisations and health professionals) has prevented the authorities from issuing a law that formally prohibited provision of care to undocumented migrants.

In order to access healthcare, migrants must obtain an ID number. This is impossible for undocumented migrants. They are obliged, therefore, to pay the entire costs for any healthcare they receive, including emergency care. For humanitarian and public health reasons, however, some health professionals disregard the rules.

Children of undocumented migrants

Only the children of undocumented migrants who had registered as asylum seekers before their claim was refused, have the same access to healthcare as nationals. This right, however, was only included in the proposed law (2008: 344) and not in the adopted text. Nonetheless, it should guide the interpretation of the law.

Children of undocumented migrants who have not claimed asylum, however, do not have any more legal access to care than adults. They are required to pay for all care received. Once again, some health professionals disregard the law for humanitarian and public health reasons.

Protection of seriously ill foreign nationals (who do not have real access to treatment in their country of origin)

The Swedish law on foreigners (Aliens Act 716/05) states that a residence permit may be granted to a foreign national after a general evaluation of his or her situation. If it is shown that the circumstances are exceptionally bad (taking health status into account) they should receive permission to stay in Sweden.

The law on foreigners, stipulates that if a removal order or an entry refusal is "*final and without appeal*", the Swedish migration bureau cannot carry out the order if medical reasons, or other special grounds, make the order impossible to execute. The duration of the permit granted will depend on the temporary or permanent character of the reasons given to justify it. In reality, it is very difficult to obtain a residence permit on medical grounds, although voluntary organisations do sometimes manage to prevent deportations.

IN ITALY (IT)

99 people were interviewed in 3 different locations in Milan:

- a mobile outreach project for homeless people, many of whom are undocumented migrants (43 people);
- a specialist health centre for drug users (33 people);
- an emergency night shelter (23 people).

These three programmes are run by partner organisations. A doctor from *Médecins du Monde* carried out the entire survey on these sites.

Access to healthcare in Italy

The Italian national health system is based on the principles of universality and solidarity and is essentially funded by taxation. The Italian Constitution guarantees the right to health and to free access to healthcare for people who are destitute.

Responsibility for health, and for organising and providing healthcare in the country, is shared between the government, the 20 regions and local health agencies (ASL).

The basic health package, which for the most part is free, is guaranteed for everyone provided that they register for the national health system through the local health agencies, and obtain a health card. Patients have to contribute towards the costs of specialist consultations (16 euros) and daily hospitalisation costs (45 euros) unless they have a certificate declaring they are destitute.

Asylum seekers and their children have the same rights as nationals.

Undocumented migrants

Undocumented migrants do not have the right to register with the national health system. They can, however, request a temporary foreigner code (STP), which is valid for six months (renewable) and provided by the local health agencies. To request an STP code—which is free and anonymous—they have to be declared destitute. Despite this, until March 2008 undocumented migrants had to pay the health charges under the same conditions as nationals. There is still very poor awareness of the fact that requirement for destitute people to pay charges has been removed, and as a result this measure is rarely applied.

The STP code gives access to care considered urgent (which cannot be delayed) or essential (a much wider definition, that includes prevention, ante-natal care, childbirth, care for children, vaccinations, and treatment of infectious disease). It does not give access to general practitioners who, as in many other European countries, are the gatekeepers to the system of specialist medical care.

Undocumented migrants have to go to a hospital or find NGO doctors who provide them with declarations and referrals, provided that the ASL centres accept them.

In January 2009, the Italian Senate passed an amendment cancelling the prohibition on reporting people to the authorities when they seek healthcare. That was finally rejected by the Italian parliament in March 2009.

Children of Undocumented Migrants

The children of undocumented migrants are included in their parents' STP card and are therefore entitled to the same care as national children.

Protection of seriously ill foreigners (who do not have real access to treatment in their country of origin)

A 1998 law enables temporary residency to be granted for *“serious humanitarian reasons”*. But the remit of this law is not clear, because the law does not include any clarification. It is jurisprudence, therefore, that will enable us to know what the rights are in reality: the judgements of the constitutional court and the administrative courts have established that *“an undocumented migrant who is ill and is residing in Italy must have the right to a residency permit for medical reasons for the length of time needed to access emergency care when they cannot be treated in their country of origin”*. These decisions have not yet been transposed into Italian law. Requests must be sent to the Migration Office at the police department.

According to a 1998 decree on foreigners, a removal order issued against an undocumented woman cannot be executed during her pregnancy, or for six months after the birth of her child. The deportation is postponed, rather than cancelled.

IN PORTUGAL (PT)

32 people were interviewed:

- in Lisbon (21 interviews), in a Médecins du Monde mobile outreach project aimed at people living in a vulnerable situation (homeless people, drug users, undocumented migrants);
- in Loures (11 interviews), in two locations.

Of the people approached, only four declined to take part in the survey (because they did not have time or because they were under the influence of alcohol).

The outreach project in Lisbon, "*Noite Saudavel*", aims to improve access to primary healthcare and to reduce the transmission of sexually transmitted infections among people living on the streets in Lisbon. The team is made up of outreach workers, a nurse and a social worker.

Loures in the conurbation of Lisbon is distinctive for its very diverse population. The "*Saude pa nos Bairro*" project, which participated in the survey, is based in three health districts. The objective is to improve access to mainstream health services and improve access to HIV testing and treatment for migrants. To reach this objective, the project provides medical consultations, carries out health promotion activities, provides information on rights, and carries out awareness raising activities concerning gender, discrimination and human rights. The team is made up of a coordinator, two nurses, a social worker, and a socio-cultural co-ordinator.

Access to healthcare in Portugal

The health system has existed since 1979. The Constitution guarantees the right to health by providing universal access to healthcare through the national health service, funded by taxation and accessible on the basis of residence in the country. Privatisation of the system began in 1989 and notable differences have been reported between the regions. Healthcare is provided in local clinics and public hospitals. Patients have to pay a contribution towards medical consultations, emergency care and medicines, depending on their therapeutic value. Some people are exempt from these charges (e.g. pregnant women, or women who gave birth less than 8 weeks previously, children under 12 years old, unemployed people, people suffering from diabetes, tuberculosis, HIV/AIDS). All residents must obtain a national health card to be able to access healthcare. General practitioners act as the entry point to specialist care.

Asylum seekers have the same access to healthcare as nationals.

Undocumented migrants

Foreign nationals who have been in the country for less than three months, or those who can't prove that they have been in the country for more than three months, are only entitled to emergency care. According to the law, this care cannot be refused.

Undocumented migrants have to pay for care, unless they are exempt from payment because they have an official document declaring that they are on a low-income. Undocumented migrants have access to the national health system if they can prove that they have been in the country for more than 90 days. In order to do this they have to obtain a document from the local district council, with documentary proof or two witness statements. They then have to go to the health centre nearest to their usual place of residence to obtain temporary registration as a patient. Depending on the place, this can be valid for one or several healthcare episodes. They have to contribute to payment, as national citizens do, unless they are exempt (low income certificate, sexually transmitted infections, vaccinations, family planning, maternity services etc.).

Children of undocumented migrants

Children of undocumented migrants can access healthcare under the same conditions as national children. To be able to access this care, they have to register on the undocumented children's register, which is under the auspices of the High Commissioner for Immigration and Intercultural Dialogue.

Protection of seriously ill foreign nationals (who do not have real access to treatment in their country of origin)

All foreigners who are suffering from an illness requiring prolonged medical care, and which prevents them from returning to their country of origin because of the risks to their health, can request a temporary residence permit (art.122(1) (g) decree – law n°23/2007).

To obtain a temporary permit, migrants must contact the Foreigners and Borders Service (art.61 (1) and (8) decree law n°84/2007) and:

- present a medical certificate provided by an officially recognised medical agent declaring that he or she suffers from a condition which requires a prolonged stay and which prevents return to his or her country of origin, where there would be risks to his or her health;
- present a travel document or a valid passport;
- present proof of accommodation;
- present proof of subsistence means;
- present a request for the consultation of the Portuguese criminal register and a document of any relevant police record, or absence of such record, from his or her country of origin.

Permits, if granted, are valid for one year and renewable for a period of two years.

IN GERMANY (DE)

The survey took place in Open Med, the *Médecins du Monde* healthcare and advice clinic for people without health insurance in Munich. Twenty-four people were interviewed (representing 80% of the undocumented migrants attending the centre during the survey period).

Médecins du Monde works in collaboration with another organisation – Café 104 (specialised in undocumented migrants' rights)—to ensure that people with problems accessing healthcare (undocumented migrants, people without health insurance) can have access to basic medical care. A team of volunteer doctors receive patients and provide primary care. For problems linked to dental care or to pregnancy, patients are referred to a network of partner health professionals. Psychosocial support and legal advice are provided to those who need it.

Access to healthcare in Germany

Health insurance has been compulsory for the entire population in Germany since the recent health reforms. The system is based on subsidiarity and solidarity and the contributions are based on income. There are some exceptions e.g. independent workers and students aged over 30 or who have spent more than 14 semesters in the university system, who mostly have to take out private health insurance. In this case, contributions are not related to income, but to the health of the individual. The system also provides for payment of 10 euros per quarter for a consultation with a general practitioner or a specialist and for dental care, 10 euros per day for hospitalisation and a contribution of 10% towards the price of medicines (maximum 10 euros per prescription). Poor people can be exempted from co-payment.

Although the legislation is national, there are differences in interpretation and implementation between different *Länder*—and even between towns.

Asylum seekers

In Germany asylum seekers do not have the same access to healthcare as nationals. They obtain equal rights only after they have spent 48 months in the country. During this period they are only entitled—under the law on services for asylum seekers—to emergency care (including dental care), maternity services, compulsory vaccinations, preventive medical tests and, in some cases, to dental prostheses. In some cases, care providers do not differentiate between acute and chronic complaints, because it is almost impossible to do so and also because it collides with ethical principles

Children of asylum seekers have access to the same care as adults. However, the law allows children to benefit from other care, depending on their specific needs.

Undocumented migrants

Undocumented migrants have, in theory, right to the same services as asylum seekers. However, members of the public administration, including social services (which are charged with covering the healthcare costs of undocumented migrants) have an obligation to report any undocumented migrant they meet in the course of their work to the immigration authorities. As a result, undocumented migrants do not seek healthcare for themselves or their children, even in serious cases, because they are worried about being reported and deported.

They also try to pay privately or use other people's card.

According to the law on infectious diseases, undocumented migrants are entitled to counselling, screening for infectious conditions and to outpatient care (sexually transmitted infections, tuberculosis etc). The law also includes provision of HIV/AIDS treatment. The obligation to report undocumented migrants, however, effectively prevents access to healthcare.

In this context, some doctors and hospitals try to provide free diagnostic tests and treatment for people transferred from NGOs ; in some cases, the care-giving professionals are doing much more than the legal system allows. Several town councils or local private initiatives are also trying to facilitate access to healthcare for all, including undocumented migrants (e.g. Munich, Berlin, Frankfurt, Bremen, Cologne...). In some regions funds financed by taxes or donations to cover the costs of medical care for undocumented migrants are also being implemented.

Children of undocumented migrants

In theory, children of undocumented migrants have access to the same services as child asylum seekers.

Like adult undocumented migrants, however, children should be reported to immigration services. Undocumented migrants, therefore, do not seek care for their children for fear of deportation from the country.

Protection of seriously ill foreigners (who do not have real access to treatment in their country of origin)

The removal of a foreign national who is ill can be postponed if the deportation is not possible because of their poor health. An undocumented migrant can obtain a *Duldung* (temporary leave to remain) for medical reasons (e.g. for pregnancy, post-traumatic stress disorder (PTSD), or a condition which prevents the deportation being carried out) by applying under article 60(a) of the law on residence. Article 25 of the same law states that a foreign national can be permitted to stay in Germany if urgent humanitarian reasons, personal reasons or public interest reasons require his or her presence in Germany. People who have been granted a *Duldung* have access to the same services as asylum seekers.

Deportation can be blocked if access to treatment for a serious illness which is life threatening, or which could lead to a serious deterioration in health, does not exist in the country of origin. In such cases the individual can obtain a residence permit and can have access to the same services as asylum seekers and, later, as German welfare recipients.

IN SWITZERLAND (CH)

Only 11 people were interviewed in a clinic run by one of *Médecins du Monde's* partners, *FriSanté*, in Fribourg. Of the people seen and who fulfilled the inclusion criteria, only six were not interviewed – the main reasons for their refusal were fear, disorientation, not wanting to respond or because they could not speak the same language as the interviewer.

The programme aims to facilitate and guarantee access to healthcare and to prevention for anyone who cannot access the mainstream health system. It also aims to encourage the respect of patients' rights and the rights of their families. The team provides nursing consultations and refers people to a network of private sector health professionals.

Access to healthcare in Switzerland

The Swiss health system is based on compulsory insurance for all Swiss residents. The insured pays the insurance company a monthly premium – which can be as much as 340 euros depending on the *canton* and the services. The person insured pays an excess of between 200 and 1,700 euros as well as 10% of their medical, inpatient and treatment charges up to a limit of 480 euros. The higher the excess, the lower the monthly premium. The poorest people, therefore, often choose a policy with higher excess, and this can lead to huge problems, and refusal to seek care, when they fall ill because they cannot pay the costs incurred.

In order to ensure access to healthcare, the *cantons* can grant subsidies to people on low incomes—this can be as much as 100% for people living in social exclusion.

Undocumented migrants

Undocumented migrants can only have access to healthcare when they have taken out health insurance. Like everyone else living in the country, they have the right—and the obligation—to insure themselves. This requires presentation of an identity document and proof of address. However, most undocumented migrants do not have the means to pay the insurance premiums because they live and work in poor conditions. Moreover, the slightest delay in premium payments can lead to a cost-recovery process that can result in undocumented migrants being reported to the authorities. The non-payment of health insurance premiums leads to a suspension of reimbursement of costs for current or subsequent treatment. For these reasons, many undocumented migrants do not take out any insurance.

In theory, action could be taken against doctors who help undocumented migrants.

Children of undocumented migrants

The children of undocumented migrants are subject to the same restrictions as their parents. Dental care—which is already difficult for residents' children—is largely inaccessible for financial reasons.

Education is compulsory for all children in Switzerland. Parents can, therefore, register their children in schools for the compulsory curriculum (primary and lower secondary). School doctors and paediatricians work in all schools. Each child in education, therefore, has access to a free programme of vaccination and prevention (weight, sight, hearing etc.) If the school doctor detects a problem, they will inform the parents who must take action to have the child treated. In addition, a school dentist carries out screening (once or several times a year) and prevention work. As with the school doctor, if the dentist identifies a problem, they inform the parents who then have to organise and pay for the treatment.

Protection of seriously ill foreigners (who do not have real access to treatment in their country of origin)

The option to grant regular immigration status on medical grounds exists in Switzerland. The federal law on foreigners (LEtr), which came into force on 1 January 2008, states in article 83 al.1 that *“the office decides to provisionally admit the foreigner if it is not possible or lawful to carry out the deportation or carrying it out cannot be reasonably required”* Section al.4 states that *“the execution of the decision cannot be reasonably required if the deportation of the person to their country of origin or provenance, puts him or her in real danger in cases such as, for example, war, civil war, widespread violence or medical necessity”*.

The process is done through an association (Caritas, Geneva AIDS Group etc). It is a long process that starts at the cantonal level—and varies between the cantons depending on their policies— then moves to the federal level if it is successful at the first stage. While the case is under consideration, the person is granted a short-term permit. If the case is approved, the person will be granted an F or B permit which enables them to stay in Switzerland and entitles them to work. If the application is not accepted, the person is deported.

The associations defending these cases, including Geneva AIDS Group, regularly appeal against official decisions, because the decision making process does not pay enough attention to certain practical factors which hinder the accessibility of treatment in the country of origin. These factors include transport problems and disruption in the supply and storage chain, which can be serious enough to risk the life of the deported individual.

2. SURVEY METHODOLOGY AND DATA ANALYSIS

- **Survey design and interview process**

The questionnaire²³ focused on the social situation and living conditions of undocumented migrants, as well as on their health status and their use of medical services. It comprised 77 questions and, of these, 73 were addressed to the respondents, 10 questions were strictly medical, and the majority were closed questions. The structure of the questionnaire, identical in all the countries, was adapted to the respective legislation and health systems. The questionnaire from the 2005-6 European Observatory survey on access to healthcare was reviewed and improved, particularly in relation to questions concerning reasons for migration, work, violence and health.

The number of people interviewed in each country depended both on the scale of the *Médecins du Monde* programmes in the country and on practical considerations, such as the availability of people to carry out the interviews. In some countries, partner organisations were mobilised in order to increase the number of people who could be interviewed. **The protocol required that people participating in the survey were selected randomly**, by constituting an exhaustive sample of all undocumented migrants seen during one or several given periods, or (less often) by systematic sampling of a fraction of the eligible people attending. In this way, the recruitment bias observed in the previous survey has been reduced. The detailed data collection protocols for each country are given in the appendices.

The large majority of interviews were carried out by volunteers from the programmes involved in the survey. These volunteers had received specific advance training for this task. Each questionnaire took between 30 and 45 minutes to complete (excluding the medical section). Usually, and whenever possible, the medical section was completed by a doctor. In some cases, however—particularly in Spain, Greece and Portugal—this section was also completed by other health professionals,²⁴ depending on the internal organisation of the programmes.

In order to include people who do not speak the language of the survey country into the sample, the interviewers had access to people who could provide interpretation where necessary (*Médecins du Monde* volunteers or people who accompanied the respondents) in 8 of the 11 countries.²⁵ In total, 17% of the interviews were carried out with the help of an interpreter. However, the language barrier was often a reason for non-participation, when translation into the survey language was not possible. Less often, people refused to participate for reasons such as a lack of time, or interest in the survey.

23. See the questionnaire in the appendices.

24. The "health" section of the questionnaire was administered by health professionals in 85% of cases. In 58% of cases, this was a doctor, in 12% of cases a nurse carried out the interview and in 15% of cases it was another health professional (e.g. psychologist, care assistant, midwife). In 7.5% of cases a medical student (at the end of their second cycle) completed this section and in 7.7% of cases it was another interviewer.

25. This relates to Germany (seven out of 24 interviews), Belgium (22% of interviews), Spain (10%), France (19%), Greece (17%), the Netherlands (10%), the United Kingdom (41%) and Sweden (28%).

- **Analysis and report preparation**

The analysis was carried out by two researchers from the social determinants of health and health service use department of the National Institute of Health and Medical Research (*Institut national de la santé et de la recherche médicale* – INSERM). They were: Dr Pierre Chauvin, epidemiologist and Inserm researcher, and Isabelle Parizot, sociologist and researcher at the national scientific research centre (*Centre national de recherche scientifique- CNRS*). They worked in close collaboration with *Médecins du Monde's* observatory on access to healthcare team. Several meetings with the principal investigators in each country enabled more in-depth analysis by consideration of the statistical data alongside the experience of field actors. In this way, the Observatory team provided additional input to the report. Finally, the report was sent to all European teams for review and comment before translation. Data were analysed with the SPSS statistical analysis programme at Inserm and are also available at *Médecins du Monde* France headquarters.

- **Presentation of results**

Given the small sample sizes in Germany, Portugal and Switzerland, this report does not present specific analyses for these three countries. The data collected in these countries, therefore, are not used for international comparisons (unless specifically indicated otherwise). The data are, however, included in the whole sample for general analyses (in particular in the “total” line in the tables and figures).

Bearing in mind the limits outlined in the introduction and the large disparity in number of survey sites in each country, **the designations and references to countries²⁶ in the rest of this report should be taken for what they are: conventions for presenting results to avoid the need to fastidiously repeat “the people interviewed in the programmes involved in the survey in country X.”** So each time that a particular country is referred to (e.g. “in Spain, the frequency of seeking healthcare is”, “the Netherlands and Sweden have similar levels of”) **it is clear that we do not imply that the results observed here are representative of the situation of all undocumented migrants in the country in question.** This is particularly true in the countries where the survey only took place in a limited number of locations, such as France (where, for example, Marseilles was not included in the sample even though it has a large undocumented migrant population), in Greece (where only Athens and Thessalonica were survey locations), the United Kingdom (where the survey only took place in London), in Sweden (in Stockholm), in Italy (Milan) and so on.

In the figures, the ISO country codes are used instead of the full country names.

BE	CH	DE	EL	ES	FR	IT	NL	PT	SE	UK
Belgium	Switzerland	Germany	Greece	Spain	France	Italy	Netherlands	Portugal	Sweden	United Kingdom

For all versions and in order to facilitate the work of the translators, a comma is used to separate whole numbers from decimals.

- **Interpretation of results and figures**

In the many figures presenting proportions or frequencies, the percentage observed is represented by a full bar and the value is indicated in the figure. This is accompanied by a line illustrating the 95% confidence interval (or 95% CI) of the observed value. To recap, there is a 95% probability that this confidence interval contains the real percentage value that we are trying to estimate (in cases where this estimation is calculated on a randomly chosen sample). Because the people interviewed were chosen by chance in the survey locations, this confidence interval quantifies in a way the uncertainty of the observed value in the populations surveyed (the smaller the sample size, the more uncertainty there is and the wider this 95% confidence interval).

26. The abbreviations of country names used in some figures and tables are those recommended by the EU publications office (See <http://publications.europa.eu/code/fr/fr-370100.htm>).

When two or more results are subject to a simple comparison (percentages, proportions, averages), it is often indicated that the results are, or are not, “significantly different.” This is a shortened version of the term “statistically significantly different” which means that it is very unlikely that the difference observed occurred purely by chance. The degree of significance (noted as a “p” value) is sometimes indicated. This value measures the degree of confidence that we can have in the fact that the difference observed is not due to chance (if it is more than 0.05, by definition and by convention, the difference is not significant.)²⁷

In addition, because the figures have been rounded up or down, it is possible that in some tables where percentages are shown, the sum is not always equal to 100.

In some cases, “multivariate” analyses have been carried out. This relates to analyses carried out with statistical models of logistic regression, which aim to estimate the relationship between a characteristic (e.g. sex) and an event (e.g. health status) by taking other characteristics into account at the same time (e.g. age, living conditions). The importance of this relationship is expressed as an Odds Ratio (OR) which represents the higher or lower level of risk statistically associated with different values of the characteristic in question (one of these values having been taken as a reference²⁸), with all other things being equal concerning the other characteristics under consideration. The OR is also subject to a 95% confidence interval. When this confidence interval includes the value 1 (equal risk, in other words), the relationship observed is not statistically significant.

27. This p value represents the probability of having just as big a difference (or an even greater difference) than that observed in the case where there is not, in reality, any difference. For example, if the proportion of single people is significantly different for men and for women with $p=0.01$, this means that, if in reality this proportion is identical in the two sexes, the risk of observing a difference as large as that witnessed in our sample is one per cent. This does not mean directly, contrary to popular belief, that the probability of having such a difference is 1%.

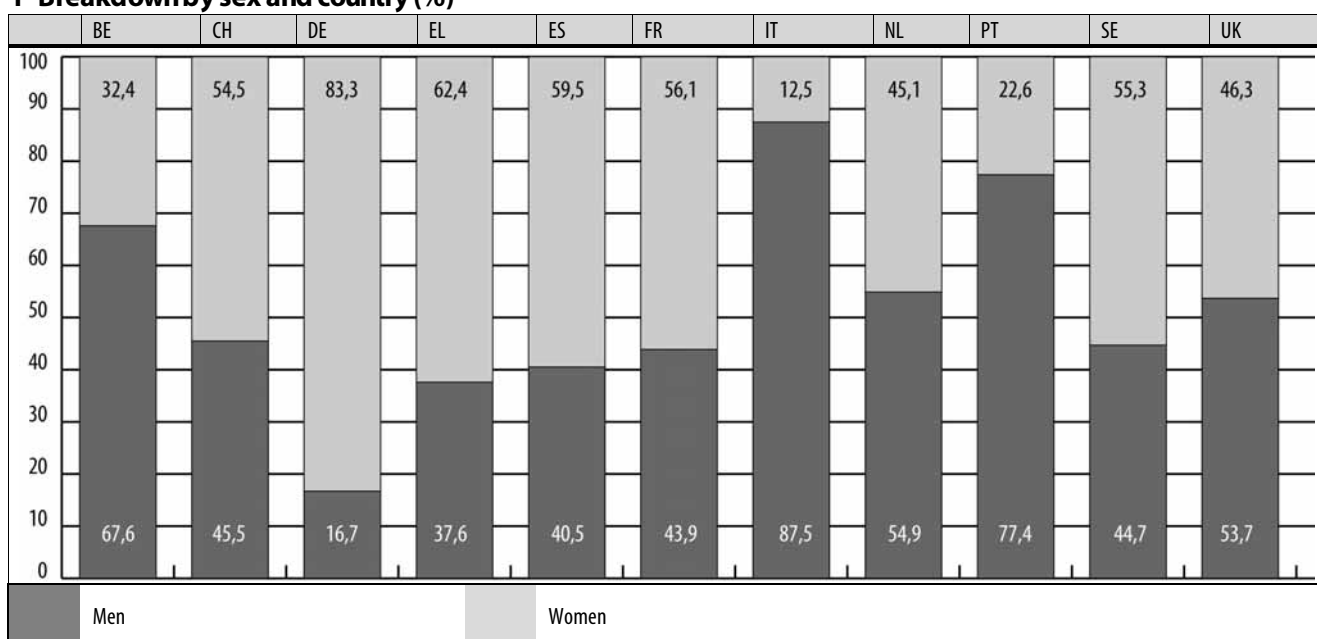
28. This reference can have a meaning (for example, if we want to estimate the risk associated with the presence of a factor, the reference chosen is naturally the absence of that factor) or can be purely conventional. When the factor studied is the survey country (in order to make multivariate comparisons of results observed in different countries), we have made an arbitrary choice in this report to use Sweden as the reference country to enable all the other countries to be ranked against each other and relative to Sweden. We could, of course, have chosen any other country– this does not change the relative ranking of countries.

3. DEMOGRAPHIC CHARACTERISTICS

- Sex and age

The population interviewed is made up of roughly equal numbers of men (50.9%) and women (49.1%).²⁹ This distribution varies considerably from one country to the next—mainly because of the different services offered by the facilities in the survey locations. In the countries where the services were mainly general practice—as in France, the Netherlands, Sweden, Switzerland and the UK—the sex ratio is more even than in countries such as Italy where the programmes are aimed at homeless people and drug users. The imbalances observed in Germany, Belgium and Greece result by chance, because the services provided in these countries are generalist in nature.

1- Breakdown by sex and country (%)



The survey population is relatively young. **More than half (55%) of adults interviewed were aged under 35.** People aged 55 years or over only accounted for 8% of the sample. On this issue, Greece and, to a lesser degree, France differ from the other countries with, respectively, 19% and 11% of the adults interviewed aged 55 years or over.

29. Nine people were described as transgender and, as instructed by the interview guide, interviewers recorded their current apparent gender (specifically female).

In all countries, the average age of respondents was between 30 and 39 (average 36). Spain and Italy differ in that they have a relatively low average (33 or 32 years), while France, Greece and the Netherlands have a relatively higher average (37, 39 and 37 years on average)³⁰

2- Age of respondents, by country*

	BE	CH	DE	EL	ES	FR	IT	NL	PT	SE	UK	Total
Average age	36 yrs	35 yrs	38 yrs	39 yrs	33 yrs	37 yrs	32 yrs	37 yrs	40 yrs	35 yrs	37 yrs	36 yrs
Minimum age	18 yrs	24 yrs	18 yrs	18 yrs	18 yrs	18 yrs	19 yrs	19 yrs	19 yrs	20 yrs	20 yrs	18 yrs
Maximum age	72 yrs	47 yrs	60 yrs	76 yrs	72 yrs	73 yrs	57 yrs	63 yrs	59 yrs	80 yrs	72 yrs	80 yrs
Age groups												
18-24 yrs	11,6 %	9,1 %	16,7 %	16,9%	24,5%	15,6 %	27,6 %	14,7 %	6,5 %	12,7 %	10,2 %	16,9 %
25-29 yrs	20,5 %	9,1 %	25,0 %	14,4 %	22,7 %	20,6 %	21,4 %	13,7 %	6,5 %	17,6 %	14,8 %	18,6 %
30-34 yrs	18,8 %	27,3 %	8,3 %	21,2 %	18,1 %	15,6 %	16,3 %	17,6 %	16,1 %	30,4 %	19,4 %	18,9 %
35-44 yrs	33,0 %	45,5 %	25,0 %	13,6 %	19,7 %	22,6 %	23,5 %	30,4 %	35,5 %	21,6 %	34,3 %	24,6 %
45-54 yrs	8,0 %	9,1 %	8,3%	15,3 %	11,1 %	15,1 %	8,2 %	16,7 %	29,0 %	15,7 %	13,9 %	13,3 %
55 +	8,0 %	-	16,7 %	18,6 %	3,7 %	10,6 %	3,1 %	6,9%	6,5 %	2,0 %	7,4 %	7,7 %
N (valid)	112	11	24	118	216	199	98	102	31	102	108	1124

*Because the figures have been rounded up or down, the sum of the percentages of the different age groups may not be equal to 100.

• Nationalities

The countries of origin of people interviewed were very varied. **In total, 97 different nationalities were recorded** and 3 people were stateless (see table in appendix 5).

Almost a third of respondents (31%) come from sub-Saharan Africa (mainly from Cameroon, Nigeria and Senegal). Nearly a fifth (18%) come from the Americas (mainly from Brazil and Bolivia) while 14% come from North Africa (8% are Moroccan and 3% are Algerian) and 13% come from Europe outside the European Union (mainly from Albania and Ukraine). In addition, the nationalities of 11% were from Asia (coming mainly from the Philippines, Mongolia, India, Bangladesh and China). Finally, 7% came from the Near or Middle East (mainly Egypt, Afghanistan, Iran and Pakistan).³¹

At the time of the survey, France, Spain and Greece had already transposed Directive 2004/38/CE of the European Parliament and of the Council of 29 April 2004 on the rights of citizens of the Union and their family members to move and reside freely within the territory of the Member States.³² In transposing this Directive, these three countries have chosen to remove the right to remain for EU citizens without financial resources or without health insurance (said to be an unreasonable burden on the host country). This is how EU citizens find themselves in a “no rights” situation, along with undocumented migrants. For this reason, the teams in Spain, France and Greece decided to include migrants from within the EU in the survey. In Belgium this was only done right at the end of the process. This is why the proportion of migrants who are EU citizens is largely under-estimated in this survey.

3- Breakdown by region of origin (%)

	Sub-saharan Africa	Americas	North Africa	Europe (non EU)	Asia	Near and Middle East	European Union	Stateless	Total
Number	346	205	152	142	128	80	67	3	1123
%	30,8	18,3	13,5	12,6	11,4	7,1	6,0	0,3	100

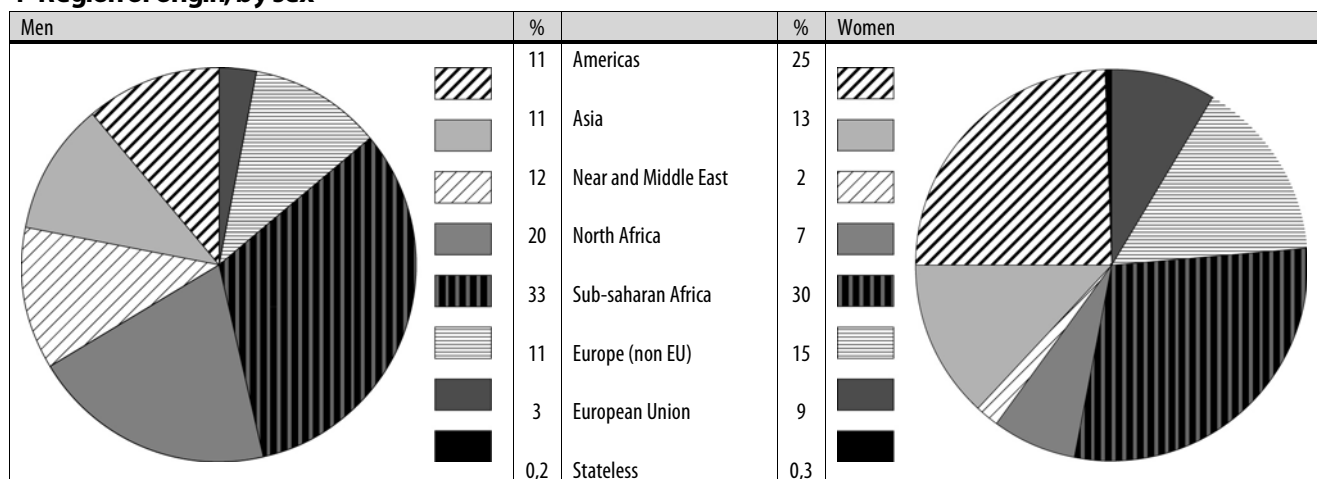
30. Since the survey only includes adults, these averages are higher than the average age of patients attending the *Médecins du Monde* centres (many of which also welcome children).

31. The categorisation of countries into continental groups is based on the *L'Etat du monde*, published annually (cf. Badie B., Tolotti S., *L'Etat du monde 2009*, Paris, La Découverte, 2008, 324 p).

32. Since our survey most European countries have transposed this directive in their own laws.

There are significant differences according to sex in relation to respondents' country of origin. Although the most common region of origin for both men and women was sub-Saharan Africa (33% for the former and 30% for the latter), 20% of men were from North Africa (compared to only 7% of women), while 25% of women originated from Central or South America or the Caribbean (compared to 11% of men).

4- Region of origin, by sex



Similarly, there were significant differences in terms of the migrants' country of origin in relation to survey country. These differences are largely due to the different immigration patterns in each country. These, in turn, relate to the geographic, economic and political situation in the country, the country's history (sometimes colonial), the history of migration patterns, and international collaboration etc. The differences observed are also related to the type of services provided in the centres where the survey took place.

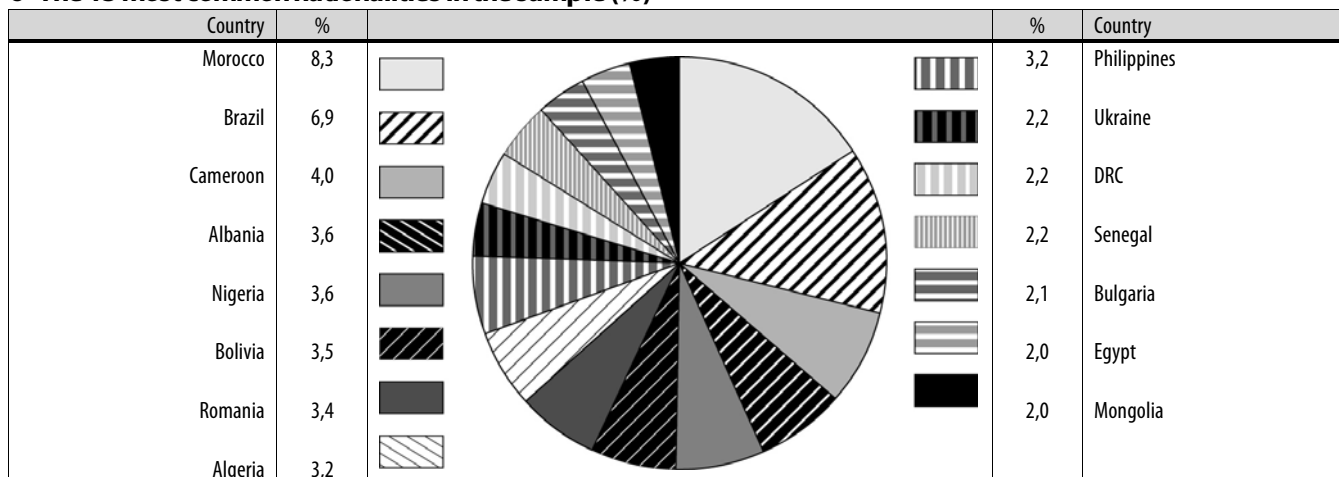
5- Region of origin, by survey country (%)

	BE	EL	ES	FR	IT	NL	SE	UK
European Union	0,9	20,5	4,6	15,6	1,0	-	-	-
Europe (non EU)	3,6	41,9	1,9	11,1	27,3	2,9	21,4	2,8
Sub-Saharan Africa	28,6	20,5	29,2	49,2	22,2	45,1	5,8	31,5
North Africa	45,5	-	12,5	16,6	24,2	4,9	3,9	4,6
Near & Middle East (incl. Pakistan)	2,7	15,4	1,4	4,0	13,1	17,7	7,8	6,5
Asia (incl. India and Bangladesh)	5,4 (1,8)	1,7 (1,7)	0,5 (0,0)	1,5 (0,0)	2,0 (1,0)	19,6 (0,0)	41,8 (10,6)	41,7 (15,7)
Americas	13,4	-	50,0	2,0	10,1	8,8	19,4	13,0
Stateless	-	-	-	-	-	1,0	-	-
Total	100	100	100	100	100	100	100	100

It is important to bear in mind that only the teams in France, Greece and, to a lesser degree, Spain included European Union nationals—who were without financial resources or health insurance and who attended the MdM programmes—in the survey. This explains the very limited numbers of EU nationals (6%) and obviously does not reflect the attendance at *Médecins du Monde* programmes, which do welcome many Europeans. If all the countries had included them, the proportions would have been different, in relation to region of origin as well as nationality (particularly relating to Romanians and Bulgarians).

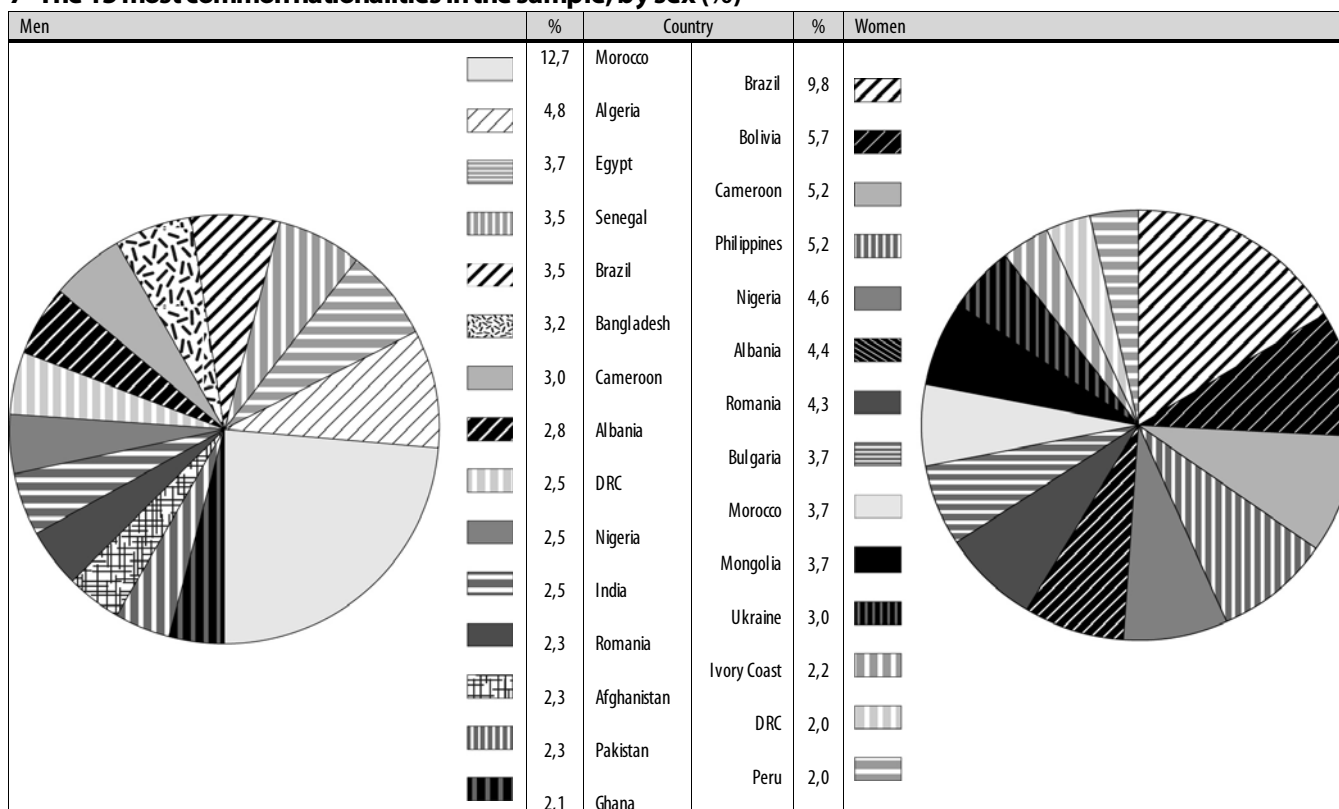
The figures below show the breakdown for the 15 most common nationalities in the sample and by sex (which are also those that relate to at least 2% of the population).

6- The 15 most common nationalities in the sample (%)



The 4 most common nationalities for women are Brazilian (10%), Bolivian (6%), Cameroonian (5%) and Filipino (5%). For men, the most common nationalities are Moroccan (13%), Algerian (5%), Egyptian (4%) and Senegalese (4%).

7- The 15 most common nationalities in the sample, by sex (%)



It is worth noting that the proportion of respondents from the Philippines in the Netherlands is linked to the fact that one of the places where the survey took place was in the premises of a Filipino association.

8- Most common nationalities by survey country (numbers) and summary of the main immigrant nationalities for each country *

BE	EL	ES	FR	IT	NL	SE	UK
Morocco : 38 Brazil : 12 DRC : 9 Algeria : 7 Guinea : 5	Albania: 30 Bulgaria: 20 Georgia: 8 Nigeria: 8 Afghanistan: 7	Brazil: 28 Bolivia: 25 Senegal: 21 Morocco: 20 Nigeria :18	Cameroon: 34 Romania: 26 Algeria: 16 Ivory Coast: 14 Congo B : 9	Morocco : 19 Ukraine : 13 Egypt : 11 Albania : 8 Niger : 5 Nigeria : 5 Tunisia : 5	Philippines : 14 Ghana : 10 Sierra Leone : 7 Uganda : 6 Sudan : 5 China : 5 Brazil : 5	Mongolia: 20 Bangladesh: 13 Azerbaijan: 11 Bolivia: 10 Philippines: 7	India : 15 Philippines : 13 DRC : 12 China : 9 Brazil : 7
Main immigrant groups by nationality* (% of total foreign migration in 2006)							
Netherlands(12%) Morocco (12 %) France (12 %)	Albania (42 %) Bulgaria (15 %) Romania (6 %)	Romania (16 %) Morocco (10 %) Bolivia (10 %)	Algeria (16 %) Morocco (13 %) China (6 %)	Romania (19 %) Albania (12 %) Ukraine (11 %)	Germany (11 %) Poland (10 %) UK (5 %)	Iraq (13 %) Poland (8 %) Denmark (6 %)	Poland (13 %) India (13 %) China (6 %)

* Source: Eurostat 2008.

4. MIGRATION

• Time period since migration

On average, respondents left their country of origin four and a half years ago (median=3.3, average=4.6, standard deviation=4.8). This average masks major differences. A fifth of respondents left his or her country less than a year ago, while one in 10 respondents left at least 10 years ago.

9- Breakdown according to time since respondents left their country of origin (%)

	%	Cumulative%
Less than a year	21,3	21,3
1 yr	14,4	35,7
2 yrs	9,9	45,6
3 yrs	10,9	56,5
4-5 yrs	15,1	71,6
6-9 yrs	18,6	90,2
10 yrs or more	9,8	100,0
Total	100	

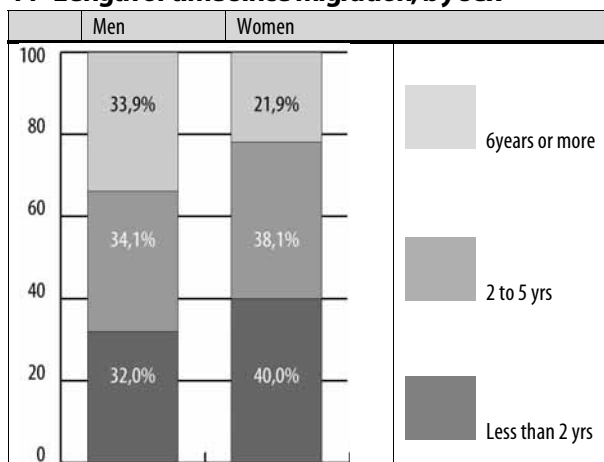
The length of time since migration differs greatly depending on the survey location. People interviewed in France had migrated relatively recently: on average they left their country of origin three years ago. For those interviewed in the Netherlands, in comparison, it has been much longer since they migrated (8 years on average, median = 7.0 years)—this may be linked to that country's very open policies towards immigrants from the 1970s to the 1990s.

10- Length of time since migration, by survey country

	BE	EL	ES	FR	IT	NL	SE	UK
Average	5,2 yrs	5,7 yrs	3,6 yrs	3,0 yrs	4,0 yrs	8,0 yrs	4,4 yrs	4,4 yrs
Distribution (%)								
Less than 2 yrs	30,6	22,4	45,8	57,3	50,0	10,3	13,6	29,0
2 to 5 yrs	36,9	33,6	37,5	27,1	22,4	25,8	67,0	45,8
6 years or more	32,4	44,0	16,7	15,6	27,6	63,9	19,4	25,2
Total	100	100	100	100	100	100	100	100

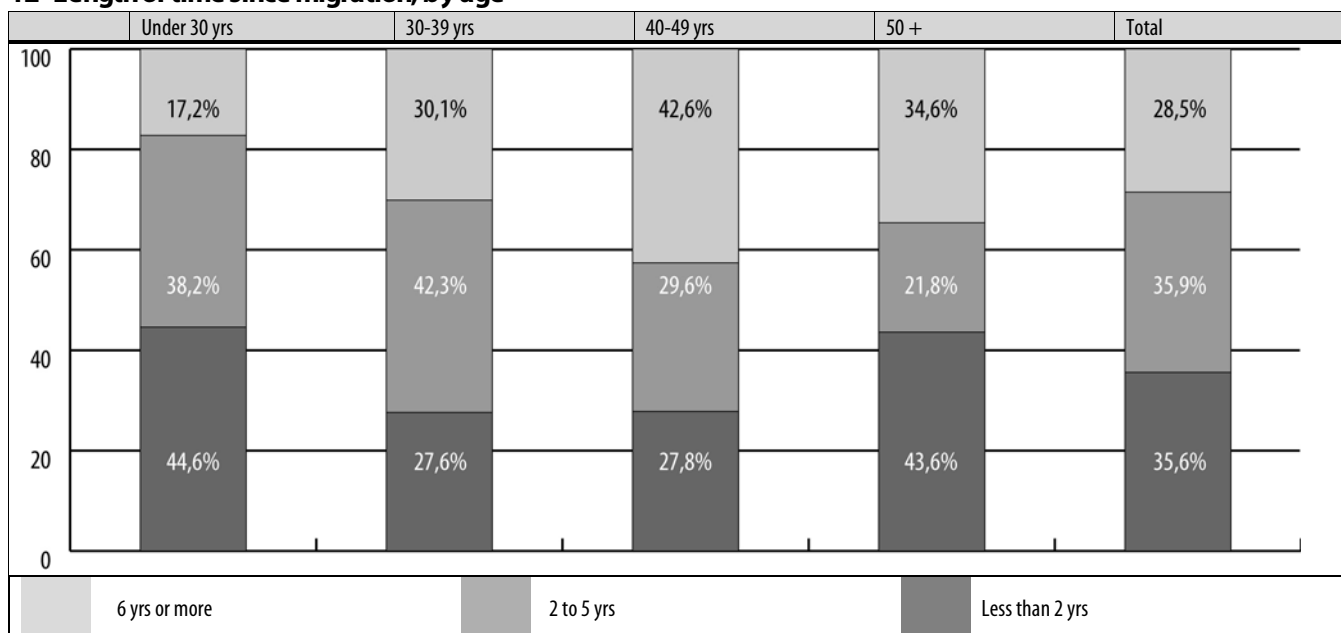
Men, on average, emigrated one year longer ago than women (5.1 years compared to 4.0 years on average). Also, the number of men having left their country of origin at least 6 years previously is significantly higher (34% compared to 22%).

11- Length of time since migration, by sex



The breakdown according to time since migration reflects the fact that migration affects men and women of different ages. Among people aged 50 or older, 44% had left their country of origin less than 2 years ago. And 17% of people under 30 had left their country at least 6 years ago.

12- Length of time since migration, by age



Migration took place longer ago for Europeans, while sub-Saharan Africans and North Africans left their countries most recently.

13- Length of time since migration, by region of origin

	Europe (non EU)	Sub-Saharan Africa	North Africa	Asia	Americas	Other*	Total
Average	5,4 yrs	4,4 yrs	5,3 yrs	4,2 yrs	3,6 yrs	4,9 yrs	4,6 yrs
Distribution (%)							
Less than 2 yrs	29,3 %	41,0 %	34,2 %	21,4 %	41,0 %	35,8 %	35,7 %
2 – 5 yrs	30,7 %	32,4 %	28,9 %	57,1 %	40,0 %	32,5 %	35,9 %
6 yrs or more	40,0 %	26,5 %	36,8 %	21,4 %	19,0 %	31,8 %	28,4 %
Total	100 %	100 %	100 %	100 %	100 %	100 %	100 %

*The "other" category includes near and middle east countries, the European Union and stateless persons.

p<10-3

- **Length of time spent as an undocumented migrant**

The majority of respondents had spent most of the time since they migrated in the survey country, where they had been for an average of 4 years (median = 3.0 years; standard deviation = 4.1). On average, they had spent 3 years there in an undocumented situation (with irregular immigration status) (median = 2.0 years; standard deviation = 3.5). This was longer for men than for women (on average 3.5 and 2.5 years respectively). The medians were 2.3 years and 1.8 years respectively, meaning that half of the men interviewed had been living undocumented for 2.3 years and half of the women had been in this situation for 1.8 years. Furthermore, **26% of men and 17% of women had been living in an undocumented situation in the country for 5 years or longer.**

14- Length of time spent as an undocumented migrant, by sex

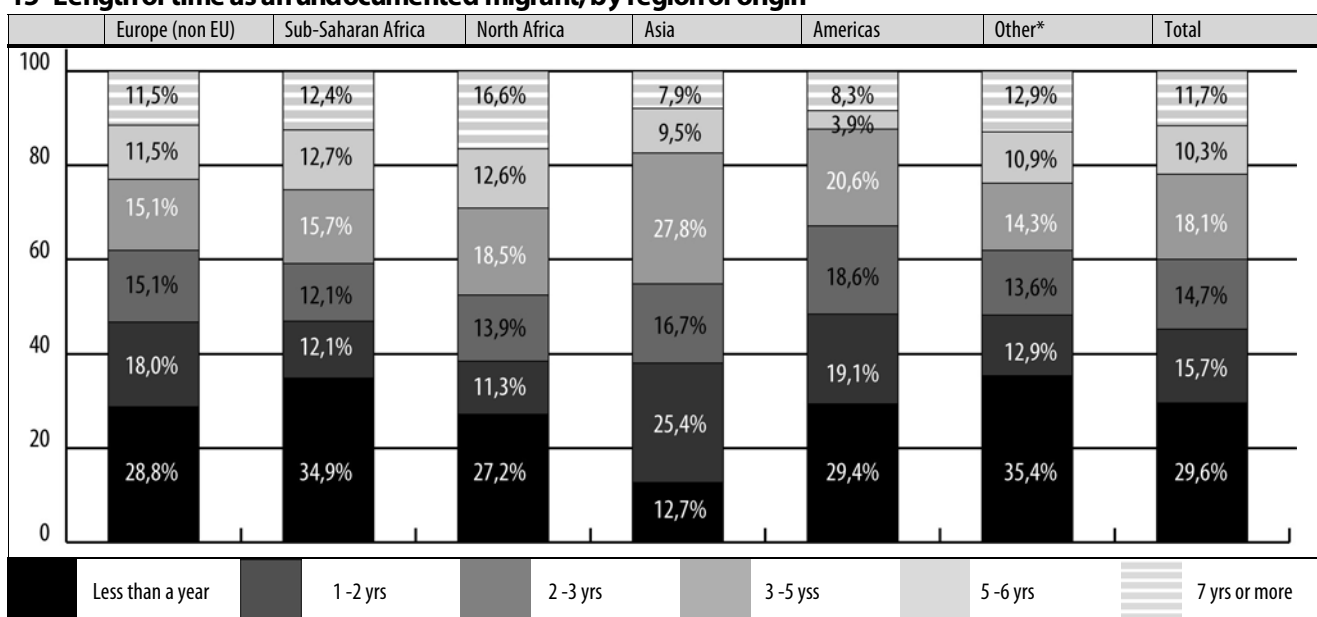
	Men	Women	Total
Average	3,5 yrs	2,5 yrs	3,0 yrs
Distribution (%)			
Less than 1 year	25,2 %	34,3 %	29,6 %
1 yr	14,6 %	16,7 %	15,6 %
2 yrs	15,1 %	14,4 %	14,8 %
3-4 yrs	18,8 %	17,3 %	18,1 %
5-6 yrs	12,1 %	8,3 %	10,3 %
7 yrs or more	14,2 %	8,9 %	11,7 %
Total	100 %	100 %	100 %

The migration pathways and the different steps, in terms of legal status, are varied. **Although around two thirds of respondents have never been in a regular migration situation in their host country, or have only had a tourist visa, the proportion of respondents who had previously been in a regular situation was far from negligible.** Thus, 18% had lived for at least 2 years in a regular situation in their current country, including 6% who had been in such a situation for 5 or more years. This relates particularly to people who had a permit that was not accepted for renewal or to asylum seekers whose claims were finally rejected.

> *P. left India and his very violent family 8 years ago, when he was 16, and arrived in Austria. His claim for asylum was refused and for 8 years he has lived on the streets. P., Indian, 24, living in Germany (Munich).*

The length of time spent as an undocumented migrant also varies by respondents' region of origin. It is, on average, longest for North Africans (3.7 years) than for the others, particularly non EU Europeans (2.8 years) and people from the Americas (2.5 years).³³

15- Length of time as an undocumented migrant, by region of origin

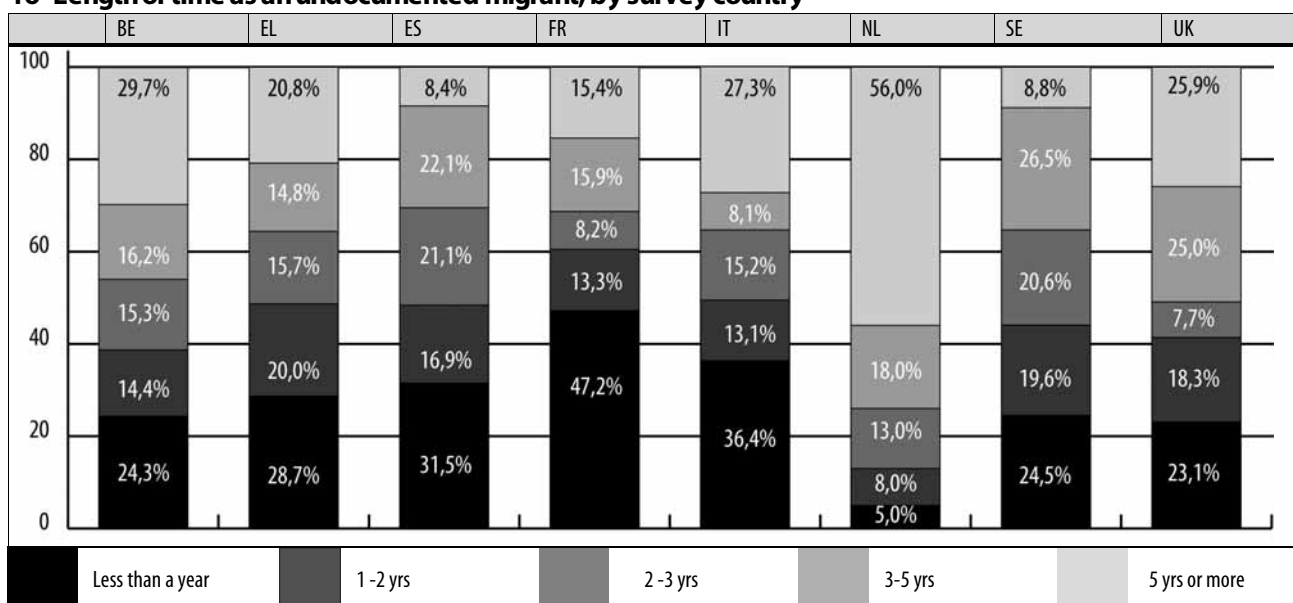


*The "other" category includes Near and Middle East countries, the European Union and stateless persons.

33. Sub-Saharan African respondents were living as undocumented migrants for, on average, 3.1 years.

Moreover (and this is obviously linked to the nationalities of origin), the length of stay in an undocumented situation varies from one survey country to another. In the Netherlands, for example, this period is, on average, longest (5.7 years). It is shortest in France and Spain (2.4 and 2.3 years), with the other countries lying between these two extremes.

16- Length of time as an undocumented migrant, by survey country



- Reasons for migration

The reasons given by respondents to explain their migration were varied but in most cases relate to problems experienced in their country of origin.³⁴ Thus, 56% of respondents said that they left their country for economic reasons or to earn a living. A further 26%³⁵ cited political, religious, ethnic, sexual orientation reasons or to escape war—in other words for reasons which, in theory, give the right to asylum (even if the host countries are far from recognising all these migrants as refugees).³⁶

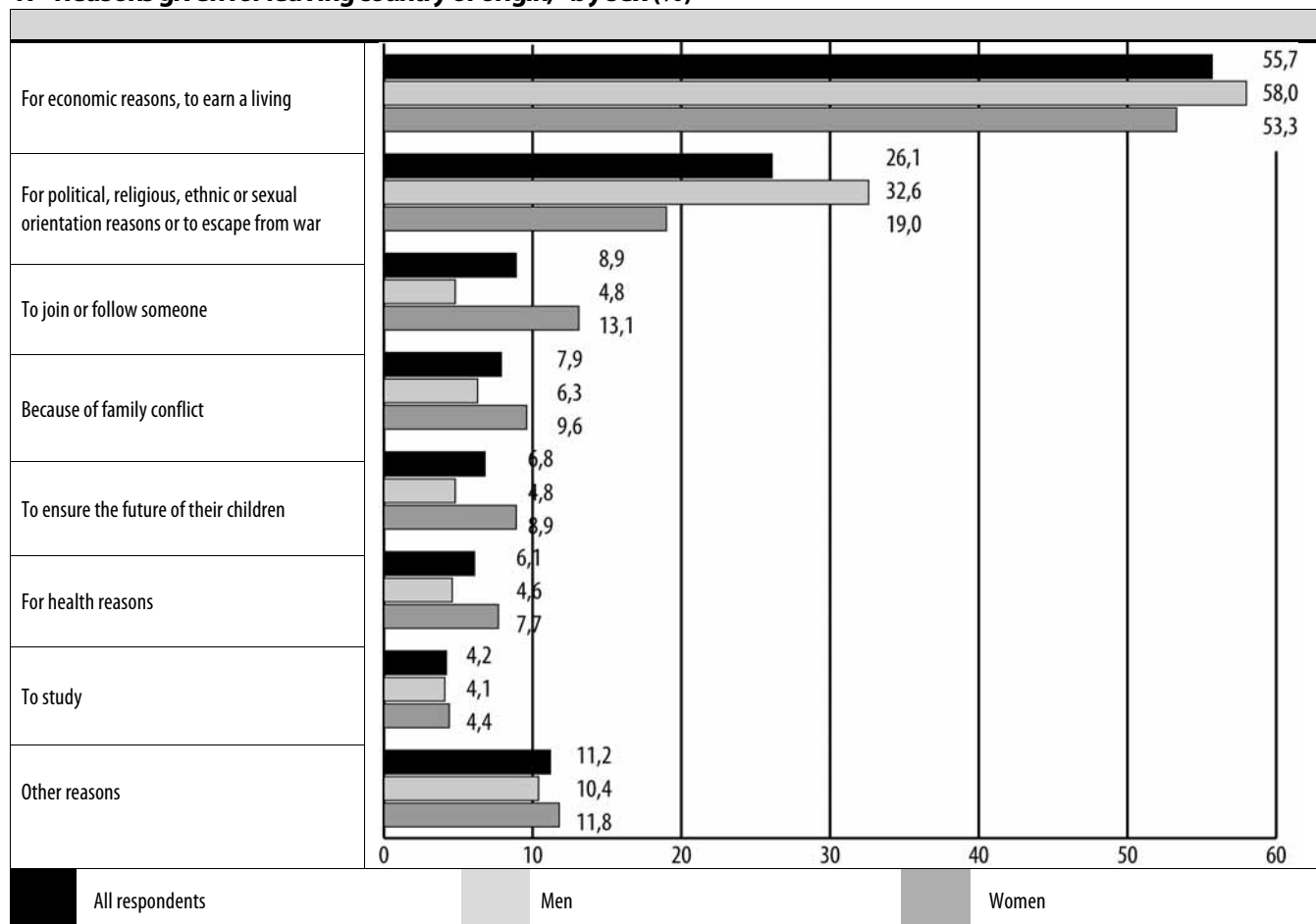
A small proportion of the respondents said they had not emigrated to flee particularly difficult conditions but instead to “discover the world” (these reasons are included in the “other reasons” category in the table below).

34. It is important to emphasise that this question triggered very powerful emotions in respondents, because of the pain they felt in thinking of the period before migration. Some respondents, therefore, had difficulty expressing the reasons for their departure.

35. 33% of men and 19% of women.

36. Bearing in mind that the rate of granting refugee status is currently low in all industrialised countries, and particularly in Europe, where it is around 20%—in other words, at the first decision, four times as many asylum seekers are refused as the number recognised as refugees (James R, “L’harmonisation des politiques d’asile en Europe”, Paris, ENA, Mémoire de Master, February 2004). Also bearing in mind that countries are not all affected in the same way by requests for asylum. The numbers of asylum requests in France, Germany, the United Kingdom and the Netherlands are at relatively low levels, historically. In Germany, for example, the number of asylum requests is lowest since 1977, in the Netherlands since 1988, and in the United Kingdom since 1989. On the other hand, some countries are witnessing large increases: + 49% in Sweden, + 105% in Greece, + 35% in Italy, + 41% in Spain (Henry P., “Asile : trompe l’œil et désordre”, Paris, France terre d’asile, 2008).

17- Reasons given for leaving country of origin,* by sex (%)



*Since each person can cite several reasons for migrating, the percentage totals are above 100.

- > *M. spent four years in prison in Zimbabwe, where he was tortured because he is gay (which is not tolerated in Zimbabwe). He still suffers from the physical and psychological aftereffects. M., Zimbabwean man, 32, living in the Netherlands*

- > *"They had already excised³⁷ me once before, and they said that they were going to do it again, as they had done to my sister – she died. She was 17. So I was afraid and I asked for a visa and came here." D., Ivorian woman, 26, living in France.*

- > *"I decided to come here because in Brazil, three years ago, we experienced a crisis – my ex-husband was unemployed and I had a lot of debts. In the beginning, I was meant to come first and my husband and two children should have joined me. But because it is difficult for a child of 13 who does not speak the language to adapt to a school, I decided that they would all stay there and that I would work here." Brazilian woman, 44, living in Spain.*

- > *"I came to the UK for economic reasons. I had had a kidney transplant in the Philippines a few years ago. The operation left me with a debt of 12,000 euros. The doctor prescribed very expensive immunosuppressant drugs for me. My salary as a civil servant was not enough to even begin to repay the debt. My only option was to leave my country and find better paid work elsewhere. I didn't come to the UK for medical treatment, and actually since I arrived I have never been to see a doctor. P., Filipino, living in the United Kingdom.*

37. This refers to the process of female genital mutilation (FGM).

Only 6% of respondents cited health as one of their reasons for migration. As it was put, the question asked implied personal health reasons, although this was not specified. Some people, however, seem to have given a positive response when the migration was actually linked to health of a member of their family. Women more commonly cited health reasons (8%) than men did (5%). This could be explained in part by the fact that, traditionally, women take care of the health of family members (children, parents etc). **We can see that the frequency with which health reasons are cited does not correlate with whether or not the legislation is favourable towards access to healthcare for undocumented migrants.** In particular, although 10.1% of respondents in France (a country relatively favourable towards access to healthcare for all) cited health as one of the reasons for migration, 8.5% of respondents in Greece and 7.8% of respondents in Sweden gave health reasons even though both these countries are among the least favourable. Similarly, we see that in Spain—where the legislation is the most clearly favourable—only 4.2% of people give health as one of the reasons for migration. **We do not, therefore, see in this survey the “pull factor” of migration for healthcare that is often highlighted in political debate.**³⁸

18- Reasons for leaving country of origin, by survey country* (%)

	BE	EL	ES	FR	IT	NL	SE	UK	Total
For economic reasons, to earn a living	46,4	55,9	76,4	51,3	92,9	36,3	27,2	38,0	55,7
For political, religious, ethnic or sexual orientation reasons or to escape from war	34,8	22,0	9,3	21,6	7,1	44,1	54,4	46,3	26,1
To join or follow someone	12,5	11,0	4,6	15,1	4,0	3,9	6,8	10,2	8,9
Because of family conflict	11,6	5,1	5,6	9,5	12,1	4,9	9,7	8,3	7,9
To ensure the future of their children	6,3	11,0	11,6	4,5	1,0	9,8	5,8	4,6	6,8
For health reasons	6,3	8,5	4,2	10,1	1,0	4,9	7,8	3,7	6,1
To study	4,5	1,7	6,0	4,5	3,0	3,9	6,8	2,8	4,2
Other reason	18,8	3,4	8,3	15,1	0,0	11,8	11,7	12	11,2

*Since each person can cite several reasons for migrating, the percentage totals in the columns are above 100.

It was non-EU Europeans (e.g. from Albania, Ukraine) who most commonly gave health as one of their reasons for migration.

19- Reasons for leaving country of origin, by region of origin* (%)

	Europe (non EU)	Sub-Saharan Africa	North Africa	Asia	Americas	Other
For economic reasons, to earn a living	50,0	41,6	68,4	53,9	72,7	58,9
For political, religious, ethnic or sexual orientation reasons or to escape from war	28,9	39,9	13,2	28,1	6,3	29,8
Because of family conflict	8,5	7,8	11,2	10,9	4,4	6,6
To ensure the future of their children	9,9	3,8	7,2	8,6	10,7	3,3
For health reasons	9,9	8,7	7,9	1,6	2,4	4,0
To join or follow someone	12,7	8,1	8,6	7,0	9,8	7,9
To study	4,2	3,5	4,6	3,1	7,3	2,0
Other reason	4,9	13,6	11,2	14,8	13,2	6,0

*Since each person can cite several reasons for migrating, the percentage totals in the columns are above 100.

> *“When I was 10, I came home from school to find my parents, my sister and my older brother dead. The 10 or so houses around our own were in an area where the Taliban and other people fought. One day they killed my family and my neighbours, because they happened to be there. I looked for my little brother, but I didn’t find him. I had to stop school and live on the streets. When I was 12, I heard a man talking about illegally transporting people to Iran. I told him that my big brother was there and that he would pay him. After a journey in a lorry and walking in the mountains for 10 days, we arrived in Tehran. The man beat me when he realised that I had lied to him and he made me work on building sites for a long time to be able to reimburse him. I wanted to go to school, but immigrants are not allowed to.*

Some friends told me that it was different in Europe. When I was 16, I found some smugglers who put me, with 6 other men, in the baggage hold of a bus for 12 hours until we reached Turkey. Again, we had to walk

38. Also, see chapter 8 for a description of health problems already known about in the countries of origin.

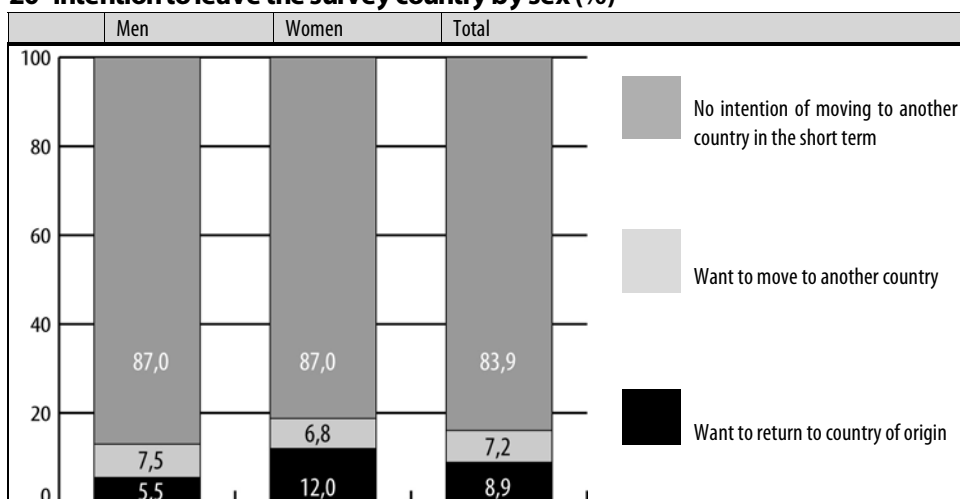
across the mountains and take another lorry. Then we stayed hidden for 6 days in a stable with 50 men. Another lorry arrived with 30 men. There were 80 of us. They crammed us into a lorry with no water or food. In Istanbul, they hid us in a cave where we could not speak nor move in case we were arrested. I was frightened.

I handed over all my savings and several of us were able to buy transport from traffickers with small boats. After travelling for four hours, frozen in the middle of winter, we arrived on the island of Lesbos. The police arrested us in a village, took us to hospital then locked us up in a prison-like centre for three days. We shouted a lot and they let me go. I took a boat for Piraeus and then I went to Patras. I was dreaming of going to France. After three missed attempts, I went into a village and collected oranges for four months, but the living conditions were horrible and I said to myself that I didn't deserve this life, that my dream was to study and I would make it. I left for Athens, where I learnt that it was possible to apply for asylum. I was sent to Thessalonica where I live in a centre for refugees. I go to school and I want to become a doctor. I do not want to sleep on the streets and beg. I'm afraid that that is what is going to happen to me. When I began this journey from Afghanistan I knew that the route could be very dangerous for a boy of my age. I knew that I could die. But I wanted to leave all those bad memories behind, these bad years and live a normal life. As soon as I can, I want to try and find my brother." V., Afghan, 17, living in Greece, the Médecins du Monde team in Thessalonica treated him for a health problem that he has had for several years.

- **Future plans: most people intend to stay in the host country, some will leave**

When asked about whether they intend to leave the survey country and move to another country in the near future, **less than 10% of respondents said that they wanted to go back to their country of origin and 7% to move to another country.**³⁹ We must emphasise, of course, that this relates to a declared intention, it does not mean that the person would have the will, or even the resources, to be able to achieve this. Proportionally more women than men wanted to return to their country of origin (while there were no significant differences according to age or marital status) and this can be largely explained by the fact that their children were still in the country of origin.

20- Intention to leave the survey country by sex (%)



* All countries except Italy

39. This question concerns the whole sample except for the people interviewed in Italy.

The desire to leave the survey country varies with respondents' parental situation. **Those respondents with children (minors) whom they don't live with most commonly intend to return to their country of origin** (14% compared to 9% of the entire survey sample)—probably to be able to join their children.

21- Intention to leave the survey country, by parental situation (%)

	Does not have any children under 18	Does have children but does not live with them	Does have children and lives with at least one of them	Total *
Wants to return to country of origin	8,1	14,0	4,9	8,9

* All countries except Italy

There are also significant differences between host countries and survey countries. **Greece appears to be a transit country more than the others**—11% of respondents in Greece intend to leave the country soon to migrate to another country (not their country of origin).

In Spain, a high proportion of respondents intend to return to their country of origin. This may be linked to the fact that migrants of South American origin—who declare this intention more often than other groups (see below)—represent half of the Spanish sample (more than in the samples in the other countries). In addition, a relatively large proportion of the respondents in Spain are women from South America whose families have stayed at home—their migration is seen as a transitional phase, a time to earn money before going back to their families.

22- Intention to leave the country, by survey country (%)

	BE	EL	ES	FR	NL	SE	UK
Want to return to country of origin	2,7	6,8	19,9	4,1	5,1	6,8	8,5
Want to move to another country	9,1	11,0	7,9	4,6	6,1	1,0	5,7
No intention of moving to another country in the short term	88,2	82,2	72,2	91,4	88,8	92,2	85,8
Total	100	100	100	100	100	100	100

In our sample, people who come from Central or South America (particularly, Bolivians or Brazilians) most commonly declare that they intend to return to their country of origin in the coming months. They are also more likely than the average (as are people from the European Union and Sub-Saharan Africa) to have lived in the survey country for less than a year.

23- Intention to leave the survey country, by region of origin (%)

	Europe (non EU)	Sub-Saharan Africa	North Africa	Asia	Americas
Want to return to country of origin	5,2	5,4	3,2	7,2	21,5
Want to move to another country	2,6	7,6	9,5	2,4	7,7
No intention of moving to another country in the short term	92,2	87,1	87,3	90,4	70,8
Total	100	100	100	100	100

• People who left their country during the last year

We can take a closer look at the situation of people who emigrated during the last year (in other words, less than a year ago) – a group that represents one fifth of the sample (21%).⁴⁰ It relates most commonly to women, 25% of them are in this situation compared to only 18% of men. This group has, on average, the same age as people who migrated longer ago (35 years compared to 34). More of them, however, are under 30 (43% compared to 34%) or are at least 50 years old (16% compared to 11%).

40. For all this section, refer to tables in the appendices.

The proportion of migrants who arrived very recently is highest in France, Italy and Spain among the survey respondents.

24- Proportion of people who migrated less than a year ago (%)

	BE	EL	ES	FR	IT	NL	SE	UK	Total
< 1 yr	18,0	14,7	25,5	42,7	31,6	4,1	4,9	8,4	21,3
1 yr +	82,0	85,3	74,5	57,3	68,4	95,9	95,1	91,6	78,7
Total	100	100	100	100	100	100	100	100	100

People in this group are generally in an even more vulnerable situation. They are twice as likely as the others to be homeless (13% and 6% respectively) and less likely to have access to stable accommodation (35% compared to 49%). And fewer of them are working (59% compared to 44%). On the other hand, there are no significant differences in terms of limiting their movements or activities for fear of being arrested between people who left their country within the last 12 months or those who left longer ago.

- > *“We came into Greece by bus. On our arrival in Thessalonica we lived on the streets for two months. It was not good for the children.” Bulgarian woman, pregnant, who has been in Greece for six months with her husband and their two children, aged four and six years.*

Twice as many undocumented migrants who emigrated less than a year ago say that they want to return to their country of origin as those who migrated more than a year ago (13% compared with 7%).

In relation to the right to access health coverage, migrants who arrived less than a year ago are less likely than the others to fulfil the necessary conditions for accessing health coverage, according to the respective laws in the 11 countries. In fact, only 64% of people in this group have the right to access health coverage, compared to 73% of less recent migrants. They are also less likely to be aware of their rights, where such rights exist —50% of migrants who arrived less than a year ago compared to 70% of migrants who arrived more than a year ago. Finally, it is worth noting that people who migrated less than a year ago less often have their healthcare costs covered in practice (when they have this entitlement in theory)—37% compared to 65% of less recent migrants.

5. FAMILY AND SOCIAL SITUATION

- **Family situation: migration leads to the rebuilding of and separation within families**

The question about family situation was not understood in a similar way in all the survey countries, making precise comparison difficult.⁴¹ We can note, nonetheless, that **more men (45%) than women (34%) live alone.**

25- Family situation, by sex (%)

	Men	Women	Total
Live alone (with or without children)	44,8	34,1	39,3
Live with his/her partner	13,8	24,7	19,4
Live with family or friends	41,4	41,2	41,3
Total	100	100	100

There are also differences between countries of residence. These depend particularly on the type of activities or programmes carried out in the locations where the survey took place, which varies between countries.

26- Family situation, by country (%)

	BE	EL	ES	FR	IT	NL	SE	UK	Total
Live alone (with or without children)	49,1	31,4	33,0	61,8	55,6	44,0	15,5	16,7	39,3
Live with his/her partner	10,7	25,4	22,3	15,6	9,1	20,0	25,2	22,2	19,4
Live with family or friends	40,2	43,2	44,7	22,6	35,4	36,0	59,2	61,1	41,3
Total	100	100	100	100	100	100	100	100	100

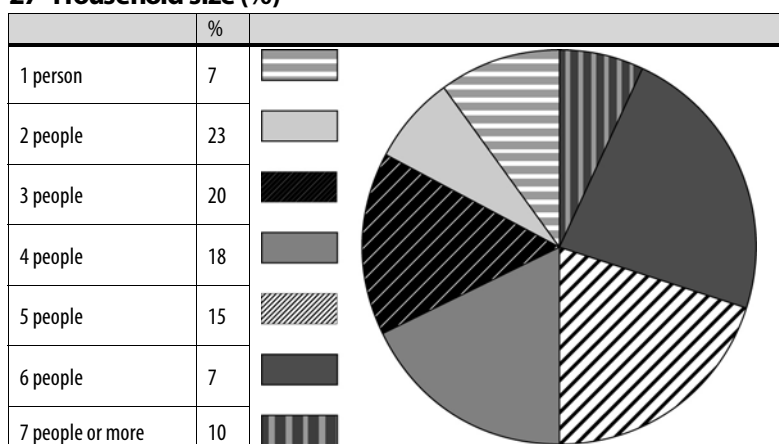
In total, 42% of respondents have children under the age of 18. Of these, however, only 41% say that they live with their children (or at least with some of them). In other words, **59% of respondents with children under the age of 18 do not live with any of their children.** This very high proportion can be explained by emigration conditions and living conditions in the destination countries. More men than women live without their children (72% compared to 50%). One in two women, however, do not live with their children.⁴²

41. For example, some interviewers considered that "living with a partner with children" should be categorised as "living with family or friends", while most interviewers ticked "living with a partner". Similarly, some single mothers replied that they live "with family" and have been categorised in this way instead of "living alone, with or without children".

42. The size of the sample of people with children is too small to enable a comparative analysis in terms of region of origin or survey country.

7% of respondents live alone while a quarter (23%) live in accommodation with another person. Over half (53%) of respondents live in accommodation inhabited by 3 to 5 people and 17% live in accommodation where 6 or more people live.

27- Household size (%)



- **Loneliness**

To complement the objective data on family and parental life, it seemed important to explore how people feel about their potential isolation by asking them questions that are more subjective, for two reasons. We know, on the one hand, that there is a correlation between social isolation and a higher risk of disease (not only mental health conditions). On the other hand, we know that social isolation, a weak network, and poor social support are factors associated with people being more estranged from the health system and with more limited health service access.⁴³

Just over half of respondents said that they feel very lonely (23%) or rather lonely (29%). This proportion seems high, especially given that the sample is composed of people who are in contact (sometimes close contact) with an association and it excludes, therefore, the most isolated migrants. **Men express the feeling of loneliness more often than women**—this may be linked to their migration conditions which more often result in men living without their partner or children.

28- Loneliness, by sex (%)

	Men	Women	Total
Very lonely	24,2	22,3	23,3
Rather lonely	32,1	25,0	28,6
Not very lonely	28,5	32,4	30,4
Not at all lonely	15,1	20,3	17,6
Total	100	100	100

People without a partner are more likely to feel lonely—63% of them are in this situation, twice as many as those who live with a partner (32%). The parental situation also seems to play a role—56% of people who have children (under 18) but who do not live with them say that they are lonely, compared to 52% of people without children and 43% of people who live with at least some of their children.

43. On this subject see the recent study specifically carried out among undocumented migrants in Milan (Devillanova C., "Social networks, information and healthcare utilization: evidence from undocumented immigrants in Milan", *J Health Econ* 2008, 27: 265-86).

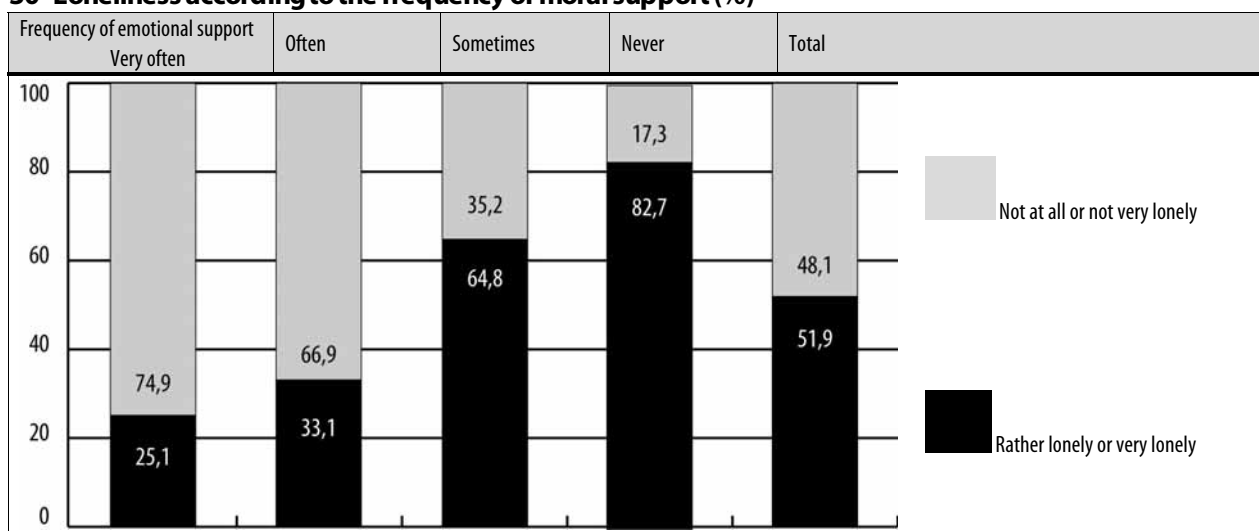
In addition, loneliness is more common among migrants who arrived in the country more than 2 years ago (57%) than among more recent migrants. Due to the length of time since actually migrating, this “effect”, like the parental situation effect, is incurred and remains in multivariate analyses adjusted for sex. It can be explained by factors that could be objective (e.g. the crumbling of networks of more recent migrants) or subjective (e.g. even for a constant level of isolation, in objective terms, a certain “resistance” to loneliness may weaken over time).

29- Risk of loneliness (multivariate analysis) adjusted for sex, parental situation and time spent in the country

		OR	CI (95 %)	
			Lower	Higher
Sex	Women	ref		
	Men	1,35	1,05	1,73
Parental situation	Lives at least with one of his/ her children	ref		
	Does not have children under 18	1,48	1,04	2,09
	Does not live with any of their children	1,85	1,24	2,75
Time spent in the country	Less than a year	ref		
	1-2 yrs	0,96	0,68	1,36
	3-5 yrs	1,56	1,10	2,22
	6 yrs or more	1,54	1,08	2,19

Finally, as we might expect, the feeling of loneliness is very linked to the extent of moral support on which respondents can depend. It affects 83% of people who say that they cannot depend on anyone for emotional support (compared to 25% of those who say that they can count on this type of support “very often”).

30- Loneliness according to the frequency of moral support (%)



> “We are abandoned. I am dead—I don’t want anything anymore and I no longer want to live. When people get up in the morning, they want to go out. I don’t want to do anything—I can’t work, I have no documents, I have nothing... That’s how my life is.” H., Kurdish, 26, living in Belgium for 14 years.

- **Moral support**

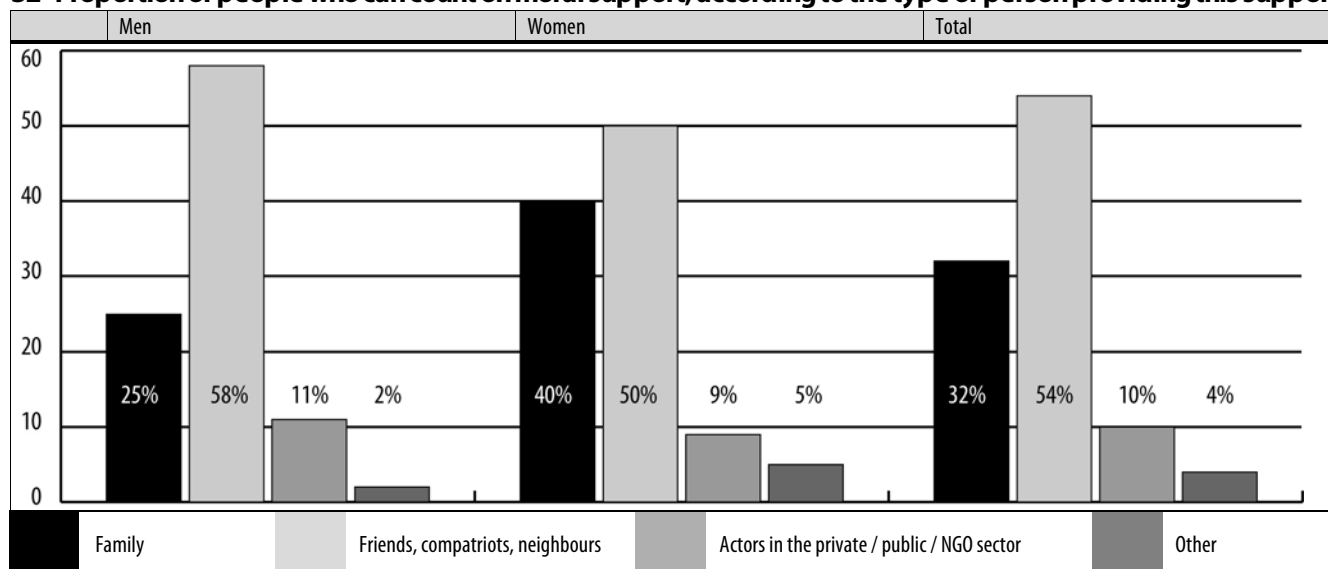
Only 47% of respondents say that they can “frequently” or “very frequently” count on someone to provide them with emotional support or to comfort them when needed. The women in the sample benefited from this potential moral support more often than the men. On the other hand, there are no differences according to age or time spent in the survey country.

31- Potential moral support for respondents (%)

	Men	Women	Total
Very often	16,2	22,1	19,1
Often	25,4	30,2	28,0
Sometimes	39,0	33,1	35,8
Never	19,4	14,6	17,2
Total	100	100	100

Respondents obtain this moral support from, above all, friends, compatriots and neighbours: 54% of the population interviewed can count (sometimes, frequently or very frequently) on such people. Family members are a little less responsive: only a third of respondents count on their family for support, although women more often than men do (40% compared to 25%). This brings us back to the fact that many migrants do not have parents in the host country, and for men this is most often the case. Finally, we see that professional or volunteer workers from the public, private or voluntary sectors only play a minor role—just 10% of respondents can count on them for emotional support (no significant difference between women and men).

32- Proportion of people who can count on moral support, according to the type of person providing this support



> *“I try to forget everything for my daughter and my son, who—thankfully—are in good health. I do not have any family or personal life, but luckily I have my neighbour—a Greek friend and her husband—who give me financial and emotional support. If they were not there, I do not know what I would do.” Moldovan woman, 27, living in Greece for 8 years.*

Although we can find that moral support is weak or absent in all the population sub-groups, people in some groups seem to be particularly isolated. **Thus, 38% of rough sleepers and 30% of people living in shelters say that they can never count on anyone for moral support.**

In a multivariate analysis, where all other things are equal in relation to sex, marital status, parental situation, nationality (by region of origin), time spent in the host country and accommodation status, the risk of not being able to count on anyone for moral support is:

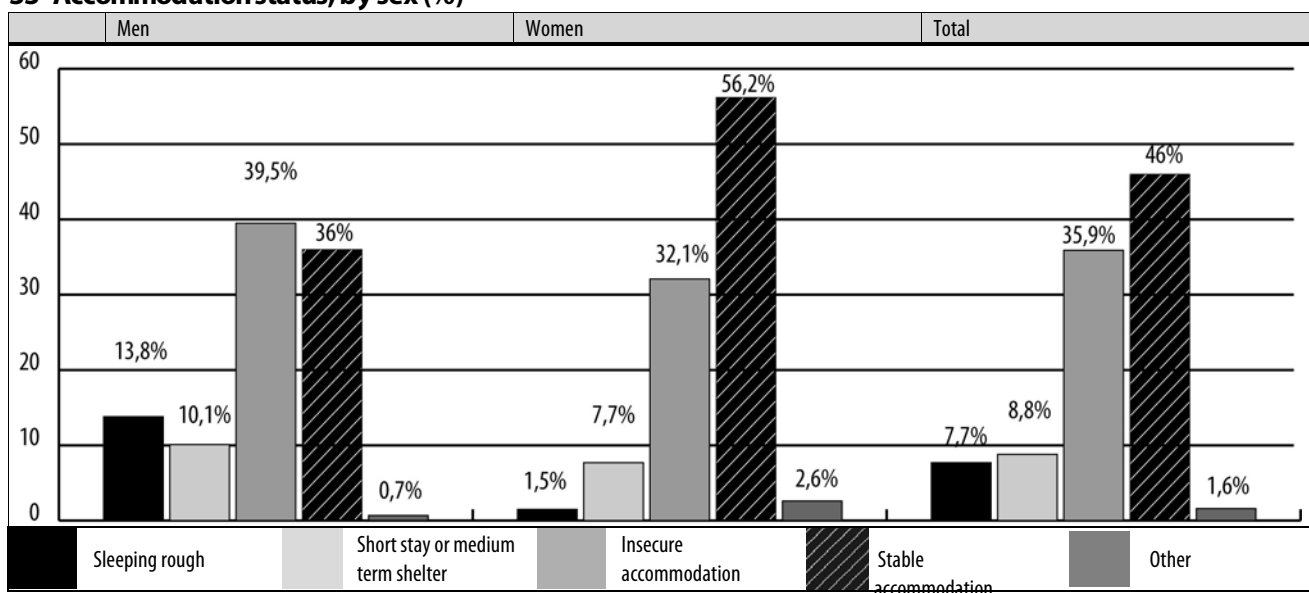
- **Twice as common for people who have children but do not live with any of them** (compared to those who have children and live with at least some of them, OR=2.06, 95% CI = [1.10-3.84]);
- **Twice as common in people from sub-Saharan Africa** (OR = 2.01, 95% CI = [1.15-3.50]) than in people from the Americas;
- **Three times more common in people who are sleeping rough** (OR = 3.46, 95% CI = [1.87-6.41]) **or staying in a short-term or medium-term shelter** (OR = 2.93, 95% CI = [1.69–5.04]) than people in stable accommodation.

• Accommodation

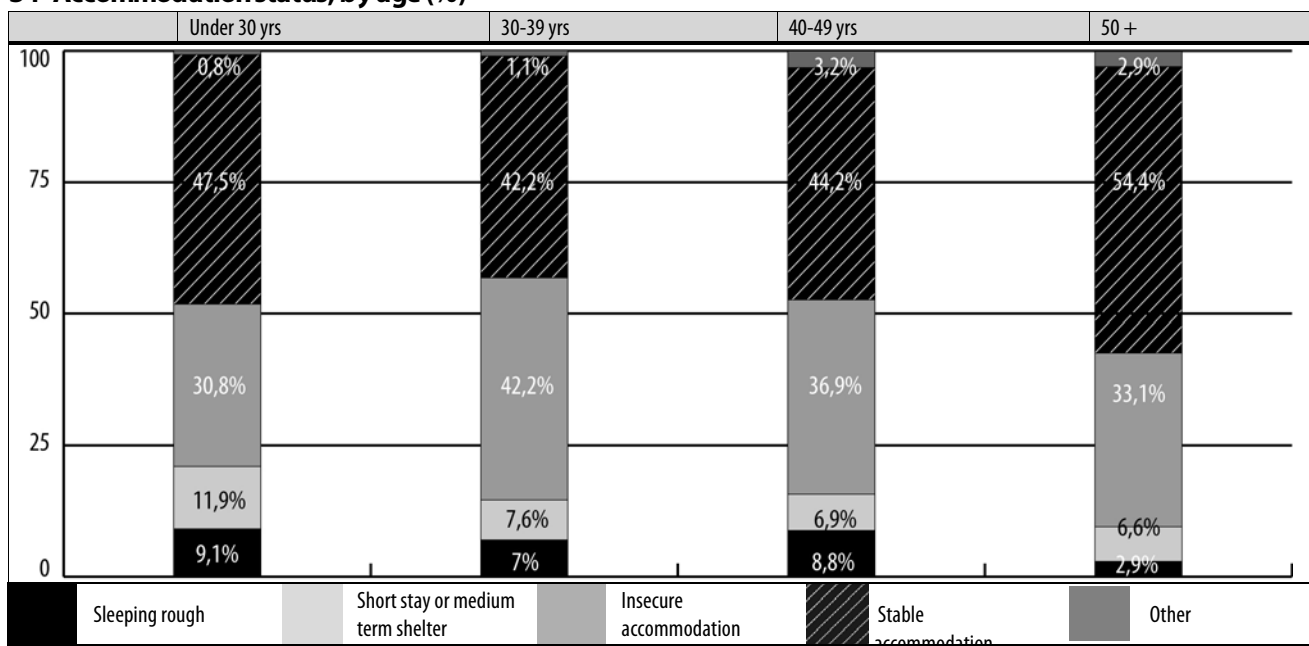
In general, surveys in Europe show that foreign nationals live in worse housing conditions than nationals—whether in terms of occupancy status, comfort or overcrowding. For undocumented migrants, the barriers to obtaining decent accommodation are even greater. These include having a low or unpredictable income, a lack of official documents to prove residence in the country or income, discrimination and abusive practices by landlords, no right to social housing, weak social networks, fear of being reported etc. Problems relating to insecure accommodation can be accompanied by overcrowding and poor and unsuitable housing conditions (insalubrious, lead, hazards...)—factors that can pose risks for the health and wellbeing of inhabitants.

The accommodation status of survey respondents was particularly unfavourable. **Less than half** of them (46%) had **access to stable accommodation**. Of the rest, 8% were sleeping rough, 9% were in short stay or medium-term shelters and 35% only had access to insecure accommodation. Two per cent were in a different situation, mainly related to staying in their place of work. Those in insecure accommodation were in a variety of situations—in the majority of cases (78%) they were temporarily staying with family members or friends while others (14%) were staying in a property without any lease or legal contract or occupied plots of land (6%). Finally, 2% were under threat of eviction or re-possession. **The situation of men interviewed is even more precarious than that of women**—14% are sleeping rough (compared to 2% of women) and only 36% have stable accommodation (compared to 56% of women).

33- Accommodation status, by sex (%)



34- Accommodation status, by age (%)



As we have seen previously, people who arrived in the survey country less than a year ago are in a more vulnerable situation than average—only 36% of them have stable accommodation, and 14% are sleeping rough. On the other hand, once people have spent a year in the host country, we do not see any notable improvement according to the length of time spent in the country—undocumented migrants continue to live in vulnerable situations.

35- Accommodation status according to time spent in survey country (%)

	Less than 1 yr	1-2 yrs	3-5 yrs	6 yrs or more	Total
Sleeping rough	14,0	3,2	3,9	10,1	7,7
Short stay or medium term shelter	10,8	9,7	6,0	8,8	8,8
Insecure accommodation	38,4	33,9	42,0	29,4	35,9
Stable accommodation	35,6	51,3	46,6	49,7	46,0
Other	1,2	1,8	1,4	2,0	1,6

$p < 10^{-3}$

The differences between country of residence and nationalities need to be considered alongside the differences in the types of project at the survey locations in the different countries. The high proportion of rough sleepers in Italy, for example, is linked to the fact that, in this country, the survey took place in programmes specifically aimed at homeless people and/or drug users. In relation to Spain, we can see that the high proportion in stable accommodation can also be related to the fact that agricultural workers, domestic workers and carers for older people are usually given rooms in their workplace. This is the same situation for people working and living in clubs. In Greece, the rental conditions are not as formal as in other countries and immigrants are able to find somewhere once they know the country better.

36- Accommodation by country of residence (%)

	BE	EL	ES	FR	IT	NL	SE	UK
Sleeping rough	4,5	2,6	3,2	8,0	44,4	2,9	-	0,9
Short stay or medium term shelter	4,5	13,7	6,0	8,5	12,1	14,7	9,7	1,9
Insecure accommodation	49	14,5	12,0	54,3	17,2	27,5	62,1	60,7
Stable accommodation	42,0	65,8	73,1	29,1	25,3	54,9	28,2	35,5
Other	-	3,4	5,7	-	1,0	-	-	0,9

In addition, the distribution of accommodation situations show that people from Asia are less vulnerable to becoming homeless (sleeping rough). Stable accommodation is most common among people from Latin America (most of whom were interviewed in Spain).

37- Accommodation status, by region of origin (%)

	Europe (non EU)	Sub-Saharan Africa	North Africa	Asia	Americas	Other*	Total
Sleeping rough	12,1	9,5	12,5	0,8	2,0	7,9	7,7
Short stay or medium term shelter	13,5	8,7	8,6	8,6	3,9	11,9	8,8
Insecure accommodation	29,8	39,3	46,1	47,7	23,5	30,5	35,9
Stable accommodation	44,0	41,9	32,2	43,0	65,7	47,0	46,0
Other	0,7	0,6	0,7	-	4,9	2,6	1,6

*The "other" category includes near and middle east countries, the European Union and stateless persons.

- > *Nowhere to live, until death: H. is 56 years old and has already been living in the Netherlands for 20 years without any residence permit or health insurance. He no longer has any contact with his family in Venezuela. He works as an artist and a cleaner, but doesn't have a regular income.*

In 2006, he was diagnosed with lung cancer. H. was admitted to hospital and underwent surgery (they removed a large part of one lung) and radiotherapy. Following this medical intervention, H. was better for a while. Then at the beginning of 2008 he began to feel very ill again. He went to hospital for tests and the results showed that his cancer had returned—the rest of the lungs, the kidneys and the liver were affected. The doctors cannot do any more for H., who has been in hospital since then, in the terminal phase with only a few months to live. H. cannot stay in hospital, he has to go home and take care of himself with painkillers.

But, H. does not have a home; he is homeless. He would like to die in a calm and peaceful place—he is thinking about a hospice. There are many hospices in the area, but it is very difficult to find a place because he does not have any health insurance and he cannot pay the fees himself. The hospital sent H. to an organisation for homeless people. This organisation, based very far from the town where H. lives, accepted to put him up during this terminal phase. H. is very scared of the idea of spending his last days far from his town and his friends. That's why he decided not to go there.

H. was thrown out of the hospital. He was left on the streets with all his belongings and enough medicines for two days. He could no longer walk, he could not get around on his own. A friend managed to get a wheelchair for him and took him to a centre for homeless people who agreed that he could stay there for several days. There, no-one really looked after him and H. could not leave because he was on the second floor and there was no lift.

Thanks to the efforts of his friends and support organisations, a hospice in H's town agreed to admit him even though he is not insured. Thanks to Médecins du Monde's network, he has access to palliative care and a legal process was started to be able to reimburse the hospice and the other actors for the costs of care provided. Several days after his arrival at the hospice, H. died.

During the last days of his life, H. wanted his experience to be used to improve palliative care for undocumented migrants in the Netherlands. He also wanted the hospital to recognise that he should not have been left on the streets and that they undertake to never do this again. "We cannot treat people in that way... even less so when they are seriously ill and do not have long to live." H., Venezuelan, 56, lived in the Netherlands.

● Accommodation conditions

The migrants interviewed were all particularly affected by another problem linked to accommodation: **overcrowding**. There are several methods available to calculate overcrowding. Here we have defined a dwelling as overcrowded when there is less than one (main) room per person.⁴⁴ **In total, overcrowding affects 68% of respondents, excluding rough sleepers (and with no significant differences for sex and age).**

People living in shelters or insecure accommodation are even more affected by overcrowding than the others: three quarters are faced with an overcrowding problem.

38- Proportion of people living in overcrowded accommodation, by accommodation status (%)

	%
Short stay or medium term shelter	73,8
Insecure accommodation	74,7
Stable accommodation	62,9
Other situation (excluding rough sleepers)	46,4
Total sample (excluding rough sleepers)	67,9

In addition, we see that, **of the people living with at least some of their children under 18, 86% are living in overcrowded accommodation.** We know that overcrowding may affect child and adolescent development (lack of privacy, difficulty separating adults' and children's space, no quiet space to do school work, nowhere to invite friends etc.). In Sweden, the team came across several babies who had been overfed to avoid them waking the other occupants. The overcrowding situation seems least serious in the Netherlands.

39- Proportion of people living in overcrowded accommodation, by survey country (%)

BE	EL	ES	FR	NL	SE	UK	Total sample*
59,4	70,5	60,6	79,4	50,0	78,4	76,4	67,9

*excluding homeless people and excluding Italy, where the data collected did not enable overcrowding to be calculated.

Several questions concerning the material conditions of the housing were also asked. Four per cent of people live in accommodation without electricity and the same proportion in accommodation without running water. 5% live in accommodation without a toilet and 16% without heating, including in countries where the temperatures can be very low in the winter (5% in the Netherlands, 8% in Belgium, 12% in France).⁴⁵ And 6% of respondents do not have access to a cooker or stove in their accommodation.

40- Housing conditions by accommodation status (%)*

	Short-stay or medium-term shelter	Insecure accommodation	Stable accommodation	Total
No heating	16,0	18,6	11,6	15,6
No stove/cooker	16,3	8,0	1,6	5,6
No toilets	-	8,0	1,6	4,7
No electricity	-	8,0	0,9	3,9
No running water	-	7,5	1,4	3,8

* These questions were not asked to rough sleepers. The data in the "other accommodation situation" category are not presented because of the small numbers, but are taken into account in the calculations on the whole sample.

44. This definition is used in publications by the French national economics and statistical institute (*Institut national de la statistique et des études économiques français – Insee*), even though we are conscious that this threshold may differ from the norms of some surveys concerning acceptable housing conditions.

45. The question concerning heating in accommodation was not asked in Sweden.

Furthermore, a third (34%) of respondents who are not homeless consider that their accommodation is harmful to their health or the health of their children. Similar proportions of men and women have this belief. On the other hand, this percentage increases with age: this is the case for 43% of people aged 50 or over (compared to only 30% under 30). We also see that accommodation that is considered unhealthy by the occupants is also often overcrowded, and most often relates to insecure accommodation.

41- Proportion of people considering that their accommodation is harmful to their health (or their children's health) according to different characteristics (%)

		%
Age	Under 30	29,7
	30-39 yrs	34,0
	40-49 yrs	36,4
	50+	42,9
Survey country*	BE	38,3
	EL	39,8
	ES	34,0
	FR	33,5
	NL	34,4
	SE	43,6
	UK	31,4
Length of time spent in the survey country	Less than a year	31,2
	1-2 yrs	26,7
	3-5 yrs	37,0
	6 yrs or more	40,1
Accommodation status	Short stay or medium term shelter	36,9
	Insecure accommodation	38,7
	Stable accommodation	29,8
	Other situation (excluding rough sleepers)	41,4
Region of origin	European Union	46,8
	Europe (non EU)	44,6
	Sub-Saharan Africa	39,9
	North Africa	31,5
	Near and middle east	26,4
	Asia	23,0
	Americas	25,6
Overcrowding	Accommodation, not overcrowded	24,9
	Overcrowded accommodation	37,2
	Total sample (excluding rough sleepers)	34,1

*Italy does not figure in this list, because the data were unworkable.

6. WORK

- Unequal circumstances

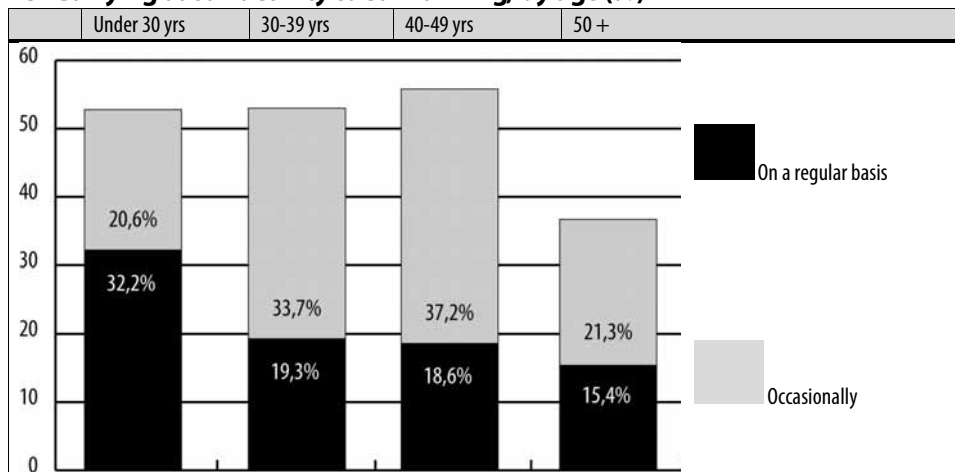
Of all the people surveyed, 19% said that they were working or carrying out an activity to earn a living on a regular basis,⁴⁶ 32% were doing so occasionally and 47% say that they have not carried out any activity to earn a living (1% did not want to answer this question). **Women in the sample are twice as likely as men to be undertaking regular income-generating activity (26% compared to 12%, p<0.001).**

42- Carrying out an activity to earn a living, by sex (%)

	Men	Women	Total
Regular activity	12,4	26,0	19,1
Occasional activity	35,9	28,0	32,2
No activity	49,7	45,6	47,3
Refused to answer	2,0	0,4	1,3

The rate of regularly undertaking an activity to earn a living is highest among the youngest (32% in the under 30s). The rate decreases with age—only 15% of people aged 50 years or older regularly carry out an income-generating activity.

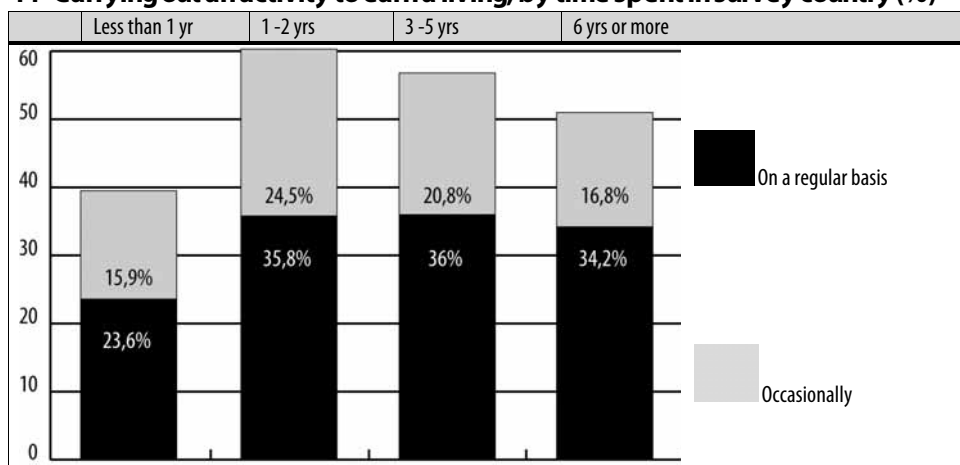
43- Carrying out an activity to earn a living, by age (%)



⁴⁶ The term “on a regular basis” in the French version questionnaire may have led to confusion in some respondents, who could have interpreted this as referring to the legality of the employment contract and not as relating to the frequency of work.

If we cross this rate of regular income generating activity with the length of time in the host country, the highest rate of regular income generating activity was among people who had been in the country for between 1 year and 5 years (36%).⁴⁷

44- Carrying out an activity to earn a living, by time spent in survey country (%)



- **Difficult working conditions**

The migrants are working in a diverse range of sectors. **Cleaning and services for individuals employed the largest numbers of respondents in our sample (23% and 20% respectively).** The contribution of services for individuals includes domestic employees and the relatively high numbers of migrants who look after children, older people or people who are ill in their homes. **Many respondents also worked in the construction industry (15%), hotel and restaurant services (9%), and prostitution (11%).** This last number is linked, of course, to how the sample is constituted since several of the survey sites are outreach programmes for sex workers. Although it seems that it was not rare for people to work in several activities in different sectors, this information was not recorded in the survey.⁴⁸ Similarly, employment insecurity can lead people to change employment sector relatively often (the data presented here, however, only present information on the main job on the day of the survey).

45- Income generating activity sectors (on a regular or occasional basis)(%)

	%
Cleaning	22,5
Work for individuals	20,4
Building, construction work	15,3
Prostitution	11,0
Hotel and restaurant services	9,4
Business	4,0
Consumer goods industries	3,8
Agriculture, forestry or fishing	2,7
Peddling	1,8
Transport	1,6
Agricultural or food industry	0,9
Other industries	0,9
Other	5,8
Total	100

47. If we cross the rate of working with the length of time in an undocumented situation, these figures and the distribution shown in the corresponding figure are practically identical.

48. Information was only recorded about the main sector of activity—which was often difficult for people working in different sectors.

- > *“As we live here illegally, my husband works from seven in the morning to three in the morning for 25 euros a day.” Argentinian woman, 23, living in Spain for 10 months.*
- > *“I would like to stop working in prostitution, but I can’t find work. It’s unbelievable. In the adverts in the newspapers, there is nothing. Because I don’t have any documents, it is even more difficult. I look for steady employment or more piecemeal work, it doesn’t matter which. You open the paper and find nothing in the job ads. In the contact adverts, however, lots of clubs are looking for girls. It’s difficult, I have been looking for three weeks already and I haven’t found anything. I found a vacancy for someone to look after an old woman with Alzheimer’s, from midday till seven in the evening. The guy said that there wasn’t much work to do—wake his mother up, sit her on the sofa in front of the TV, feed her and put her to bed. I told him that it wasn’t very difficult, but it didn’t leave me any time to find extra work, because 500 euros is not enough to live on. I send all the money I earn to Brazil and only keep here what I need to pay rent and to eat. I send the rest of it and don’t allow myself any treats. The crisis is also affecting prostitution – there is no work.” Brazilian woman, 44, living in Spain.*

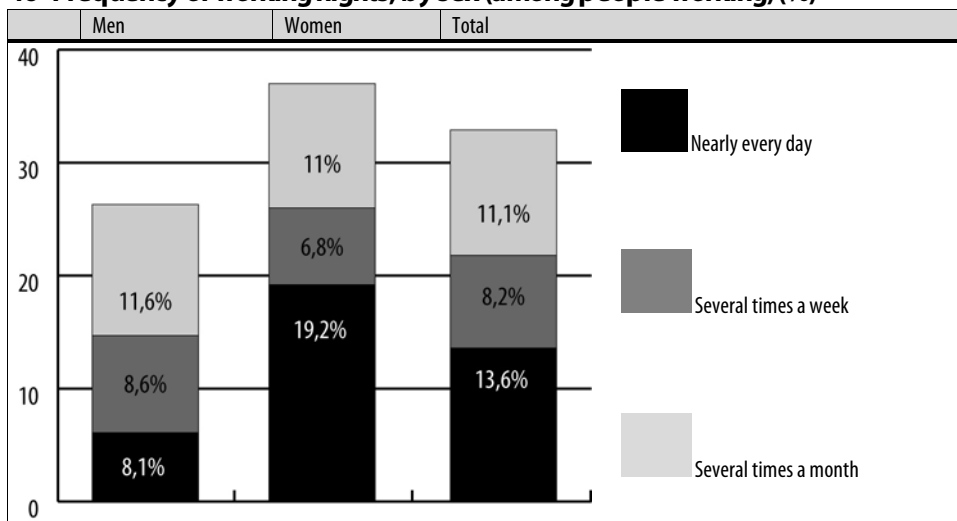
Among respondents who work (on a regular or occasional basis) **37% work more than 10 hours per day** (16% nearly every day, 10% several times a week, 12% several times per month). No significant differences for sex or age were observed.

Working night shifts was relatively common (even when the definition used here—working between midnight and 5am—is more restrictive than the definition commonly used in surveys).

So, **22% of respondents carry out paid work at night nearly every day or several times a week. This affects women more often than men** (26% and 14.7% respectively), particularly in relation to working nights on a daily basis (19% and 6% respectively).

These night shifts relate to different situations: respondents working in prostitution are particularly affected, as are many people providing services to individuals (such as looking after people who are old or sick), and people working in the cleaning, hotel and restaurant sectors.⁴⁹

46- Frequency of working nights, by sex (among people working) (%)



49. Even when people working in prostitution are removed from the calculations, the difference in frequency of working nights on a daily basis remains important.

- > *She has had some very difficult experiences with work. She has often worked 12 to 14 hours a day and, in the end she had to fight to get the money promised (for example, 150 euros per month). This happened to her several times: people put pressure on her by threatening to report her to the authorities if she didn't agree. At the moment, she is working for several individuals—cleaning, window cleaning, gardening etc. L. Ukrainian woman, 58, living in Germany for eight years.*

There was another indicator of difficult working conditions: **8% of interviewees had been victims of an occupational injury since they arrived in the country.** Of course, this frequency depends on the length of stay in the survey country⁵⁰ (seven years on average for those saying they have already had an occupational injury and four and a half years for the others, $p=0.002$). After adjustment for the length of stay, there are no differences according to respondents' age or sex. The crude occupational injury rates are shown in the following table. In fact, after adjustment for the length of stay, there are no longer any significant differences between countries (because of the small sample sizes). **The risk of having experienced an occupational injury, however, appears highest in Spain and the Netherlands, while it is lowest in France.**

47- Proportion of respondents who have experienced an occupational injury since they arrived in the country (%)

NL	ES	EL	BE	FR	Total sample
16,5	12,7	9,4	6,3	2,5	8

- > *He had a first occupational injury in Italy, before he arrived here, with a fractured wrist. Then he fell from scaffolding and had to have stitches. Moroccan man, 30, living in Switzerland.*
- > *J. had an accident at work and broke his foot. A friend took him to a Spanish doctor who told him that he needed an operation immediately. He tried several hospitals that asked him—at the emergency admissions department—to pay because he did not have any health insurance. Seeing J's suffering, his friend ended up lending him his insurance card and J. was admitted to a clinic where he should have been operated on the next day. J. left the clinic during the night, before the operation, because he was afraid of being arrested or of damaging his friend's situation. J., Nicaraguan man, 53, living in Germany.*

50. This prevents any comparison with the rate of occupational injuries in the general population.

7. ACCESS AND RIGHTS TO HEALTH COVERAGE⁵¹

- Rights to access health coverage vary from one country to another

According to national laws,⁵² 70% of respondents could have their medical costs covered in light of their situation. The exact form and functioning of this access vary greatly from one country to another.⁵³ Country data are only available for Belgium, Spain, France, Greece and Italy.⁵⁴

48- Theoretical access to health coverage (%)

	BE	EL	ES	FR	IT	Total
Individual meets the criteria for access	98,2	2,7	72,7	88,9	55,3	69,8
Individual does not meet the criteria for access	1,8	93,6	22,7	11,1	44,7	28,2
Unknown	0,0	3,6	4,6	0,0	0,0	1,9

- Poor awareness of the right to access healthcare

Respondents were asked about their knowledge in relation to their theoretical rights to benefit from access to health coverage.⁵⁵ In total, three quarters of respondents (76%) who could benefit from access to health coverage know their rights. In contrast, **a quarter of them do not know that they could have access to health coverage.** This proportion is highest in the UK, where more than half of respondents are unaware of this possibility. In Spain, in contrast, nearly all of the respondents are aware of this possibility.

49- Proportion of people who are theoretically entitled to access health coverage who know their rights (%)

	BE	ES	FR	IT	UK	Total
Yes	58,2	94,3	76,7	65,4	47,7	76,5
No	41,8	5,7	23,3	34,6	52,3	23,5

Among those people who are aware of their rights, **only a little over half of them know in sufficient detail the steps to take to access the health services they are entitled to.** People who are less well informed about the procedures are particularly numerous in France, Spain and Italy. At least a third of respondents in Belgium and the UK were completely unaware of the steps to take to access healthcare.

50- Knowledge of necessary steps to take to obtain access to healthcare among people who know their theoretical rights (%)

	BE	ES	FR	IT	UK	Total
Yes, I'm sure	54,7	61,9	53,5	59,0	55,1	57,5
Yes, I think, but I'm not sure	9,4	28,2	26,8	41,0	14,3	24,9
No	35,9	9,9	19,7	0,0	30,6	17,7

51 Health coverage in some countries means that healthcare costs are totally or partially covered, in other countries it means that people have access to healthcare free at the point of need.

52. See chapter 1 on legislation relating to access to healthcare in each country.

53. Cattacin S., Chimienti M., "Difference sensitivity in the field of migration and health: national policies compared", Geneva: Research report of the Department of Sociology of the University of Geneva, 2006.

54. This "situation analysis" was not done in London (considering that, in theory, all people could theoretically register with a general practitioner and have access to primary care), in the Netherlands (where coverage of healthcare charges are done on a case by case basis, directly by the health professional who can be reimbursed) and in Sweden (where there are no arrangements for covering healthcare charges in place). No country analysis could be done for Germany, Portugal and Switzerland, given their small sample sizes (see chapter 1- Presentation of results).

55. This question—unlike the previous one—was also asked in the UK.

- **Realising rights: many pitfalls along the way**

Only two-thirds of people aware of their rights had undertaken the necessary procedures to obtain these rights. **The proportion was lowest in Belgium and France (a third and a half respectively had taken the necessary steps, alone or with some form of assistance).** In both countries the bureaucratic procedures for undocumented migrants to obtain access to their rights are among the most complex. Conversely, in Southern European countries and in the UK, once people are aware of their rights, most of them actively took steps to obtain access.

51- People taking the necessary steps to realise their right to health coverage in practice as a proportion of those who know their theoretical rights (%)

	BE	ES	FR	IT	UK	Total
Yes	34,4	75,7	54,7	84,6	84,0	65,9
No	62,5	23,2	45,3	15,4	16,0	33,1
Don't know	3,1	1,1	0,0	0,0	0,0	1,0

Among people engaged in the processes to obtain their rights, more than half say that they have encountered at least one problem along the way. In decreasing order of frequency, these are:

- administrative problems in 74% of cases (problems getting the documents which are required, abusive demands, unsuitable opening hours, being sent from one office to another etc.);
- a lack of awareness of services and/or entitlement (23%);
- language barriers (21%),

A third of people reporting problems also describe barriers which are certainly more subjective but are no less problematic—such as fear of being arrested or reported (16%), being refused help by social services (8%) or health professionals (8%), or fear of being discriminated against or not welcome (6%).

In the final count, only 60% of those people taking the necessary steps effectively had access to health coverage, on the day of the survey. **Once again, these proportions were lowest in Belgium and France (50% and 24% respectively), testifying to the “obstacle course” facing undocumented migrants when they try to realise their rights.**⁵⁶ The situation was most favourable in Spain and Italy.

52- People who have effective access to health coverage on the day of the survey as a proportion of people taking the necessary steps to realise their rights (%)

	BE	ES	FR	IT	UK	Total
Yes	50,0	67,2	24,0	100,0	60,0	59,8
Refused	22,7	3,6	5,3	0,0	35,0	8,6
Pending	27,3	27,7	66,7	0,0	2,5	29,8
Don't know	0,0	1,5	4,0	0,0	2,5	1,8

- > *C. has been in France for six months. She gave birth, in hospital, three months ago and her baby is covered by the mother-and-child protection programme. Since her arrival, none of the health professionals that she has met (doctor, midwife, hospital staff...) have suggested that she request the state medical aid (AME) for her and her family. She showed us several invoices for medical consultations or medication, with the social security healthcare costs form, but she doesn't know what this form is for. The request for healthcare coverage was done the day she went to Médecins du Monde in Paris. C., Romanian woman, 21, living in France for 6 months.*

56. Reminder: these proportions concern people who are theoretically entitled to have access to health coverage according to the law in both these countries (see the description of criteria for access to healthcare by country at the beginning of the report).

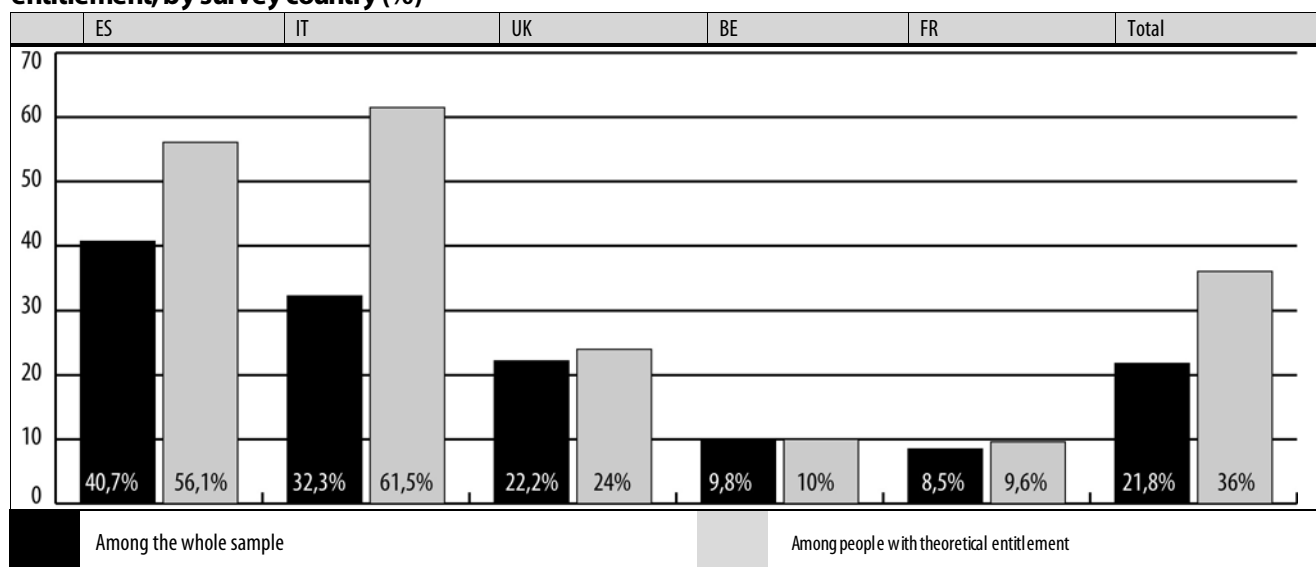
The proportion of people with effective access to health coverage has been estimated (i) among all respondents in each country and (ii) among those who were theoretically entitled, in light of their situation and the entitlement criteria in each country.

Of the entire survey population, only 22% of undocumented migrants have effective access to health coverage, with no significant differences for respondents' sex, age, or family situation. This proportion is similar to that observed in the previous *Médecins du Monde* European Observatory on Access to Healthcare survey, published in 2007 (24%).⁵⁷ In the beginning this increases with the length of time spent in an undocumented situation in the host country—only 9.5% of people who have been undocumented migrants for less than a year have access to health coverage compared to 15.6% of people who have been undocumented for more than a year. After 2 years, however, the proportion no longer increases in the survey population (staying at around 23%). This observation is probably linked to the selection bias inherent in the survey (those who, after two years, have obtained access to healthcare coverage have less reason for—and therefore a lower probability of—attending a programme linked to the Observatory).

- **Rights to access health coverage are seldom realised**

In total, only a small minority—a fifth—of undocumented migrants interviewed benefited from access to health coverage. In situations where people had the theoretical right to access health coverage, only a third (36%) had access in practice, and there were major differences between countries.

53- People having effective health coverage among the whole sample and among those with theoretical entitlement, by survey country (%)



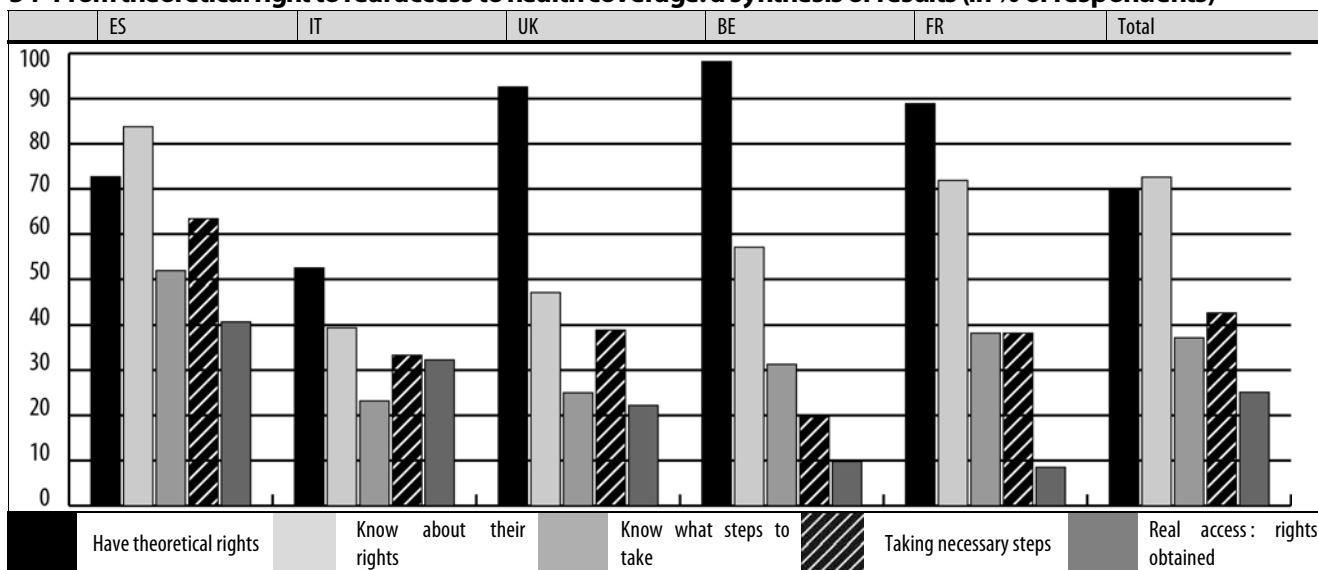
To summarise the spectrum of difficulties and restrictions concerning access to health coverage for undocumented migrants, all the previous analyses can be related to all the people interviewed.

57. European Observatory on Access to Health Care. "European survey on undocumented migrants' access to healthcare", Paris, *Médecins du Monde*, 2007. http://www.mdm-international.org/index.php?id_rubrique=10.

We can see that the countries fall into several groups:

- Countries where, in theory, more than three quarters of respondents have access to health coverage, but where, in practice, effective access to health coverage remains poor (less than one in four, going as low as less than one in ten). In other words, the gap between the theoretical rights and the reality, in practice, is greatest (UK, Belgium and France⁵⁸);
- A country where nearly three-quarters of respondents have the theoretical right to health coverage and where, in practice, just under half of respondents have access. This equates to a differential of just under one in two (Spain);
- A country where, in theory, one in two people should have access to health coverage and, in practice, only a third have access. This differential is also just below one in two (Italy).

54- From theoretical right to real access to health coverage: a synthesis of results (in % of respondents)



Note on interpretation: In some cases, the percentage of people claiming to know the steps to take to access health coverage is less than the number of people who have started to take these steps—some people can have the process started for them (by social workers, NGOs etc) without themselves understanding what is involved.

58. In addition, in France the granting of residence permits on medical grounds (allowed for in law for certain conditions where return to the country of origin would have serious health consequences because of a lack of effective access to appropriate care) has been subject to increasing attacks by the government since 2002 (see *La régularisation pour raison médicale en France, un bilan de santé alarmant*, Paris, Observatoire du droit à la santé des étrangers, collectif ODSE, 2008). <http://www.odse.eu.org>.

8. HEALTH STATUS

- **Perceived health**

We know that the perceived health of a population is a subjective indicator, but most studies show a good general correlation (although not necessarily at the individual level) between this indicator and objective (and/or medical) indicators of health.⁵⁹ Within the entire sample, **a third of men (34%) and a quarter of women (23%) perceived their state of health to be bad or very bad. This is much higher than in the general population, whichever national or European population we compare with.**

Although there is considerable variation in the distribution of this indicator between the different European countries (which shows both north-south and west-east gradients⁶⁰), the undocumented migrants interviewed in our survey say that **they are in bad or very bad health 3 times more often than the population of the 25 EU countries.** More specifically, they say this 4 to 7 times more often than the British, Dutch or Swedish populations, up to 8 times more often than the Belgian population and 16 times more often than the German population.⁶¹

We were unable to systematically compare the perceived health status of undocumented migrants with regular migrants because there is a lack of good data concerning regular migrants in most European countries. In fact, the scientific literature contains few representative surveys on migrant health. A Swedish study⁶² from 2006 (based on data collected in 1996 in the first Swedish national study on immigrants) saw that Kurdish immigrants were twice as likely to declare that their state of health was bad as the Swedish population of the same age. They were also three times as likely to have problems sleeping. In France, according to the data from the decennial health survey conducted in 2002-3, the self-reported health of migrants⁶³ was worse than that of people born in France. The poor socioeconomic conditions in which migrants live can explain, in part, the poorer state of perceived health.⁶⁴ Another study that is relevant is the survey conducted among a representative sample of immigrants in the Basque Country in 2005.⁶⁵

59. Kaplan G.A., Goldberg D.E., Everson S.A. et al., "Perceived health status and morbidity and mortality: evidence from the Kuopio ischaemic heart disease risk factor study", *Int J Epidemiology* 1996, 25: 259-65; DeSalvo K.B., Bloser N., Reynolds K., He J., Muntner P., "Mortality prediction with a single general self-rated health question: a meta-analysis", *J Gen Internal Med* 2005, 21: 267-75.

60. Carlson P., "Self-perceived health in East and West Europe: another European health divide", *Soc Sci Med* 1998, 46: 1355-66.

61. Data from the National Health Interview Surveys (round 2004), Eurostat, 2007.

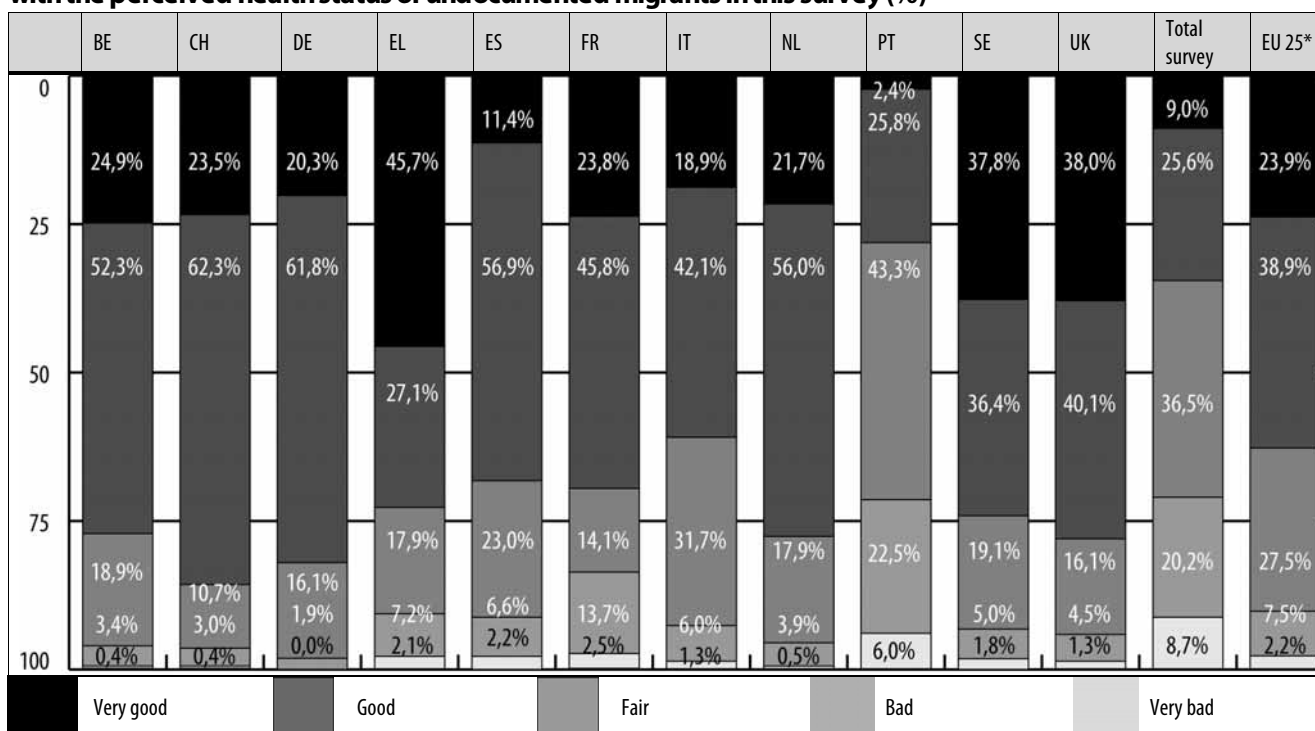
62. Taloyan M., Johansson L.M., Johansson S.E., Sundquist J., Koctürk T.O., "Poor self-reported health and sleeping difficulties among Kurdish immigrant men in Sweden", *Transcult Psychiatry* 2006, 43: 445-61.

63. Meaning people born overseas, irrespective of whether they are now French.

64. Dourgnon P., Jusot F., Sermet C., Silva J., "La Santé perçue des immigrés en France", Paris, Irdes, Questions d'économie de la santé, 2008, n°133.

65. Rodriguez E., Lanborena N., "Encuesta de salud de los diferentes colectivos de inmigrantes asentados en la Comunidad Autónoma del País Vasco", Basque Country University and Médicos del Mundo/Munduko Medikiak, Spain, 2006.

55- Comparison of perceived health status of general populations in the 11 survey countries and in EU in total with the perceived health status of undocumented migrants in this survey (%)**



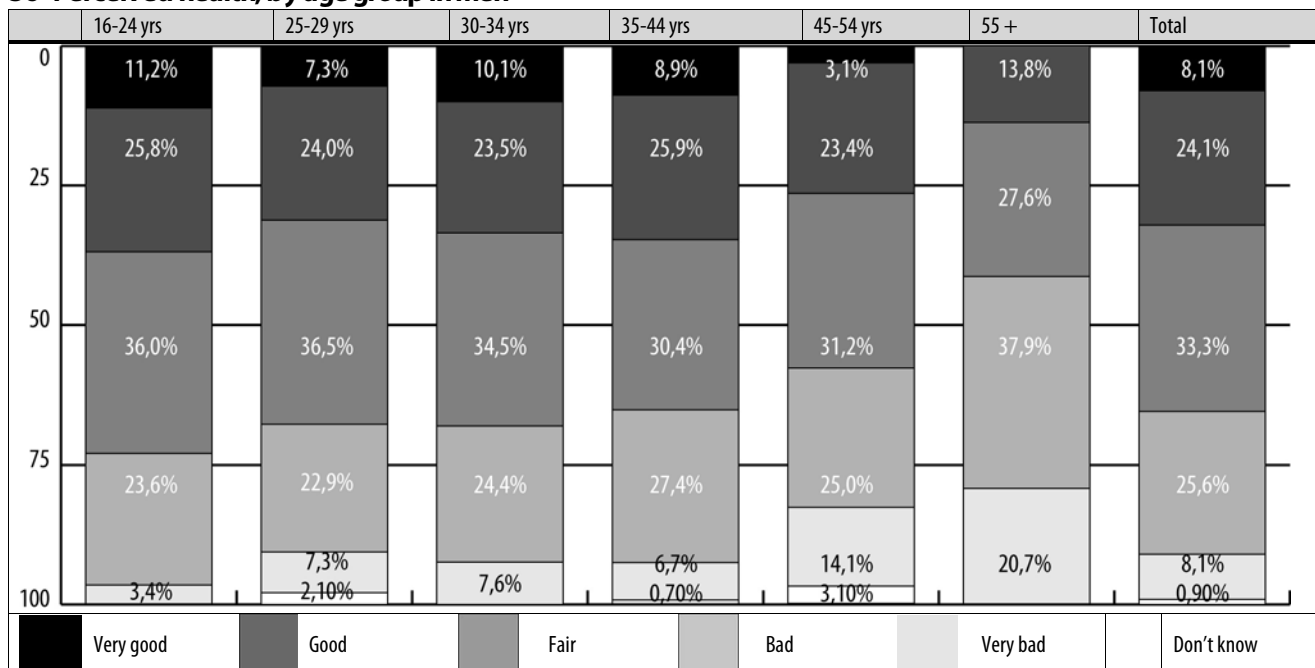
*European Union countries, **Source: National Health Interview Surveys (round 2004), Eurostat, 2007.

In contrast to what is normally seen in the general population, men’s perceived state of health is worse than women in all age groups except over 55 years old (where a third of women consider themselves to be in very bad health). This poor perceived health status in immigrant men was also observed in a recent general population study in Barcelona (but undocumented migrants were not studied specifically).⁶⁶

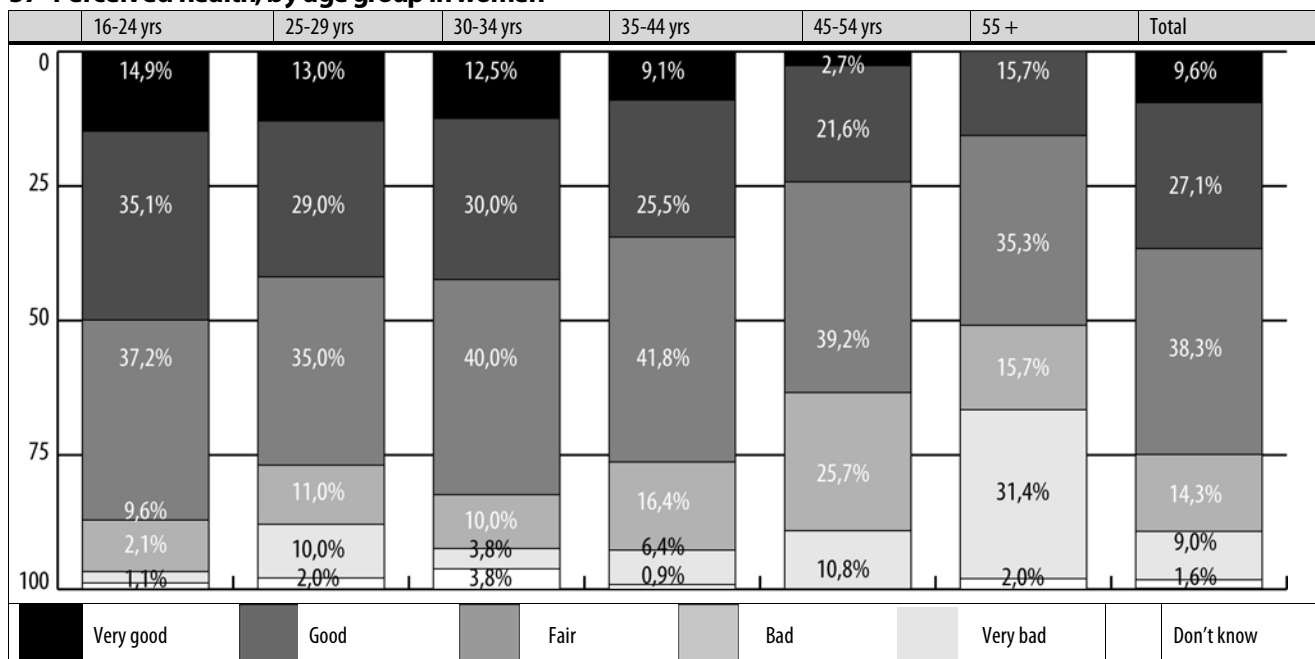
Health naturally deteriorates with age. It is important to emphasise, however, that in the youngest group (18-25 years), 27% of men and 12% of women already say that their health is bad or very bad.

66. Borrell C., Muntaner C., Solè J., et al., “Immigration and self-reported health status by social class and gender: the importance of material deprivation, work organisation and household Labour.” J Epidemiol Community Health, 2008, 62: e7.

56- Perceived health, by age group in men



57- Perceived health, by age group in women



- Health problems diagnosed**

Only 20% of respondents did not indicate any health problem on the day of the survey.⁶⁷ In total, 1,457 symptoms, complaints or illnesses were reported by the interviewers. The pattern of health problems—categorised by system or anatomical region—is similar to that observed in any generalist health service.⁶⁸ The digestive and musculoskeletal systems and psychological aspects were most commonly affected.

67. In many of the programmes where the survey took place, people do not specifically come for medical reasons.

68. A Spanish medical publication notes that migrants attend medical services for reasons which are similar, in their diversity and frequency, to those of people traditionally attending front-line services. Without denying that some diagnoses are more common given migrants' geographical origins (particularly certain infectious

58- Frequency of conditions and health problems in the survey population (%)

System	%	Condition / Health problem	%	System	%	Condition / Health problem	%
Musculoskeletal	19,13	Other musculoskeletal symptom/complaint	6,94	Infectious	6,39	Viral hepatitis	1,51
		Spinal symptom/complaints	5,34			Urinary/kidney infections	0,89
		Trauma/Injury	2,94			Other infectious disease	0,71
		Other locomotor diagnoses	2,58			Skin infections	0,71
		Back syndrome	1,33			Eye infections	0,62
Psychological, mental health	16,29	Anxiety-stress-somatization disorder	4,72			HIV ⁶⁹	0,44
		Depressive disorder	4,36			Ear infections	0,44
		Psychoactive substances abuse (drugs)	4,00			Tuberculosis	0,44
		Psychological problems	2,14			Gastrointestinal infections	0,36
		Abuse of psychoactive substances (alcohol)	0,98			Sexually transmitted infections (female)	0,27
		Abuse of psychoactive substances (tobacco, medication)	0,09				
Digestive	12,27	Digestive symptom/complaint	8,27	Endocrinology, nutrition	7,37	Diabetes (insulin dependent and non insulin dependent)	4,00
		Other digestive system disease	3,38			Other endocrine/metabolic/nutritional diseases	1,60
		Ulcers	0,62			Overweight, obesity	1,33
Respiratory	11,13	Upper respiratory infection	2,94	Neurology	6,05	Metabolic symptoms/conditions	0,44
		Asthma	2,05			Neurological symptoms/conditions	4,18
		Other respiratory disease	2,05			Epilepsy	0,98
		Lower respiratory infections	1,78			Other neurological disease	0,89
		Other respiratory symptoms / complaints	1,60			Skin symptoms/complaints	2,05
		Cough	0,71			Other skin disease	1,69
Gynaecology, obstetrics	9,44	Uncomplicated pregnancy and delivery	4,36	Dermatology	5,16	Atopic and contact dermatitis	0,53
		Female genital symptom/complaint	2,05			Parasites/candidiasis	0,53
		Menstrual problems	1,33			Rash / lumps/ swelling	0,36
		Other female genital disease	1,07	Oral health	3,91	Gum and teeth disease	3,91
		Complicated pregnancy/delivery	0,36	Urological	2,58	Urinary symptoms/ complaints	1,87
		Pregnancy, childbirth symptoms or complaints and family planning	0,18			Other urinary/kidney diagnosis	0,71
Contraception	0,09	Ophthalmology	1,78	Other eye diagnosis	1,16		
Cardiovascular	9,69	Arterial hypertension	4,27	Ear, nose and throat	1,52	Eye symptom/complaints	0,62
		Vascular conditions and diseases	1,69			Ear symptom/complaints	0,98
		Other cardiovascular diagnoses	1,42			Nose, sinus symptom/complaints	0,27
		Cardiovascular symptom/complaints	1,33			Other ear diagnoses	0,27
		Ischaemic heart disease, arrhythmia	0,98			Anaemia	0,89
General and non specific	9,16	Other general symptoms/complaints	3,11	Haematology, Immunology	1,43	Other blood/lymph/spleen conditions	0,27
		General and unspecified	1,42			Blood/lymph/spleen conditions symptoms/complaints	0,27
		Fears and worries	1,07			Other male genital system diagnoses	0,62
		Follow-up	0,71	Male genital	0,98	Male genital symptom/complaints	0,36
		Medication	0,62				
		Other reason for encounter	0,44				
		Medical examination	0,44				
		Additional tests	0,36				
		Therapeutic counselling, listening	0,36				
		Care provided	0,36				
		Cancers - malignancy	0,27				

45% of people who declare at least one health problem (i.e. 32% of the survey population) are affected by at least one chronic health problem (see table in appendix 5). These proportions increase with age, of course, and this proportion is higher among men than women (which is consistent with the differences noted earlier in terms of perceived health status). Men are nearly one and a half times more likely to present with (at least) one chronic condition than women of the same age (OR = 1.38, 95% CI = [1.03-1.84]). We must also emphasise that 35% of people suffering from a chronic health problem live in insecure accommodation (all categories combined);⁷⁰ half of them feel lonely (very lonely 23.5%, rather lonely 28.0%), and 17% cannot count on anyone for emotional support.

or parasitic diseases or chronic diseases such as diabetes), the authors underline the point that, despite the fact that the immigrant population attending is relatively young, their reasons for attending services do not differ greatly from those of the general population. (Juryent M, Nunez S., Miro O., "Medical emergencies in the adult immigrants", *An Sist Sanit Navar*, 2006, 29 (S1): 27-34).

69. A diagnosis of HIV infection or AIDS was given in only five cases: three men and two women who came from Argentina, Brazil, Liberia, Nigeria and Moldova. None of them knew they were positive before emigrating. All are on anti-retroviral treatment.

70. 9% are rough sleepers and 7% live in a short or medium term shelter.

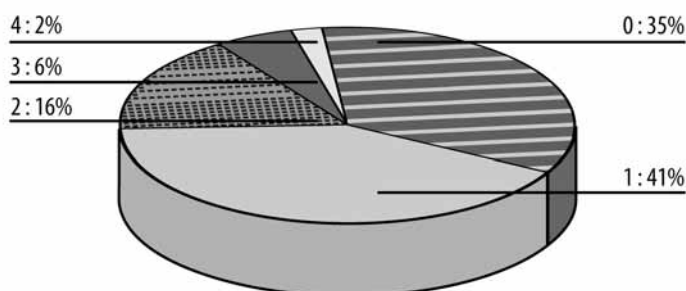
- **Medical follow-up and treatment needs**

Based on the symptoms and diagnoses reported and coded,⁷¹ we can estimate that **at least 24% of the population need medium or long-term healthcare⁷²** and that at least 17% of the population need healthcare in the short term (18% have healthcare needs which cannot be categorised as long-term or short-term based on the coding alone). **In addition, after adjusting for age and sex, people suffering from a chronic health problem do not receive any more medical follow-up than the rest.**

The healthcare needs of this population are very considerable. According to the health professionals who carried out the survey, **two-thirds of people interviewed (65%), had at least one health problem for which treatment was preferable, necessary (29%), or indispensable (21%).** Less than 1 patient in 10 (8%), presented with a health problem for which treatment was considered precautionary. It is important to emphasise that some people suffering from serious health problems are living in harmful living conditions. Of the respondents for whom a professional has judged that they suffer from a condition for which treatment is indispensable, for example, 8% are rough sleepers and 7% are living in a short-stay or medium-term shelter. Furthermore, 15% cannot count on anyone for moral support.

Of the people who are ill,⁷³ one third (33.5%) have different conditions affecting at least 2 different biological systems (21%). A further 12.5% have conditions affecting 3 or more symptoms. Thus, **24% of all respondents present with at least 2 health problems for which treatment is considered preferable** (and 6% with conditions where treatment is considered to be indispensable). These high frequencies, in a population that is generally young, are a sign of delays in accessing healthcare.

59- Breakdown of the population by the number of health problems for which treatment is considered to be at least preferable



Note: 16% of respondents have 2 health problems for which treatment is considered to be (at least) preferable.

> *M. lived for four years in prison in Zimbabwe and he still suffers from the physical and psychological consequences. He tells how he was tortured there because he is gay, which is not tolerated in Zimbabwe. He speaks of being overwhelmed by terrible pain in his legs and knees. "These pains appear suddenly during the night and really make me suffer," he says. The doctor from the detention centre at first prescribed painkillers for him—the results were not great, so that treatment wasn't continued. No tests were carried out to determine the cause of the problem. M. also reports that he has terrible nights, he has very little appetite and he feels very weak. The consequences of the torture in Zimbabwe are profound. He says he has already thought about taking his life. "I thought that it would be better to die sooner than to live with such pain and suffering and without any hope for the future," he said. M. Zimbabwean man, 32, living in the Netherlands.*

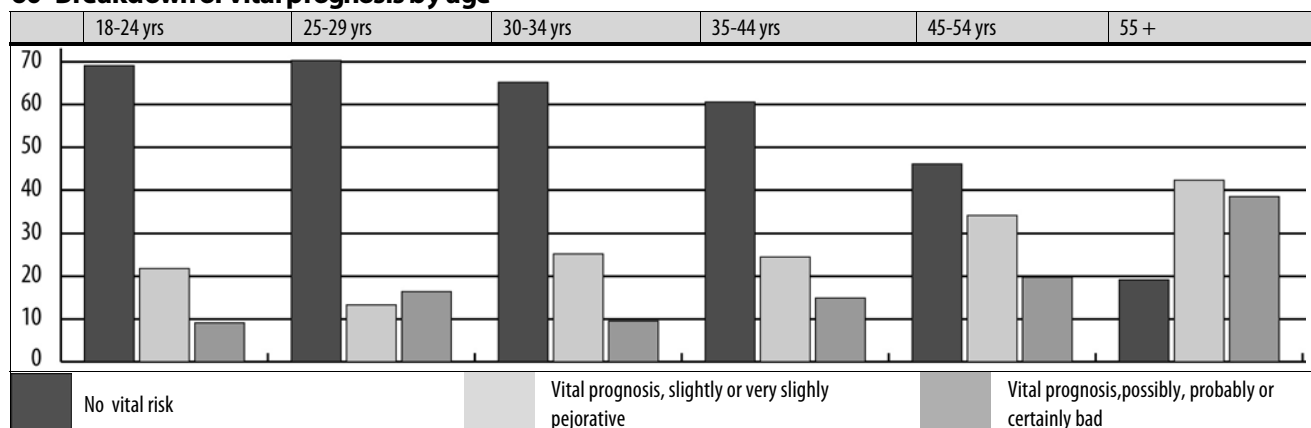
71. The authors thank Georges Fahet of the Midi-Pyrenees regional health observatory and Michel Verdier from Médecins du Monde France's IT department for having made available the analytical tools which they developed to analyse the ICPC.

72. In this report, medium or long-term care corresponds to care for more than six months (definition given in the Médecins du Monde Observatory on access to healthcare in France reports).

73. By "people who are ill" we mean the 80% of the survey population who declared at least one symptom, complaint or disease.

The corollary of this is that 16% of the population presents with a vital prognosis⁷⁴ which is considered to be possibly, probably or certainly bad if they do not receive treatment. Of course, this proportion increases considerably with age and 39% of people aged 55 or older are in this situation (17.3% of respondents in this age group have a vital prognosis which is probably or certainly bad).

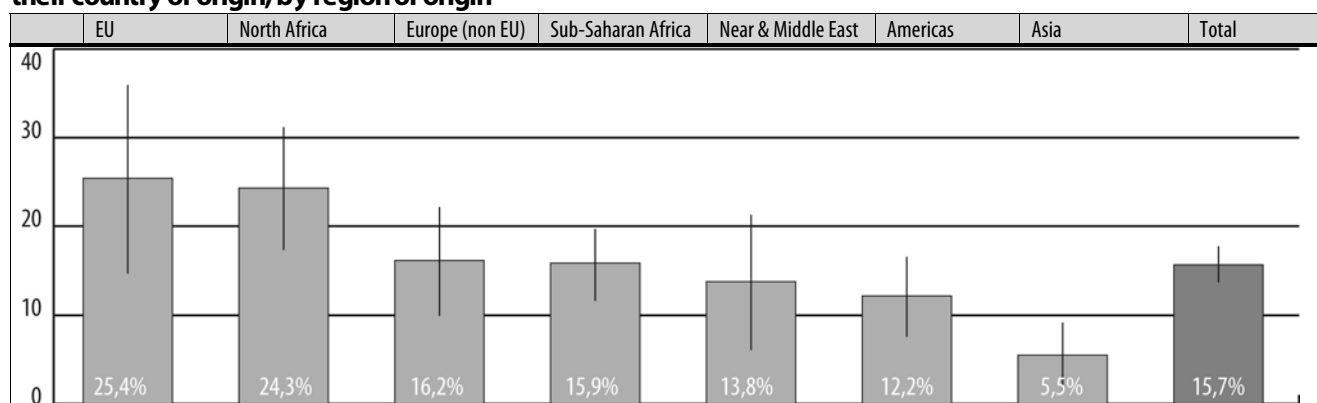
60- Breakdown of vital prognosis by age



- **Healthcare needs not linked to migration to Europe**

Within the survey population, 15.5% of people were suffering (on the day of the survey) from a chronic health problem that they knew about before they left for Europe, with no real differences between countries of origin. Slightly higher proportions of respondents from the European Union and North Africa were in this situation—concerning nearly a quarter of people from these regions.

61- Proportion of the population with at least one current chronic health problem that they already knew about in their country of origin, by region of origin



74. The vital risk, estimated by health professionals, was recorded for 57% of the survey population. This was not recorded in the UK, Italy or Portugal. In the other countries, the response rate varies between 100% (Belgium) and 71% (France). This vital risk was estimated after recording the health problems which the person was suffering from on the day of the survey and categorising these (particularly as acute or chronic). It is evaluated—in the absence of treatment—by a single question with six categories (see figure following) according to a methodology adapted and simplified from that used in France by the Institute for Research and Documentation in Health Economics (see Perronnin M, Rochaix L., Tubeuf S., "Construction d'un indicateur continu d'état de santé agrégeant risque vital et incapacité", *Questions d'économie de la santé*, Paris, Irdes, 2006, n° 107).

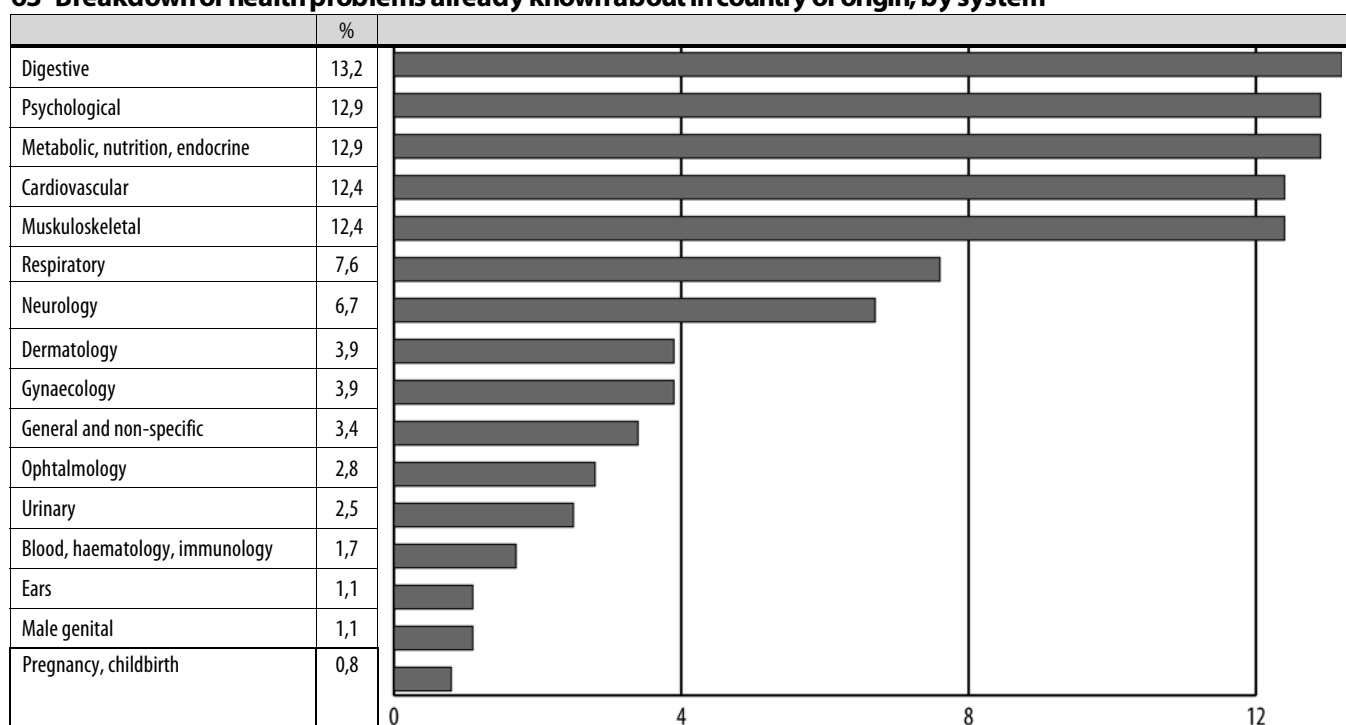
These figures must be put into context by a detailed examination of the health problems in question. The list below details, in decreasing order of frequency, the problems and diagnosis known in the country of origin that were cited at least twice (in other words, by at least 2% of people).⁷⁵

62- Breakdown of most commonly cited health problems that were already known in the country of origin (cited at least twice)

	n	%	cumulative %	continued	n	%	cumulative %
Other psychological disorders	15	4,3	4,3	Other cardiovascular disease	2	0,6	49,1
Hypertension complicated	14	4,0	8,4	Other skin disease	2	0,6	49,7
Allergic rhinitis	11	3,2	11,6	Other urinary condition	2	0,6	50,3
Dysuria	11	3,2	14,7	Other peptic ulcer	2	0,6	50,9
Hypertension (uncomplicated)	10	2,9	17,6	Headaches	2	0,6	51,4
Diabetes non insulin dependent	10	2,9	20,5	Depression	2	0,6	52,0
Gastralgia	9	2,6	23,1	Heart pain	2	0,6	52,6
Musculoskeletal pain	9	2,6	25,7	Skin pain	2	0,6	53,2
Feeling/behaving irritable	8	2,3	28,0	Abdominal pain epigastric	2	0,6	53,8
Headache	7	2,0	30,1	Unwanted pregnancy	2	0,6	54,3
Other digestive system disease	7	2,0	32,1	Haemorrhoids	2	0,6	54,9
Diabetes insulin dependent	6	1,7	33,8	Postural hypotension	2	0,6	55,5
Rectal/anal pain	6	1,7	35,5	Laryngitis	2	0,6	56,1
Low back symptoms/complaints	5	1,4	37,0	Mouth disease	2	0,6	56,6
Migraine	5	1,4	38,4	Nausea	2	0,6	57,2
Blindness	4	1,2	39,6	Otitis externa	2	0,6	57,8
Back pain	4	1,2	40,8	Facial paralysis	2	0,6	58,4
Gout	4	1,2	41,9	Suicide attempt	2	0,6	59,0
Excess weight	4	1,2	43,1	Neck syndrome	2	0,6	59,5
Post-traumatic stress	4	1,2	44,2	Cough	2	0,6	60,1
Foot pain	3	0,9	45,1	Swallowing problems	2	0,6	60,7
Knee pain	3	0,9	46,0	Somatization disorder	2	0,6	61,3
Phlebitis	3	0,9	46,8	Benign genital tumour	2	0,6	61,8
Rhinitis	3	0,9	47,7	Duodenal ulcer	2	0,6	62,4
Anxiety disorder	3	0,9	48,6	Heart valve disease	2	0,6	63,0

*Other conditions were, therefore, cited at a frequency of less than 2 per 1,000 individuals.

63- Breakdown of health problems already known about in country of origin, by system



75. These 224 problems represent 63% of the total 356 health problems known in the country of origin.

Examination of this long and highly disparate list and of the graph on the breakdown of health problems by system demonstrates several things:

- purely symptomatic problems and complaints, which are not part of a precise diagnosis, were very frequently cited;
- common place chronic symptoms or minor complaints (digestive pain, bone and joint pain, allergic rhinitis, gout, peptic ulcer etc) were frequently cited. We cannot seriously imagine that these conditions could have prompted people to emigrate or to move to a country where they would have to live in the poor living conditions that undocumented migrants face in destination countries;
- known diagnoses of potentially serious chronic conditions, on the other hand, were seldom cited (the three most commonly cited—arterial hypertension and the two types of diabetes—represent collectively less than 12% of the health problems recognised before migration and concern less than 3% of the survey population);⁷⁶
- psychological problems were relatively frequent (13% of cases), particularly problems like depression, anxiety, irritability and post-traumatic syndromes.

It is worth reiterating that, as described previously, only 6% of respondents cited health reasons among their reasons for emigrating.

These findings dispel the myth, outlined in some political discourse, of foreigners migrating illegally to come and get medical treatment in Europe. This idea of “immigration for healthcare” or “health tourism” does not reflect the reality in this survey population. Such situations appear rarely—or rather exceptionally—in the survey population, as several national reports in different European countries have already shown.⁷⁷

- > *Mrs L. came to Médecins du Monde because she felt tired and had had a cough for several weeks. She had just finished training to be a couturier and should have started—undeclared—working, but she felt too weak. She presented with a general change in health and clinical examination identified the possibility of pulmonary tuberculosis. A chest x-ray was ordered and carried out within 24 hours, as well as standard biological tests. She was offered, and accepted, tests for hepatitis and HIV. Mrs L was smiling and thanked everyone warmly. A month later she came back to the clinic—she had just got out of hospital after three weeks in an infectious diseases ward. She was admitted to hospital immediately after the chest x-ray, which was abnormal and suggestive of tuberculosis. On top of the tuberculosis, additional tests identified two other serious chronic conditions: diabetes and hepatitis B. Mrs L., Chinese woman, 30, living in France.*

• Violence suffered before migration and at the time of the survey

The issue of violence during the migration process is increasingly recognised and is cause for concern, particularly for front-line health professionals working with these groups. The issue goes wider than the torture and political violence which asylum seekers face.⁷⁸ More general, high quality, representative studies on this subject are lacking.⁷⁹

76. In particular, as we emphasised previously, none of the five people with HIV/AIDS knew about their condition before they arrived in the host country.

77. In the Netherlands, we would quote a government report: Smeets R.M.W., de Beaufort I.D., Entzinger H., “Medische aspecten van het vreemdelingenbeleid”, Nijmegen: Landelijke Commissie Medische Aspecten van het Vreemdelingenbeleid, 2004.

78. Loutan L., Bierens de Haan D., Subilia L., “La santé des demandeurs d’asile: des maladies transmissibles aux syndromes post-traumatiques”. Bull Soc Pathol Exot 1997, 90: 233-7.

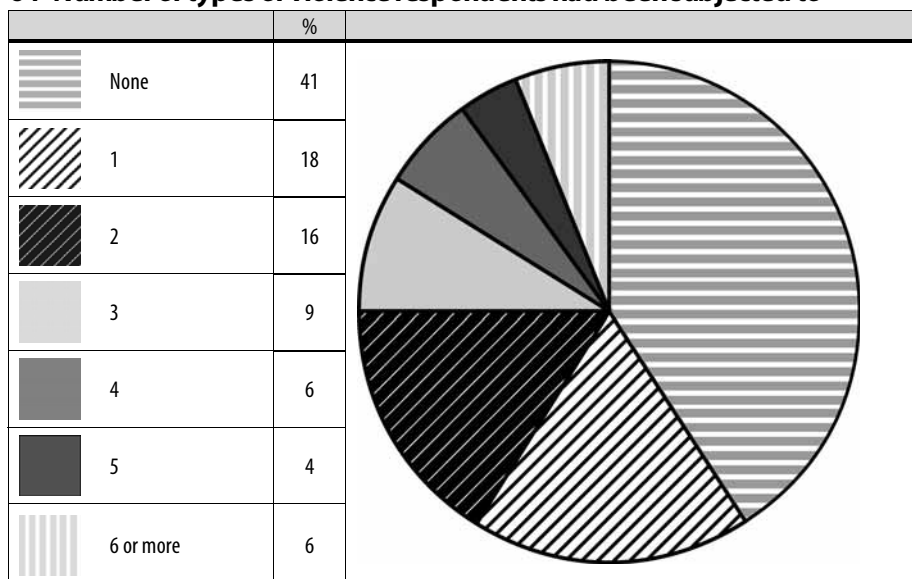
Gerritsen A.A., Bramsen I., Devillé W., van Willigen L.H., Hovens J.E., van der Ploeg H.M., “Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands”. Soc Psychiatry Psychiatr Epidemiol, 2006, 41: 18-26.

79. Lindert J., Brähler E., Wittig U., Mielck A., Priebe S., “Depression, anxiety and posttraumatic stress disorders in labor migrants, asylum seekers and refugees. A systematic overview [in German]”, Psychother Psychosom Med Psychol, 2008, 58: 109-22.

Our survey included a section on potential violence that respondents had been subject to before, during and since their arrival in Europe, which contains 10 categories: suffering from hunger or lacking enough to eat, living in a country at war, physical violence (including domestic violence), being prohibited from earning a living or denied access to money earned, violence by police or armed forces, being subject to surveillance or restriction on activities, being threatened or imprisoned for their ideas, torture and sexual assault and a category for *other* types of violence. Given the sensitive nature of these questions, only some of the teams decided to ask them. In total, just under half of the survey population was asked about violence they had been subjected to during their lives in five countries (Germany, Belgium, France, Greece and Italy).⁸⁰

Many of the respondents have faced violence: **59% of the population questioned reported having been subjected to at least one type of violence** of the 10 types mentioned (see table). Moreover, people had often had multiple experiences of violence—40% report having been subjected to several types of violence and 18% to only one type of violence.

64- Number of types of violence respondents had been subjected to



- > *Mrs B. tells me that she came to work, that she is a bit lonely. But she is ok—she has friends. She smiles. She says that she is anxious, she has a problem with her head, and she doesn't sleep well. We approach the section on violence cautiously. She says that she's ok, but the smile has disappeared. She starts to cry. She tries to smile, but clearly it is hard. She explains, in her own words, that it is not easy to express herself in French, but she expresses herself all the same. She had a boyfriend in France—she was a virgin. A year ago, he beat her and raped her. She has never seen him again. Since then she has had nightmares at night, sleeps badly, has anxiety attacks, has a headache. Yes, she would like to speak to a psychologist, but it is not easy in French. Mrs B., Moroccan woman, 25, living in France.*
- > *"In Mali, I lost my papa when we were little. Our mother went to the market to sell condiments, to look after us. We were eight children. I am the oldest in my family. When I was at school, on holiday, I went to people's homes to work, so that I could pay for the books and bags. I am against excision—because I was a victim of it. Because I had been cut badly in Mali. The man who I was engaged to was always telling me "you have not been circumcised well" ("excised"⁸¹). There is a term in bambara, I don't know how to say that in French... The men say that you are like a man if you have not been cut well. That shocked me. I left him. Every time he said that to his friends, I was ashamed. In Mali, many women have been victims of that. They have a lot of pain and many problems in childbirth... because they have been cut. If you have sex it hurts.*

80. In these countries, the response rate to these questions is excellent: 84% in the Belgian programme, 88% in the German programme, 87% and 97% in two French programmes and 100% in all the other programmes.

81. This refers to the process of female genital mutilation (FGM)

I do not want my children to be victims, as I was. I do not want that. My daughter was a victim. I came so that my future children will not be victims. In Mali, they do not want to stop. There are women who are only there to do that. If you say that you don't want to, they will say that you are behaving like "whites." If I had the means here, I would like to set up a project to fight against excision." S., Malian, 29, living in Saint-Denis in France.

Still with reference to the 10 types of violence outlined, **41% of respondents have been victims of violence in their country of origin, 24% since they arrived in the host country**, and 7% during their migration journeys. Migration to Europe seems, therefore, to have enabled many people to escape the violence that they had been subject to in their country of origin, while not protecting them from violence in the host country. It is important to underline that this relates to reported data and, as such, may be affected by reporting bias (known in all surveys). In addition, the violence that people were subjected to during their migration journeys appears to be under-reported in relation to what the *Médecins du Monde* teams know about the journeys of migrants attending their services.

Three types of violence had been experienced as often in the destination country as in the country of origin: sexual assault, confiscation of financial resources and "other violence" (a heterogeneous category which can include psychological or moral violence). Being deprived of food is certainly less common in the host country than in the country of origin, but many people are still affected nonetheless—**15% of the survey population have experienced not having enough to eat since they arrived in the host country**. The other categories of violence are more often experienced in the country of origin.

Similar proportions of men and women have been subjected to violence—throughout their lives, in the period preceding migration, or since arrival in the host country. In contrast, significant differences between the sexes appear for four types of violence. More men have been physically threatened or imprisoned for their ideas (14% compared to 6% of women). Three times as many men have been victims of violence by police or armed forces (22% compared to 7% for women). Men are also more likely to have been prohibited from earning money or denied access to money that they had earned (22% compared to 16%). Women, in comparison, report that they have been victims of sexual assault more often than men (12% compared to 1% of men).⁸²

65- Proportion of people having been victims of violence at any time in their lives, before, during, or since migration

	Throughout their lives % CI (95 %)		Before migration	During the journey	Since arrival
Suffered from hunger or lacked enough to eat	35,5	31,3-39,8	21,1	4,6	14,7
Lived in a country at war	27,4	23,7-31,4	26,1	1,6	-
Suffered physical violence (domestic or other)	20,0	18,6-25,8	16,0	0,8	4,2
Money confiscated (or prevented from working)	19,5	16,2-23,1	9,4	0,9	9,4
Violence by police or armed forces	16,5	13,4-20,0	11,4	1,5	4,1
Surveillance or has had restrictions on behaviour	12,8	10,1-16,1	10,8	0,0	2,0
Been physically threatened or imprisoned for ideas	11,0	8,5-14,1	10,2	0,3	0,5
Torture	7,0	5,0-9,6	6,1	0,6	0,3
Sexual assault	6,4	4,4-8,9	3,2	0,0	3,2
Other violence (unspecified)	8,4	6,1-11,1	3,2	0,9	4,3

Note on interpretation: 35.5% of respondents say that they have suffered from hunger or have not had enough to eat. And still in relation to the whole sample, 21.1% of respondents have been deprived of food before their migration, 4.6% during the migration journey and 14.7% since their arrival in the current country of residence.

- > *"At home I was a taxi driver, and one day I was car-jacked by some bandits who ran loose in my village—a small quiet village. With my parents, we went to complain and then we could no longer live in the village for fear of reprisals by the bandits. We had to flee and hide. My father decided that I should leave the country to save my life. They got together and found the money to send me to Dubai. I stayed in Dubai for a year. Then, I learned that my village was bombed and my whole family had been killed." Indian man, 31, has been living in Belgium for one year.*

82. It is highly possible that there will be a reporting bias on this point, if we consider that men who have been subject to sexual violence are less likely to report it in this kind of survey.

- > *A. came to the UK from Iran six years ago to seek asylum. He is an artist and had been imprisoned for three months and tortured for having published critical political cartoons. His body is marked by deep scars. Freed, he lived for 10 years under constant surveillance, with his telephone bugged, without any identity documents (these had been confiscated) and he was constantly followed. As soon as he could get his passport back, he fled Iran, where he and his family were subject to repeated death threats. Three of his cousins had been killed. A., Iranian man, living in the United Kingdom*

To conclude this chapter, we need to stress that these figures probably represent minimum frequencies because we know that there is normally an under-reporting bias when this type of “rapid” survey covers such private issues. In addition, the questions posed systematically focused on physical violence—without taking emotional and psychological violence into account. According to a survey of migrants— asylum seekers, refugees, documented and undocumented migrants—in the Netherlands and Belgium,⁸³ most of the violence that the respondents had been subjected to was psychological in nature (humiliation etc).

- > *“I had a difficult and painful childhood. My father was a thief and was in prison very often. When he was out, he beat my mother who had become an alcoholic and he beat me and my little brother and sister. I left them when I was 19 and I went to Greece, illegally. I had heard that the life in Greece was better, more humane. I went to an office that I thought was a travel agent, but in fact it wasn’t. A man purchased me and 19 other girls from my country and Ukraine. He took us by car to Bulgaria then into Greece on foot across the mountains. In Thessalonica, we were locked in a house and made to work as prostitutes. My pimp beat me and threatened that if I ran away he would find me and send me back. He abused us sexually, the other girls and me, on top of everything else.*

I ran away six months after I arrived with a man that I met there. I was not in love with him, but I liked him a lot and I trusted him. He took me to his parents’ place in Athens. They didn’t want me or like me because I am Moldovan. After five or six months I fell pregnant and I learned that I was HIV positive. Obviously, it was as a result of my past. I tried to kill myself several times by taking medicines. My mother-in-law found me and saved me each time. I didn’t want my life. I wanted to die.” Moldovan woman, 27, living in Thessalonica, Greece.

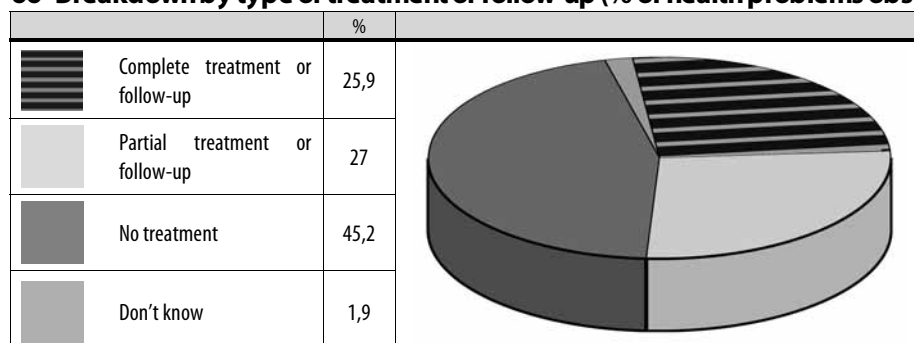
83. Keygnaert I., Wildon R., Dedoncker K. et al., “Hidden violence is a silent rape: prevention of sexual and gender-based violence against refugees and asylum seekers in Europe, a participatory approach report”, Ghent, International Centre for Reproductive Health, Ghent University, 2008.

9. ACCESS TO HEALTHCARE AND PREVENTIVE CARE

- Inadequate medical care and follow-up

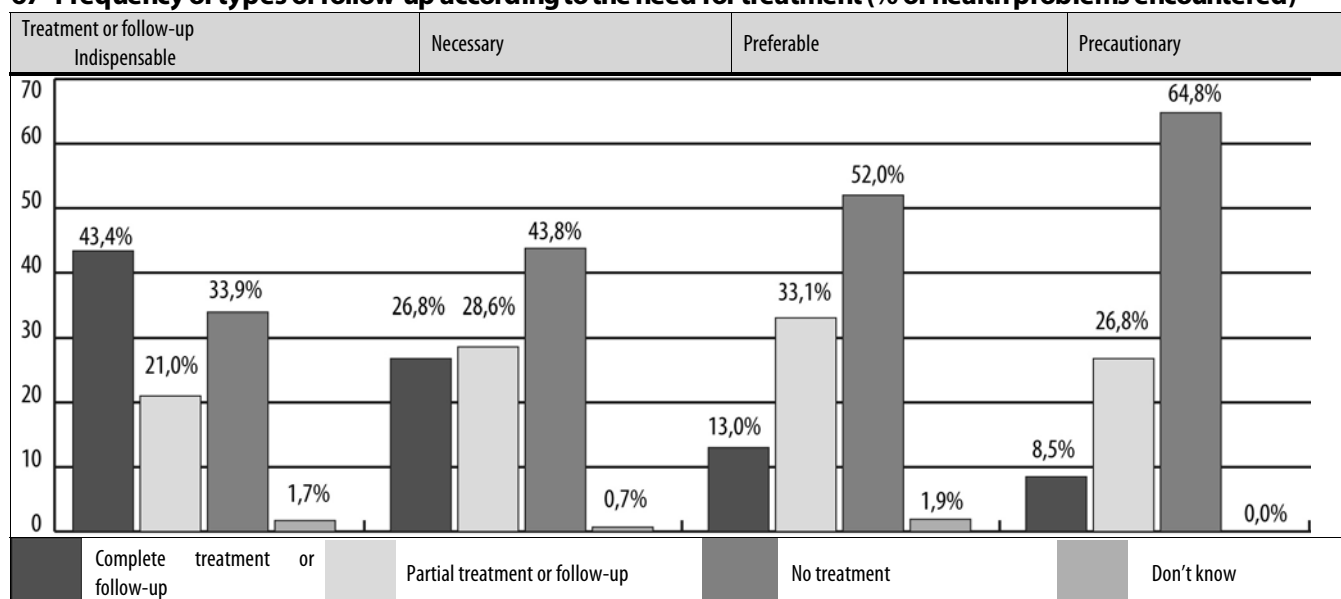
Of the 1,371 health problems identified among the survey population, only 1 in 4 (26%) are receiving complete treatment or follow-up. Another quarter (27%) are only partially treated or followed-up and nearly half (45%) were not receiving any treatment or follow-up at the time of the survey.

66- Breakdown by type of treatment or follow-up (% of health problems observed)



In general, the more important the treatment is considered to be by the health professional,⁸⁴ the more likely—fortunately—that the problem is being correctly treated or monitored. Nevertheless, a third (34%) of health problems for which treatment was considered to be indispensable were not receiving any treatment or follow-up and a fifth were only receiving partial treatment at the time of the survey. Less than half of the health problems (43%) for which treatment was considered to be indispensable were receiving complete treatment or follow-up. When the treatment was “only” considered to be necessary, nearly one in two problems (44%) were not being treated at all. Finally, only 13% of less serious health problems—for which treatment is nonetheless preferable—were being completely taken care of. In total, 38% of the population presented with at least one untreated health problem (and more than 10% with at least two...).

67- Frequency of types of follow-up according to the need for treatment (% of health problems encountered)



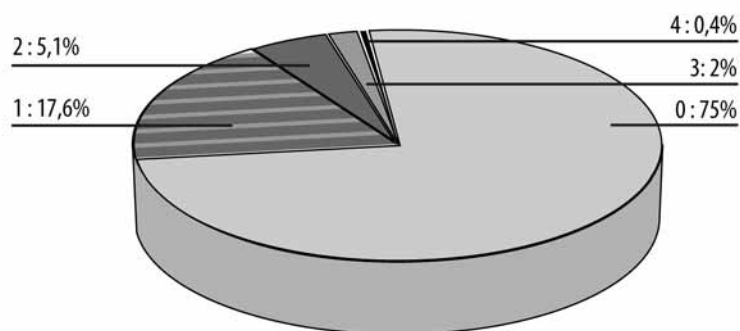
84. The health section of the questionnaire was administered by a health professional in 85% of the cases. In 58% of cases by a doctor, in 12% by a nurse, in 15% of cases by another health professional (psychologist, care assistant, midwife), in 7.5% of cases by a medical student and in 7.7% of cases by another worker.

This observation that health problems are very often not receiving medical follow-up is to be considered alongside the high prevalence of chronic diseases and the self-perceived health status of the survey population (worse than for the European population in general) (see preceding chapter). The lack of follow-up is an aggravating factor which needs to be improved, in the interests of public health and equality of access to healthcare. According to the World Health Organization in Europe, “non-communicable diseases and their causes concentrate among the poor and vulnerable. People in low socioeconomic groups have at least twice the risk of serious illness and premature death as those in high socioeconomic groups. When improvements occur, the benefits are unevenly distributed. People in high socioeconomic groups often respond better and benefit more from health interventions. Overall, a comprehensive strategy to fight against non-communicable diseases would help countries' health systems promote health and prevent disease in the whole population, actively target people at high risk and improve the care of those already suffering. Action to reduce inequalities in health needs to be an integral part of all measures.”⁸⁵

- **Delays in seeking healthcare**

Since their arrival in the country, a quarter of the population (25%) received treatment too late (at least once) for at least one of their current health problems. This proportion is even higher in relation to chronic health problems—33% of chronic health problems were treated too late at least once. While this is logical (the likelihood of receiving late treatment increases with longer-lasting health problems), it is worrying nevertheless.

68- Frequency of number of current health problems receiving late treatment at least once in the host country



Note on interpretation: 5% of respondents have two current health problems which have received late treatment at least once in the host country.

Respondents received treatment late at least once for a wide range of range of conditions and illnesses. The table in Appendix 5 indicates the frequency of the 69 diagnoses cited at least twice by doctors (equivalent to 70% of cases). Excluding symptoms, the chronic or potentially serious illnesses which were subject to delays in treatment include: diabetes, hypertension with complications, post-traumatic syndrome, hypothyroidism, pyelonephritis, HIV/AIDS, ischaemic heart disease, cancer, and depression.

- > *The first time that she came to Open Med [the MdM programme], E. had been suffering from abdominal pain for weeks, but she had not dared to ask anyone for help. It was the first time that she had been ill since she had arrived in Germany. In fact, a year before, when she went back to Croatia, she was diagnosed with ovaritis. When she returned to Germany she did not go for treatment because she didn't have enough money. In addition, she says that she speaks German very badly and that she did not feel capable of going to see a German doctor. But the pain became unbearable. She then asked a neighbour for help and the neighbour accompanied her to MdM. The MdM doctor diagnosed an ovarian tumour and recommended an urgent operation. She does not know where to go for the operation, or how to pay for it. E., Croatian woman, 38, has been living in Germany, on and off, for several years.*

85. WHO website : http://www.euro.who.int/mediacentre/PR/2006/20060908_1

• Ante-natal monitoring

Of the women interviewed, 11% were pregnant (55 women). Of these, **under half (48%) were having their pregnancies monitored** (the survey doesn't collect data on how far advanced the pregnancies were). This proportion was almost identical in all countries, except Sweden, where more than 80% of pregnant women were monitored (but the small sample sizes prevent any rigorous statistical comparison).⁸⁶

The ante-natal monitoring rates relate closely to whether women had access to healthcare "the last time they were ill": **80% of women pregnant on the day of the survey were being monitored when they already had access to healthcare, compared to 44% of women without existing access to healthcare** (not significant, but the sample sizes are small). The rate is even lower in pregnant women who have been in the survey country for a year or less (30%).

- > *"My sister was pregnant. We went to the hospital 20 days before she gave birth to a boy. They said that she did not have the right to any medical care because we are undocumented and we had to pay." O. Albanian Roma, in Greece for a year.*

- > *When I first came to Project: London [Médecins du Monde] I was already very pregnant – I think I was in my sixth month of pregnancy. I had received no ante-natal care, and I was not registered with a GP. I had tried to go to a medical centre when I was three months pregnant, but they asked me for my passport and whether I was "entitled to receive care from the NHS." I went to the hospital to book the delivery: I had to have a caesarean section. The financial personnel were extremely aggressive and rude to me. They told me that if I can't pay, if I don't have the money, that I need to leave. At one point, one of the payment officers started screaming at me, telling me very rudely to "Sit here! Speak about money!" I was heavily pregnant at this point, and very close to tears. She threatened to take me to court if I didn't pay, and said that if I tried to leave the country, they would pursue me in Ecuador. I couldn't take her screams anymore and I broke down. I was sitting there in a little heap on the floor, crying ... No one came to speak to me. I tried to explain to them that I simply did not have the money to pay for the services and the delivery, that I was not working and had no relatives here. At this point, I was living off vouchers given to me by a local charity—on 28 euros per week. They told me to go and sell the vouchers and give the money to the hospital! I had a very traumatic delivery, and the mix of painkillers and antibiotics I received afterwards damaged my liver. I was sick for the next five months, with severe pains in my joints to the point that I couldn't walk, as well as fevers, headaches, and shivering and shaking. Of course, I constantly worried about my child—if something were to happen to me, what would happen to my baby? Ms D., student from Ecuador, in London.*

• Case study: Access to healthcare the last time they felt ill

The last time that interviewees felt ill, 80% of people affected did not have any effective access to health coverage.⁸⁷ There were no differences according to sex, age or family situation. The figures for each country confirm the analyses of the previous chapter, even if they are not strictly comparable.

In France, the proportions of people without effective access to health coverage during their last episode of illness and on the day of the survey are similar, at around 90%. This is also the case in Belgium (a few people had lost access to the AMU in the meantime). The proportions are also similar for respondents in Spain (around 60%).

In the United Kingdom, 10% of people had lost their access to health coverage between their last episode of illness and the day of the survey: this could be due to people who have moved without registering with a new doctor (general practitioner).

86. During the survey, a specific programme for pregnant women was run in the Médecins du Monde clinic in Stockholm in order to ensure access to ante-natal monitoring.

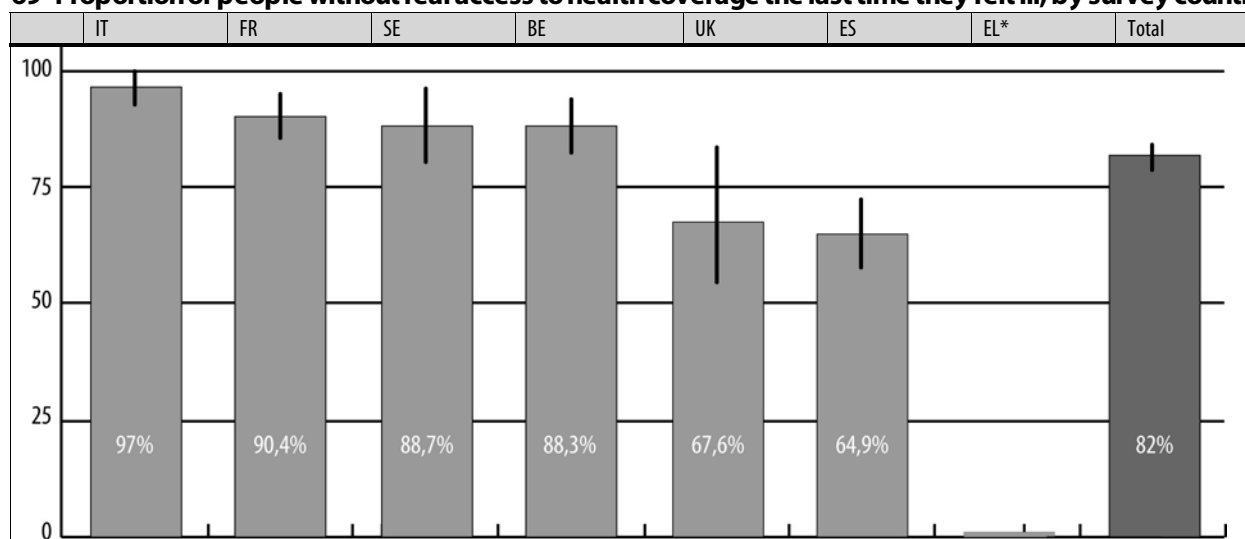
87. The 20% who have not felt ill, are excluded from the following calculations.

The highest proportion of people without access to health coverage the last time that they were ill is in Italy. In 2004, a survey by MSF in another region (Campania) observed that 89% of undocumented migrants did not have healthcare coverage.⁸⁸ In our survey, nearly 30% of people without healthcare coverage during their last episode of illness (the case for most respondents) had access on the day of the survey. This is probably explained by the fact that the Italian programmes involved in the survey provided people with follow-up support.

In Sweden, the 13% who did have access to health coverage during their last episode of illness includes people who were asylum seekers at the time of their last illness episode and who have since had their claims rejected, and are now classified as undocumented migrants.

Greece, it is worth remembering, has no system to enable access to health coverage for undocumented migrants, except for urgent care.

69- Proportion of people without real access to health coverage the last time they felt ill, by survey country



The question was not asked in Greece—the absence of access to health coverage is represented in this figure (see chapter on theoretical rights); Neither was the question asked in the Netherlands because the general practitioner deals with requests for healthcare coverage on a case-by-case basis.

Questioned about what action they took the last time that they were ill, 71% of respondents say they consulted a health professional. At first glance, this seems like a satisfactory result.

70- Action taken during last illness episode

	n	%		n	%
Consulted a health professional	646	71,3	Did nothing at all	51	5,6
Dealt with it himself/ herself	101	11,1	Other*	8	0,9
Consulted a neighbour, friend, family member	54	6,0	Consulted a traditional practitioner	5	0,6
Took advice from a pharmacist	52	5,7			

*The “other” category include consulting non-medical social services (for about half) and travelling to a neighbouring country to attend health services (from Greece).

In reality, the action taken depends heavily on whether individuals had effective access to health coverage at the time. People with such healthcare coverage, therefore, are more likely to have consulted a health professional than the others (87% compared to 67%, 20-point difference). Conversely, people without healthcare coverage are more likely to have dealt with it themselves (13% compared to 2% of people with healthcare coverage). **In addition, people with healthcare coverage were more likely to attend mainstream health services (46%) or hospital emergency departments (40%) than specific services (15%),** while people without healthcare coverage mostly consulted specific services⁸⁹ (57%).⁹⁰

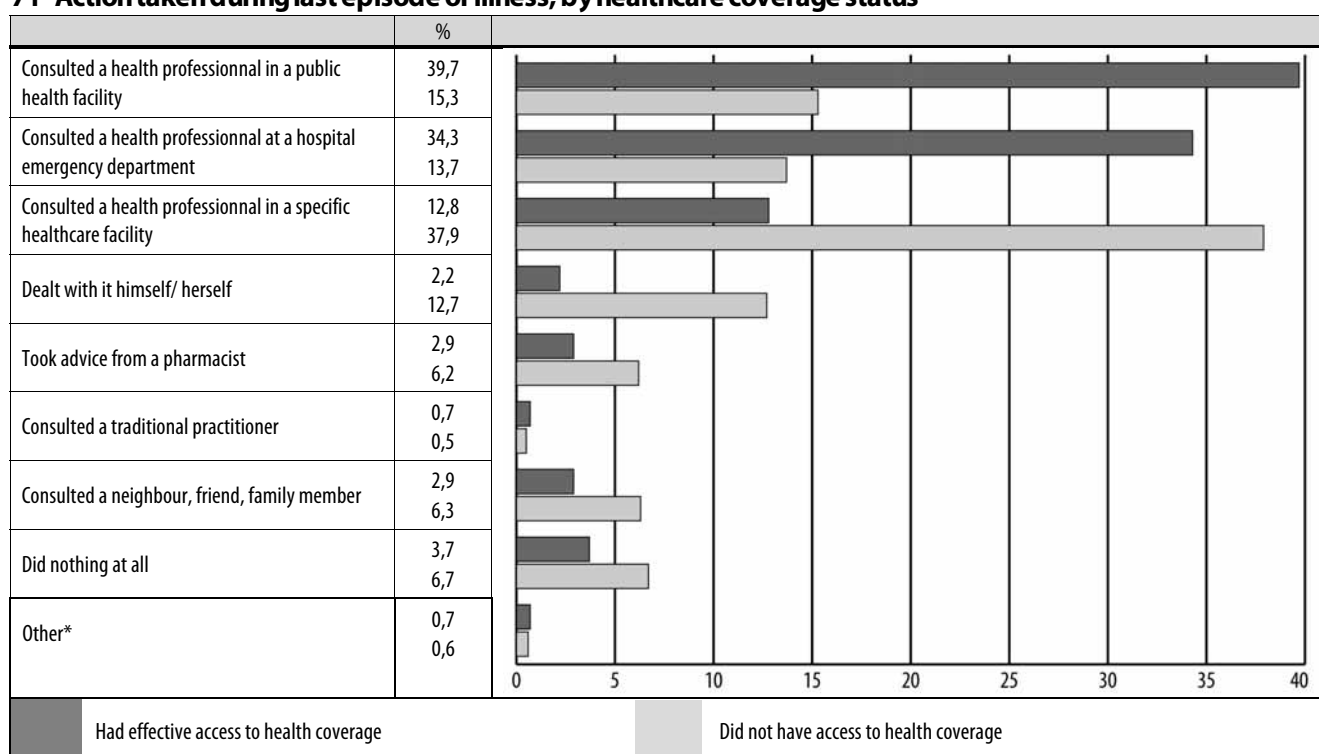
88. Virgilio A., Defilippi L., Moschochoritis K, Ravinetto R, “Right to healthcare for vulnerable migrants”, *The Lancet*, 2007; 370: 827-28.

89. This refers to services which are specifically targeted at particular vulnerable groups, such as people excluded from healthcare, homeless people etc. It includes voluntary sector programmes (like the MdM programmes and other NGO projects) but also includes services like the PASS (*Permanences d'accès aux soins de santé*) facilities in French hospitals and the Walk-in Centres in the UK.

90. No difference according to sex or age (neither in terms of type of facility attended, or the relationship between healthcare coverage and the type of service attended)

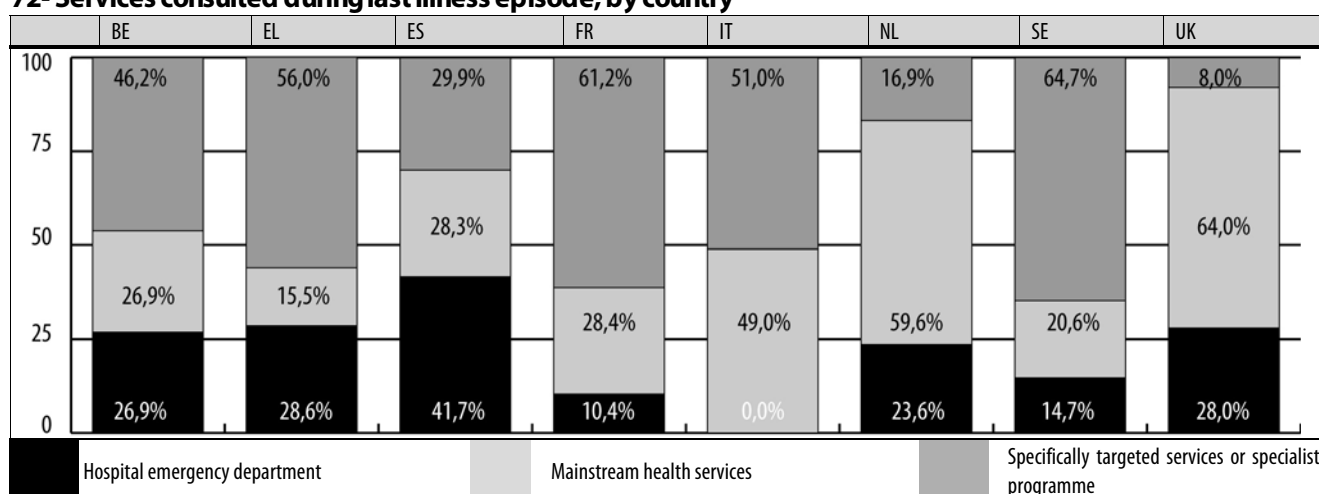
Because they were unable to consult a doctor, people without access to health coverage were twice as likely to consult a pharmacist (6% compared to 3%), a friend, neighbour or family member (6% compared to 3%), or to have done nothing (7% compared to 4%). Traditional practitioners were consulted very rarely (less than 1% of cases), with no significant differences between respondents who had healthcare coverage and those who did not.⁹¹

71- Action taken during last episode of illness, by healthcare coverage status



Differences between countries in terms of the types of services consulted should be interpreted with caution, particularly in relation to the UK and Italy, where the sample sizes are quite small. Nevertheless, it is in both of these countries—and in the Netherlands—where the proportion of people consulting mainstream health facilities when they last felt ill is highest (between 49% and 64%). The proportion is lowest in Greece (16%) and all other countries lie in between (a fifth to a quarter of respondents consulted mainstream services). For this particular population—recruited in specifically targeted centres or specialist programmes—seeking care from hospital emergency departments is particularly low in Italy, but also in France and Sweden. Conversely, in France, Sweden, Greece and Italy the majority sought care from a specific service.

72- Services consulted during last illness episode, by country



91. We do not see any substitution of western medicine by traditional medicine. This reflects the results of other studies which, in general, show that in migrant populations—even recent migrants—people seek both types of healthcare in a “mixed” system rather than choosing between one or the other.

• The example of HIV screening – widespread misunderstanding

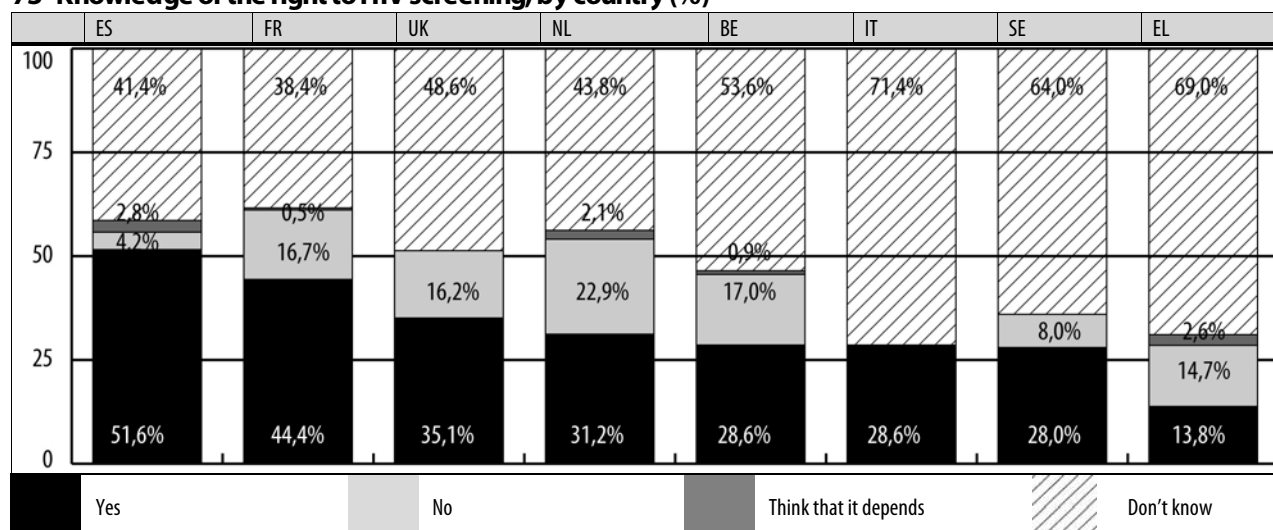
There are many barriers—cultural, social and structural—to migrants in Western Europe accessing an HIV test. There is poor understanding of the disease and the available treatment, for example. There is also a lack of awareness of testing and treatment services, as well as fear of stigmatisation. For undocumented migrants in particular, these barriers are combined with the fact that they are even further from accessing prevention and treatment services. This is particularly true in countries where political discussion about “fighting against immigration for healthcare” uses HIV/AIDS as a symbol of so-called “health tourism”,⁹² even though this is extremely marginal, particularly when it relates to people living in a vulnerable situation (this question will be revisited later). **Only a third (35.4%) of all respondents know that an undocumented migrant can have access to a HIV test free of charge.** Moreover, 12.9% say that this is not the case and 50.1% say they do not know.

The responses are very different from one country to the next. **Knowledge of existence of free testing is highest in Spain and in France.** In both countries two positive factors combine to explain the difference. Firstly, migrants often master the host country’s language (Spanish speakers from Latin America in Spain, and French speaking North Africans and sub-Saharan Africans in France) so they are potentially more receptive to general public information on this issue. Secondly, campaigns to encourage migrants to attend screening services have been developed to differing degrees (particularly within the programmes which participated in the survey in both countries).

In contrast, **the majority of undocumented migrants interviewed in Belgium, Italy, Sweden and Greece are unaware of this right:**

- In Sweden and Greece, the generally restrictive legislation on access to healthcare for undocumented migrants certainly has an influence on the widespread lack of awareness about the availability of free HIV testing.
- In the United Kingdom, the fact that undocumented migrants do not have access to antiretroviral treatment⁹³ obviously does not facilitate the promotion of screening. The availability of treatment and access to treatment in the early stages of the infection are powerful factors in encouraging people to take a test, as has been seen in developing countries since access to anti-retroviral treatment has become more widespread.

73- Knowledge of the right to HIV screening, by country (%)



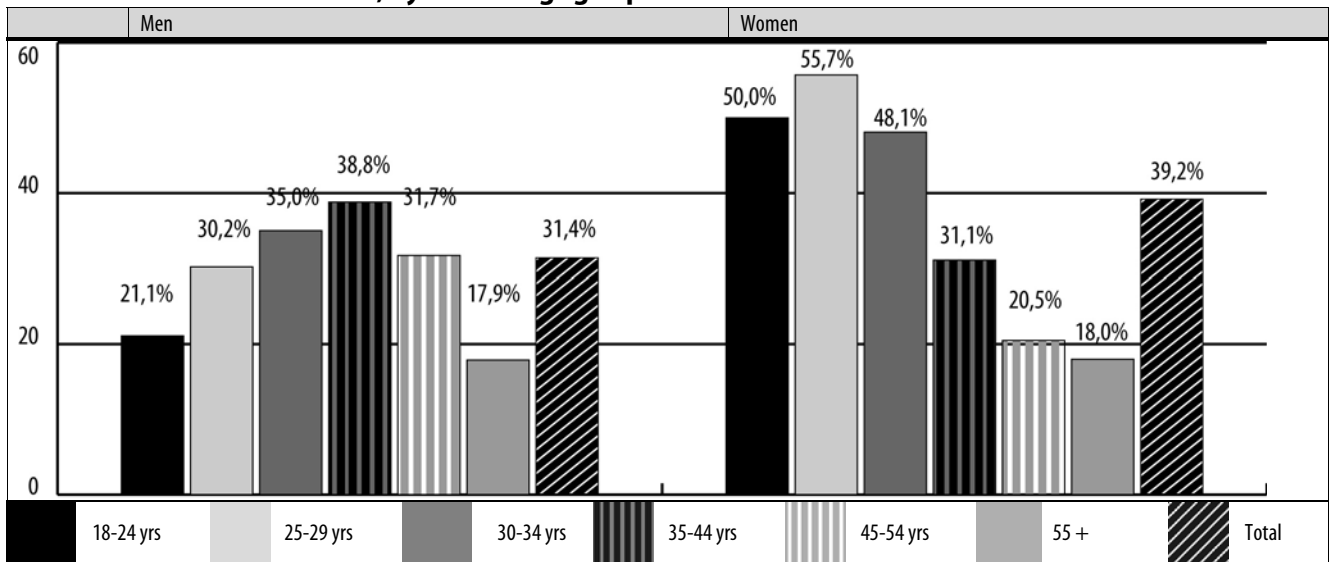
92. Fakoya I., Reynolds R., Caswell G., Shiripinda I., “Barriers to HIV testing for migrant black Africans in Western Europe”, *HIV Med*, 2008, 9(S2): 23-5.

93. Cf. Terrence Higgins Trust & National Aids Trust, “*Note on access to HIV treatment for undocumented migrants and those refused leave to remain*,” THT, February 2006 and National AIDS Trust. “*The myth of HIV health tourism*,” NAT, October 2008.

> Miss X. arrived in France at the age of 18 to look for work. She looks after children and is staying with a friend. When we approach the subject of violence, she tells us that she was raped when she was 13. Miss X. came to see a doctor because she felt tired, had had sore joints for a long time, and slept poorly. This suggested a psychosomatic condition. As part of our prevention activities, we offered her screening for HIV and hepatitis. She agreed and did not seem to be worried—she had not taken any risks. The HIV test was positive. Miss X., from the Ivory Coast, 25, living in France

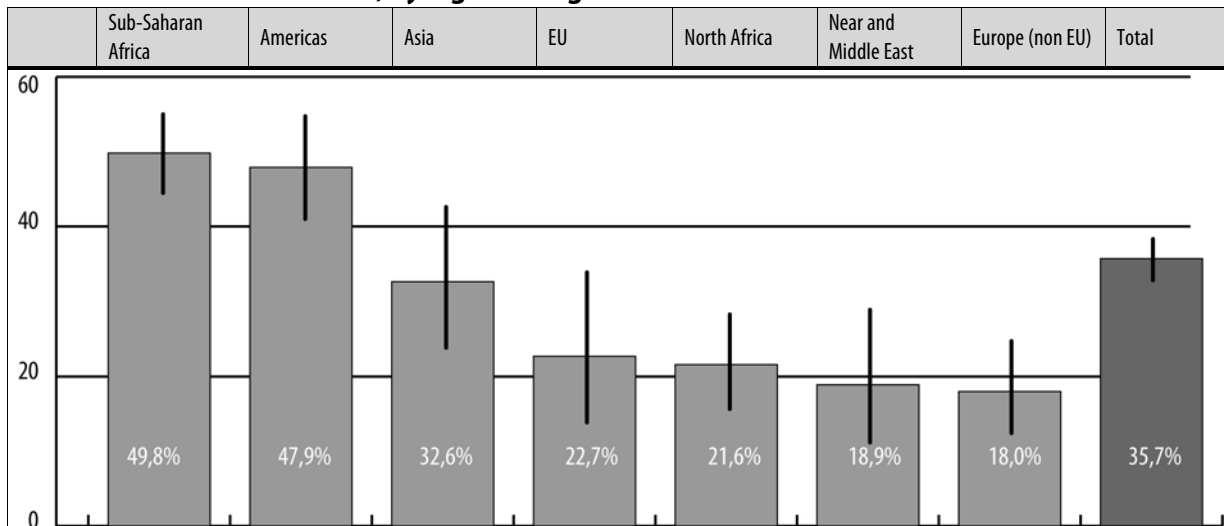
With more than a third (35.7%) of respondents having previously wanted to take an HIV test while in the survey country, the demand for testing is far from negligible. More women than men had wanted to have an HIV test (39.1% compared to 31.3%, $p = 0.01$). In the 18 to 29 year old age group, the majority of women wanted to have an HIV test. The rate peaks later in men (in the 35-44 year old age group) and never reaches more than 38.8%, irrespective of age. In women, the rate decreased greatly after 45 (indicating that it may be more linked to childbearing rather than sexuality) while in men it doesn't decrease until the age of 55 and reaches an identical rate in the two sexes from this age onwards (18%).

74- Wanted to have an HIV test, by sex and age group



The desire to have an HIV test was most common in people originating from sub-Saharan Africa and the Americas, including the Caribbean (nearly half of respondents). This wish was least common in people from North Africa, the Near and Middle East, and Europe (less than a quarter of respondents).

75- Wanted to have an HIV test, by region of origin

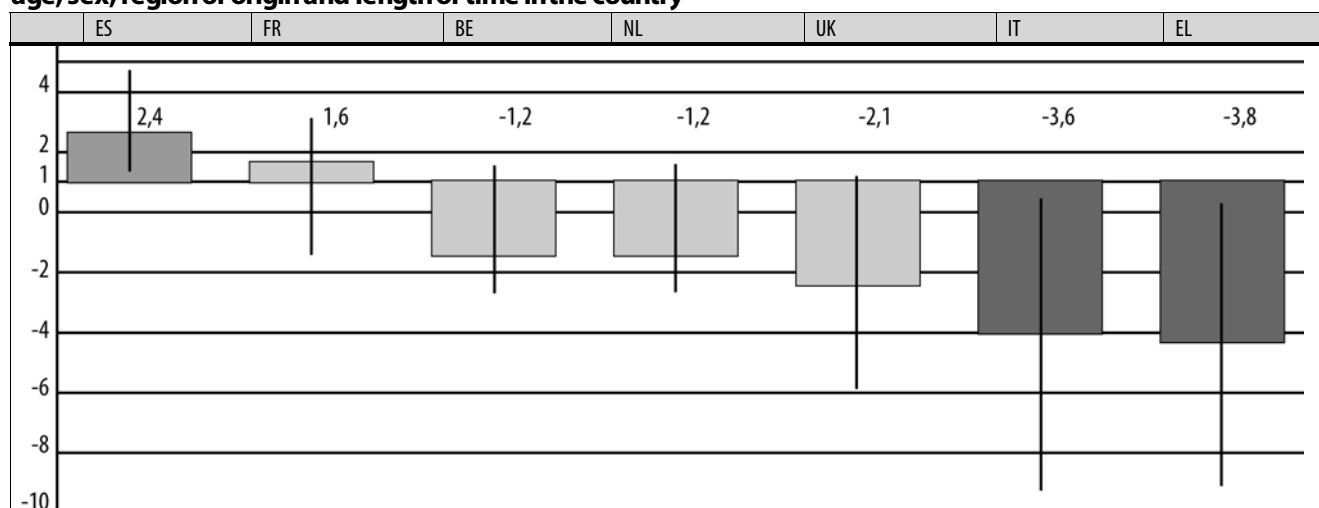


The very low rates of wanting to have an HIV test among Europeans—EU nationals or not—are notable. These are despite the fact that in Central Europe HIV is predominantly spread through young adult heterosexual transmission and that the incidence of HIV infection in Eastern Europe is very high (four times higher than the European Union in 2006).⁹⁴

The desire to have an HIV test also depends on how long people have been in the survey country. As we might expect, people who have already wanted to have a test have been living in the country longer than the others (57 months on average compared to 47 months, $p=0.005$). This desire to have a test, therefore, varies according to respondents' age, sex, geographical origin and length of time in the survey country. Analysis of potential differences between countries should take these different characteristics into account.

In multivariate analysis, therefore, **adjusted for sex, age, length of time in the country and geographical origin, the probability of having wanted to have a test appears significantly higher in Spain⁹⁵** (people there are 2.4 times more likely to have wanted to have a test than in Sweden, which was arbitrarily chosen as reference country). Conversely, **the rate is significantly lower in Italy and in Greece**, where people are three or four times less likely to have wanted to have a test (compared to Sweden).⁹⁶ In France, Belgium and the Netherlands, the probability is similar to the estimated probability in Sweden. The probability is halved in the UK (because of the sample size, however, the difference is not significant).

76- Estimated probability of having wanted to have an HIV test by country, after adjustment for respondents' age, sex, region of origin and length of time in the country



OR estimated by logistic regression, reference=Sweden

Note on interpretation: in comparison with Sweden, respondents in Italy were 3.6 times less likely to have wanted to have an HIV test and 2.4 times more likely in Spain (the results highlighted in grey are not statistically significant).

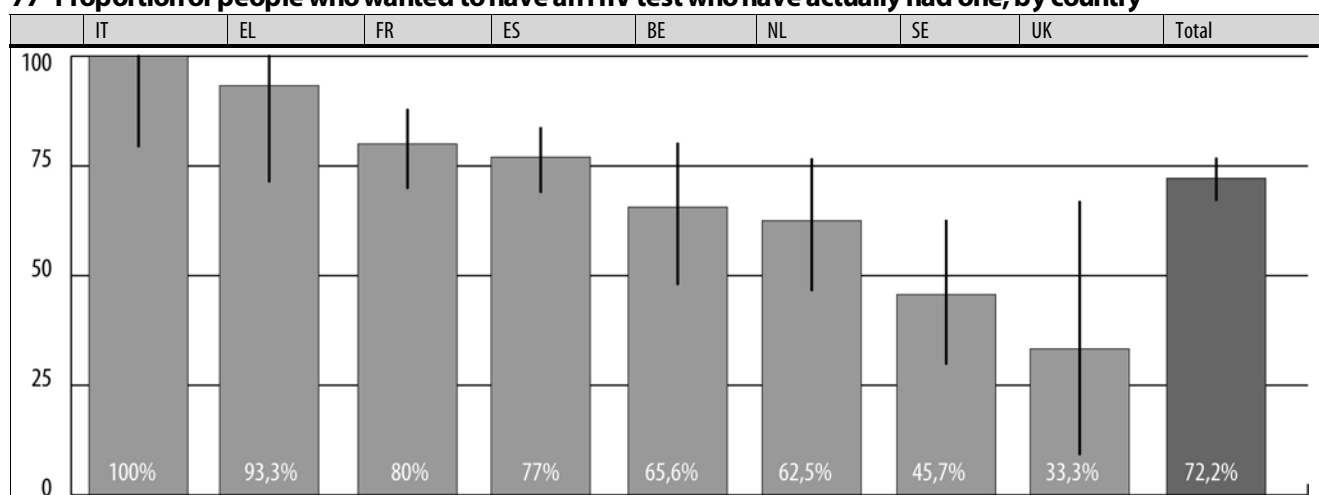
94. EuroHIV, "HIV/AIDS surveillance in Europe. End-year report 2006", Saint-Maurice, *Institut de veille sanitaire*, 2007, No. 75.

95. Most programmes in Spain include specific HIV/AIDS prevention

96. There is no significant difference between these two countries and Sweden

Of those who had wanted to have an HIV test, 72% had actually taken one. Conversely, a third of respondents who had wanted to have a test have not been able to make it happen. This proportion increases with age and length of time in the host country, but there are no differences between the sexes. Inability to translate a desire for an HIV test into action tends to be slightly more common among North Africans (but the difference is not significant). Adjusting for age, sex and geographical origin the rate of test realisation is highest in Spain, France, Italy and Greece. (The results were similar in relatively “simple” analyses, such as that shown in the figure below). The rates were lowest in Sweden and the UK⁹⁷—namely, in the two countries where anti-retroviral treatments are not available, free of charge, to undocumented migrants.

77- Proportion of people who wanted to have an HIV test who have actually had one, by country



Of the reasons given for not wanting to have an HIV test, no (perceived) need was by far the most common. Although the lack of individual data means that we can't go any further in terms of assessing respondents' risk of exposure to HIV, the prevalence of this “no need” seems very high. 16% of the reasons given—including lack of knowledge, fears and erroneous beliefs, but not counting language reasons—could also be taken into account and “corrected” by provision of adequate information. **In general, these results reflect poor information provision and inadequate promotion of the test among undocumented migrants.** Clearly, there is still much work to be done on this issue among these particular groups.

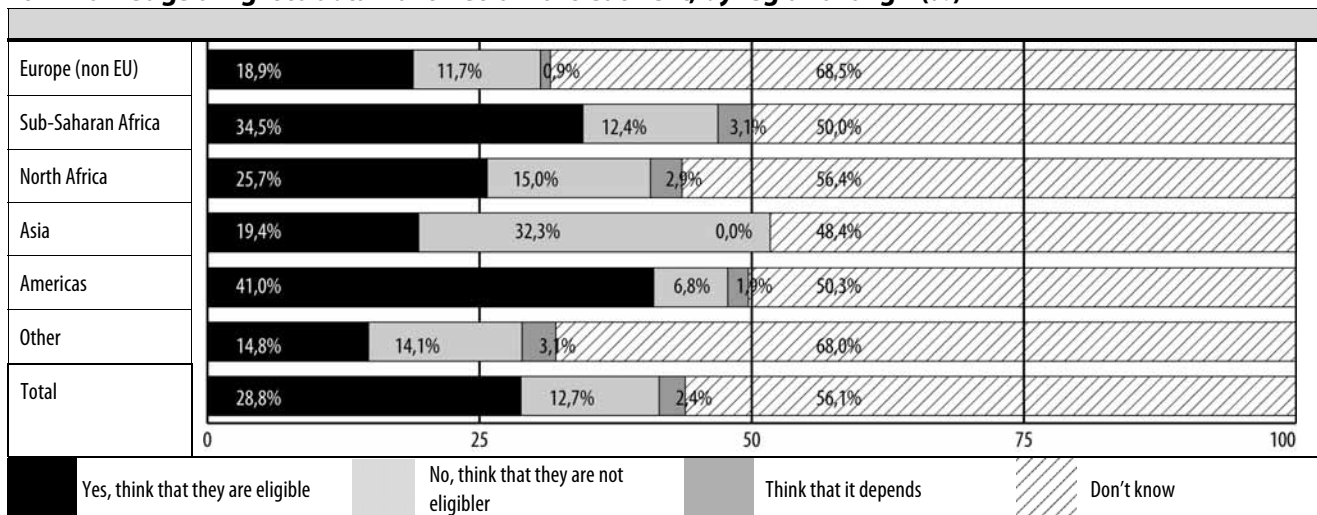
78- Frequency of reasons given for not wanting to have an HIV test

Reason	%
Doesn't feel that s/he needs it	82,8
Already done the test and results known	6,5
Test too expensive or believes that it has to be paid for	5,9
Lack of knowledge about the disease or the test	3,0
Fear of results, prefer not to know	2,6
Fear of being reported or arrested	2,1
Language barriers	1,6
Would not know what to do if the results are positive	1,3
Fear of discrimination or being unwelcome	1,0
Afraid that the results won't be kept confidential	0,8
Doesn't know	1,7
Other reasons	3,6

97. The confidence interval of this proportion is particularly large in this country (the result not very accurate) because of the small numbers of people interviewed.

Another information gap exists concerning access to HIV treatment—**only a third of respondents (29%) in 9 of the 11 countries⁹⁸ know that an undocumented migrant could be eligible for HIV treatment free of charge**, 13% say (wrongly) that this is not the case and 56.1% say that they don't know. There is no difference in knowledge about free access to treatment between men and women. People aged between 35 and 44 are better informed, as are people from the Americas (and Caribbean) and sub-Saharan Africa. People are least well informed about the availability of treatment in Greece (10.4%), but the differences between countries of residence are not significant after adjustment for geographical origin.

79- Knowledge of right to obtain anti-retroviral treatment, by region of origin (%)



Beyond anti-retroviral treatment, the fact that so many people gave wrong answers about this serious illness reflects a **widespread lack of knowledge among respondents and a lack of information on their rights in relation to medical care and treatment.**

98. The question was not asked in the UK (where undocumented migrants must pay for the treatment) and in Sweden (treatment provided through specific networks).

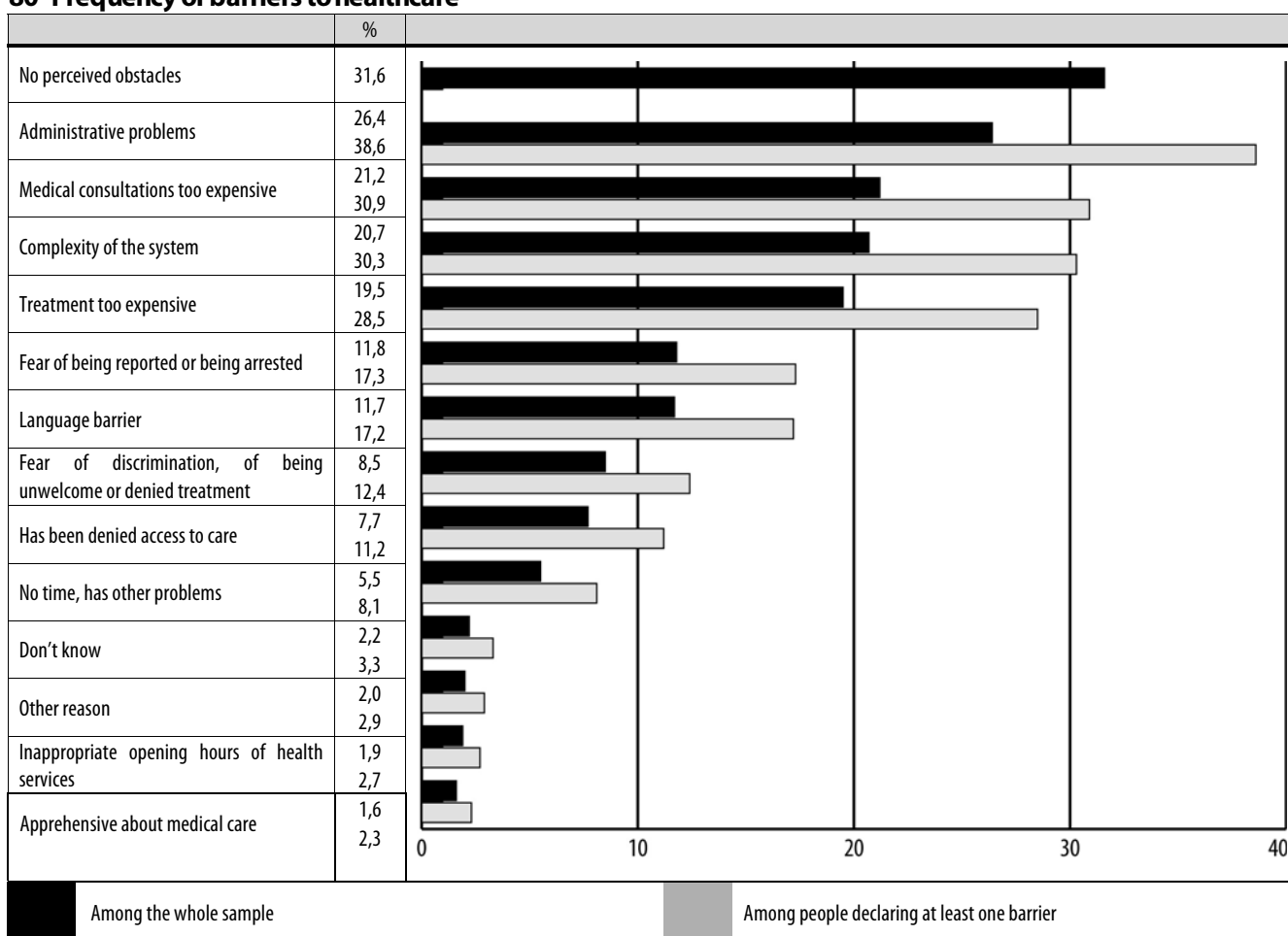
10. BARRIERS TO ACCESS AND CONTINUITY OF CARE

• Barriers cited by respondents

Nearly 70% of the population surveyed have experienced obstacles when they tried to access healthcare. The frequency is shown in the following figure (among the entire population surveyed and among those declaring at least one barrier). The question concerning obstacles was an open question which did not include any suggestions for responses (the interviewers coded spontaneously cited obstacles into categories and sometimes added any other obstacles mentioned—again spontaneously—at another point in the interview).

The most commonly cited obstacles, by far, are administrative and financial barriers. We also witness that fear (whether or not based on a previous experience) of being reported or arrested, of discrimination, or of being refused healthcare was also very common.

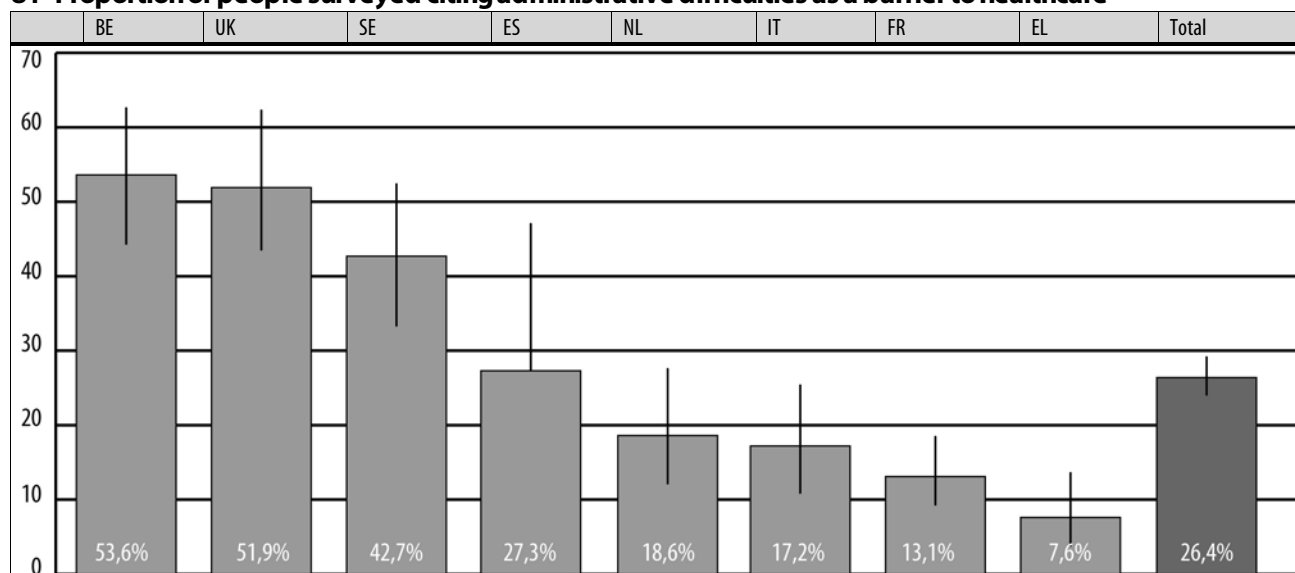
80- Frequency of barriers to healthcare



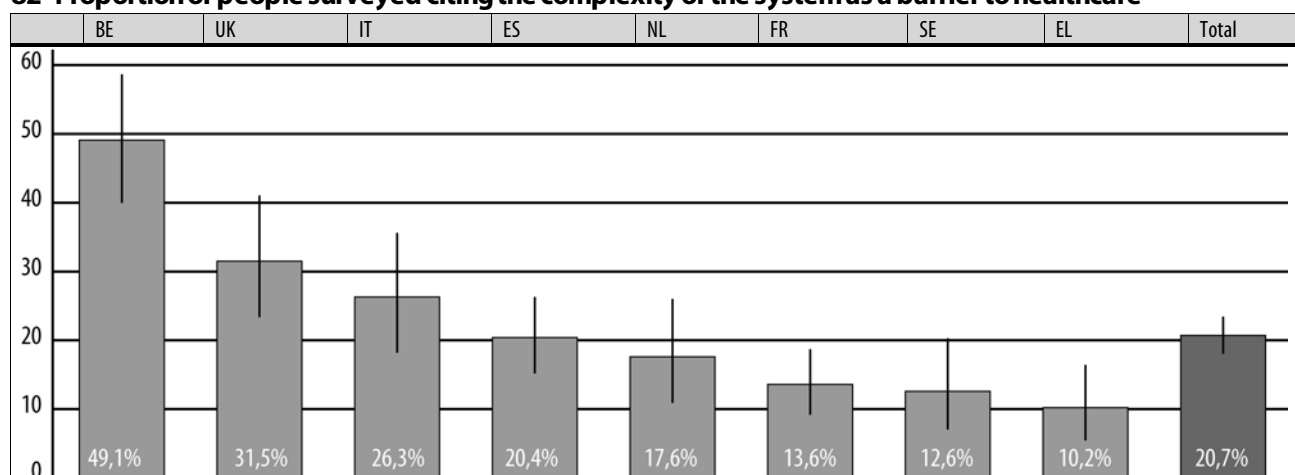
Note on interpretation: 26.4% of the entire sample cites administrative difficulties as a barrier to accessing healthcare. This barrier was cited by 38.6% of people declaring at least one barrier.

There were significant differences between countries in terms of the frequency of the main barriers to healthcare. In Belgium, the United Kingdom and in Sweden, administrative problems were cited most often (around half of respondents). Half of the respondents in Belgium find the system complicated—as do a third and a quarter of respondents in Spain and Italy respectively. These two barriers were cited least often in France and Greece.

81- Proportion of people surveyed citing administrative difficulties as a barrier to healthcare



82- Proportion of people surveyed citing the complexity of the system as a barrier to healthcare

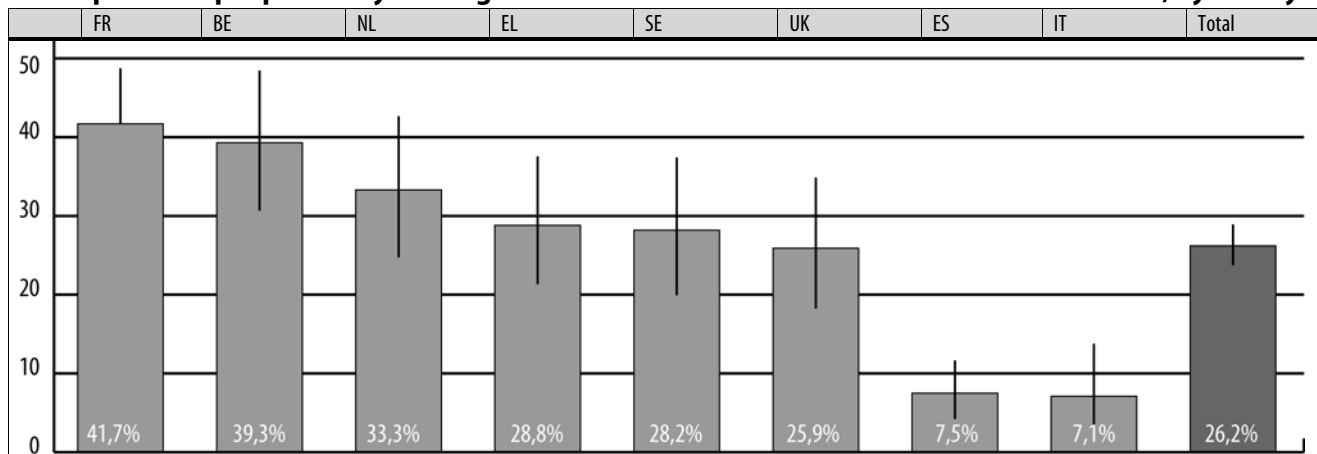


> *"I had pain in the knee and the stomach. I told them that I had many health cards, but not the one for Valencia, and they told me that they couldn't do anything unless I had the Valencia card, which I've been waiting four months for." Q, Malian man, 28, living in Spain.*

Treatment and consultation costs were cited as barriers to healthcare least often in Spain and Italy, where public clinics exist. In Spain, more specifically, patient charges for medicines vary between regions—while patients are not charged at all in Valencia, for example, they have to pay 40% of the costs in Bilbao, as in most other Spanish regions.

In contrast, financial obstacles are most commonly cited—by 40% of respondents—in Belgium and France, the two countries where, as described previously, less than 10% of respondents had real healthcare coverage. In France, the remuneration of general practitioners for each service they provide (along with the increasingly relentless pursuit of outstanding hospital fees) also contributes towards this opinion among people who are not insured. In Belgium—or, more specifically, in Brussels where the survey took place—the existence of several “medical houses” (where medical consultations, and sometimes medicines, are free of charge) does not prevent financial obstacles from being cited very often. In the Netherlands, where cover for healthcare costs for undocumented migrants is obtained at the request of the doctor on a case by case basis, this financial barrier is cited by one third of respondents.

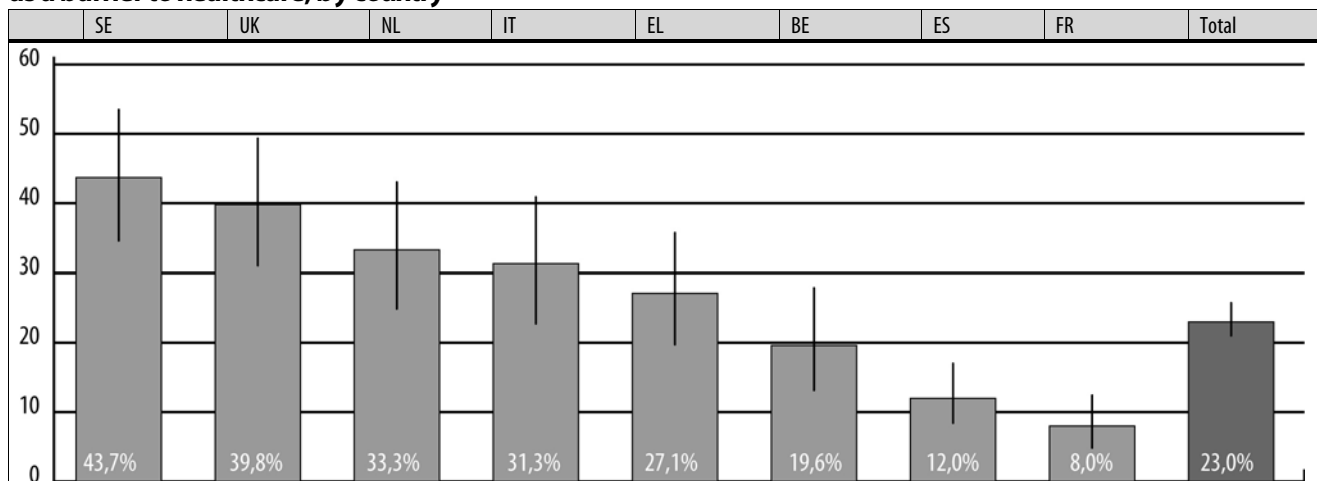
83- Proportion of people surveyed citing consultation or treatment costs as a barrier to healthcare, by country



> “The gynaecologist had said that pregnant women must be helped in emergencies. But, I had a visa, so it didn’t work. My father had to borrow from people to pay all the fees—nearly 800 euros (visits, scans that I had to have every fortnight because of my illness) and the delivery (1,145 euros). I gave birth at three o’clock in the morning and I was out by 10am. I did not want to stay there because I thought that I would have to pay more—they said that I could stay until midnight without paying more, but I was worried. They prescribed medicines for me (injections for two weeks) that I wasn’t able to buy.” Mrs B., Algerian, 36, living in France for 4 months.

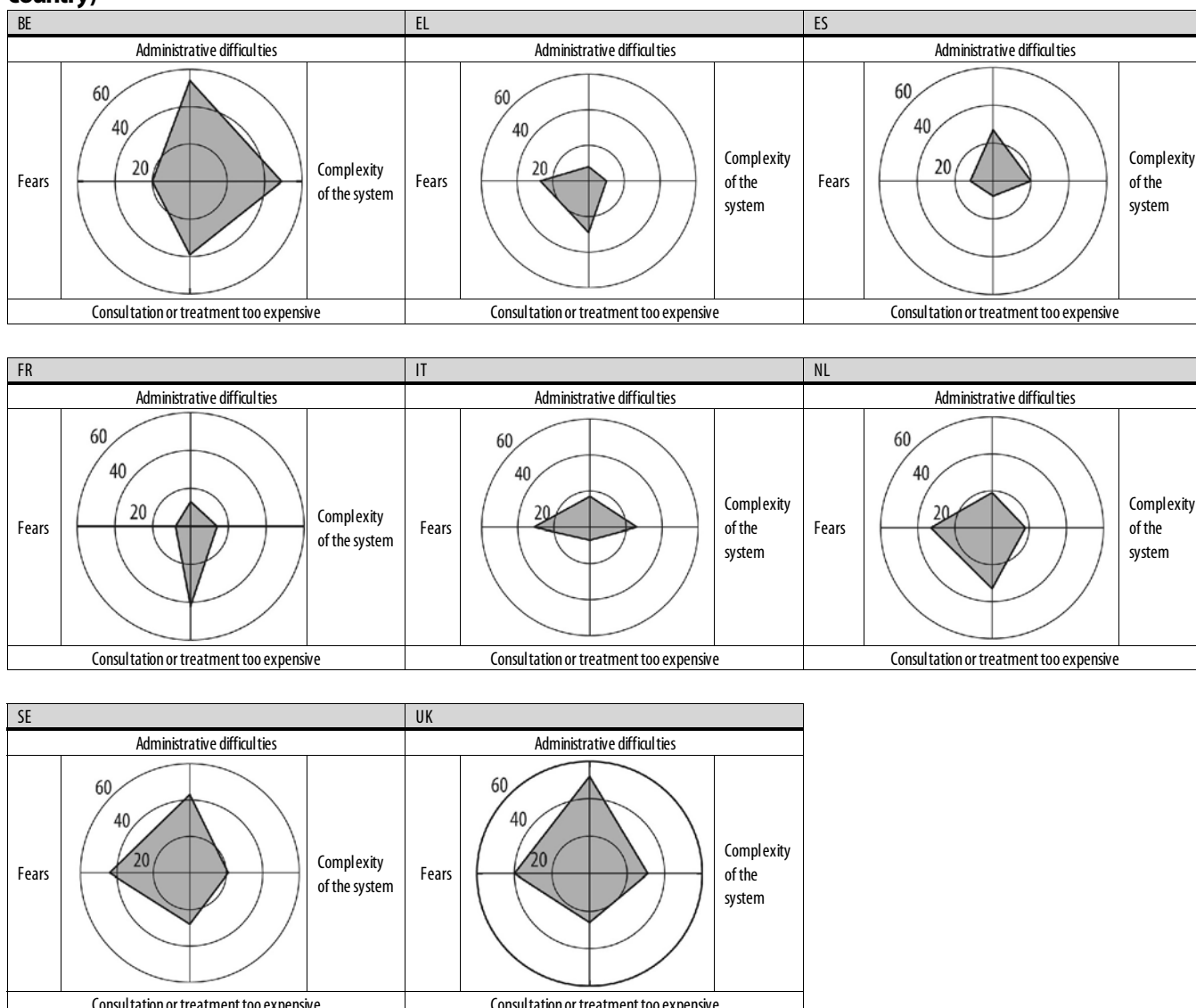
Unsurprisingly, the frequency of worries about denunciation, arrest, discrimination or being refused care in the different countries is quite close to the pattern of experiences concerning racism or discrimination in healthcare facilities. This group of barriers was most commonly cited in Sweden, the United Kingdom and the Netherlands. These are also the countries where respondents most commonly report such experiences. Spain, Belgium and France, however, are the countries where these two indicators are least common.

84- Proportion of respondents citing fear of being reported, arrested, discriminated against or refused healthcare as a barrier to healthcare, by country



The situation in the various countries can also be summarised and compared in the following figure.

85- Frequency of the four main categories of barriers to healthcare cited by respondents (radar diagram for each country)



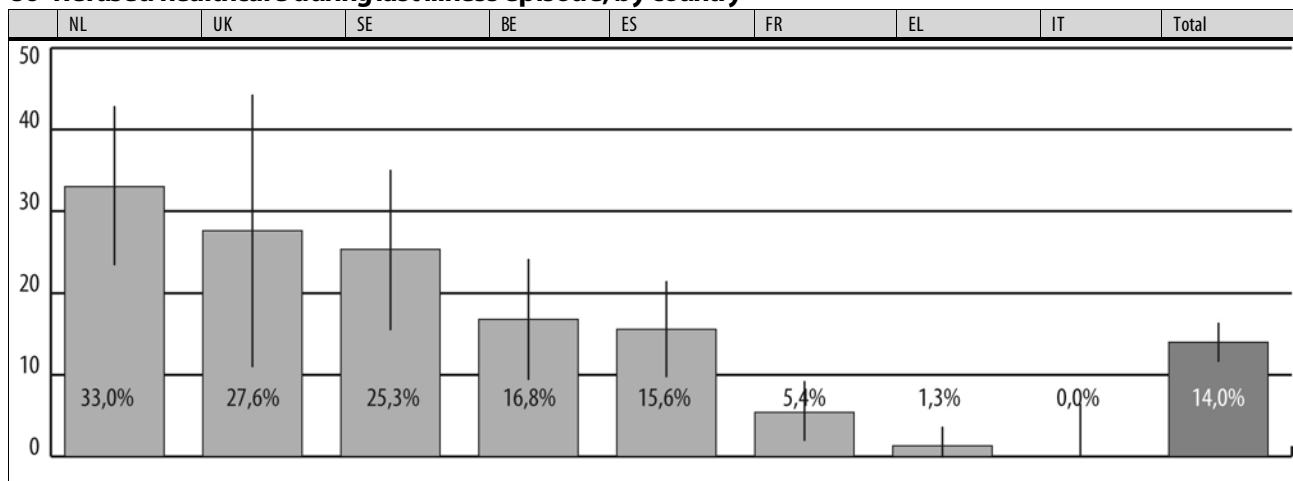
Note on interpretation: the coloured areas are in proportion to the frequency of barriers cited in each country, in relation to the four aspects highlighted in these figures. The extent and the shape of these coloured areas allow us to directly compare the situation described by the respondents in each country and display this in a visual form.

• Refusal of healthcare

The issue of whether people have been refused healthcare was first asked in relation to the last time that they were ill. On that occasion, **14% of people affected said that they have been refused healthcare.**⁹⁹ There are **significant differences in this rate, identical in men and women, between countries.** The rate is highest in the Netherlands—where no specific facilities for undocumented migrants exist—affecting one third of respondents and in the UK and Sweden (a quarter of respondents in each case). The rate is around 15% in Spain and Belgium. It is lower, or zero, in other countries. The Greek team indicates that people do not even try to access mainstream services because they know that they won't be accepted, which would explain the low refusal rate in Greece.

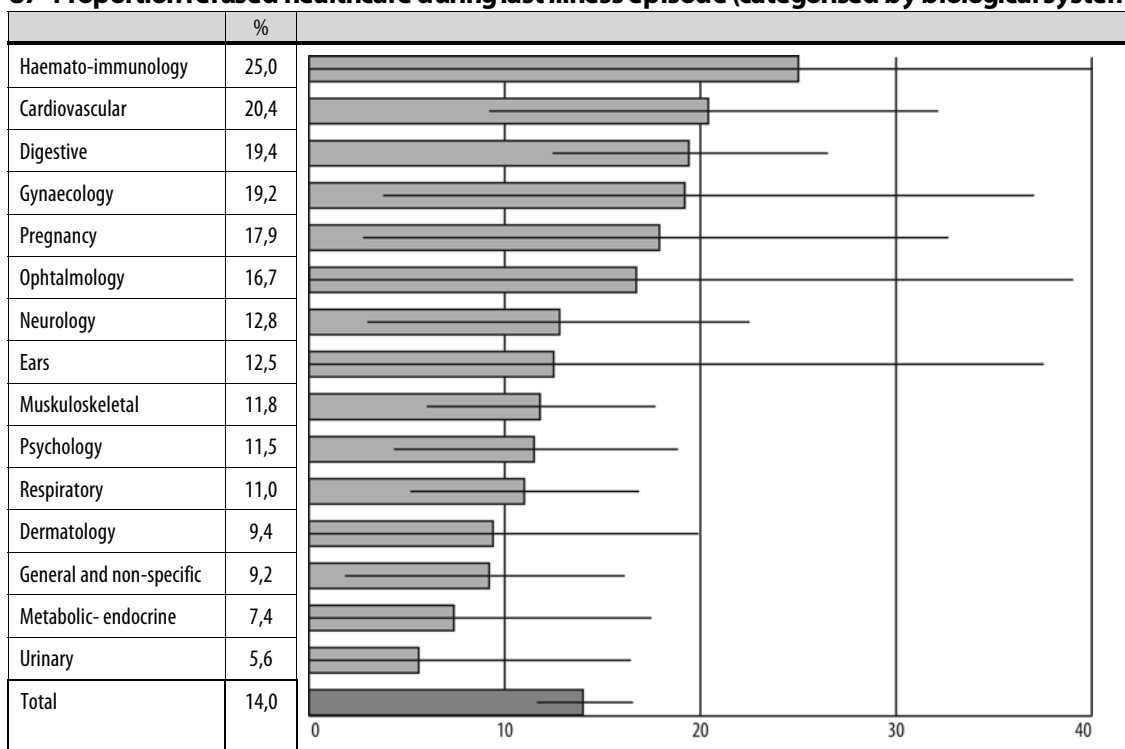
99. Compare this rate, relating to the last illness episode, with the proportion of people (8%) who cite refusal of care as a barrier to healthcare in general (see below).

86- Refused healthcare during last illness episode, by country



Particularly people with cardiovascular, digestive or gynaecological symptoms or complaints were refused care. The data unfortunately show that refusal was not uncommon in relation to pregnancy (18% of woman having had health problems linked to their pregnancies had been refused care—but because the sample sizes were small, this proportion is subject to considerable statistical uncertainty). Equally worrying, refusal is not particularly confined to the most minor symptoms and complaints. In fact, the opposite was true—not only in relation to the broad categories of condition, but in terms of detailed diagnoses. In fact, the more closely a biological system affected is linked to vital functions (cardiology, haematology etc) or the more serious the diagnosis, the higher the rate of refusal.

87- Proportion refused healthcare during last illness episode (categorised by biological system)



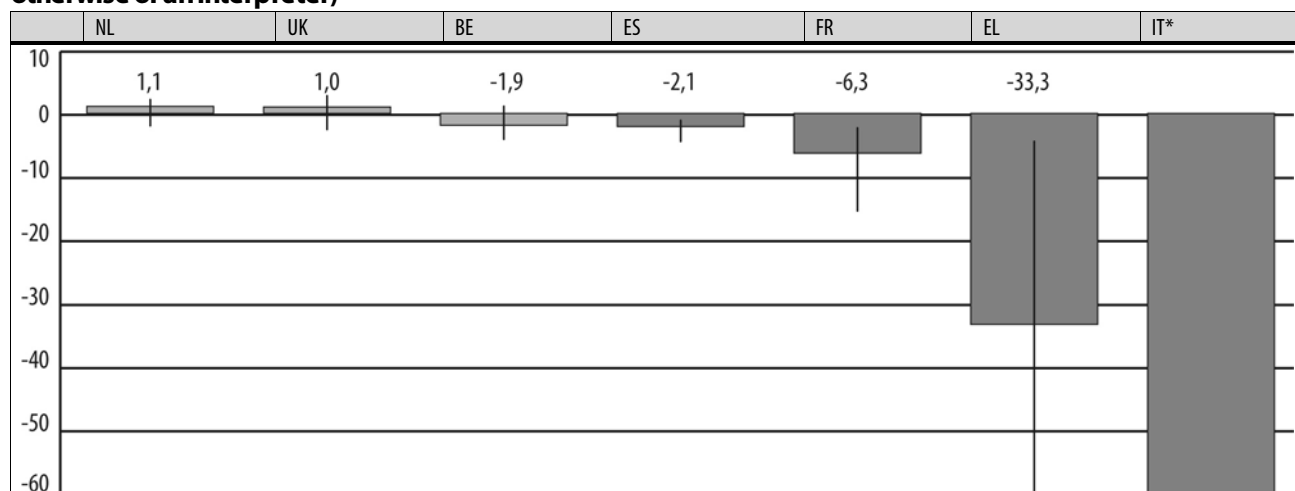
Note on interpretation: of those who presented with a psychological problem during their last episode of illness, 11.8% had been refused care although that relates to a limited number of people. This reflects a rate of refusal of care which could vary from 4% to 18% (see the line indicating the confidence interval).

> “I went to a medical centre in our town. I said that I had taken steps to get a health card and that I had a statement which enabled me to go to the emergency department. I had a fever and it seemed to be flu, but I did not have any medicines or any information saying what I could take. So I went to this centre and the woman on reception asked me where I come from and looked at my statement (F6) and she told me that they couldn’t treat me because my case was not an emergency and that is what Médecins du Monde is for. I replied that when I handed in the documents I was told that I could go to the emergency department and because I didn’t feel well I had decided to come. Apart from Médecins du Monde, I am very isolated and I did not know who could look after my girls. I asked her why they couldn’t care for me and she replied “it’s not free, we pay for it by working.” I told her that this is a public service and that it was essential for people. She replied that I shouldn’t believe that they were going to pay for everything migrants wanted. I was shocked by what she said. It was the first time that I felt rejected.” Argentinian woman, 23, living in Spain for six months.

In fact, it is neither the diagnosis nor the severity of the complaint which determines whether care is refused as much as the type of service. Although the possibility of multiple responses for services attended prevents direct attribution, we can see that **twice as many people who attended (at least) one public healthcare facility or emergency department say that they have been refused care than those who (at least) attended one specifically targeted health centre** (refusal rates were 20.9%, 20.5% and 11.5% respectively).

After adjusting for the type of service attended, length of time in the host country and whether or not an interpreter was present for the interview,¹⁰⁰ the ranking of countries in relation to how often healthcare was refused remains the same.

88- Estimation of the risk of refusal of healthcare during last illness episode by survey country, after adjustment for type of services attended, length of time since migration and interview circumstances (the presence or otherwise of an interpreter)



(OR estimated by logistic regression, reference = Sweden)

* From a statistical point of view, the risk is “infinitely” low for Italy and it is not possible to estimate the confidence interval because no cases of healthcare being refused were reported.

Note on interpretation: In comparison with Sweden, respondents in Spain are 2.1 times less likely to have been refused care (the relationships which are not significantly different are shown in grey).

It is still difficult, however, to interpret differences between countries. In fact, it is very likely that many undocumented migrants anticipate that they will be refused care and, because of this, do not try to consult services, particularly mainstream services. The refusal rates also reflect the internalisation of discrimination by individuals themselves, particularly in countries where the rates are very low. **Conversely, while the principle of universal access to healthcare of Beveridgian systems¹⁰¹ may mean that fewer undocumented migrants are discouraged from consulting mainstream services, they seem to be harmed by how often they face refusal of care.**

100. The presence of an interpreter during the interview is related to a significantly higher rate of refusal of care being reported: 20.5 % compared to 12.7 %, p = 0,02.

101. In a Beveridgian system (named after Lord Beveridge, 1879-1963), social protection is universal, based on solidarity, and applies to the whole population “from the cradle to the grave” (for example in the UK, Sweden and some Mediterranean countries which were based on the Beveridgian model in the 1970s—namely Spain, Italy, Greece and Portugal).

- > *“Getting medical care during my pregnancy was almost impossible. Everyone I knew was scaring me. ‘You go to the hospital, and they’ll deport you!’ But there was one time I really was not feeling well, so I went to a walk-in clinic for a check-up. There they told me that they couldn’t help me, and that if I got worse I should go to the emergency department at the hospital. A little while later I tried going to a general practitioner to get help—I was five months pregnant by this point—but they refused to register me because of my status, because of my papers. A woman there even left a note saying that if I ever came back they wouldn’t give me any care because I was not entitled to it. ‘You’ll have to pay 2,800 euros upfront and we’ll give you a midwife,” she said. So I went straight to the hospital. Unfortunately, things there were not much better. They said things like, “Why did you have a baby in this country?” and the person in charge of getting payments from overseas visitors threatened to put me on a plane back to Uganda. I was again told to pay 2,800 euros upfront or threatened with deportation. They also told me that once I was in labour, I wouldn’t be able to call an ambulance, or I would have to pay 340 euros. When I tried to explain that I don’t have that kind of money, they only said “your only option is to give birth at home, then.” So I did not have any antenatal care for my baby during my pregnancy. F. from Uganda, went to Britain two years ago to see her dying sister.*

- > *In September 2006, Mrs O. had an accident. Since then she has suffered from lower back pain. Her doctor sent her back to hospital for x-rays. When she arrived in hospital, they refused to give her the x-rays because she didn’t have insurance and she did not have enough money to pay the whole cost. Several weeks later, her doctor sent her to the hospital again, this time for blood tests. Once again, Mrs O. couldn’t have the test—for the same reasons as before. Even though there had previously been a financial agreement negotiated between an NGO and the hospital finance department when Mrs O. had attended the emergency department, the hospital refused to carry out the blood tests. Several months later Mrs O. was suffering from palpitations and her doctor really wanted her to have tests to be able to come up with a precise diagnosis. But she didn’t dare go to the hospital after having been refused twice. Neither she nor her doctor knew what else they could do. In the end, the doctor contacted a colleague in cardiology who agreed to treat her free of charge. Mrs O, from Ghana, 48, living in the Netherlands for five years.*

- > *In October 2007, Mrs Z. suffered from violent stomach pain. Her doctor suspected kidney stones and sent her to hospital for tests. She went, but they refused to do the tests because she didn’t have insurance and she couldn’t pay. So her doctor prescribed powerful painkillers, but the pain persisted. A month and a half later, the doctor sent her to hospital after having called the urology department. At the urology department reception, Mrs Z. was again told that she couldn’t have the tests unless she paid. Ten months later she is still suffering and still doesn’t have access to care. Mrs Z., from Armenia, 32, living in the Netherlands for four years.*

- **Experience of racism – in general and in health services**

In the last 15 years,¹⁰² a growing number of epidemiological studies focusing on racism and its impact on health have included questions about racism and the subjective aspects of racism experienced. Although this line of questioning only addresses one aspect of a much more complex phenomenon—and although the results don’t always concur—the vast majority of these studies conclude that racism can harm health (including mental health, of course, but also some health-related behaviours as well as cardiovascular health, for example).¹⁰³

The survey population was asked a question on racism.¹⁰⁴ **One third of respondents had personally been victims of racism during the last year** (36%, 95% CI = [33.1%-38.9%]). 10% consider that this had happened “often” and 26% “occasionally”, with no significant differences for sex.

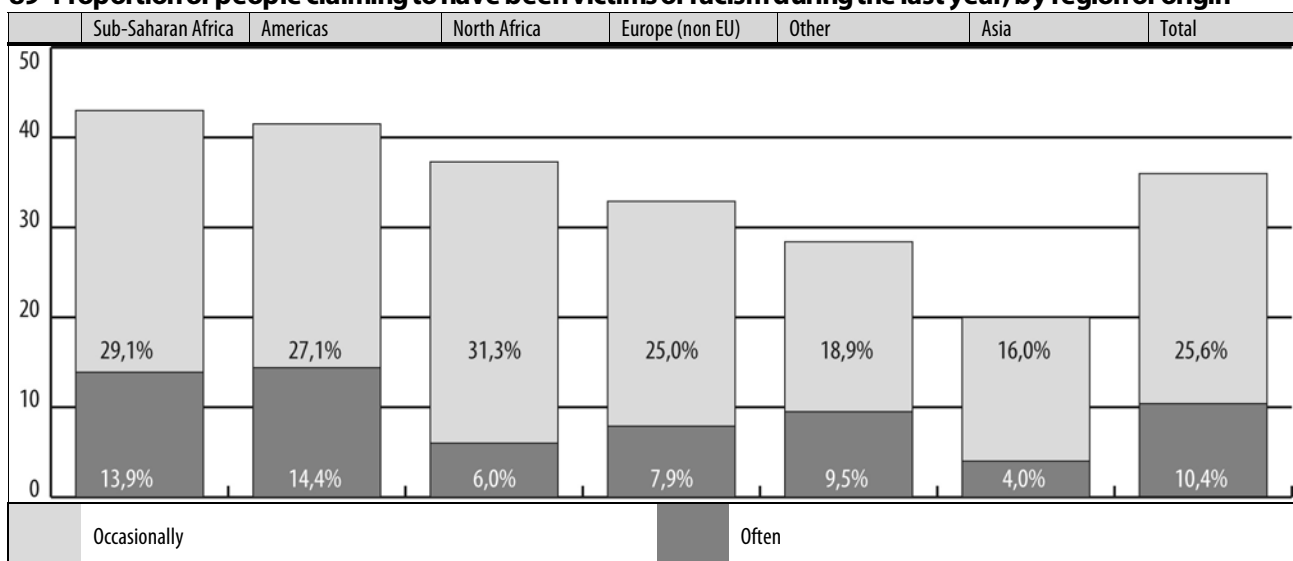
102. The first article to look at the health impact of racism in the public health field was published by Krieger and Coll in 1993 (Krieger N, Rowley D, Hermann A.A., Avery B, Phillips M.T., “Racism, sexism and social class: implications for studies of health, disease, and well-being”, *Am J Prev Med*, 1993; 9: 82–122).

103. In 2006, 138 articles were found and only 12 of these were European (Paradies Y., “A systematic review of empirical research on self-reported racism and health”, *Int J Epidemiol*, 2006, 35: 888-901.)

104. “In the past year (or since you arrived here) in the different aspects of your life—personally and socially—have you personally been a victim of racism (discrimination linked to your colour, geographical origin etc.)?”

Of all respondents, Africans, people from Latin America and the Caribbean, and North Africans say more often that they have been victims of racism. Europeans and Asians appear to be less exposed.

89- Proportion of people claiming to have been victims of racism during the last year, by region of origin



- > *"I feel excluded every day. Today, for example, like every day at the market, they don't want me to be served first because I am black. That also happens every day on the bus. I think that this happens because they think that the economic crisis happened because migrants are here." Woman, 24, from Nigeria living in Palma de Majorca, Spain, for 3 years.*

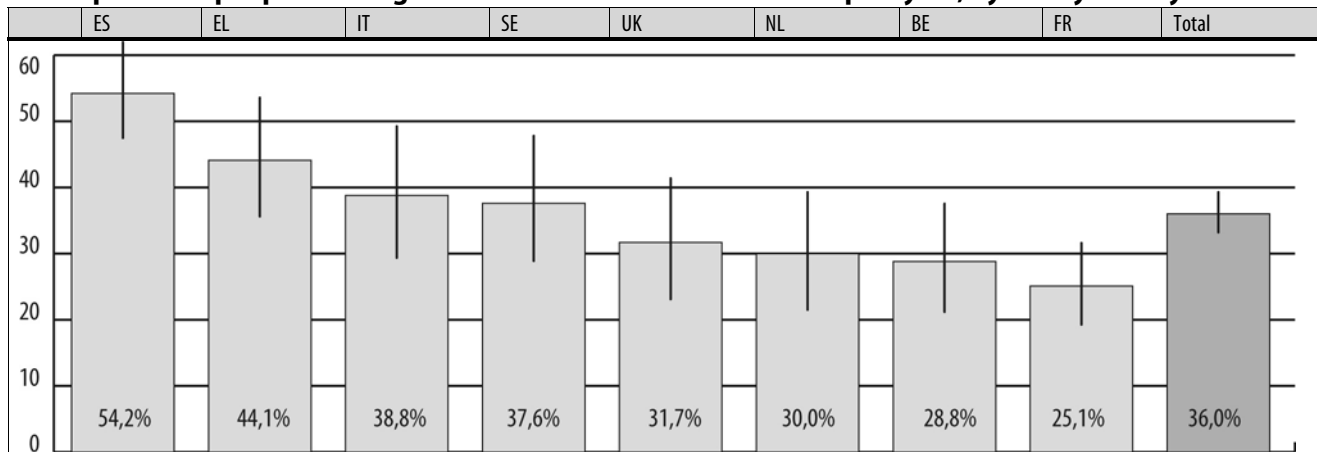
In a multivariate analysis, adjusting simultaneously for sex, age, geographical origin, and length of time in the survey country, results show that:

- the same proportions of men and women are affected;
- people aged between 25 and 44 years are affected twice as much as younger or older people;
- **the risk of being a victim of racism is associated with the length of stay according to a U curve.** This is highest during the first year in the survey country, lowest between one and two years, then increases again, regularly, to reach the highest level again after six years.
- This could be explained by the combined effect of two phenomena that develop in opposite directions. On the one hand, a reduction in situations where the person is faced with racist people and/or experiences hostile reactions the longer they spend in the country (by learning avoidance strategies and/or integrating host country cultural norms). On the other hand, sensitivity to signs of racism (and therefore to considering that they have been a victim of racism) increases with the length of time spent in the host country.
- **The risk is twice as high in sub-Saharan Africans (OR = 1.88, 95CI% = [1.22-2.90]) and is also higher among North Africans (OR = 1.40, even though the difference is not significant, 95% CI = [0.84-2.34]).** In contrast, the risk is halved for Latin Americans (OR = 0.51, 95% CI = [0.28-0.91]).

These proportions are significantly different between survey countries. The proportion is lowest in France. The high proportions witnessed in Spain, Greece and Italy can undoubtedly be linked to the fact that these three countries have only recently become immigration countries after decades of emigration. In addition, it seems that in Spain the question was broadened by the interviewers to include discrimination and was not restricted to racism alone.

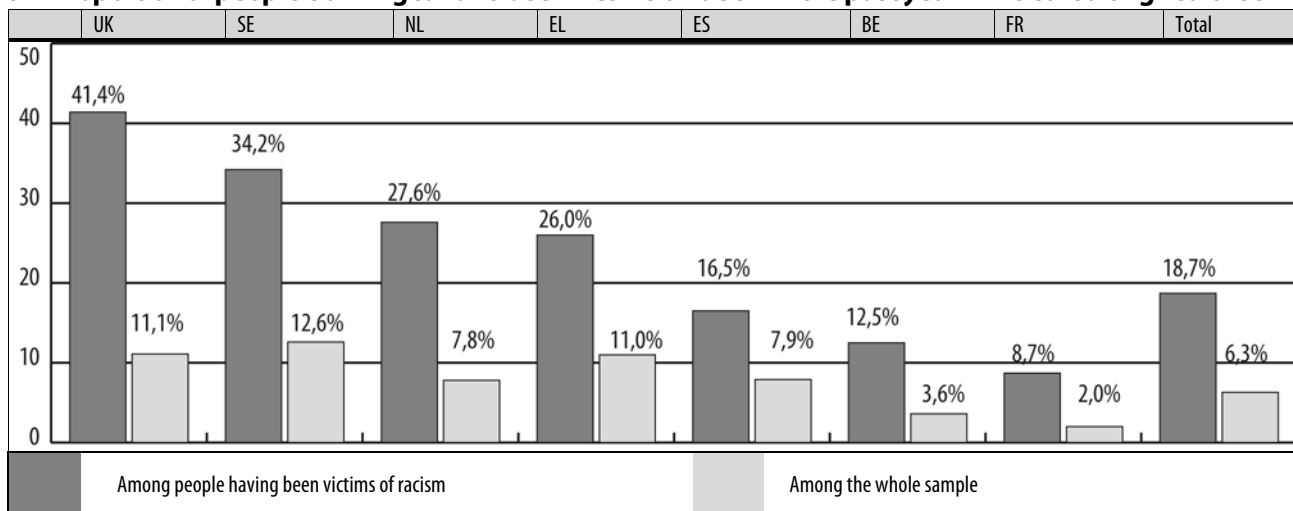
By way of comparison, in 2006 7% of the Swedish population aged between 18 and 84 (5% of men and 8% of women) declared that they had been victims of discrimination (all reasons) in the past 3 months¹⁰⁵ and an equal proportion had been victim of discrimination in the health sector. In France, a 2005 survey among a representative sample of the adult population in Paris and its suburbs (14% of whom are migrants) found that 3% of people said they had often been victim of racism, and 11% occasionally, in the past year.¹⁰⁶

90- Proportion of people claiming to have been victims of racism in the past year, by survey country



For 19% of those who consider that they have been victims of racism, this happened at least once while they were consulting health services or a health professional.

91- Proportion of people claiming to have been victims of racism in the past year while consulting health services



105. Health and Discrimination Project, "Discrimination, a threat to public health", Stockholm, National Institute of Public Health, 2007.

106. Chauvin P., Parizot I., "Les inégalités territoriales de santé dans l'agglomération parisienne", Paris, Editions de la DIV (coll. Etudes et recherches), 2008.

The highest proportions of people who felt they experienced racism within the health system were in Sweden (13% of respondents), the UK and Greece (11% for both). These numbers were lowest in France (2%) and Belgium (4%) with the Netherlands¹⁰⁷ and Spain¹⁰⁸ lying in between. These figures should be seen alongside the different legislative positions in the countries relating to access to healthcare for undocumented migrants. It is notable, in fact, that in the countries where this legislation is the most restrictive, respondents more commonly feel that they have been victims of racism while consulting health services. Of course, these results and differences should be interpreted with caution, given the way in which this sample was constituted (in specifically targeted services and programmes). In addition, the survey does not show in which types of services, or with which health professionals, people had faced racist reactions. We can, however, say that there is a strong correlation between having experienced racism in a health structure and being refused healthcare (43.4% were refused care compared to 7.7% in those who do not claim to have been victims of racism, OR = 5.67, 95% CI = [3.30-9.72]).

- **Restrictions on movements or activities because of fear of arrest**

More than half of respondents (60%) say that they have to limit their movements or activities because of fear of being arrested.¹⁰⁹ This happens “very often” for 26%, “often” for 17% and “sometimes” for 17%. There are no statistical differences according to sex and age on this issue (although the restriction on activities seems to reduce as people get older). This restriction can relate to a variety of fields. Various testimonies describe, for example, how people fear travelling on public transport, going to see a doctor, or going to pick up their children from school.

- > *She waits, hidden in the shadows on the street corner, and we have to convince her that it is not risky for her to summon her courage and come into our premises. She has cystitis, needs glasses and has high intraocular pressure. She has high blood sugar, hypertension and needs a gynaecological check-up. When we ask her what she has done until now about her health problems, she answers “I looked after myself.” She hides away and is constantly moving, changing where she lives. She doesn’t dare go into the city centre because she is afraid of the police. M., Peruvian woman, 44, living in Germany for 13 years.*
- > *The first time that R. came to Médecins du Monde Germany, we were struck by her nervousness. It took time for her to be less frightened. A year ago she went to a Catholic hospital and they gave her medication for her diabetes and high blood pressure. She took them for two months, but she didn’t have enough money to buy more and didn’t dare return to the hospital. She is in a very poor state of health generally and must get treatment without delay. R., Croatian woman, living in Germany for 14 years.*
- > *“I am suffering so much these days. If I am ill, I cannot work. I’m afraid. I don’t go out often —just to the two streets next to where I live. I miss my family, but I want to live. I am someone who loves life, I want to live.” Indian woman, 31, living in Belgium for a year.*
- > *Three months after he arrived in the Netherlands, B. was in a metro station. He saw two police officers coming towards him. Because of his negative experience with the police in Malta (he had been beaten with a club and still has aftereffects on his shoulders and knees) he was afraid and took to his heels. In his haste, he fell down the stairs and broke both ankles. The police called an ambulance which took him to the emergency department at the nearest hospital. B., from Ivory Coast, 35, living in the Netherlands.*

107. In the Netherlands a small number of health professionals agree to treat undocumented migrants because their health cover is arranged on a case by case basis, at the initiative of, and request of, the health professional.

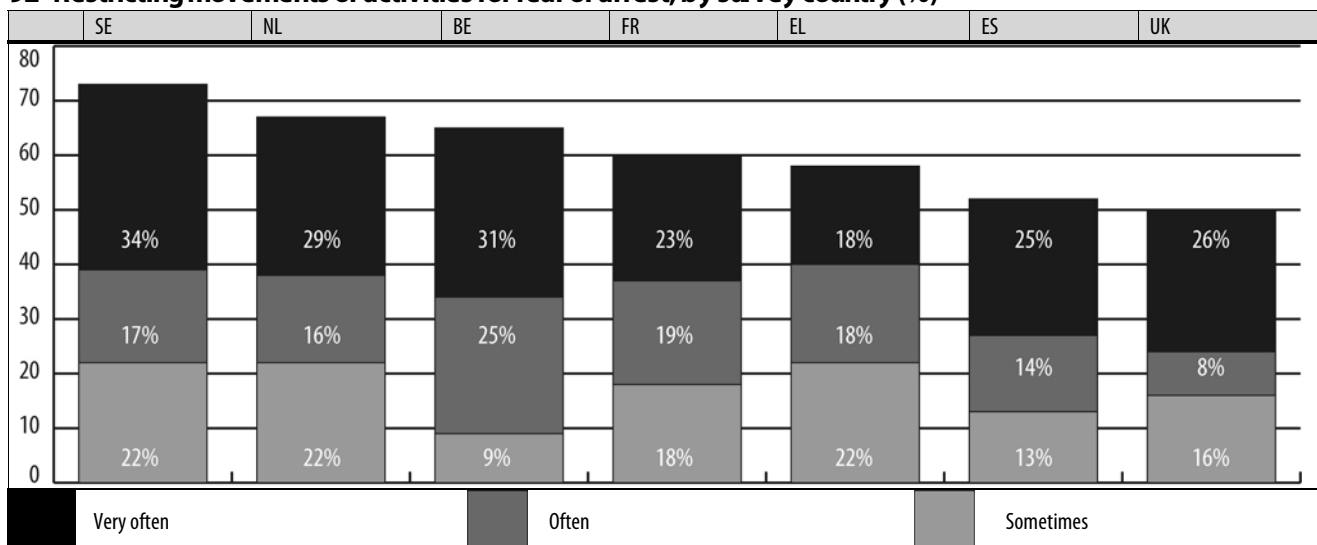
(Oort M. van, et al., “Gezondheidsklachten van illegalen: een landelijk onderzoek onder huisartsen en Spoedeisende Hulpafdelingen”, Utrecht, NIVEL, 2001).

108. In Italy, the question of racism during attendance at health services cannot be analysed.

109. These figures relate to the whole sample excluding respondents in Italy, where the question was not asked.

There are major differences between survey countries. In Belgium and Sweden more than half (56% and 51% respectively) of respondents limit their activities often or very often.

92- Restricting movements or activities for fear of arrest, by survey country (%)



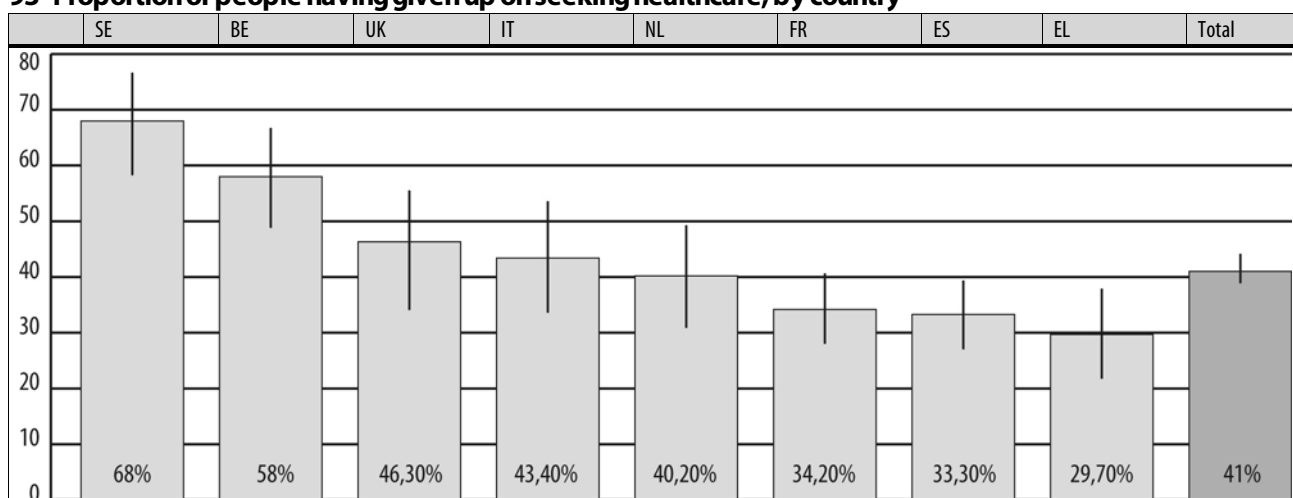
After adjusting for survey country, there are no significant differences between the different regions of origin in terms of whether respondents restrict their activities (sometimes or often) for fear of arrest—with the exception of those people coming from South America who, in effect, are half as likely to restrict their activities as other groups.

- **Giving up on healthcare**

In the whole survey population, 41% of respondents had given up on seeking healthcare within the last 12 months (of these, 53% report facing at least one barrier to healthcare). There were no significant differences for sex or age.

More than two-thirds of respondents had given up on seeking healthcare in the last 12 months in Sweden, as had more than half of respondents in Belgium. In France¹¹⁰ and Spain this related to a third of respondents.

93- Proportion of people having given up on seeking healthcare, by country



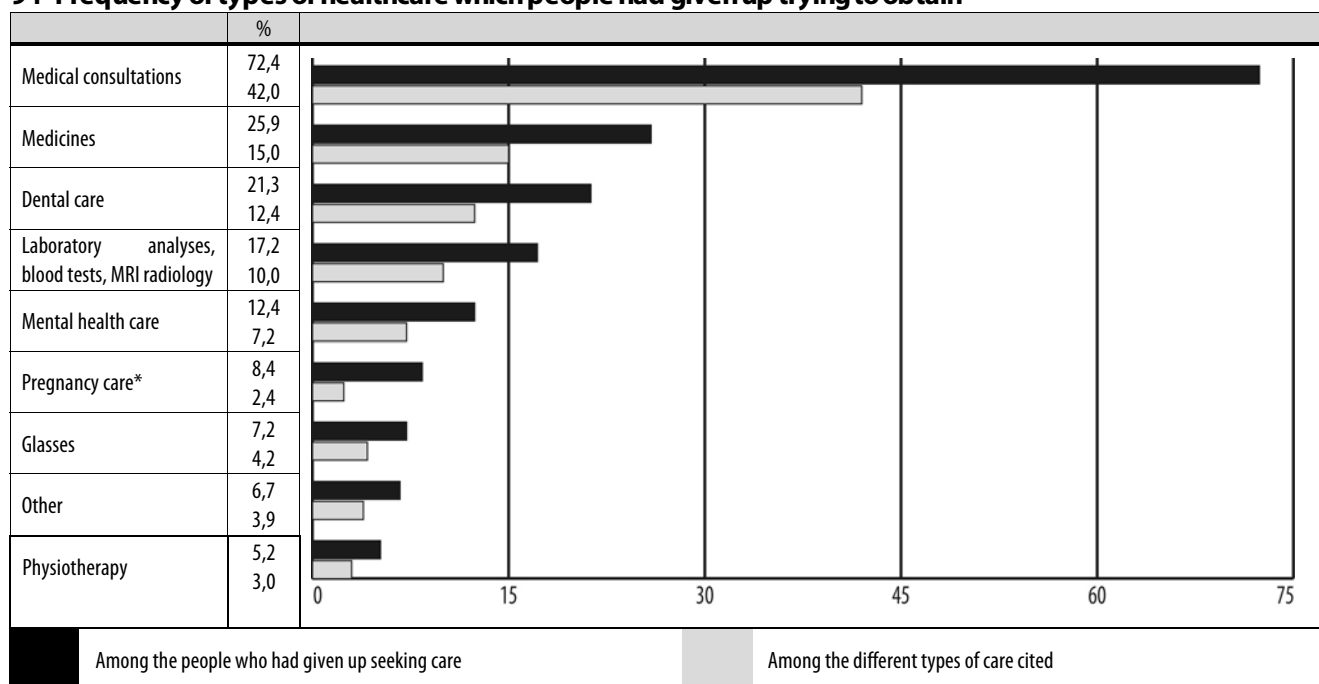
110. This is the same proportion as seen in the general population in France without additional health insurance (32% in 2006, source: Irdes, 2008) but with a very different types of care in question :in the French general population, dental care and glasses are the most common, but for undocumented migrants general medical consultations top the list.

The issue of having given up on seeking healthcare in the last 12 months is significantly dependent on whether people had access to real healthcare coverage at the time of the survey. **People without healthcare coverage have given up on seeking healthcare three times more often than those with coverage** (OR = 3.07, 95% CI = [1.83 – 5.13]). This result is reinforced by the fact that an identical association is observed in relation to whether the person had access to healthcare coverage the last time they felt ill (rather than on the day of the survey) (OR = 3.00, 95% CI = [1.91 – 4.65]). The lack of access to healthcare coverage explains a large part, but not all, of the differences between countries. After adjustment for whether the individual had real access to healthcare coverage, we see that respondents in Spain and France were four to five times less likely to give up on seeking healthcare than those interviewed in Belgium or the UK (although the differences are not significant because the sample sizes become small).

> *“I was 16 at the time and I came alone from Nigeria. When I arrived in London I requested asylum. Six months later I received a letter from the government telling me my claim had been refused. I then moved about constantly, staying with people I knew. I did not have any medical follow-up during all that time. If I was ill and I had a little money, I would go to the corner shop and buy medicines. But most of the time I didn't have money so I stayed home, gritted my teeth and just put up with it. I could not get registered with a general practitioner because they all asked me for a passport and I wasn't able to show them one. If you don't have a passport in this country, they talk to you differently.” T, Nigerian, 22, living in the UK for 6 years.*

The type of healthcare which respondents have most often given up on trying to access are medical consultations (cited by 30% of respondents), medicines (10% of respondents) and dental care (9% of respondents). 8% of women who have given up on trying to get medical care cited pregnancy care (equal to 4% of women interviewed).¹¹¹

94- Frequency of types of healthcare which people had given up trying to obtain



* Frequency among women who had given up on seeking care.

Note on interpretation: 25.9% of the people having given up trying to obtain some care have given up trying to obtain medicines. Medicines represent 15% of the types of care people have given up trying to obtain.

111. A recent Swiss study, at Geneva University Hospital, found that undocumented migrants, on average, came for an initial pregnancy appointment 4 weeks later than other women and that only 63% of undocumented women had this first consultation during the first trimester of her pregnancy. (Wolff H, Epiney M, Lourenco A.P. et al., "Undocumented migrants lack access to pregnancy care and prevention", *BMC Public Health* 2008, 8: 93).

In addition, **29% of parents had had to give up on seeking care for their children within the past 12 months.** Most commonly the care that they had given up seeking related to medical consultations (visits or care from a doctor), and vaccinations. **Of people living with their children (under 18), 14% say that they had to give up on seeking vaccinations for their children in the past 12 months.** The small sample sizes do not allow any more precise analysis of these data.¹¹²

95- Frequency of types of healthcare which people gave up seeking for their children

	% de ceux qui ont renoncé	% sur l'ensemble des parents
Consultations, visits or treatment by a doctor	45	18
Vaccinations	35	14
Dental care	23	10
Laboratory analyses, blood tests, MRI or radiology	22	9
Medicines	15	6
Glasses	12	5
Physiotherapy sessions	10	5
Mental health or psychological care	7	3
Other care or unknown	5	2

Because respondents can mention more than one type of healthcare, the percentages add up to more than 100.

112. It's worth remembering the results of the first report of *Médecins du Monde's* European Observatory on Access to Healthcare, published in 2007. Of those who were concerned about vaccinating their children (and having responded to the questions relating to vaccination), just over half (53.5%) knew that their child could have access to free vaccinations and/or where to go to get this care (51.5%). Of the barriers to vaccination cited in the survey, a lack of awareness of where to go to get vaccination was first (56%), followed by fear of being reported (24%).

Part two:
**Qualitative survey on access to healthcare
for the children of undocumented migrants**

1. INTRODUCTION AND METHODOLOGY

The statistical survey conducted in 2008 by *Médecins du Monde's* European Observatory on Access to Healthcare focused on the living conditions, health and healthcare use of migrants living in Europe without residency status. However, it then seemed important as a next step to add information about access to healthcare for the children of undocumented migrants. Therefore, and in tandem with the quantitative survey, interviews and case studies were collected from undocumented migrants living in Europe with one or more children. The aim was to better understand access to healthcare for these children, using information obtained by asking their parents about how they sought care and their experiences in doing so.

It was not simply a case of analysing the implementation of legislation regarding healthcare for the children of undocumented migrants in the various countries. It focused instead on gathering information from some of the parents to record their points of view, and finding out how they manage and perceive access to healthcare for their children.

The interviews were conducted at *Médecins du Monde* project sites, whether the children were clients or not. This was done in order to broaden the sample to include case studies for the children whose parents had been able to assert their right to care within mainstream services.

The areas covered by the survey range from the families' situation and living conditions to the health status of the children and their access to healthcare. The interviews varied in length, delving into more depth in some areas than others, according to the situation and willingness of the people questioned.

In total, 32 case studies or interviews were collected in eight countries¹¹³ for this report:

- **France** - eight interviews (seven in Saint-Denis and one in Paris);
- **Greece** - eight interviews (four in Athens and four in Thessalonica);
- **Sweden** - five interviews in Stockholm;
- **Belgium** - three interviews in Brussels;
- **The Netherlands** - three interviews in Amsterdam;
- **United Kingdom** - two interviews in London;
- **Switzerland** - two interviews in Fribourg;
- **Spain** - one in the Canary Islands.

As in the quantitative survey, the sample of interviews gathered at the *Médecins du Monde* projects feature neither those suffering from the greatest exclusion from healthcare (who would not be reached by these types of projects) nor those better integrated into the system (who don't need to go to these types of projects).

113. See the list of interviews and background of the participants in the appendix.

2. LIVING CONDITIONS CAN AFFECT THE HEALTH OF CHILDREN

The right to health isn't just about access to healthcare. It is also about the right to live in decent conditions. However, the living conditions experienced by undocumented migrants are often perceived to be sub-standard. Many of the parents questioned recognised and regretted that their poor living conditions had an effect on their children's health. Both physical and mental health are put at risk.

- **Harmful living conditions**

Economic difficulties, resulting mainly from the inability to work legally, were highlighted by many of those questioned. Such difficulties often gave rise to problems with housing. Even when the interviewees could count on their relatives, friends or community for support, lodgings weren't necessarily available or stable. The absence of a residency permit or of pay slips makes access to housing even more difficult, adding to the vulnerability of those questioned. As a result, many found themselves in particularly unhealthy, decaying and overcrowded accommodation.

Many parents admitted they were forced by circumstances to live in **unhealthy surroundings**. Problems with damp and mould were mentioned, as was difficulty heating the rooms. But they also highlighted exposure to toxic products (for example, lead paint which can cause poisoning), or problems with household equipment such as heaters or faulty sanitation systems. Take, for example, the case of a 30-year-old woman living in Greece with her 15-month-old son, her sister's 3 children and her 65-year-old mother. All six live in a two-room apartment which she describes as old, dark, damp and very cold in winter. She believes that this environment has a detrimental effect on the children, but she has had to live there for the last seven years because the rent is so low:

- > *"The kids are always ill, even in summer. The damp and mould are like a cancer, eating away at them slowly...But I can't afford anything better..." Mrs. S., Albanian, living in Greece for 12 years, lives with her son, 3 nephews and mother.*

Another woman describes the living conditions she experienced when her son was small:

- > *At the time she lived with two children and their father in a "tiny studio flat": "the toilets were in the same room, the kids stayed in bed all the time because there was no space to move[...] There was a lot of dust." She believes such conditions caused the allergies from which her son, who was very young at the time, now suffers. Mrs. A., Albanian, in Belgium for eight years, lives with her partner and their two children aged seven and five.*

Overcrowding also appears common.¹¹⁴ This can have a negative effect on the health and development of children and adolescents for many reasons including the lack of privacy, no quiet space to do homework, or not having somewhere to invite friends round.

A testimony collected by interviewers in Sweden featured parents who overfed their baby so that it didn't wake up the other inhabitants of shared housing—because that would have led to their eviction.

Another example is a 29-year-old woman and her two children in the Netherlands.

114. According to the questionnaire, 86% of those asked who live with one or more children (and aren't homeless) suffer from overcrowding.

- > *Having been in lodgings for short periods with her children, she was now living for the first time in a stable place for six months, which she paid for herself: a room sub-let in a house. The cramped conditions and lack of privacy nevertheless appear problematic, considering she lives with an autistic boy of nine and a seven-year-old girl. Mrs. V., Nigerian, in the Netherlands for 11 years, lives with her 2 children, 9 and 7.*

Overcrowding also has consequences for those recovering from illness. The situation is worse still when the people do not have anywhere to live.

- > *This is the case for Mrs. C., recently arrived in Brussels with her partner and six children. They spent 20 days in a tent in autumn, when “the weather was very cold”. She also spoke about being unable to provide food for her children, living only off bread thrown out by others for three days. Mrs. C., Romanian, recently arrived in Belgium, lives with her six children.*

● Frequent moves can affect children’s health

Residential instability can also negatively affect children. Some undocumented migrants are forced to move frequently, due to evictions, temporary lodgings with family or institutions, or job opportunities that involve relocation. Several were accommodated in turn by friends, family members or acquaintances, shelters, churches or charities. **Residential instability can lead to stress for children as well as a lack of familiarity with surroundings and difficulties adapting.** It is also likely to affect their health.

A 22-year-old woman shares her concerns about being homeless, whilst caring for her three-month-old baby.

- > *Currently living with friends who would like her to leave. “With this cold, I am so frightened, as that kind of cold makes babies ill.” She will have to leave her friend’s place soon but doesn’t know where to go. She is looking into shelters for young mothers, but would love to find stable accommodation and stop this constant moving from place to place. “If only I could find somewhere stable, just a place to lay my head. Moving from place to place each night with a baby frightens me...” Mrs. G., Ivorian, in France for two years, lives with her daughter, three months old.*

Constantly moving can unsettle children, or put their medical follow up at risk. An Eritrean woman living in London with her four-year-old son explains.

- > *Having suffered verbal and physical abuse from her partner, she left him, taking her two-year-old son with her. They were housed in accommodation for asylum seekers, but never allowed to stay more than a few months in each place. Changing so frequently meant she had to frequently register with a new general practitioner. Her son had to change nursery, meet new teachers, form new friendships. She feels this lack of stability has badly affected her child’s development and is appalled by the way asylum seekers are sent from one institution to the next without preparation: “They say that if you have “Section 4” status you don’t have the choice, you have to move, that’s all. We have ties here, friends, health visitors, doctors. They understand our situation, and have spent time with us. And when we are moved on we only get one or two days notice... But I say we are human beings after all, not animals! They say we should be grateful not to be deported and that means we are lucky.” Mrs. S.F., Eritrean, lives in the United Kingdom with her four-year-old son who was born in the United Kingdom.*

The case of Mrs. I.'s son is another example. An 18-year-old boy, his medical treatment was interrupted by an upheaval.

- > *Born in Romania, he has been in France since he was 15 years old. Two years ago, because his puberty was delayed, his mother took him to a doctor who prescribed him a hormonal treatment—three injections per week for two years. He only underwent treatment for six months in the end because his mother was unable to find an address for another doctor to repeat the prescription before returning to Romania. Now back in France, she would like her son to take up the treatment again, but they have to wait until they are once again able to benefit from the state medical aid they lost in returning to Romania. The difficulties experienced by Mrs. I. concerning the medical monitoring of her son, appear, in part to be related to the precariousness of their living conditions, in particular being obliged to move frequently and the speed at which Roma camp-dwellers are expelled from sites. Her lack of French language skills, (whilst she understands well, she speaks very little French), further add to the difficulties she faces in managing their situation. Mrs. I., Roma from Romania, in France for 3 years with her 3 children aged between 14 and 20 years old.*

- **Health issues related to anxiety**

Over and above financial and housing concerns, **being an undocumented migrant means being forced to “hide”, living under the constant threat of being arrested or separated from loved ones, which leads to a very difficult context for children to grow up in.** Some respondents feel that this leads to mental and physical problems for their children.

This is the case for a woman living in Switzerland for 9 years with her 15-year-old son.

- > *She believes that the gastric disorders and weight problems from which he suffers, as well as her own heart problems, are related to the stress generated by their status: “My son was arrested by three policemen in plain clothes, during a previous expulsion. As a consequence I have made him promise to remain silent so it won’t happen again... He mustn’t tell anyone where we live in order to protect the people who sublet the apartment to us. [...] My son is also suffering from stress and to compensate, he eats [...] I am always on the alert. Each time I hear a car door close, I run to the window to see who it is. I am very nervous, which has led to heart trouble.” Mrs. S.-D in Switzerland for 9 years, lives with her 15-year-old son.*

The confidence and self-esteem of children can also be affected by the precarious lifestyle, lack of rights and the discrimination they face. Even those parents who have been able to build a relatively stable environment for their family are not able to protect them from stress, psychological problems or mental health issues.

This is demonstrated by a Bolivian family who has been living in Sweden for two years, but who lost residency status around six months ago.

- > *The parents and four of their children share an apartment with another couple. The father works and the mother is grateful they are able to live in the apartment for a prolonged period. The two adolescent girls go to school, but according to their mother they are frightened and sometimes depressed. Mrs. X., Bolivian, in Sweden for 2 years, lives with her partner, 5 of their children aged between 3 and 16 years old, and other relatives.*

One woman regrets the fact that her children have been faced with racism and discrimination: her 7-year-old son, who twice got into a fight with another student who called him an “illegal.” (Mrs. B., Algerian, in Belgium for four years, lives with her partner and two children aged seven and four.)

- **Lack of status changes the parent-child dynamic**

The health status of adults and children are often linked. In spite of the efforts made by parents to protect their children, their difficulties are inevitably intertwined. Their concerns and their distress sometimes affect their own mental health, which, in turn, affects the children.

- > *A nine-year-old boy, who was born in Armenia and moved to Sweden at the age of three, suffers from serious health problems linked to his family's precarious situation and constant upheavals. They lived in Sweden, then Finland, before returning to Sweden following the Dublin Convention. For several years the child was silent and showed signs of depression. His problems could come from many sources, but it is agreed that the serious depression from which his mother suffers (she has attempted suicide on several occasions) does nothing to help his own health. He is currently at school and receives counselling with his parents. His sister has chronic kidney trouble. Their father is very worried about his children's health and thinks his wife's depression makes finding work harder and consequently deepens the financial difficulties they face. In spite of the hardships he faces, he remains positive and grateful for the help he has received in Sweden, in particular from Médecins du Monde and the Asylum Committee. Mrs. S.B., Armenian, in Sweden during 6 years with her partner, their 9 and 6 year old children and relatives, expelled a few months after the survey.*

In addition, the financial and social difficulties, language barriers and isolation of their parents place children in a difficult situation, particularly when they are forced to play the **role of intermediary** between their parents and the society in which they live. It is not unusual that children—educated and with a much better understanding of the host country's language—take on the **role of translator** or interpreter. Some provide real support to their parents—and as a consequence take on **adult responsibilities**.

- > *Mrs U. left her child, M., in Morocco when she came to Europe, promising they would be reunited. After four years of trying, she was able to get her over to the Netherlands two years ago. Her mother says that since that moment her daughter has become her "right arm" helping her to manage issues linked to her irregular status as well as coping with her sons, one of whom has learning disabilities and the other who suffers from attention deficit disorder and hyperactivity. Mrs. U. is very concerned about her daughter's future, as she would like her to continue her studies after high school—something that isn't possible for undocumented migrants in the Netherlands. She worries that her daughter suffers in silence and about the pain she has suffered up to now, for which she feels responsible. Mrs U., Moroccan, in the Netherlands for 6 years, lives with her 3 children aged between 14 and 3.*

Several parents expressed their guilt at being unable to offer their children what they had hoped, despite their best efforts. They worry both about the present and the future for their children.

- > *Mr. R. lives in Greece with his four children and is sorry "not to be able to buy them clothes and other things they need for school or free time..." He is pleased they are in good health but underlines the fact that "the only [health] problem he is worried about for his daughters is their weight, they are so thin. All four of them are really thin because I am unable to feed them properly [...] In Greece our life is difficult but we are safe. We aren't living in fear of our lives, but we do worry about what we are going to eat." Mr. R., Yemeni, in Greece for two years, lives with his partner and their four children aged between one and nine.*

When living conditions are particularly hard, parents are torn between concern for, or even feelings of guilt towards, their children and the fear of returning to their country of origin. In spite of the difficulties encountered, many of the people interviewed underlined the importance of staying in the new host country. The reasons are, of course, always complex and differ according to the individual concerned, but the two key arguments focus on the problems in their country of origin and the positive aspects of the new host country. One aspect of their motivation for staying in the host country centres specifically on their children's future—being able to offer them a better future than the one they could have in their country of origin. Some mentioned health problems which, if they were not treated in Europe, would mean their children's lives would be put at risk. Many acknowledged a better standard of living, better access to education, the freedom experienced in the host country, and also the chance to escape war or violence in their country of origin:

- > *Mrs S.-C. is from Mongolia and has been living in Switzerland for six years, where she came originally for her studies. She highlights the freedom women enjoy in Switzerland, as opposed to her country of origin. She would like her girls to live in a country where the status of women is not downgraded: "I would like them to stay here, we have freedom here. [...] Even if I have to leave Switzerland, I would like my children to stay." Mrs S.-C., Mongolian, in Switzerland for 6 years, lives with her partner, their children who are 2 and 10 years old and other relatives.*
- > *Mrs. S.-D. has lived in Switzerland for nine years with her son. She is sorry about the stress he has suffered because of their irregular status but insists that the situation would be much worse in their country of origin. The war scattered her family and their living conditions were dangerous: she shared rented accommodation with alcoholics and people suffering from mental health problems. She says her son would probably be on drugs and in danger of being attacked "just for his jacket which wasn't even new." Mrs. S.-D., in Switzerland for 9 years with her 15-year-old son.*

- **Effects of health status on social situation**

Whilst many people mentioned the influence their living conditions had on their children's and their own health, some also stated that being in poor health can also be an important factor in worsening the family's social situation. This risk exists for everyone, whatever their status or background, but is of particular concern for a vulnerable undocumented migrant, often with little social support and less state support than other citizens.

When adults are unwell, this can lead to an inability to work and the inability to guarantee an income. When it is the children who are ill, this can put a strain on the social support network or complicate living arrangements with relatives, for example. The repercussions can, in fact, touch all areas of social life.

In the following example, the health problems of Mrs. V.'s son were a factor in the deterioration in their social situation, which was already problematic because of the lack of access to care and inability to work legally.

- > *Mrs. V. had difficulty getting housing because of her irregular status and her lack of financial means. These difficulties were heightened because of the behaviour of her nine-year-old son who suffers from autism: this meant that the people who were housing them asked them to leave and find new lodgings. In general, just the fact that she is undocumented affects her and her children's health considerably. If she had insurance for healthcare, her family would have access to better treatments, in particular her daughter whose hip problems require treatment which falls outside the cover offered in the Netherlands for undocumented migrants. In the same way, if she had a work permit, she could earn money and offer her children a stable place to live, a more roomy, clean, healthy and dignified environment for her autistic son. She summarizes: "When all your rights are denied, when you live under miserable conditions and you beg money and food... how can that not affect your health?" Mrs. V., Nigerian, in the Netherlands for 11 years, lives with her 2 children, 9 and 7.*

3. THE PARENTS' JOURNEY THROUGH THE HEALTH SYSTEM

- **Relationships between parents and health system**

An analysis of case studies and interviews reveals three typical relationships between the health system and the child's health.¹¹⁵

- **Confusion:** this type of relationship characterises people who feel “lost” in the medical and/or administrative system of the country. They neither know their rights nor those of their children in relation to access to healthcare. For their children, they very seldom consult health professionals—and generally use hospital emergency departments.
- **Adaptation:** this type of relationship characterises people who manage to look after their children by resorting to medicine when they consider it necessary, but who feel this presents various difficulties (obstacles, their own reticence, etc).
- **Integration:** this third type of relationship characterises people who don't feel they have any problems with healthcare for their children. It is underpinned by a good knowledge and understanding of the country's health system and provision for children of undocumented migrants.

This typology does not aim to classify undocumented migrants in a categorical way. But identifying these three stages makes it possible to understand their experience of accessing care for their children, whilst taking into account that these may differ according to the health problem experienced, and above all that the experiences evolve, notably in line with the amount of time spent in a country, and number of times access to care was required. **Many people questioned said they had experienced all three relationships to the system since their arrival in the country:** initially confused and not knowing what to do, they slowly learned their way around the system and how to best ensure that their children's rights were respected in accessing care, up to the point where some of them no longer felt any particular difficulty with consultations or treatment (at least for everyday complaints) of their children.

- > *Mrs. U.'s son was born in Morocco, where he was diagnosed with nephrotic syndrome when he was two years old. He was placed under treatment but Mrs. U. was keenly aware of the limitations of care in Morocco and decided to move to France with him. She was obliged to leave the country and travelled to the Netherlands to join her parents-in-law. During the first few months, she didn't take her son to the doctor. Her in-laws told her that he couldn't access care because he didn't have papers. She didn't understand the Dutch healthcare system, didn't speak Dutch and had no other networks outside her family; so she continued to give her son the medicines prescribed in Morocco, brought over by fellow Moroccans. Seven months after their arrival he suffered a “crisis.” Concerned, she went to a healthcare centre for vulnerable people and they sent her to hospital. With great difficulty, she managed to see a doctor who examined the child and gave her a letter of medical recommendations for her to give to a doctor in Morocco: “You can get help, but in your own country!” Her son suffered from “repeated crises”, so was obliged to return several times to the hospital and see the doctor “who was as unsympathetic as ever.”*

Without medical cover, she paid for each consultation in cash, and was not offered the financial support the existing legislation sets out for destitute undocumented migrants. It was in another hospital where she went for an emergency, and having met a first, then a second, social worker that she was finally informed about her right to free care, given her financial and social situation. Mrs. U.'s children now benefit from adequate healthcare, following a long period of research fraught with difficulties, which cost the family a lot of energy, time, concern and even had costs in terms of health. Today, the children enjoy basic care adapted to their needs: family doctor, paediatrician, orthopaedic doctor. Mrs U., Moroccan, in the Netherlands for 6 years, lives with her 3 children, between 3 and 14 years old.

115. These relationships should be considered not as an exact reflection of the situation experienced by those questioned, but as key trends—this distinction offers a tool for understanding the experiences of undocumented migrants and the healthcare access for their children.

- **Information plays a key role**

The range of difficulties expressed by the interviewees in their attempts to access healthcare are many and varied. **One of the key things learnt from the analysis of the case studies is the pivotal importance of information about health, the healthcare system and migrant rights.**

Gathering such information on healthcare and social support is done through many sources: family, fellow migrants, people “met by chance” etc. It is also done through people met in institutions, reception centres and NGOs working with migrants and vulnerable people. Some migrants go straight to hospital to find out. But even once they grasp certain facts, **a lack of thorough understanding of the system, and the complexity of the steps needed to ensure that their rights are respected** can mean difficulties in accessing care.

Dependence on information passed on through social connections can bring additional problems. **Information is sometimes wrong, contradictory, incomplete or not relevant** for the person or child in question. Moreover, as we saw previously, **even in public institutions or NGOs the staff or volunteers are not always (and sometimes hardly at all) informed about the rights of undocumented migrants to access care**, or about the real possibility of receiving treatment. Some expressed a lack of interest in helping or supporting foreigners who come to them for advice.

The fact that children's rights are not always respected adds to the confusion for parents when considering how to ensure their care. Having been faced with refusals from the very places that should, in theory, welcome their children, some begin to doubt their rights.

Difficulties linked to a lack of information sometimes lead to a **delay or to giving up the search for care**. This is more likely, though not always, to be the case during the first few months after arrival in the host country. The migrants haven't yet had the time to get to know and understand the system well; and the fact that they often don't speak the language means that not only access to information but also contact with healthcare professionals is more complicated. However, such delays can obviously lead to a deterioration in health.

Moreover, the consequences of delay are sometimes administrative or social. This was the case for an 18-year-old disabled man who just missed out on care available for minors:

- > *Suffering from a muscular disease, Mrs. S.-A.'s son is 18 years old. He is disabled and in a wheelchair, which he has had since he was a child and which is now too small for him. His parents were afraid to ask for help and lacked the right information. It is only recently that someone told them about the services that are available. But this young man is now over 18, which means he can no longer benefit from the rights accorded to children, which would have meant he could have received a suitable new wheelchair. One of his sisters, aged eight, suffers from terrible sight problems, also left too long without care because of a lack of information. One of the doctors at Médecins du Monde sent her on to an ophthalmologist. Without a letter from the doctor, and as her case wasn't classed as urgent, initially she was refused because of her undocumented status. Médecins du Monde followed up several times and eventually she was seen in a specialist centre where she was diagnosed with three very serious problems, which, without treatment, could have led to blindness. Mrs. S.-A., Salvadorian, in Sweden for 3 years, lives with her partner and their 8 children aged between 2 and 18.*

Such examples underline the importance of timely intervention, and the repercussions delays can have on health or disability. Moreover, a lack of understanding concerning the right to access care, combined with fear, or feeling uncomfortable asking for help, means a real danger of the health or social situation getting worse.

In the absence of information about their rights to healthcare, **self-medication** is a solution for some people. Parents give their children, without medical advice, medicines that have been leftover from previous illnesses or given to them by friends whose children have the same symptoms. Some parents, determined that their child see a doctor, pay for consultations and treatment, **although they are entitled to receive them for free**. This doesn't necessarily allow them to complete the child's treatment; and such costs can have serious consequences for the already precarious financial situation of the family.

- > *Mr. F. has been living in France for 11 years without a residency permit, with his wife and their five children born in France. Whilst in theory he can access state medical aid, he isn't clear about his healthcare rights. When a teacher pointed out that his nine-year-old daughter was having trouble with her sight, he paid for her to visit an ophthalmologist in town. He also paid for the glasses which cost 300 euros. Shortly afterwards, his daughter broke her glasses and he couldn't afford to buy her a new pair. The school sent her to Médecins du Monde where she was given a new pair of glasses. Mr. F., Guinean, in France for 11 years, with her partner and their 5 children aged between 8 months and 11 years old.*

Sometimes, **community networks are mobilised to cover the costs**: relatives, compatriots, or members of a religious community are asked to pay for specific needs. When a condition is ongoing, there is a danger that the money dries up or damages relationships with friends or family.

- > *Mrs. V. is Nigerian. She came to the Netherlands when she was 18 years old. During her first pregnancy, 9 years ago, she was cared for by an obstetrician and gave birth in hospital. The costs were entirely covered by her church, in spite of the legal possibility of the costs being covered by government, as is the case with pregnancy for destitute undocumented migrants. Mrs. V., Nigerian, living in the Netherlands for 11 years, lives with her 2 children aged 9 and 7.*

● Difficulties experienced when trying to access medical care for children

Many people experienced various difficulties when trying to access medical care for their children. It is impossible to cover them all. In addition, the situations are always specific to the person in question, to the health need, the legal structure of the particular country, the healthcare system, etc. We can, however, highlight some key areas which help us understand how **the relationship with the healthcare system and care of children is gradually built up, and that there are often barriers, which, as time passes, parents manage—more or less—to negotiate or circumvent**.

Whatever entitlement children have to care in each country, **how this works in practice is, to say the least, not systematic**. As such, several people experienced **refusal of care or were asked to pay**. Those who were able to see a doctor did so **at the price of being discriminated against, or humiliated by consultants during interviews they saw as “rushed”**:

- > *“In the IKA¹¹⁶ system they don't explain what to do for our children or how to do it. The doctors seem annoyed by our problems... The truth is that I would prefer not to use IKA even if I am entitled to, because I am concerned about some of the treatments... The paediatrician didn't seem keen on my daughters, she didn't even look at us! Happily, my daughters aren't ill very often so we don't have to use IKA that much. At the Médecins du Monde policlinic the atmosphere is welcoming, my kids smile and seem happy. The paediatricians really enjoy what they do. I think they really enjoy volunteering and love kids.” Mr. R. Yemeni, living in Greece for two years, with his partner and four girls aged between one and nine.*

116. Greek public healthcare system.

Regardless how hospitable healthcare systems are, **the way in which the parents are received, as well as the financial and medical care that they and their children receive, is largely dependent on the person they meet** (whether that be a doctor, receptionist, social worker.) The difference in attitude is linked in part to the professional's knowledge regarding the rights in question, but also to their own sensitivities and attitude towards undocumented migrants. In this context, it is sometimes only with the support of an individual or NGO that migrants are able to exercise their rights.

- > *In Sweden, a 14-year-old boy was only treated for tuberculosis thanks to the efforts and tenacity of a school doctor. He was seen by the school nurse (just after his family lost residency rights) who suspected he had tuberculosis. The school doctor sent him to the central hospital for a lung scan. But when he got there he was refused care. The school doctor then telephoned the hospital doctor directly, but again the child was refused care. The headmaster had to call the hospital and inform them about Swedish law with regards to treating children—provided they are failed asylum seekers—so that at last the boy was able to have an x-ray. Mrs. Z., Bolivian, living in Sweden with her partner and their 14-year-old son.*
- > *Mrs. U. has seen two sides of accessing care as an undocumented migrant living in the Netherlands: on the one hand she faced rejection, refusal and humiliation because she didn't have medical cover and couldn't afford to pay; on the other hand, she found adequate cover, support and confidence, once she was able to take advantage of her rights. She believes that things can go "better or worse, be easy or hard", depending on who you are faced with. She concludes that there are a lot of benefits available in the Netherlands for undocumented migrants, but, in spite of these rights, you have to "fight" to get them. Her nine-year-old son has been receiving weekly or monthly hospital care for the last five years, according to his needs. He suffers from nephrotic syndrome and has severe learning disabilities. In spite of the fact this has been going on for years, the hospital continues to send out bills for the extensive care he has received. Mrs. U. is now supported by a charity, who responds systematically to these requests, reminding them of their legal obligations. In spite of these letters, they haven't stopped sending out the bills and Mrs U.'s debt continues to mount. Mrs. U., Moroccan, living in the Netherlands for 6 years, lives with her 3 children aged between 3 and 14.*

The fact that children's rights aren't respected affects confidence in the healthcare system and in the treatments that are received. Some people even questioned the diagnosis and prescriptions given:

- > *Mrs. A. and her husband waited for two hours at Brussels' hospital accident and emergency department for a doctor to see their son. The doctor told them he would not be treated because he was undocumented. Her husband became agitated and insisted their son received care. Eventually the doctor did conduct a consultation, diagnosed an infection and prescribed a course of medicines. But Mrs. A. was not convinced by the diagnosis and didn't want to give her son the medicines he had been prescribed; she took him to see another doctor the next day. Mrs. A., Albanian, living in Belgium for eight years, lives with her partner and their two children aged seven and five.*

Faced with the constant feeling that their rights are being ridiculed, some people prefer not to take the risk of being refused care again, or of being insulted or subject to discrimination again, and so turn away from public health systems. **The fear of being challenged and arrested by the police—or of being reported—is another reason some people avoid trying to access care.** As a result, organisations like *Médecins du Monde* are perceived as being more welcoming, non-discriminatory, and safe, compared to public health structures:

- > *"For vaccinations or other health problems for our kids, we come to the Médecins du Monde polyclinic... I did go a few times to the hospital but they treated us with indifference. The hospitals are cold and it's difficult. I don't understand how it works and, honestly, I am worried about being deported. At Médecins du Monde, I feel like an individual and respected... And anyway, I don't trust hospital doctors. Last year I had to go to the emergency department because my son was very ill and it was very late at night. He had been coughing and shouting for two days, wasn't eating anything and had a very high fever. I was very worried; I took him to the paediatric centre which was open that night. The paediatrician didn't help us at all. He said there was*

nothing seriously wrong with the boy, that I was overreacting and he sent me away. The boy didn't sleep a wink and cried until morning, he was purple. Fortunately I took him to Médecins du Monde early the next day and they diagnosed him with bronchitis." Mrs S., Albanian, in Greece for 12 years, living with her 1-year-old son, 4 nephews, aged between 6 and 17, and her mother.

The various qualities attributed to the *Médecins du Monde* centres underline the gaps that some parents face in the public healthcare system, in particular their lack of confidence in the system, the inconvenient opening hours, and the lack of respect or understanding they receive there. On the contrary, what they enjoy about the healthcare centres run by the voluntary sector is the personal approach and a holistic response to their needs (medical, social, psychological, in the form of moral support).

- > *A 29-year-old woman from Mongolia brings her children to FriSanté¹¹⁷ "if it isn't very serious" and "to the doctor" if their health status is more worrying. She has developed friendly ties with a healthcare professional at FriSanté: "At school my daughter knows the answers but she is very shy, because at home she can't really talk... She doesn't have many friends... Mrs. X. from FriSanté who sometimes takes my daughter with hers. The other day they went up to the mountains. It was like a dream." Mrs. A, Albanian, in Switzerland for 6 years, lives with her partner and 2 daughters aged between 2 and 10.*

Language barriers have already been mentioned. **A poor command of the host country's language makes accessing information more difficult but also complicates the journey through the care system.** Some people, in charge of their children's health ask their relatives—sometimes their own children—to come to appointments with them to interpret. This solution can cause additional problems, particularly when the parents would prefer not to share their health concerns (whether they are stigmatised diseases or not). In some cases, an NGO network is able to sort out volunteer translators.

Mr. R. explains that he has to take his daughters to the doctor but that the surgery hours are not compatible with his working schedule:

- > *"Within the IKA system, the paediatric sessions are in the morning, which makes it really difficult for me because I work every morning. And I am the only one who can take the girls to the doctor because my wife doesn't speak Greek." Mr. R., Yemeni, living in Greece, in Thessalonica, for two years, father of four girls, aged between one and nine.*
- > *O.'s family arrived in Greece two months ago and none of them speak Greek. When the son became ill, his mother took him to a centre for asylum seekers and refugees, who sent them to a healthcare centre with an interpreter. O., Afghan, in Greece for 2 months, 12 years old, living with his parents and 5 brothers and sisters.*

• **Self-sufficiency of some parents in the healthcare system**

Not everybody feels powerless and lost when faced with the healthcare system. The capacity to find one's way around and move through the system without problems depends in part on the rights granted in the particular country. It also stems from the length of time someone has been in the country, on the social support that they have received and on individual abilities, strength and empowerment. Having lived for several years with regular status can also be a bonus: they already know the healthcare system and the fact that they have already had contact with that country's doctors reassures them that their children can also receive care.

117. FriSanté offers nurse consultations (see explanation of the Swiss system at the beginning of the report).

Many of those questioned said that they hadn't had any particular problems consulting a doctor. They didn't think that their administrative status would affect their children's treatment in any way. **Knowing their rights, being able to navigate the administrative system, some knew the country's healthcare system quite well; or knew a healthcare centre or doctor whom they used as a point of reference.**

Benefiting from healthcare cover, they took their children to the doctor each time it was necessary. One mother thought there wasn't a problem and even added, as a joke:

- > *"Actually, I probably go too often! The moment my daughter starts to feel ill, I go to see the doctor." Mrs. L., Filipino, in France for three years, lives with her partner and six-year-old daughter.*

It is interesting to look at the account of another woman, who is comfortable navigating the French healthcare system. Covered by state medical aid, her children receive good medical care thanks to her command of the language, good information and the fact that she has a known general practitioner (GP).

- > *Mrs. K's children, covered by state medical aid, are cared for by a GP and the local mother and child centre. She is wholly satisfied with her doctor. "A doctor very close by accepts state medical aid" and is careful not to prescribe anything which isn't reimbursed. "He always chooses medicines that are covered." For more expensive treatments and those that aren't covered, Mrs. K. understands how to use NGO networks: her son is treated by Médecins du Monde for his sight problems. She says she has never felt that she or her children were discriminated against by the healthcare professionals or doctors she has encountered. Mrs. K., Algerian, in France for eight years, lives with her partner and their three children aged between seven and four.*

Like this woman, some parents occasionally call upon healthcare centres specifically for those in difficulty or who are undocumented. This offers one option to ensure good healthcare cover for their children. Some come to *Médecins du Monde* to access more expensive care which is poorly covered by the system. Others come to ask health-related questions, or about how to access care and to gain a better understanding of how to use the system. Sometimes it is a case of complementing information already given to them by a healthcare professional which has been badly understood or not sufficiently explained.

- > *Mr. H's stepdaughter receives regular care at the mother and child centre. His partner had just been hospitalised with pleuro-pulmonary tuberculosis. He came to Médecins du Monde to find out what kind of tests he and his stepdaughter should have. Mr. H., Cameroonian, in France for six months, lives with his partner and three-year-old stepdaughter.*

Benefiting from health coverage and understanding the system allows parents to maintain some **independence in managing their children's care**. By developing a detached, even critical, view of the healthcare system, some are able to compare the advantages and disadvantages attached to the different possibilities available for their children. Several people then evaluate the different structures in light of their own criteria and priorities, and choose accordingly in line with the specific healthcare issue, or their preference:

- > *Mrs. A. knows both the healthcare system and her rights in Brussels well. She explains that the advantage of going to the hospital emergency department is that she doesn't need to have a document which says she needs urgent care. She is careful to always carry this document and not use the emergency services—except on weekends, if necessary, when her GP isn't available. Mrs. A., Albanian, in Belgium for eight years, lives with her partner and their two children, seven and five.*
- > *"I choose a paediatrician based on first impressions. I saw three different ones until I found the right one in whom I felt confidence. [...] An example, my daughter was bitten by a small dog and I went to see the paediatrician who didn't say anything and so I changed." Mrs. D., Argentinian, in Spain for 10 months, lives with her partner and their children aged 5 and 2.*

But for someone to state that they don't have a problem accessing care doesn't necessarily mean that they didn't face difficulties on the way. **It is indeed probable that some parents assume that as undocumented migrants, they must face certain obstacles or administrative barriers.** Some seem so relieved that their children are cared for, that they "forget" (or don't realise) that it is more difficult for them than for others.

- > *Mrs. A., for example, receives emergency medical care (AMU) for her and her children. The health card offers her free access to care and treatment "without any problem". In her view the steps needed to benefit from the card are complex and heavily administrative, for example, the quarterly justification of urgent care and annual renewal of healthcare cover: "It's tiring... But without this paper, where would I find the money to pay for my care?" Mrs. A., Albanian, in Belgium for eight years, lives with her partner and their two children aged seven and five.*

Moreover, even when children are medically covered, difficulties can arise if complicated conditions come up. Basic care for acute problems is indeed more easily accessible than specialised care. Healthcare centres and professionals are often unclear as to which treatments are covered or not; and in some countries they aren't covered at all. This is what Mrs. V. found in the Netherlands.

- > *Mrs. V.'s children have multiple health concerns. Her son suffers from autism and has eczema, whilst her daughter has a serious hip problem. They both go to school: he attends a special school and she goes to regular classes. Following years of difficulty, even refusal, when trying to access care, they are now able to get free basic care. The family has been visiting a general practitioner who (being able to access a specific fund set up for such cases by the Dutch government) doesn't charge for consultations or treatment. She is still facing barriers, however, when it comes to specialised care, in particular for physiotherapy prescribed for her daughter's hip. The funds allocated to undocumented migrants don't cover this type of treatment—in any case not for more than a couple of sessions. Mrs. V., Nigerian, in the Netherlands for 11 years, with her 2 children aged 9 and 7.*

● **"Key moments" in the process of accessing care**

In several interviews, those questioned recalled "key moments" which were steps towards an improvement in their access to care and health. It is often a meeting with someone who gave them a vital piece of information on their right to health coverage, or who signposted them to a healthcare centre that welcomed undocumented migrants. It is also often a meeting with a professional or organisation who shows them the way, or gives them the right advice, or helps them to improve their social and administrative situation.

- > *Mrs. G.'s pregnancy was one such key moment. She had been living in France for two years but had never seen a doctor, not knowing where to go or what to do when she was ill "When I am ill, I lie down and wait until I feel better." When she became pregnant, her partner didn't want the child and they separated. She wanted to keep the baby but hadn't had any medical care. "I didn't know where to go, I had a lot of problems." It was in her eighth month of pregnancy that her friend took her to the doctor because she was ill. Her friend wanted to take her to hospital, but she refused and was eventually taken to the emergency department at a Paris hospital. It was only then that her pregnancy began to be monitored and that, at the delivery, a social worker organised state medical aid (AME). She was also told that she could access mother and childcare centres (PMI) free of charge. Since then, her daughter has been cared for at a PMI close to her home. "When my baby is ill, I bring her here." As for her own health needs, the PMI told her that Médecins du Monde could look after her for free whilst her AME claim was being processed. Mrs. G., Ivorian, in France for two years, lives with her three-month-old daughter.*

Voluntary sector organisations such as Médecins du Monde play an important role in giving information and guidance to people, which means that they are better equipped to tackle the healthcare system independently.

- > *Mr. E. has been in France for eight months without a residency permit. Whilst he suffers from a skin condition, this was the first time he had visited a doctor since his arrival. "I didn't know where to go, where I could ask for help." It was one of his compatriots who told him about Médecins du Monde, where they helped him to obtain state medical aid (AME). This information appears to be the starting point for better access to care for Mr. E. and his family. He came to the organisation, who explained how things worked at the centre and what he needed to do to obtain AME. He was also very grateful for the information he was given concerning his two-year-old son: he had been regularly cared for by a family doctor in Moldova, but hadn't been seen by a doctor since his arrival in France eight months earlier, because they didn't know where to go. Médecins du Monde told him about the mother and child protection programme. Mr. E., Moldovan, in France for eight months, with his partner and their two-year-old son.*

These examples highlight the vital importance of information and support to ensure an improvement in the living conditions and health of children and their families. In contrast, they also underline the vast number of **"missed opportunities"**, i.e. the moments when migrants came into contact with people who could have shared information with them, but hadn't thought to, wanted to, or didn't have the time to give them the right information. There were also "missed opportunities" when migrants came into contact with people at institutions or NGOs who didn't have access to information that would have been useful... For example, most of the people interviewed had children at school, but only a few had received advice and information from school social workers on access to care for migrants without residency permits.

Conclusion

This latest survey of *Médecins du Monde's* European Observatory on Access to Healthcare has been a tremendous collective effort.

Since 2007, around 40 people, mainly people working on the ground, have gathered to work jointly with two well recognised researchers. Drawing on their experiences together, they composed their questions and managed to identify what was essential to document through a questionnaire. What was more essential was the comparison of the results, putting them in context with the realities from the ground, in order to improve the analysis for the report.

Our work is not driven by ideology or preconceived ideas. Nor do we set ourselves up as academic experts. *Médecins du Monde's* European Observatory is based on the everyday efforts of the *Médecins du Monde* teams on the ground in 11 European countries. It is also born of their individual and collective refusal to accept the suffering of those **whom society attempts to deny legitimacy as human beings and labels as 'illegal'**.

This second report again focuses solely on undocumented migrants living in precarious conditions, in order to build on the results of the first report. It highlights the obstacles which undocumented migrants interviewed in different programmes face in trying to protect their health.

There are alarming signs in relation to the key determinants of health: housing, work, isolation, violence, poverty and a lack of information. Living conditions for undocumented migrants in Europe are harmful to their health, even though many migrants have faced considerable health risks in their past, such as deprivation, armed conflict, physical and psychological violence and dangerous migration journeys to name a few. Our statistics and our case studies show that undocumented migrants interviewed did not come to Europe for medical treatment. In general, they are young people who came to Europe to build a future but the welcome they receive and their living conditions have or will impact negatively on their health.

When dealing with such a small population (the highest estimates suggest that undocumented migrants represent, on average, 1.5% of the population in each country) we should have in place a more coherent public health response, along with more open and better performing health programmes to support this poorly treated group.

However, the picture today shows there are multiple barriers to healthcare, in relation to both treatment and prevention. The undocumented migrants seen by the *Médecins du Monde* teams do not seek healthcare often. When they do, it is often for serious health problems and they have already delayed seeking medical help. Furthermore nearly half of them do not manage to get proper medical treatment or follow-up. More specific studies are needed into the health consequences of this neglect of serious health problems.

One particularly shocking observation to emerge from the qualitative and quantitative surveys is the finding that, often, children don't have access to care either. This is despite the fact that they should be protected under the International Convention on the Rights of the Child (1989).¹¹⁸ It is stated clearly in article 24 that "*States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services.*"

118. <http://www.unhcr.ch/html/menu3/b/k2crc.htm>

The other unpleasant surprise is that almost half of the pregnant women we interviewed did not have access to antenatal care, with alarming testimonies of their experience in trying to access healthcare. Under international human rights law, pregnant women should be protected by the International Convention on the Rights of the Child under the same article as above, which stipulates *"States take measures to ensure pre-natal and post-natal healthcare for mothers."* (paragraph 2-D).

We call on all European governments to take concrete action to ensure that these rights are respected.

In relation to women, the frequency with which they have to live with violence, combined with their specific problems in accessing healthcare, mean that more detailed investigation is needed into how the health of the most vulnerable women can be protected. This is particularly important for Roma women, who are victims of specific discrimination, as well as homeless and asylum seeking women.

This report reveals the reality of life for the undocumented migrants we meet on a daily basis. We should focus on learning, jointly but also individually, from these individuals through their courage, persistence and survival strategies. We have to stop rejecting them and leaving them in a situation where none of their fundamental rights are respected because of their immigration status.

As we have seen, people do not migrate to Europe because of their health problems. On the other hand, the living conditions and barriers to healthcare which undocumented migrants face in Europe damage their health and run counter to human rights and medical ethics.

We call on all European countries to ensure that everyone who needs it receives equal access to treatment and prevention, regardless of immigration status or financial means.

To achieve this, we call on European governments to ensure that immigration policy is not allowed to undermine health policy. It is also particularly important to protect patient confidentiality, which is essential for the trust between patients and medical staff. We do not accept, therefore, any kind of denunciation, or reporting, within healthcare provision.

Our demands require European governments to strengthen or introduce mechanisms which ensure health coverage and healthcare access for all vulnerable people, including undocumented migrants. Only then will there be fairness and equity in terms of access to healthcare.

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Appendices

APPENDIX 1: 2008 SURVEY QUESTIONNAIRE



European observatory on access to healthcare survey 2007-2008

File number _____

Purpose of the survey:

We would like to invite you to participate in a survey. You are not obliged to take part. Your participation will not have any influence whatsoever on the care offered to you by Médecins du Monde, you are free to answer or not to answer questions. This survey is completely anonymous and confidential. We want to use the results of this survey to improve access to healthcare for undocumented migrants in Europe. The questionnaire begins by addressing different health topics, living conditions, income, immigration and violence experienced. Remember that you are totally free to choose whether to answer any question and you can stop the questionnaire at any time if you like.

NOTE:

In italic : to be filled directly by the interviewer

SQ: Specific (optional) question, each country / town has to decide either to as or not the question

- unique choice
- multiple choice

Country: _____ City/Town: _____

Programme: _____

Interviewer's name(s): _____

Doctor's name: _____

Interpreter present:

- 1 yes
- 2 no

1. File number (software): __/__/__/____

File number will be attributed by the software - File number will be entered by the person in charge of entering the data into the computer programme and will subsequently be used to locate the questionnaire.

2. Interview date: __ / __ / ____ (dd/mm/yyyy)

3. Time of interview: ____ . ____

24-hour format (eg. 20.30 and NOT 8 :30pm)

GENERAL DATA

To be filled directly by interviewer

4. Gender:

- 1 M
- 2 F
- 3 Transgender

Note: if the person is transsexual, two replies are required : 'transgender' and the apparent gender, male or female

5. Date of birth:

Note : Only record the month and year

__ / ____ mm/yyyy

or Age : __ years (or estimated age)

6. What is your nationality? (including stateless person)

SQ: 7. Do you want to add your ethnic group? If you agree, could you precise which ethnic group you belong to?.....

SOCIAL STATUS AND LIVING CONDITIONS

8. Do you live:

- 1 alone (with or without children)
- 2 with your partner
- 3 with relatives or friends

9. Do you have any children (under 18 years)?

- 1 yes
- 2 no

If Yes: 10. Do you live with any of them?

- 1 yes
- 2 no

11. What are your current housing conditions?

(Tick only one answer)

- 1 sleeping rough (in the streets or in emergency accommodation for one night only)
- 2 Short stay shelter (hotels, shelter for homeless, women, or migrants, etc. / < one month)
- 3 Middle stay shelter (idem / one month or +)
- 4 People living in insecure accommodation
- 4.1 Temporarily with family/friends
- 4.2 No legal (sub)tenancy (without any contract)
- 4.3 Illegal occupation of land (illegal camping)
- 4.4 Under threat of eviction or re-possession
- 5 Stable accommodation (personal accommodation or lodging long-term with family or friends)
- 6 Other (please describe): _____

If the person is not homeless

12. Which of the following do you have inside your accommodation:

Note :if the toilet is in the hall/corridor, they are considered to be outside the accommodation → answer no

- 12.1. Running water 1 Yes 2 No
- 12.2. Toilet (WC) 1 Yes 2 No
- 12.3. Gas ring or cooker 1 Yes 2 No
- SQ: 12.4. Heating 1 Yes 2 No
- SQ: 12.5. Electricity 1 Yes 2 No

13. How many rooms are there in your accommodation? (Don't count kitchen, bathroom or entry hall)

(note : if the interviewee lives in a hostel then only note his/her room)

_____ rooms

14. In total, how many people live in this accommodation? (including yourself)

(note: at least 1 person since the respondent is counted ; if the respondent lives in a hostel, only count the people living in the same room)

_____ people

15. In your view, do you believe your accommodation is affecting your health and/or children's health? (humidity, damp, peeling paint, etc.)

- 1 yes
- 2 no

16. Do you have a regular or temporary work or other activity to earn a living?

- 1 yes, regularly
- 2 yes, occasionally
- 3 no
- 4 (does not wish to respond)

If you have work or other economic activity:

17. What do you do?(note: write the most regular activity)

To be filled directly by interviewer

18. In which sector?

(do not ask the question to the interviewed person – ask more details concerning Q17 and then code yourself or mention ‘other’)

01 Agriculture, Forestry, Fishing (primary work)

02 Agricultural or food industry (factory work)

03 Consumer goods industry (including textiles)

04 Other industries: -----

05 Building, construction work

06 Business

07 Hotel and restaurant management /services

08 Cleaning

09 Transport

10 Work for individuals

11 Other: -----

SQ: Each country or city, has to decide whether or not to ask questions 19, 20, 21, 22

Regarding this main activity ...

SQ: 19. Do you work nightshifts? (between midnight and 5 am)?

1 Almost everyday

2 Several times a week

3 Several times a month

4 Rarely or never

SQ: 20. Do you work more than 10 hours per day?

1 Almost everyday

2 Several times a week

3 Several times a month

4 Rarely or never

Ask all respondents:

SQ: 21. Since your first entry into [country], have you been the victim of an accident at work?

(Note: record any accident regardless of the legality of the work)

1 yes

2 no

If yes:

SQ: 22. How long after you arrived? -----

23. Do you personally have other sources of income (support from friends or family, from community organisations or welfare benefits ...)

1 yes

2 no

3 (does not wish to respond)

24. Does your household have other sources of income (generated by other members of the household)?

1 yes

2 no

3 does not know

4 (does not wish to respond)

SQ: Each country or city, has to decide whether or not to ask questions 25, 26 and 27

SQ: 25. Counting all the income of all the family members (including family support, benefits etc.): what was the income in your household last month?

(note: anyone you share daily expenses with counts as a member of your household)

or: about ----- [local currency] per month

or: doesn't know

or: does not want to respond

SQ: 26. In total, how many people living there are covered by this income (including you)?

(note: at least 1 person since the respondent is counted)

(note: anyone you share daily expenses with counts as a member of your household)

----- people

SQ: 27. Of these, how many are children under 14?

(Note: verify that everyone was included when calculating household income)

----- children under 14

SOCIAL SUPPORT

28. In general, would you say that you feel ...

1 Very lonely

2 Rather lonely

3 Not very lonely

4 Not at all lonely

29. Here in [country], can you rely on someone to support you emotionally and to comfort you if needed?

1 Very frequently

2 Frequently

3 Sometimes

4 Never

If yes:

30. Who? (several answers possible)

1 Family

2 Friends, compatriots, members of the community, neighbours

3 Actors in the private/ public/ NGO sectors

4 Other, specify: -----

31. When (which date) did you leave your origin country to emigrate?

Note: Record only the month and year

___/___ mm/yyyy

32. In total (including every time you have been here), how long have you lived in [country of survey]?

----- months or ----- years

33. In total, for how long have you been in [country of survey] without authorization?

----- months or ----- years

34. Why did you leave your country?

(several answers possible)

1 For economic reasons, to earn a living

2 For political, religious, ethnic or sexual orientation reasons or to escape from war ...

3 Because of family conflict(s)

4 To ensure the future of your children

5 For health reasons

7 To join or follow someone

8 To study

9 Other, specify: -----

35. In the following months, do you intend to leave [country of survey] to live in another country? (on a voluntary basis)

1 yes

2 no

36. If yes, where do you want to go?

37. Do you currently limit your activities and movements for fear of being arrested?

1 Very frequently

2 Frequently

3 Sometimes

4 Never

RIGHT TO HEALTHCARE - PRACTICAL KNOWLEDGE ABOUT ACCESS TO HEALTHCARE

38. This question must be adapted to each national context; the objective is to summarise the conditions that must be met to receive healthcare as provided by the national legal framework

39. Summary of rights: is adapted to each national legal framework (taking into account the answer to the previous question, is the person now eligible for the type of healthcare envisaged by the law?)

40. Knowledge of rights: is adapted to provisions in national law.

GERMANY

Do not ask any questions

BELGIUM

39. Is the respondent eligible for the AMU?

1 Yes

2 No

3 Does not know

40. Did you know that persons in your situation (undocumented migrants), can obtain the AMU?

- 1 yes
2 no, or does not know anything about it

SPAIN

38. Are you registered on the local civil register?

- 1 yes → question 44
2 no → question 43
3 does not know

39. Taking into account the answers to the previous question, is the respondent eligible for the healthcare card?

- 1 Yes
3 No
3 does Not know

40. Did you know that persons in your situation (undocumented migrants), are able to obtain the healthcare card?

- 1 yes
2 no, or does not know anything about it

FRANCE

38. When did you arrive for the last time in France?

__/____ mm/yyyy

38bis. Been in France for more than three months

- 1 yes
2 no
3 does not know

38ter. Revenue less than 600 € per month (per person living alone

- 1 yes
2 no
3 does not know

39. On the basis of the answers to the previous questions, does the person meet the requirements for AME?

- 1 yes
2 no
3 does not know

40. Do you know that persons in your situation, undocumented migrants, are able to obtain AME?

- 1 yes
2 no, or does not know anything about it

GREECE

Do not ask any questions

ITALY

40. Do you know that persons in your situation, undocumented migrants, are able to obtain free healthcare in hospitals for immediately necessary treatment?

- 1 yes
2 no, or does not know anything about it

THE NETHERLANDS

Do not ask any questions

PORTUGAL

38. When did you arrive for the last time in Portugal?

__/____ mm/yyyy

38bis. Have you been in Portugal for more than three months

- 1 yes
2 no
3 does not know

39. On the basis of the answers provided to the previous question, does the person meet the requirements needed to obtain the national healthcare card

- 1 yes
2 no
3 does not know

40. Do you know that persons in your situation, undocumented migrants, are eligible for the national healthcare card?

- 1 yes
2 no, or does not know anything about it

UNITED KINGDOM

38. Are you registered with a general practitioner (GP)?

- 1 yes
2 no
3 does not know

39. Do not ask

40. Did you know that persons in your situation, undocumented migrants, can register with a general practitioner (GP)?

- 1 yes
2 no, or does not know anything about it

SWEDEN

Do not ask any questions

SWITZERLAND

Do not ask any questions

If yes in 40:

41. Do you know the administrative procedure(s) necessary to obtain this (access to healthcare)?

- 1 yes, I'm sure
2 yes, I think so, but I'm not sure
3 no

42. Have you initiated the procedure for yourself (either yourself or someone else for you)?

- 1 yes → question 44
2 no
3 I do not know, I am not sure

If no in 42:

43. Why?

(Note: don't mention anything, but ask again "have you found any other difficulties" twice)

- 01 no difficulty, didn't feel the need
02 doesn't know
03 administrative complexity, doesn't know where to go, unsuitable timetables, difficulties with collating the necessary documents, abusive requests...
04 unaware of entitlement / rights, didn't know that the service / scheme existed
05 costs (translation, intermediaries...)
06 language barrier
07 social services refused to help
08 health professionals refused to help
09 fear of discrimination or of being made to feel unwelcome
10 fear of being denounced or being arrested
11 other reason expressed: _____

If yes in 42:

44. Was the attempt successful?

1 <input type="radio"/> Yes	If 1: From the moment you initiated the procedure (filling in the papers, putting together documents required), how much time did it take before you succeeded? <input type="radio"/> _____ months (if less than one month, code 00) <input type="radio"/> Doesn't know
2 <input type="radio"/> No, I was refused	If 2: From the moment you initiated the procedure (filling in the papers, putting together documents required), how much time did it take before you were informed that you were refused? <input type="radio"/> _____ months (if less than one month, code 00) <input type="radio"/> Doesn't know
3 <input type="radio"/> No, it is still pending	If 3: How long have you been waiting since you initiated the procedure (filling in the papers, putting together documents required)? <input type="radio"/> _____ months (if less than one month, code 00) <input type="radio"/> Doesn't know
4 <input type="radio"/> I do not know	If 4: How long have you been waiting since you initiated the procedure (filling in the papers, putting together documents required)? <input type="radio"/> _____ months (if less than one month, code 00) <input type="radio"/> Doesn't know

If yes in 42:

45. What are the main difficulties that you encountered during this procedure?

(Note: don't mention anything, but ask again "have you found any other difficulties" twice)

01 no difficulty

02 doesn't know

03 administrative complexity, doesn't know where to go, unsuitable timetables, difficulties with collating the necessary documents, abusive requests...

04 unaware of entitlement / rights

05 procedure cost (translation, intermediaries...)

06 language barrier

07 social services refused to help

08 health professionals refused to help

09 fear of discrimination or of being badly welcome

10 fear of being reported or being arrested

11 other reason expressed: _____

ACCESS TO PREVENTION, HEALTHCARE AND TREATMENT

46. Last time you felt ill in (country), what was your health problem?

or 1 never felt ill in (country): go to question 51

or _____

ICPC code ____

47. DID YOU HAVE healthcare coverage at that time?

(question must be adapted to national context)

GERMANY

47. Do not ask any questions

BELGIUM

47. When you last felt ill did you have AMU?

1 yes

2 no

3 does not know

SPAIN

47. When you last felt ill did you have a "healthcare card"?

1 yes

2 no

3 does not know

FRANCE

47. When you last felt ill did you have AME?

1 yes

2 no

3 does not know

GREECE

47. Do not ask any questions

ITALY

47. Do not ask any questions

THE NETHERLANDS

47. Do not ask any questions

PORTUGAL

47. When you last felt ill did you have the "national healthcare card"?

1 yes

2 no

3 does not know

UNITED KINGDOM

47. When you last felt ill were you registered with a general practitioner (GP)?

1 yes

2 no

3 does not know

SWEDEN

47. Do not ask any questions

SWITZERLAND

47. Do not ask any questions

48. How did you deal with this last health problem? Or who did you consult about this problem? (several answers possible)

1 dealt with it himself/herself

2 consulted a doctor/dentist/nurse or other healthcare professional

3 took advice from a pharmacist

4 consulted a traditional practitioner

5 consulted a neighbour, friend, family member

6 did nothing

7 other, specify: _____

49. If the person consulted a health professional, ask the following question:

Where did you go for medical care? (several answers possible)

1 hospital emergency department

2 a public healthcare facility

3 a specific healthcare facility (only for the poor, homeless, or undocumented people, like MdM)

50. When you last felt ill, did any health professional or medical care facility (this includes administrative personnel, i.e. secretaries/ receptionists) refuse to provide medical attention?

1 yes

2 no

ACCESS TO TESTING AND TREATMENT FOR HIV / AIDS

Only ask in cities where HIV screening is free:

51. As far as you are aware, can someone who does not have documents to be in the country legally benefit from a free test for HIV-AIDS in _____ (city and country)?

1 yes, they can obtain a free test

2 no, they cannot obtain a free test

3 (do not prompt) it depends

4 (do not prompt) does not know

In all cities:

52. Since you have been in [country], have you ever wanted to have a test for HIV?

1 yes

2 no

If no in 52:

53. Why?

(do not prompt for any of the reasons below)

01 HIV testing already done and results known

02 doesn't feel he/she needs it

03 afraid that the results won't be kept confidential

04 the test is too expensive or believes that it has to be paid for

05 fear of results, prefers not to know

06 would not know what to do if results are positive (does not know about treatment or is cautious about treatment)

07 language barrier

08 fear of discrimination or of being unwelcome

09 fear of being reported or being arrested

10 other reasons: _____

If yes in 52:

54. Have you been able to do a test?

1 yes

2 no

Instruction for the interviewer: don't forget to inform the person of their right to free screening, and if necessary inform the person where s/he can go for screening.

The following question should only be asked in countries where treatment is free:

55. In your opinion, are undocumented migrants eligible for free HIV-AIDS treatment in _____ (name of country)?

- 1 Yes, they are eligible for free treatment
- 2 No, they are not eligible
- 3 (do not prompt) it depends
- 4 (do not prompt) does not know

Instructions to interviewer: Don't forget to inform people systematically whether such treatment is available, as well the conditions of entitlement.

HEALTH PROBLEMS / ACCESS TO HEALTHCARE AND TREATMENT

56. In general, how would you describe your health? Is it ...

- 1 very good
- 2 good
- 3 fair
- 4 bad
- 5 very bad
- 6 (do not cite) don't know

Ask women only

57. Are you pregnant?

- 1 yes (enter into the table that follows even if there are no complications or problems with the pregnancy)
- 2 no
- 3 does not know

58. If yes, have you had access to antenatal care during this pregnancy?

- 1 yes
- 2 no

59. Information taken by a health professional

- 1 doctor
- 2 dentist
- 3 nurse
- 4 other medical employee

Q° 60 to 70 : To be asked and filled by a health professional if possible - Don't forget to ask about other possible chronic medical conditions, even if they are not the reason for today's consultation.

From which illness(es) or medical problems do you currently suffer?

	1st prob/diagnosis	2nd prob/diagnosis	3rd prob/diagnosis	4th prob/diagnosis
60. Diagnosis (mention the diagnosis if it is known, or if not, the symptoms)				
60 bis. ICPC code				
61. Is the problem currently treated or followed-up?	1 <input type="radio"/> yes totally 2 <input type="radio"/> yes, partially 3 <input type="radio"/> no 4 <input type="radio"/> doesn't know	1 <input type="radio"/> yes totally 2 <input type="radio"/> yes, partially 3 <input type="radio"/> no 4 <input type="radio"/> doesn't know	1 <input type="radio"/> yes totally 2 <input type="radio"/> yes, partially 3 <input type="radio"/> no 4 <input type="radio"/> doesn't know	1 <input type="radio"/> yes totally 2 <input type="radio"/> yes, partially 3 <input type="radio"/> no 4 <input type="radio"/> doesn't know
62. Since you arrived in [the country], has it happened at all that this problem was not treated or checked in time?	1 <input type="radio"/> yes 2 <input type="radio"/> no 3 <input type="radio"/> doesn't know	1 <input type="radio"/> yes 2 <input type="radio"/> no 3 <input type="radio"/> doesn't know	1 <input type="radio"/> yes 2 <input type="radio"/> no 3 <input type="radio"/> doesn't know	1 <input type="radio"/> yes 2 <input type="radio"/> no 3 <input type="radio"/> doesn't know
63. Is this health problem acute or chronic?	1 <input type="radio"/> acute 2 <input type="radio"/> chronic 3 <input type="radio"/> doesn't know	1 <input type="radio"/> acute 2 <input type="radio"/> chronic 3 <input type="radio"/> doesn't know	1 <input type="radio"/> acute 2 <input type="radio"/> chronic 3 <input type="radio"/> doesn't know	1 <input type="radio"/> acute 2 <input type="radio"/> chronic 3 <input type="radio"/> doesn't know
64. Treatment or medical follow-up is... Note : Do not comment on whether this is currently being done or not	1 <input type="radio"/> indispensable 2 <input type="radio"/> necessary 3 <input type="radio"/> preferable 4 <input type="radio"/> precautionary 5 <input type="radio"/> not necessary / non existent 6 <input type="radio"/> doesn't know	1 <input type="radio"/> indispensable 2 <input type="radio"/> necessary 3 <input type="radio"/> preferable 4 <input type="radio"/> precautionary 5 <input type="radio"/> not necessary / non existent 6 <input type="radio"/> doesn't know	1 <input type="radio"/> indispensable 2 <input type="radio"/> necessary 3 <input type="radio"/> preferable 4 <input type="radio"/> precautionary 5 <input type="radio"/> not necessary / non existent 6 <input type="radio"/> doesn't know	1 <input type="radio"/> indispensable 2 <input type="radio"/> necessary 3 <input type="radio"/> preferable 4 <input type="radio"/> precautionary 5 <input type="radio"/> not necessary / non existent 6 <input type="radio"/> doesn't know
65. Were you aware of this medical problem before your departure for Europe? Note : was suffering from the condition and knew it	1 <input type="radio"/> yes 2 <input type="radio"/> no 3 <input type="radio"/> not relevant / not applicable	1 <input type="radio"/> yes 2 <input type="radio"/> no 3 <input type="radio"/> not relevant / not applicable	1 <input type="radio"/> yes 2 <input type="radio"/> no 3 <input type="radio"/> not relevant / not applicable	1 <input type="radio"/> yes 2 <input type="radio"/> no 3 <input type="radio"/> not relevant / not applicable

5 hard to comply with the prescription

6 does not want therapy

7 other: _____

Note: Don't forget to question the respondent about other possible chronic medical conditions, even if they are not the reason for today's consultation.

If the topic of HIV/AIDS has not been addressed, ask:

Did you already do the HIV test? Do you know the results?

If results are positive, complete the table below and the three following questions

66. Has a doctor ever told you that you need antiviral treatment?

- 1 yes
- 2 no (doesn't need)
- 3 doesn't know

67. If yes, do you take antiviral treatment/medication?

- 1 yes
- 2 no

68. If 2: If you have not taken antiviral treatment, why?

- 1 treatment not prescribed
- 2 treatment is too expensive
- 3 afraid of side effects
- 4 afraid of being stigmatised

Doctor's summary: must be completed by a doctor (or another health professional)

69. In total: overall vital risk class (without treatment)

Note: This question can be coded on file without seeing the patient risk

0. No vital bad

1. Vital prognosis, very slightly pejorative

2. Vital prognosis, slightly pejorative

3. Vital prognosis, possibly

4. Vital prognosis, probably

5. Vital prognosis, certainly bad (guideline: death almost sure within 5 years)

SQ -Violence - Each interviewer has to decide whether or not to ask these questions - Questions regarding different kinds of violence that people may have suffered from before or after their arrival in Europe

SQ: 70. Yourself, during the course of your life... (circle the relevant response)

Form of violence	No	Yes	If yes, chronology in relation to the arrival in [country]		
			Before	During the trip	Since arrival
SQ: 70.1. Have you lived in a country at war?	1	2	3	4	-
SQ: 70.2. Have you ever been beaten up or injured as a result of domestic violence or during an assault?	1	2	3	4	5
SQ: 70.3. Have you been prohibited from earning money or denied access to money you had earned?	1	2	3	4	5
SQ: 70.4. Have you suffered from hunger or lacked enough to eat?	1	2	3	4	5
SQ: 70.5. Have you been physically threatened or imprisoned for your ideas?	1	2	3	4	5
SQ: 70.6. Have your behaviour or your actions been restricted or forbidden? (including by a friend or by family)	1	2	3	4	5
SQ: 70.7. Have you ever been the victim of violence by police or army forces?	1	2	3	4	5
SQ: 70.8. Have you ever been sexually assaulted?	1	2	3	4	5
SQ: 70.9. Have you ever been tortured?	1	2	3	4	5
SQ: 10. Have you suffered from any other type of exposure to violence that has not been mentioned in the questions above?	1	2	3	4	5
SQ: 70.11. Which one? Specify if possible:					

71. In the past year (since you have been in [country]), in the different aspects of your life – personally and socially, have you personally been a victim of racism (discrimination linked to your colour, geographic origin, etc.)?

- 1 Yes often
2 Yes, occasionally
3 No

If yes in 71:

72. Did this happen at all when you were seeking medical advice (doctor, hospital, social health system)?

- 1 yes
2 no

OBSTACLES TO ACCESSING AND CONTINUING HEALTHCARE

73. Generally speaking, what are the main obstacles you have faced when trying to access health services (for yourself or your children) since you arrived in [country]?

(Guideline: do not quote any of the obstacles below, ask the questions 2 more times "Do you encounter any other obstacles?")

- 01 No perceived obstacles
02 medical consultation is too expensive
03 treatment is too expensive
04 opening schedules of health services are not adapted
05 does not have the time, or has more important problems (housing, food, etc)
06 administrative problems (whatever problems)
07 system is complex (does not know his/her rights, does not know where to go)
08 language barrier
09 was denied access to healthcare
10 fear of discrimination, of being unwelcome or denied treatment
11 fear of being reported or being arrested
12 apprehension of medical examination or treatment, does not like going to the doctor
13 other reasons expressed: _____

14 Does not know

To be filled directly by interviewer

73 bis. Summary of the interview: what are the main obstacles identified throughout the interview (not cited spontaneously by the respondent in previous response)

- 01 no perceived obstacle
02 medical consultation is too expensive
03 treatment is too expensive
04 opening schedules of health services are not adapted
05 does not have the time, or has more important problems (housing, food, etc)
06 administrative problems (whatever problems)
07 system is complex (does not know his/her rights, does not know where to go)
08 language barrier
09 was denied access to healthcare
10 fear of discrimination, of being unwelcome or denied treatment
11 fear of being reported or being arrested
12 apprehension of medical examination or treatment, does not like going to the doctor
13 other reasons expressed: _____
14 does not know

If at least one obstacle:

74. Did this or these obstacle(s) lead you to give up seeking medical advice/treatment for yourself in the past 12 months? (Guideline: if the person has been in [country] for less than a year, ask for the period of time "since you have been in [country]"; if the person did not need any medical treatment during that time, answer "no")

- 1 yes
2 no

If yes:

75. What type of medical treatment did you give up seeking in the last 12 months?

(Guideline: do not quote any of the below treatments, ask the question twice "Did you give up any other treatment?")

- 1 Dental care
2 Glasses, contact lenses (optical care)
3 Physiotherapy
4 Medical check up or medical treatment
5 Maternity care/ ante-natal checks
6 Laboratory tests, blood tests, MRI or X-Ray
7 Pharmacy, drugs
8 Mental health or psychological treatment
9 Other treatment or unknown

76. Did this or these obstacle(s) lead you to give up seeking medical advice/treatment for your children in the past 12 months?

- 1 yes
2 no
3 not applicable, no children or no need

If yes:

77. What type of medical treatment did you give up seeking for your children in the last 12 months?

(Guideline: do not quote any of the below treatments, ask the question 2 times « Did you give up any other treatment? ») SEE PREVIOUS

- 1 Vaccinations
2 Dental care
3 Glasses, contact lenses (optical care)
4 Physiotherapy
5 Medical check up or medical treatment
6 Laboratory analyses, blood tests, MRI or radiology
7 Pharmacy, drugs
8 Mental health or psychological treatment
9 Other treatment or unknown

APPENDIX 2: METHODOLOGY AND STATISTICAL SUMMARY OF INTERVIEWS BY COUNTRY

● **BE / BELGIUM**

MDM BELGIUM PROTOCOLS

Town(s)	BRUSSELS
Project(s)	Healthcare and Advice Clinic (CASO - Médecins du Monde)
Number of questionnaires completed	112
Start and end dates	From 23/04/2008 to 04/08/2008
Dates chosen	Tuesday and Thursday (morning and afternoon) = 4 sessions out of 7 per week
Interviewers	In pairs Interviewer profiles for the social section: nurses, doctors, support workers, lab technician, project manager... Interviewer profile for the medical section: 1 doctor
Selection methodology	All clients who fit the criteria for inclusion.
At what point during the consultation were they questioned?	Equally split between the social worker (social section) and the doctor (medical section).

KEY FIGURES FOR THE POPULATION SURVEYED IN BELGIUM	%	n		%	n
Men	67,6	75	Activity/travel limitations for fear of arrest		
Women	32,4	36	Very often	31,3	35
Average age (years)		36	Often	25	28
Top 5 nationalities			Occasionally	8,9	10
Morocco		38	Never	34,8	39
Brazil		12	Accommodation		
DRC		9	Sleeping rough	4,5	5
Algeria		7	Short stay or medium term shelter	4,5	5
Guinea		5	Insecure accommodation	49	55
Employment status			Stable accommodation	42	47
Regular	7,1	8	Main obstacles to care		
Occasional	40,2	45	Administrative difficulties	53,6	-
Unemployed	52,7	59	Complexity of the system	49,1	-
No response	0	0	Cost of consultation or treatment	39,3	-
Night work frequency			Fear of being reported, arrested, discriminated against or refusal of care	19,6	-
Several times per week/almost every day		Nr			
Several times per month		Nr			
Less frequently or never		Nr			
Length of time in country					
Under two years	30,6	-			
2 to 5 years	36,9	-			
6 years or more	32,4	-			
Reason for migration					
Economic reasons	46,4	52			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war...	34,8	39			
Family dispute	11,6	13			
For children's future	6,3	7			
For health reasons	6,3	7			
To join others	12,5	14			
To study	4,5	5			
Other reason	18,8	21			

● CH / SWITZERLAND

MdM SWITZERLAND PROTOCOLS

Town(s)	FRIBOURG
Project(s)	Healthcare Centre FriSanté (Partners' clinic)
Number of questionnaires completed	11
Start and end dates	From 15/06/2008 to 17/09/2008
Dates chosen	Mondays and Thursdays (morning and afternoon) = At each session.
Interviewers	One interviewer per questionnaire. Interviewer profile: a nurse.
Selection methodology	All clients who fit the criteria for inclusion.
At what point during the consultation were they questioned?	Following the medical consultation.

KEY FIGURES FOR THE POPULATION SURVEYED IN SWITZERLAND	%	n		%	n
Men	45,5	5	Activity/travel limitations for fear of arrest		
Women	54,5	6	Very often	27,3	3
Average age (years)		35	Often	45,4	5
Top 5 nationalities			Occasionally	27,3	3
Brazil		2	Never	0	0
Mongolia		2	Accommodation		
Cameroon		2	Sleeping rough	0	0
Kosovo, Gabon, Morocco, Ecuador, Algeria		1 per nat.	Short stay or medium term shelter	0	0
Employment status			Insecure accommodation	45,5	5
Regular	18,2	2	Stable accommodation	54,5	6
Occasional	36,3	4	Main obstacles to care		
Unemployed	45,5	5	Administrative difficulties	Nr	-
Refus de répondre	0	0	Complexity of the system	Nr	-
No response			Cost of consultation or treatment	Nr	-
Night work frequency	0	0	Fear of being reported, arrested, discriminated against or refusal of care	Nr	-
Several times per week/almost every day	20	1			
Several times per month	80	4			
Less frequently or never					
Length of time in country	18,2	-			
Under two years	54,5	-			
2 to 5 years	27,3	-			
Reason for migration					
Economic reasons	90,9	10			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war...	18,2	2			
Family dispute	0	0			
For children's future	0	0			
For health reasons	9,1	1			
To join others	0	0			
To study	0	0			
Other reason	18,2	2			

● **DE / GERMANY**

Mdm GERMANY PROTOCOLS	
Town(s)	MUNICH
Project(s)	Healthcare Centre (for people without health cover) (Open Med - Médecins du Monde)
Number of questionnaires completed	24
Start and end dates	From 04/01/2008 to 08/08/2008
Dates chosen	Tuesday (late afternoon) and Friday (morning) = At each session.
Interviewers	In pairs Interviewer profiles: for the social section: 1 medical student, 2 social work students, 1 sociologist, 1 ethnology student, 1 interpreter. For the medical section: doctors.
Selection methodology	All clients who fit the criteria for inclusion.
At what point during the consultation were they questioned?	Preferably following the medical consultation.

KEY FIGURES FOR THE SURVEY POPULATION IN GERMANY	%	n		%	n
Men	16,7	4	Activity/travel limitations for fear of arrest		
Women	83,3	20	Very often	29,2	7
Average age (years)		38	Often	25	6
Top 5 nationalities			Occasionally	20,8	5
Brazil		3	Never	25	6
Peru		3	Accommodation		
Croatia		2	Sleeping rough	0	0
Kenya		2	Short stay or medium term shelter	8,3	2
Togo		2	Insecure accommodation	25	6
Employment status			Stable accommodation	66,7	16
Regular	25	6	Main obstacles to care		
Occasional	12,5	3	Administrative difficulties	Nr	
Unemployed	62,5	15	Complexity of the system	Nr	
No response	0	0	Cost of consultation or treatment	Nr	
Night work frequency			Fear of being reported, arrested, discriminated against or refusal of care	Nr	
Several times per week/almost every day	0	0			
Several times per month	22,2	2			
Less frequently or never	77,8	7			
Length of time in country					
Under two years	45,8	-			
2 to 5 years	25,0	-			
6 yrs or more	29,2	-			
Reason for migration					
Economic reasons	54,2	13			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war...	12,5	3			
Family dispute	12,5	3			
For children's future	0	0			
For health reasons	16,7	4			
To join others	12,5	3			
To study	0	0			
Other reason	33,3	8			

● **EL / GREECE**

MdM GREECE PROTOCOLS

Town(s)	THESSALONICA	ATHENS
Project(s)	Polidinic (Open Polidinic – Médecins du Monde)	Polidinic (Open Polidinic – Médecins du Monde)
Number of questionnaires completed	68	50
Start and end dates	From 08/01/2008 to 24/07/2008	From 01/03/2008 to 26/08/2008
Days chosen	Monday to Friday (morning and afternoon) = At every session	Monday to Friday (morning and afternoon) = At every session
Interviewers	In pairs Interviewer profile for the social section: socio-anthropologist. Interviewer profile for the medical section: doctor	In pairs Interviewers profile: psychologists, doctors (medical validation) and social worker.
Selection methodology	All clients who fit the criteria for inclusion (without language barriers).	Random (without language barriers).
At what point during the consultation were they questioned?	Following the medical consultation.	In the waiting room.

KEY FIGURES FOR THE POPULATION SURVEYED IN GREECE	%	n		%	n
Men	37,6	44	Activity/travel limitations for fear of arrest		
Women	62,4	73	Very often	17,8	21
Average age (years)		39	Often	17,8	21
Top 5 nationalities			Occasionally	22	26
Albania		30	Never	42,4	50
Bulgaria		20	Accommodation		
Georgia		8	Sleeping rough	2,6	3
Nigeria		8	Short stay or medium term shelter	13,7	16
Afghanistan		7	Insecure accommodation	14,5	17
Employment status			Stable accommodation	65,8	77
Regular	16,1	19	Other	3,4	4
Occasional	32,2	38	Main obstacles to care		
Unemployed	51,7	61	Administrative difficulties	7,6	-
Night work frequency			Complexity of the system	10,2	-
Several times per week/almost every day	27,3	15	Cost of consultation or treatment	28,8	-
Several times per month	9,1	5	Fear of being reported, arrested, discriminated against or refusal of care	27,1	-
Less frequently or never	63,6	35			
Length of time in country					
Under two years	22,4	-			
2 to 5 years	33,6	-			
6 yrs or more	44,0	-			
Reason for migration					
Economic reasons	55,9	66			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war . . .	22	26			
Family dispute	5,1	6			
For children's future	11	13			
For health reasons	8,5	10			
To join others	11	13			
To study	1,7	2			
Other reason	3,4	4			

● **ES / SPAIN**

MdM SPAIN PROTOCOLS

Town(s)	TENERIFE (Canary Islands)	VALENCIA	TOLEDO
Project(s)	CASSIM	CASSIM	Intercultural Healthcare Mediation Programme
Number of questionnaires completed	39	36	30
Start and end dates	Start: 01/05/2008	From 01/05/2008 to 15/06/2008	Start: 23/05/2008
Dates chosen	Cs CASSIM North: Monday and Wednesday afternoon and Tuesday morning Cs CASSIM South: Monday and Thursday morning = every session	- 11 days in May and 5 days in June (Monday, Tuesday, Wednesday morning and Thursday afternoon) = 5 sessions/week	- 1 day per week (full day) = 2 sessions in 7 per week
Interviewers	In pairs Interviewer profile: 1 social worker or 1 nurse or volunteer and 1 doctor in charge of the medical consultation.	1 interviewer per questionnaire. Interviewer profile: social workers, nurses, teachers, youth workers, support workers, student interns.	Interviewer profile: 2 intercultural mediators, 1 social worker.
Selection methodology	Random. According to the availability of the interviewers.	Everyone who came for a social or medical consultation. Two people interviewed per day.	Everyone who came to the centre.
At what point during the consultation were they questioned?	After or before reception. Always prior to medical consultation.	On reception.	Following the consultation.

Town(s)	GALICIA (Corunna and Vigo)	BALEARICS (Palma, Majorca)	ALICANTE
Project(s)	Mobile clinic for people working in prostitution.	CASSPEP and "Dones del mon" (Médecins du Monde)	CASSIM and CASSPEP (Médecins du Monde)
Number of questionnaires completed	25	23 (15 CASSPEP and 8 Dones del mon)	21 (16 CASSIM and 5 CASSPEP)
Start and end dates	Start: 5 May 2008	Start: June 2008	May and June 2008
Dates chosen	- For 10 days (Mondays, Tuesdays (+ evening) and Wednesday, Thursday evening) Activity: 3 sessions/week	- For 15 days in the morning. Activity: Casspep and Dones del Mon: 9 sessions/week	- 8 days in May (Monday and Wednesday afternoons and Thursday and Friday mornings) - 7 days in June (Tuesday and Thursday mornings and Wednesday and Thursday evenings) Activity: Cassim: 5 sessions/week and Casspep: 6 sessions/week
Interviewers	Interviewer profile: 1 medical volunteer and 1 sociologist with help from social workers, nurses.	1 interviewer per questionnaire. Interviewer profile: 1 nurse.	1 interviewer per questionnaire. Interviewer profiles: social worker, student social workers, anthropologist, teacher, nurse.
Selection methodology	Everyone supported by the programme.	Random. According to the availability of the interviewers and availability of space.	Everyone who had a medical or social consultation and who agreed to participate in the survey. Mainly women from the CASSPEP project.
At what point during the consultation were they questioned?	During the consultations.	On reception.	On reception.

Town(s)	BILBAO	MADRID
Project(s)	CASSIM (Médecins du Monde)	Mobile clinic for transsexuals offering medical and social consultations.
Number of questionnaires completed	21	21
Start and end dates	Start: 28/04/2008	Start: 27 May 2008
Dates chosen	- On 16 half-days (Monday and Thursday afternoons) Activity: 2 sessions/week	- 8 half-days schedules per week (daytime and evening for the mobile clinic) Activity: Mobile clinic: 4 sessions/week Programme for transsexuals: 1 session/week
Interviewers	1 interviewer per questionnaire. Interviewer: doctor.	1 interviewer per questionnaire. Interviewer: support worker or youth worker.
Selection methodology	All clients.	All clients.
At what point during the consultation were they questioned?	Following the medical consultation.	During the reception, the medical consultation and the consultation on risk prevention.

KEY FIGURES FOR THE POPULATION SURVEYED IN SPAIN	%	n		%	n
Men	39,4	85	Activity/travel limitations for fear of arrest		
Women	60,6	131	Very often	25,2	54
Average age (years)		33	Often	14	30
Top 5 nationalities			Occasionally	12,7	27
Brazil		28	Never	48,1	103
Bolivia		25	Accommodation		
Senegal		21	Sleeping rough	3,2	7
Morocco		20	Short stay or medium term shelter	6	13
Nigeria		18	Insecure accommodation	12	26
Employment status			Stable accommodation	73,1	158
Regular	41,2	89	Other	5,7	12
Occasional	35,2	76	Main obstacles to care		
Unemployed	22,7	49	Administrative difficulties	27,3	-
Non response	0,9	02	Complexity of the system	20,4	-
Night work frequency			Cost of consultation or treatment	7,5	-
Several times per week/almost every day	38,8	57	Fear of being reported, arrested, discriminated against or refusal of care	12	-
Several times per month	6,1	9			
Less frequently or never	55,1	81			
Length of time in country					
Under two years	45,8	-			
2 to 5 years	37,5	-			
6 yrs or more	16,7	-			
Reason for migration					
Economic reasons	76,4	165			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war...	9,3	20			
Family dispute	5,6	12			
For children's future	11,6	25			
For health reasons	4,2	9			
To join others	4,6	10			
To study	6	13			
Other reason	8,3	18			

● **FR / FRANCE**

Mdm FRANCE PROTOCOLS			
Town(s)	SAINT-DENIS	PARIS	LYON
Project(s)	Healthcare and Advice Clinic (Mdm)	Healthcare and Advice Clinic (Mdm)	Healthcare and Advice Clinic (Mdm)
Number of questionnaires completed	72	71	56
Start and end dates	From 10/12/07 to 08/08/08	From 10/12/07 to 08/08/08	From 12/02/08 to 08/08/08
Dates chosen	Thursday morning and Tuesdays (morning and evening) = 3 sessions in 8 per week	Mondays, Wednesdays and Thursday mornings = 3 sessions in 8 per week	3 to 4 half days per week = 3/4 sessions for 5 weeks
Interviewers	In pairs or alone. Interviewer profiles: for the social section, support workers, nurses, intern nurses and doctor. For the medical section: doctors.	In pairs or alone. Profile of interviewer for the social section: a social worker, a doctor and support workers. For the medical section: doctors.	In pairs. Profile of interviewer for the social section: support worker, nurse. For the medical section: doctors.
Selection methodology	Random: 1 person in 3 and 1 person in 5 (according to the activities and people seen).	Random: 1 person in 2, in reverse order of arrival at the centre.	All clients who fit the criteria for inclusion.
At what point during the consultation were they questioned?	Social section, on arrival. Medical section during the medical consultation.		

KEY FIGURES FOR THE POPULATION SURVEYED IN FRANCE	%	n		%	n
Men	43,9	86	Activity/travel limitations for fear of arrest		
Women	56,1	110	Very often	22,8	45
Average age (years)		37	Often	19,3	38
Top 5 nationalities			Occasionally	17,8	35
Cameroon		34	Never	40,1	79
Romania		26	Accommodation		
Algeria		16	Sleeping rough	8	16
Ivory Coast		14	Short stay or medium term shelter	8,5	17
Congo B		9	Insecure accommodation	54,3	108
Employment status			Stable accommodation	29,1	58
Regular	7,5	15	Main obstacles to care		
Occasional	37,7	75	Administrative difficulties	13,1	-
Unemployed	54,8	109	Complexity of the system	13,6	-
Night work frequency			Cost of consultation or treatment	41,7	-
Several times per week/almost every day	7,1	8	Fear of being reported, arrested, discriminated against or refusal of care	8	-
Several times per month	14,3	12			
Less frequently or never	78,6	66			
Length of time in country					
Under two years	57,3	-			
2 to 5 years	27,1	-			
6 yrs or more	15,6	-			
Reason for migration					
Economic reasons	51,3	102			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war. . .	21,6	43			
Family dispute	9,5	19			
For children's future	4,5	9			
For health reasons	10,1	20			
To join others	15,1	30			
To study	4,5	9			
Other reason	15,1	30			

● IT / ITALY

MdM ITALY PROTOCOLS

Town(s)	MILAN		
Project(s)	Mobile Clinic for Homeless People (in the evening) (Partners' clinic)	Day Centre for Drug Users (Partners' centre)	Homeless Centre (in the evening) (Partners' centre)
Number of questionnaires completed	43	33	23
Start and end dates	22/04/08 to 31/08/2008		
Days chosen	Not recorded.		
Interviewers	1 interviewer per questionnaire. Interviewer profile: doctor-psychologist.		
Selection methodology	Not recorded.		
At what point during the consultation were they questioned?	Not recorded.		

KEY FIGURES FOR THE POPULATION SURVEYED IN ITALY	%	n		%	n
Men	87,5	84	Activity/travel limitations for fear of arrest		
Women	12,5	12	Very often	Nr	Nr
Average age (years)		32	Often	Nr	Nr
Top 7 nationalities			Occasionally	Nr	Nr
Morocco		19	Never	Nr	Nr
Ukraine		13	Accommodation		
Egypt		11	Sleeping rough	44,4	44
Albania		8	Short stay or medium term shelter	12,1	12
Niger		5	Insecure accommodation	17,2	17
Nigeria		5	Stable accommodation	25,3	25
Tunisia		5	Other	1	1
Employment status			Main obstacles to care		
Regular	2,1	2	Administrative difficulties	17,2	-
Occasional	32,3	31	Complexity of the system	26,3	-
Unemployed	54,1	52	Cost of consultation or treatment	7,1	-
Non response	11,5	11	Fear of being reported, arrested, discriminated against or refusal of care	31,3	-
Night work frequency					
Several times per week/almost every day	6,3	2			
Several times per month	37,4	12			
Less frequently or never	56,3	18			
Length of time in country					
Under two years	50,0	-			
2 to 5 years	22,4	-			
6 yrs or more	27,6	-			
Reason for migration					
Economic reasons	92,9	92			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war . . .	7,1	7			
Family dispute	12,1	12			
For children's future	1	1			
For health reasons	1	1			
To join others	4	4			
To study	3	3			
Other reason	0	0			

● **NL / NETHERLANDS**

MdM NETHERLANDS PROTOCOLS

Town(s)	AMSTERDAM	EINDHOVEN	UTRECHT
Project(s)	Het Kerkhuis, Filipino Domestic Workers, Stichting Sikaman, ASKV, De Open Deur, Centrum 45, Casa Migrante, Wereldpand, Het Wereldhuis	Vluchtelingen in de Knel	Huize Agnes / STIL
Number of questionnaires completed	62	10	10
Start and end dates	Het Kerkhuis: From 20/02/08 to 28/05/08 Filipino Domestic Workers: From 05/03/2008 to 12/04/2008 Stichting Sikaman: 16/04/2008 ASKV: 126/04/2008 De Open Deur: From 27/05/2008 to 28/07/2008 Centrum 45: From 06/06/2008 to 11/07/2008 Casa Migrante: From 17/06/2008 to 09/07/2008 Wereldpand: 14/04/2008 Het Wereldhuis: 02/07/2008	From 25/03/2008 to 21/04/2008	Huize Agnes: From 18/04/2008 to 25/04/2008 STIL: From 09/04/ to 07/05/2008
Days chosen	Het Kerkhuis: 7 days (6 in the morning and 1 in the evening) Filipino Domestic Workers: 7 days (evening) Stichting Sikaman: 1 day (afternoon) ASKV: 1 day (evening) De Open Deur: 7 days (6 afternoons and 1 evening) Centrum 45: 3 days (afternoon) Casa Migrante: 6 days (evening) Wereldpand: 1 day (afternoon) Het Wereldhuis: 1 day (morning)	4 mornings	Huize Agnes: 2 day (afternoon) STIL: 3 days (morning)
Interviewers	1 interviewer per questionnaire. Interviewer profiles: Het Kerkhuis: anthropologist, anthropology student, healthcare professional, medical assistant, psychologist. Filipino Domestic Workers: anthropology student, healthcare professional, medical student. Stichting Sikaman: anthropologist. ASKV: medical student. De Open Deur: lawyer and psychologist. Centrum 45: healthcare professional. Casa Migrante: psychologist. Wereldpand: medical student. Het Wereldhuis: anthropologist.	Interviewer profiles: anthropology student, healthcare professional, medical assistant.	Interviewer profile: Huize Agnes: anthropology student, doctor. STIL: lawyer, doctor, anthropology student.
Selection methodology	Het Kerkhuis – Het Wereldhuis: All clients. Filipino Domestic Workers – Stichting Sikaman – ASKV – De Open Deur – Centrum 45 – Casa Migrante – Wereldpand: All clients met by appointment.	All clients who spoke the same language as the interviewers.	Huize Agnes: All clients who fit the criteria and spoke English or Dutch. STIL: Clients coming for a social or legal consultation.
At what point during the consultation??	Not recorded.	Not recorded.	Not recorded.

Town(s)	THE HAGUE	ROTTERDAM	HAARLEM
Project(s)	Paardenberg / Oase Stek	ROS	De Huiskamer / Stem in de Stad
Number of questionnaires completed	6	6	3
Start and end dates	Paardenberg: From 09/04/2008 Oase Stek: From 17/04/2008 to 24/04/2008	10/04/2008 and 17/07/2008	De Huiskamer: 23/04/2008 Stem in de Stad: 14/03/2008
Days chosen	Paardenberg: 1 day (morning) Oase Stek: 2 days (morning and day)	2 days (morning)	De Huiskamer: 1 day (afternoon) Stem in de Stad: 1 day (morning)
Interviewers	Interviewer profile: Paardenberg: healthcare professional. Oase Stek: healthcare professional.	Interviewer profiles: healthcare professional, student and psychologist.	Interviewer profiles: De Huiskamer: medical assistant - Stem in de Stad: anthropologist
Selection methodology	Paardenberg – Oase Stek: All clients who fit the criteria and spoke English or Dutch.	All clients met by appointment.	De Huiskamer: Offered to all clients. Stem in de Stad: Offered to those who spoke the same languages as the interviewers.
At what point during the consultation??	Not recorded.	Not recorded.	Not recorded.

Town(s)	LEIDSCHENDAM	TILBURG	ARNHEM
Project(s)	Stichting Noodopvang	VLOT	Blankenspoor Huisarts – Eigen Praktijk
Number of questionnaires completed	2	2	1
Start and end dates	19/05/2008 and 13/06/2008	16/06/2008	12/04/2008
Days chosen	2 days (mornings)	1 day (afternoon)	1 day (afternoon)
Interviewers	Interviewer profiles: medical students, medical assistants.	Interviewer profile: lawyer.	Interviewer profile: lawyer.
Selection methodology	All dients met by appointment.	All dients met by appointment.	All dients met by appointment.
At what point during the consultation were they questioned?	Not recorded.	Not recorded.	Not recorded.

Town(s)	LEIDEN
Project(s)	Fabel van de Illegaal
Number of questionnaires completed	1
Start and end dates	22/05/2008
Day chosen	1 day (morning)
Interviewers	Interviewer profile: medical student.
Selection methodology	All dients met by appointment.
At what point during the consultation were they questioned?	Not recorded.

KEY FIGURES FOR THE POP. SURVEYED IN THE NETHERLANDS	%	n		%	n
Men	54,4	56	Activity/travel limitations for fear of arrest		
Women	45,6	46	Very often	29	29
Average age (years)		37	Often	16	16
Top 7 nationalities			Occasionally	22	22
The Philippines		14	Never	33	33
Ghana		10	Accommodation		
Sierra Leone		7	Sleeping rough	2,7	3
Uganda		6	Short stay or medium term shelter	14,7	15
Sudan		5	Insecure accommodation	27,5	28
China		5	Stable accommodation	54,9	56
Brazil		5	Other	0	0
Employment status			Main obstacles to care		
Regular	23,8	24	Administrative difficulties	18,6	-
Occasional	17,8	18	Complexity of the system	17,6	-
Unemployed	57,4	58	Cost of consultation or treatment	33,3	-
Non response	1	1	Fear of being reported, arrested, discriminated against or refusal of care	33,3	-
Night work frequency					
Several times per week/almost every day	4,9	2			
Several times per month	4,9	2			
Less frequently or never	90,2	37			
Length of time in country					
Under two years	10,3	-			
2 to 5 years	25,8	-			
6 yrs or more	63,9	-			
Reason for migration					
Economic reasons	36,3	37			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war...	44,1	45			
Family dispute	4,9	5			
For children's future	9,8	10			
For health reasons	4,9	5			
To join others	3,9	4			
To study	3,9	4			
Other reason	11,8	12			

● PT / PORTUGAL

MdM PORTUGAL PROTOCOLS			
Town(s)	LISBON	LOURES	LOURES
Project(s)	Noite Saudavel (MdM)	Bairro Quinta da Serra (MdM)	Crescer em saude (MdM)
Number of questionnaires completed	21	7	4
Start and end dates	06/04/2008, 14/04/2008, 18/04/2008, 28/04/2008, 30/04/2008, 04/05/2008, 07/05/2008, 09/05/2008, 14/05/2008 and 20/06/2008	02/04/2008, 07/04/2008, 09/04/2008, 07/05/2008 and 09/09/2008	27/04/2008, 14/05/2008, 21/05/2008 and 28/05/2008
Days chosen	From Monday to Friday (evening) = At every session.	From Monday to Friday (morning) = 5 sessions in 6/week.	Wednesday (afternoon) = 1 session in 5/week.
Interviewers	Interviewer profile: support workers and doctors.	Interviewer profile: nurses.	Interviewer profile: nurses.
Selection methodology	All clients who fit the criteria.	All clients who fit the criteria.	All clients who fit the criteria.
At what point during the consultation were they questioned?	At the end of the consultation.	At the end of the consultation.	At the end of the consultation.

KEY FIGURES FOR THE POPULATION SURVEYED IN PORTUGAL	%	n		%	n
Mens	77,4	24	Activity/travel limitations for fear of arrest		
Women	22,6	7	Very often	9,4	3
Average age (years)		40	Often	3,1	1
Top 5 nationalities			Occasionally	9,4	3
Brazil		14	Never	78,1	25
Cape Verde		4	Accommodation		
Guinea		4	Sleeping rough	21,9	7
Angola		3	Short stay or medium term shelter	21,9	7
Ukraine		3	Insecure accommodation	37,5	12
Employment status			Stable accommodation	18,8	6
Regular	31,3	10	Main obstacles to care		
Occasional	15,6	5	Administrative difficulties	Nr	-
Unemployed	50	16	Complexity of the system	Nr	-
Non response	3,1	1	Cost of consultation or treatment	Nr	-
Night work frequency			Fear of being reported, arrested, discriminated against or refusal of care	Nr	-
Several times per week/almost every day	26,7	4			
Several times per month	13,3	2			
Less frequently or never	60	9			
Length of time in country					
Under two years	22,6	-			
2 to 5 years	25,8	-			
6 yrs or more	51,6	-			
Reason for migration					
Economic reasons	62,5	20			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war...	6,3	2			
Family dispute	0	0			
For children's future	0	0			
For health reasons	0	0			
To join others	12,5	4			
To study	3,1	1			
Other reason	18,8	6			

● **SE / SWEDEN**

MdM SWEDEN PROTOCOLS

Town(s)	STOCKHOLM
Project(s)	Healthcare Centre for Undocumented Migrants (Médecins du Monde)
Number of questionnaires completed	103
Start and end dates	From 16/01/2008 to 24/07/2008
Days chosen	In the evening = at every session.
Interviewers	1 interviewer per questionnaire. Interviewer profiles: 2 medical students, 1 nurse, 2 political science students.
Selection methodology	Random 1 patient in 3 then 1 patient in 2.
At what point during the consultation were they questioned?	Clients were chosen upon arrival at the clinic and another appointment was scheduled for their interview.

KEY FIGURES FOR THE POPULATION SURVEYED IN SWEDEN	%	n		%	n
Men	44,7	46	Activity/travel limitations for fear of arrest		
Women	55,3	57	Very often	34,4	35
Average age (years)		35	Often	16,7	17
Top 5 nationalities			Occasionally	21,6	22
Mongolia		20	Never	27,5	28
Bangladesh		13	Accommodation		
Azerbaijan		11	Sleeping roughr	0	0
Bolivia		10	Short stay or medium term shelter	9,7	10
The Philippines		7	Insecure accommodation	62,1	64
Employment status			Stable accommodation	28,2	29
Regular	18,4	19	Main obstacles to care		
Occasional	44,7	46	Administrative difficulties	42,7	-
Unemployed	36,9	38	Complexity of the system	12,6	-
Night work frequency			Cost of consultation or treatment	28,2	-
Several times per week/almost every day		Nr	Fear of being reported, arrested, discriminated against or refusal of care	43,7	-
Several times per month		Nr			
Less frequently or never		Nr			
Length of time in country					
Under two years	13,6	-			
2 to 5 years	67,0	-			
6 yrs or more	19,4	-			
Reason for migration					
Economic reasons	27,2	28			
For political reasons, religious reasons, ethnic tensions, sexual orientation or to flee war. . .	54,4	56			
Family dispute	9,7	10			
For children's future	5,8	6			
For health reasons	7,8	8			
To join others	6,8	7			
To study	6,8	7			
Other reason	11,7	12			

● UK / UNITED KINGDOM

MdM UNITED KINGDOM PROTOCOLS

Town(s)	LONDON	LONDON
Project(s)	Healthcare and Advice Clinic (Project: London – Médecins du Monde)	New North London Synagogue (NNLS – Partners' centre)
Number of questionnaires completed	101	7
Start and end dates	From 23/01/2008 to 19/06/2008	From 23/01/2008 to 19/06/2008
Days chosen	Monday, Wednesday, Friday (afternoons) : At every session.	
Interviewers	1 interviewer per questionnaire. Interviewer profiles: students, support workers trained to carry out the survey. The medical section was conducted by the medical team during the consultation.	
Selection methodology	All clients who fit the criteria.	Random
At what point during the consultation were they questioned?		

KEY FIGURES FOR THE POPULATION SURVEYED IN THE UK	%	n		%	n
Men	53,7	58	Activity/travel limitations for fear of arrest		
Women	46,3	50	Very often	25,7	27
Average age (years)		37	Often	7,6	8
Top 5 nationalities			Sometimes	16,2	17
India		15	Never	50,5	53
The Philippines		13	Accommodation		
DRC		12	Sleeping rough	0,9	1
China		9	Short stay or medium term shelter	1,9	2
Brazil		7	Insecure accommodation	60,7	65
Employment status			Stable accommodation	35,5	38
Regular	18,5	20	Other	0,9	1
Occasional	18,5	20	Main obstacles to care		
Unemployed	63	68	Administrative difficulties	51,9	
No response	0	0	Complexity of the system	31,5	
Frequency of night work			Cost of consultation or treatment	25,9	
Several times per week/almost every day	18,9	7	Fear of being reported, arrested, discriminated against or refusal of care	39,8	
Several times per month	5,4	2			
Less often or never	75,7	28			
Length of time in country					
- Less than 2 years	29,0				
- 2 to 5 years	45,8				
- 6 years or more	25,2				
Reason for migration					
Economic reasons	38	41			
For political reasons, religious reasons, ethnic tensions, sexual orientation, or to flee war...	46,3	50			
Family dispute	8,3	9			
For the children's future	4,6	5			
For health reasons	3,7	4			
To join others	10,2	11			
To study	2,8	3			
Other reasons	12	13			

APPENDIX 3: LIST OF PEOPLE INTERVIEWED DURING THE QUALITATIVE SURVEY

	Country and town where interview took place	Name	Country of Origin	Been living in the country for	Age	Lives with
1	Greece, Athens	Mrs. M.	Afghanistan	4 months.	-	2 sons, 6 and 2 y. old.
2	Greece, Athens	Mme N.	Afghanistan	2 months.	35 y. old.	Partner and 6 children from 6 to 14 y. old.
3	Greece, Athens	O.	Afghanistan	2 months.	12 y. old	His parents and 5 brothers.
4	Greece, Athens	Mrs. P.	Russia	15 years.	19 y. old	Partner and baby girl.
5	Greece, Thessaloniki	Mrs. Q.	Albanian	9 years.	38 y. old	Partner and 3 children, from 8 to 15 y. old.
6	Greece, Thessaloniki	Mr. R.	Yemen	2 years.	26 y. old	Partner and 4 girls aged 1,5,7 and 9.
7	Greece, Thessaloniki	Mrs. S.	Albania	12 years.	30 y. old	1 son, 15 months, 4 nephews and nieces : 6 to 17 y. old.
8	Greece, Thessaloniki	Mrs. T.	Russia	15 years.	19 y. old	Partner and 1 daughter aged 2 y. old.
9	France, Saint- Denis	Mr. E.	Moldavia	8 months.	24 y. old	Partner and son, 2 y. old.
10	France, Saint- Denis	Mr. F.	Guinea	11 years.	49 y. old	Partner and 5 children from 8 months to 11 y. old.
11	France, Saint- Denis	Mrs. G.	Ivory Coast	2 years.	22 y. old	Partner and one daughter, 3 months.
12	France, Saint- Denis	Mr. H.	Cameroon	6 months.	34 y. old	Partner and stepdaughter, 3 y. old
13	France, Saint- Denis	Mrs. I.	Romania/ Roma	3 years.	39 y. old	3 children from 14 to 20 years old.
14	France, Saint- Denis	Mr. J.	Romania/ Roma	4 years.	46 y. old	Partner and 7 children from 6 to 23 y. old.
15	France, Saint- Denis	Mrs. K.	Algeria	8 years.	38 y. old	3 children : 4 to 7 y. old.
16	France, Paris	Mrs. L.	The Philippines	3 years.	-	Partner and daughter, 6 y. old.
17	The Netherlands	Mrs. U.	Morocco	6 years.	30 y. old	3 children : 3 to 14 y. old.
18	The Netherlands	Mrs. V.	Nigeria	11 years.	29 y. old	2 children : 7 and 9 y. old.
19	The Netherlands	Mrs. W.	Ghana	15 years.	-	1 son, 6 y. old.
20	Spain, Canary Islands	Mrs. D.	Argentina	10 months.	23 y. old	Partner and 2 children : 3 and 5 y. old.
21	Sweden	Mrs. X.	Bolivia	2 years.	-	Partner and 5 children from 3 to teenage.
22	Sweden	Mrs. Z.	Bolivia	2 & ½ yr.	-	Partner, 1 son, 14 y. old.
23	Sweden	Mrs. S-B	Armenia	6 years.	-	2 children, 6 and 9 y. old and another family.
24	Sweden	Mrs. Y.	Mongolia	4 years.	-	1 child, 4 y. old.
25	Sweden	Mrs. S.-A.	El Salvador	3 years.	-	8 children: 4 from 2 to 11 y. old, 1 in wheelchair.
26	Switzerland	Mrs. S.-C.	Mongolia	6 years.	29 y. old	Partner and 2 daughters, 2 and 10 and 3 adults.
27	Switzerland	Mrs. S.-D.		9 years.	47 y. old	1 son, 15 y. old.
28	UK	Mrs. S.-E.	The Philippines	-	-	1 son, 2 months old.
29	UK	Mrs. S.-F.	Eritrea	-	22 y. old	1 son, 4 y. old.
30	Belgium	Mrs. A.	Albania	8 years.	27 y. old	2 children, 5 and 7 y. old and partner.
31	Belgium	Mrs. B.	Algeria	4 years.	41 y. old	2 children, 4 and 7 y. old and partner.
32	Belgium	Mrs. C.	Romania	A few months.	36 y. old	8 children.

APPENDIX 4: ACRONYMS

Acronym	Definition
AME	Aide médicale d'État – state medical aid (FR)
AMU	Aide médicale urgente – urgent medical aid (BE)
ASL	Agences sanitaires locales – local health agencies(IT)
Caso	Centre d'accueil, de soins et d'orientation – healthcare and advice clinics (FR)
Casspep	Centro de Atención Socio-Sanitaria a Personas que Ejercen la Prostitución – Socio-medical centre for people working in prostitution (ES)
Cassim	Centro de Atención Socio-Sanitaria a Inmigrantes – Socio-medico centre for migrants(ES)
CPAS	Centre public d'action sociale – Social work centre (BE)
CMU	Couverture maladie universelle – universal health coverage (FR)
EU	European Union
Fedasil	Agence fédérale pour l'accueil des demandeurs d'asile – Federal agency for asylum seeker reception (BE)
GP	General practitioner (family doctor)
MDM	Médecins du Monde
MSF	Médecins sans Frontières
OR	Odds Ratio
PMI	Protection maternelle et infantile – Mother and child health protection programme (FR)
STP	Etranger temporairement présent – temporary migrant (IT)

APPENDIX 5: ADDITIONAL TABLES

96- Nationality of the respondents (in descending order)

Nationality	Total	Men	Women	Nationality	Total	Men	Women
Marocco	92	72	20	Cape-Verde	5	4	1
Brazil	73	20	53	Equatorial Guinea	5	4	1
Cameroon	45	17	28	Sri Lanka	5	3	2
Albania	40	16	24	Chile	5	1	4
Nigeria	39	14	25	Cuba	5	1	4
Bolivia	39	8	31	Paraguay	5	1	4
Romania	36	13	23	Dominican Republic	5	1	4
Algeria	36	27	9	Poland	4	1	3
Philippines	36	8	28	Burkina Faso	4	2	2
Ukraine	25	9	16	Kenya	4	0	4
Democratic Republic of Congo	25	14	11	Madagascar	4	0	4
Senegal	25	20	5	Croatia	3	1	2
Bulgaria	24	4	20	Sub-Saharan Africa (with no precision)	3	3	0
Egypt	23	21	2	Benin	3	2	1
Mongolia	23	3	20	Central African Republic	3	0	3
Ivory Coast	21	9	12	Syria	3	2	1
Bangladesh	19	18	1	Mexico	3	3	0
India	19	14	5	Stateless	3	1	2
China	18	10	8	Montenegro	2	1	1
Ghana	17	12	5	Serbia	2	1	1
Tunisia	16	11	5	Turkey	2	2	0
Peru	16	5	11	Turkey-Kurdistan	2	2	0
Mali	15	10	5	Burundi	2	1	1
Afghanistan	15	13	2	Liberia	2	2	0
Iran	15	11	4	Rwanda	2	1	1
Guinea	13	9	4	Chad	2	0	2
Uganda	13	4	9	Lebanon	2	1	1
Pakistan	13	13	0	Palestine	2	1	1
Congo	12	5	7	Nepal	2	1	1
Georgia	11	6	5	Uzbekistan	2	1	1
Russia	11	2	9	Vietnam	2	1	1
Azerbaijan	11	6	5	Guatemala	2	1	1
Colombia	11	4	7	Nicaragua	2	2	0
Ecuador	11	4	7	El Salvador	2	1	1
Armenia	10	4	6	Uruguay	2	2	0
Angola	10	7	3	Venezuela	2	0	2
Sudan	10	8	2	Latvia	1	0	1
Argentina	10	5	5	Europe non EU (with no precision)	1	0	1
Ethiopia	9	2	7	Djibouti	1	1	0
Niger	9	9	0	Gabon	1	0	1
Sierra Leone	9	5	4	Guinea Bissau	1	1	0
Somalia	9	6	3	Zimbabwe	1	1	0
Moldavia	8	3	5	Syria-Kurdistan	1	0	1
Kosovo	8	6	2	Indonesia	1	0	1
Eritrea	7	5	2	Thailand	1	1	0
Togo	7	4	3	Haiti	1	0	1
Mauritania	7	5	2	Honduras	1	1	0
Comoros	6	2	4	Surinam	1	1	0
Iraq	6	5	1	TOTAL	1108	567	541
Bosnia Herzegovina	5	2	3				

97- List of chronic health problems and diagnoses

	n	% among people suffering at least from a chronic health problem	cumulative %	% among the sample of the survey	n
Other musculoskeletal symptoms/complaints	26	7,2	7,2	2,3	2,3
Digestive symptoms/complaints	22	6,1	13,3	2,0	4,3
Spinal symptoms/complaints	18	5,0	18,3	1,6	5,9
Diabetes (insulin dependent and non insulin dependent)	17	4,7	23,1	1,5	7,4
Hypertension	17	4,7	27,8	1,5	8,9
Abuse of psychoactive substances (drugs)	16	4,4	32,2	1,4	10,3
Uncomplicated pregnancy and delivery	15	4,2	36,4	1,3	11,7
Depressive disorder	15	4,2	40,6	1,3	13,0
Other digestive system diseases	12	3,3	43,9	1,1	14,1
Trauma/Injury	12	3,3	47,2	1,1	15,1
Neurological symptoms/conditions	11	3,1	50,3	1,0	16,1
Upper respiratory infection	10	2,8	53,1	0,9	17,0
Gum and teeth disease	9	2,5	55,6	0,8	17,8
Other locomotor diagnoses	9	2,5	58,1	0,8	18,6
Skin symptoms/complaints	8	2,2	60,3	0,7	19,3
Lower respiratory infections	7	1,9	62,2	0,6	19,9
Administrative	6	1,7	63,9	0,5	20,5
Asthma	6	1,7	65,6	0,5	21,0
Other psychological problems	6	1,7	67,2	0,5	21,5
Vascular conditions and diseases	6	1,7	68,9	0,5	22,1
Female Genital symptoms/complaints	6	1,7	70,6	0,5	22,6
Urinary symptoms/complaints	6	1,7	72,2	0,5	23,1
Anxiety-Stress-Somatization disorder	5	1,4	73,6	0,4	23,6
Other cardiovascular diagnoses	5	1,4	75,0	0,4	24,0
Other metabolic diagnoses	5	1,4	76,4	0,4	24,5
Other eye diagnoses	5	1,4	77,8	0,4	24,9
Other female genital diagnoses	5	1,4	79,2	0,4	25,4
Overweight-Obesity	5	1,4	80,6	0,4	25,8
General symptoms/complaints	5	1,4	81,9	0,4	26,2
Menstrual problems	5	1,4	83,3	0,4	26,7
Anaemia	4	1,1	84,4	0,4	27,0
Diagnoses NOS	4	1,1	85,6	0,4	27,4
Other	4	1,1	86,7	0,4	27,8
Skin infections	4	1,1	87,8	0,4	28,1
Results	4	1,1	88,9	0,4	28,5
Back syndrome	4	1,1	90,0	0,4	28,8
Abuse of psychoactive substances (alcohol)	4	1,1	91,1	0,4	29,2
Other neurological diagnoses	3	0,8	91,9	0,3	29,4
Other respiratory diagnoses	3	0,8	92,8	0,3	29,7
Other reason for encounter	3	0,8	93,6	0,3	30,0
Viral hepatitis	3	0,8	94,4	0,3	30,2
Urinary/kidney infections	3	0,8	95,3	0,3	30,5
Fears and worries	3	0,8	96,1	0,3	30,8
Eye syndroms/complaints	3	0,8	96,9	0,3	31,0
Cough	3	0,8	97,8	0,3	31,3
Other male genital diagnoses	2	0,6	98,3	0,2	31,5
Other urinary and kidney diagnoses	2	0,6	98,9	0,2	31,7
Other respiratory syndroms/complaints	2	0,6	99,4	0,2	31,9
Therapeutic counselling, listening	2	0,6	100	0,2	32,0
Ischaemic heart disease, arrhythmia	2	0,6	100,6	0,2	32,2
Atopic and contact dermatitis	2	0,6	101,1	0,2	32,4
Epilepsia	2	0,6	101,7	0,2	32,6
Complicated pregnancy/delivery	2	0,6	102,2	0,2	32,7
Eye infections	2	0,6	102,8	0,2	32,9
Gastrointestinal infections	2	0,6	103,3	0,2	33,1
Ear infections	2	0,6	103,9	0,2	33,3
Sexually transmitted infections (female)	2	0,6	104,4	0,2	33,5
Infectious diseases NOS	2	0,6	105,0	0,2	33,6
Parasites / Candidiasis	2	0,6	105,6	0,2	33,8
Cardio-vascular symptoms/complaints	2	0,6	106,1	0,2	34,0
Male genital symptoms/complaints	2	0,6	106,7	0,2	34,2

continued	n	% among people suffering at least from a chronic health problem	cumulative %	% among the sample of the survey	n
Tuberculosis	2	0,6%	107,2%	0,2%	34,3%
Other ear diagnoses	1	0,3%	107,5%	0,1%	34,4%
Blood/lymph/spleen diagnoses	1	0,3%	107,8%	0,1%	34,5%
Other skin disease	1	0,3%	108,1%	0,1%	34,6%
Rash/lumps/swelling	1	0,3%	108,3%	0,1%	34,7%
Ulcers	1	0,3%	108,6%	0,1%	34,8%
Pregnancy, childbirth, family planning symptoms/complaints	1	0,3%	108,9%	0,1%	34,9%
Metabolic symptoms/complaints	1	0,3%	109,2%	0,1%	35,0%
Ear symptoms/complaints	1	0,3%	109,4%	0,1%	35,1%
Blood/lymph/spleen conditions symptoms/complaints	1	0,3%	109,7%	0,1%	35,1%
Care provided	1	0,3%	110,0%	0,1%	35,2%
Follow-up	1	0,3%	110,3%	0,1%	35,3%
Medication	1	0,3%	110,6%	0,1%	35,4%
Abuse of psychoactive substances (tobacco, medication)	1	0,3%	110,8%	0,1%	35,5%

98- List of problems and diagnoses subject to delayed treatment in the host country, in decreasing order (cited at least twice)

	n	%	continued	n	%
Behavioural problems	16	4,02	Chronic sinusitis	3	0,75
Hypertension complicated	12	3,02	Laryngitis	3	0,75
Stomach function disorder	12	3,02	Hypothyroidism	3	0,75
Gastralgia	10	2,51	Lipid disorder	3	0,75
Rectal pain	10	2,51	Pyelonephritis	3	0,75
Swallowing problems	10	2,51	Fear of AIDS/HIV	2	0,50
Diabetes Non Insulin Dependent	10	2,51	Anaemia	2	0,50
Dysuria	10	2,51	HIV/infection/AIDS	2	0,50
Chest pain	9	2,26	Gastrointestinal infections	2	0,50
Other psychological symptoms	7	1,76	Malignant neoplasm stomach	2	0,50
Muscle pain	7	1,76	Peptic ulcer	2	0,50
Unwanted pregnancy	7	1,76	Ear discharge	2	0,50
Allergic rhinitis	6	1,51	Otitis externa	2	0,50
Mouth/tongue/lip disease	6	1,51	Ischaemic heart disease	2	0,50
Low back symptoms/complaints	5	1,26	Shoulder pain	2	0,50
Acute stress reaction	5	1,26	Foot pain	2	0,50
Chronic alcohol abuse	5	1,26	Musculoskeletal congenital anomaly	2	0,50
Dyspnoea	5	1,26	Back syndrome	2	0,50
Post traumatic stress disorder	5	1,26	Tendinitis	2	0,50
Fever	4	1,01	Osteoarthritis	2	0,50
Anorexia, bulimia	4	1,01	Osteoporosis	2	0,50
Weakness/tiredness	4	1,01	Cluster headache	2	0,50
Hypertension uncomplicated	4	1,01	Migraine	2	0,50
Postural hypotension	4	1,01	Depression	2	0,50
Haemorrhoids	4	1,01	Somatization disorder	2	0,50
Headaches	4	1,01	Upper respiratory infection acute	2	0,50
Chronic bronchitis	4	1,01	Asthma	2	0,50
Influenza	4	1,01	Lumps/swellings	2	0,50
Blindness	3	0,75	Skin infection	2	0,50
Knee pain	3	0,75	Herpes	2	0,50
Musculo-skeletal pain	3	0,75	Cystitis	2	0,50
Sexual desire reduced	3	0,75	Urinary calculus	2	0,50
Anxiety disorder	3	0,75	Other urinary disease	2	0,50
Cough	3	0,75	Benign genital tumour	2	0,50

