

***"It's necessary to forge
respect, not fear"***

F., MDM France patient, Lyon, february 2006

**European survey
on undocumented migrants' access
to health care.**

Médecins du Monde European Observatory on Access to Health Care



june 2007



Editorial



The European Union now has 27 countries. Some have long been prosperous, whereas others are emerging from decades of poverty and have briskly growing economies. The goal is to create a free-trade zone fostering the wealth of all, but it must include fighting against pockets of poverty and precariousness that are still too common.

To do so the European Union has adopted several strong principles, including abolition of capital punishment and the right of all to the best health care. **But those statements of intention must become reality.** Today, the continent's poorest and most vulnerable populations live in conditions that threaten their health and often exclude them from basic care.

The various EU countries' health care systems are still very different from each other. Not all of them can offer the same level of care, but the EU must strive towards that goal. Organising member states' health care systems is not a European priority, although the fight against major epidemics (HIV, tuberculosis) and threats (bird flu) is. The fact cannot be overlooked that people in the most precarious situations are the most vulnerable to epidemics and the furthest outside the health care system. Neglecting to include the poorest populations in the health care improvement process would be fundamentally wrong in human, public health and financial terms.

Foreign nationals, and in particular undocumented migrants, are among the poorest, most excluded and most discriminated against. That is why we wanted, through this survey, to examine their access to care in several EU countries both, in theory and practice. They must be given the possibility of becoming full-fledged citizens and stakeholders. Access to health care is an indispensable precondition for achieving that goal. The honour of the European Union, which is so strong because of its values, is at stake.

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Introduction



Médecins du Monde is an international humanitarian organisation whose purpose is to treat the most vulnerable populations in situations of crisis and exclusion worldwide and in every country where a national delegation is present by

- inspiring the voluntary, free-willing commitment of doctors, other health professionals and professionals in other disciplines necessary for its activities,
- ensuring that it has all the skills required for carrying out its mission,
- fostering close relationships with the populations treated.

Médecins du Monde, based on its medical practice and in total independence,

- draws attention to potential crises and threats to health and dignity in order to help prevent them,
- mobilizes partners for solidarity actions in the area of health,
- denounces, with the testimonials it gathers, infringements of human rights and in particular obstacles to health care,
- develops new public health approaches and practices around the world based on respect of human dignity,
- promises its donors to maintain totally transparent relationships,
- campaigns to lay the groundwork for the values of humanitarian medicine in accordance with an ethics of responsibility.

Médecins du Monde can now be found in 12 European countries¹. In every one, the organisation is carrying out health projects aimed at vulnerable populations experiencing difficulty in accessing both prevention and care. MDM teams in Europe work on a day-to-day basis with the Romas, homeless people, drug users, prostitutes, isolated people without financial resources, poor migrants with or without papers, children with lead poisoning, children without access to vaccinations, etc.

The *Médecins du Monde* European network's first meetings concluded with high hopes because the European Union reaffirmed and extended the basic right to health care for everybody residing on its soil.

Several European texts, such as the Convention for the Protection of Human Rights and Fundamental Freedoms and the European Social Charter, recognise the right of all persons to the protection of their health.

The European Convention for the Protection of Human Rights and Fundamental Freedoms has a universal scope. In other words, it must be applied to everybody living in one of the signatory states, regardless of nationality and legal residency status.

Thus, the European Court of Human Rights has laid down the principle of equal treatment between foreigners and nationals based on article 14 of the Convention.

Article 14 – Prohibition of discrimination. *The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.*

Thus, when national law provides for a social service, all people are entitled to take advantage of it based on the principle of non-discrimination.

¹. Germany, Belgium, Cyprus, Spain, France, Greece, Italy, the Netherlands, Portugal, the United Kingdom, Sweden and Switzerland.

The European Social Charter offers protection in many areas, in particular social protection. A general non-discrimination clause supplements the enjoyment of those rights.

Article 11 – Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable.

Article 13 – Anyone without adequate resources has the right to social and medical assistance.

Article 16 – The family as a fundamental unit of society has the right to appropriate social, legal and economic protection to ensure its full development.

Article 17 – Children and young persons have the right to appropriate social, legal and economic protection.

Article 30 – Everyone has the right to protection against poverty and social exclusion.

The Council of Europe's Committee of Social Rights has affirmed that the Charter's protections must extend to undocumented migrants and that this is the "essence" and "general objective of the Charter". And since access to "health care is an essential precondition" (...) "to human dignity", any State bound by the Charter must grant the right of medical assistance to all "foreign nationals, even if they are undocumented migrants".

On the basis of these texts, which do honour to the EU, MDM in Europe has chosen to focus on the most vulnerable populations today. This also involves a population with which ALL the MDMs in Europe work: those who do not have an acceptable residence permit at the time we met them - the undocumented.

An objective look at their access to health care in the various EU countries should help to identify the most favourable measures for a real public health policy. Then they must be implemented in all the countries, enabling the entire Union to move forward.

MDM's goal is to obtain access to health care for all, in particular the most insecure populations, in every European country by:

- obtaining improved health care access for migrants, and in particular children and people without residency permits,
- obtaining the non-expulsion of people suffering from serious pathologies if they cannot be treated in their countries of origin, and guaranteeing them access to treatment in Europe.

MDM has created a **European Observatory on Access to Health Care** that will help us document health care access difficulties in Europe for people in precarious situations. The evidence is based on field observations, surveys and face-to-face interviews with the most vulnerable people in order to convince governments and European institutions of the need to improve access to prevention and health care.

MDM makes no claim to being a research organization, which means we must impose two restrictions on our surveys:

- each question the patient is asked must directly bring him or her a benefit in terms of access to health care coverage and treatment;
- the questions asked must contribute to knowledge about the problems patients encounter and about their health.

In 2005-06, the *Médecins du Monde* European Observatory on Access to Health Care developed and conducted a simultaneous statistical survey of undocumented migrants in seven countries. At the same time, the patients interviewed described their situations and we gathered information on national health care access laws.

2. Decision of the Committee of Social Rights of the Council of 3 November 2004, made public in March 2005, pursuant to a complaint lodged by the *Fédération Internationale des Droits de l'Homme (FIDH, International Federation of Human Rights Leagues)*, in collaboration with the *Ligue des Droits de l'Homme (LDH, Human Rights League)* and the *Groupe d'information et de soutien des immigrés (GISTI, Immigrant Information and Support Group)*, filed in 2003 (collective complaint procedure in case 14/2003 FIDH vs. France) - <http://www.coe.int>

The first findings of the European Observatory on Access to Health Care show the advantages of this kind of survey, considering the weakness and scarcity (or even inexistence) of national surveys on the social, health and medical situations of foreign nationals living in Europe in precarious administrative situations – much less comparative European surveys.

All the observations, descriptive statistics and testimonials point in the same direction: this population is very insecure, lives in difficult conditions, has significant health care needs and usually lacks health care coverage.

That is why, given their lack of financial resources, in most cases undocumented migrants do not have effective access to prevention and treatment unless it is free.

Will the European Union rise to the challenge of ensuring that no one within its borders goes without health care because they are missing an administrative document, their status has changed due to a law or elections, or reforms have modified the way care is organised?

What is the value of administrative status worth compared to the fair and equal treatment of everyone in the human community?

Which pathologies can a residency permit recognise?

We recognise only one kind of human being, and know of no pathology that can be stopped by a piece of paper.





Summary of the survey

The living conditions of the persons surveyed are difficult. Some 40% consider their housing situation precarious and 11% are homeless. Almost all of them are living below the poverty threshold.

By and large, **the persons surveyed are not aware of their rights.**

One-third is unaware of their right to health coverage.

Most do not know that they are entitled to free HIV screening and nearly two-thirds are unaware that HIV treatments are free.

Child immunisation is another area where information is lacking. Only a small majority of the population concerned by this issue knows their children are entitled to free vaccinations and/or where to go for them.

Most of the people surveyed do not have health care coverage either because they lack information about their rights or have not undertaken the process to obtain these, or because the administrative procedures are still under way.

In the survey population as a whole, **two people in 10 perceive their health as poor or very poor.** The main disorders mentioned are digestive, musculoskeletal, psychological or, for women, gynaecological. **Only one-third of the people suffering from a chronic health problem is currently receiving treatment.** Nearly half of the people stating that they have at least one health problem suffered as a consequence of the **delay in recourse to care.**

We asked people what they did to obtain care the last time they were ill; 75% consulted a doctor and 20% did not.

During the last health problem, **one person in ten met with a refusal of treatment from health care professionals.**

Some of those health problems were emergencies (in particular, fractures and burns, but also pregnancies and personality disorders), serious illnesses (insulin-dependant diabetes, viral hepatitis) or acute infectious diseases (sinusitis, pneumonia).

The most frequent obstacles to health care access and treatment continuity voiced by the people surveyed are lack of knowledge about their rights, lack of knowledge about where to go for treatment, treatment cost, administrative problems, fear of being reported to the authorities and of discrimination, and linguistic and cultural barriers.

Presentation of the survey



Little is known about the situation of undocumented migrants living in Europe. One thing is certain: their social and economic situation is very insecure³. Various testimonials also demonstrate the problems they encounter when trying to claim their right to care and to benefit from assistance from the health care system⁴. By and large, national health care programmes often discriminate against temporary migrants (most migrants fall into that category at one time or another), asylum-seekers⁵ and those who either do not have residence permits when they arrive or who eventually lose them⁶. They face many, and often considerable, obstacles to good health, in particular discrimination, legal status, linguistic and cultural differences, an array of social and economic problems and difficult living conditions in general⁷. But since **the overwhelming majority of national surveys do not take undocumented migrants into account, there is a lack of statistical information about their living conditions, health and access to care**⁸.

The findings presented here must be considered as a “statistical testimonial” of the situations observed in the different European Observatory centres. They do not claim to present a representative snapshot of the problems that all undocumented migrants in Europe face in gaining access to health care, if only because the people surveyed have at least been able to make contact with treatment structures where the survey took place. However, for lack of representative surveys (that are very difficult to conduct and currently do not exist), the quantitative findings presented here help to identify some major trends and international differences that, despite the caution advised in interpreting them, illustrate and shed light on the range of problems that this population faces in access to health care.

This is the first European Observatory for Access to Health Care survey. It mobilised almost all the MDMs in Europe. The entire MDM network joined forces and worked on this issue, taking account of their differences and trying to overcome them. There are many disparities between countries involving:

- legislation governing access to health care,
- populations encountered and their problems,
- field teams' practices,
- contexts,
- methods of intervention,
- definition of concepts,
- vocabulary used,
- language, which can lead to different understandings and interpretations of situations.

The questionnaire used to collect the data resulted from many months of discussions and a working seminar attended by at least one representative from each MDM to implement the survey on a common foundation. The survey took place from July 2005 to February 2006.

3. Chauvin P, the Europromed Working Group, eds. *Prevention and health promotion for the excluded and the destitute in Europe*. Amsterdam, IOS Press, 2002, 198 p.

4. Brixi O. Santé et migration. In: Lebas J, Chauvin P. *Précarité et santé*. Paris, Flammarion Médecine-Sciences, p. 99-102.

For example, on the issue of the right to residency for medical reasons in France, see the 2003 report of the Observatoire du Droit à la Santé des Etrangers. (http://www.odse.eu.org/rubrique.php?id_rubrique=14)

5. Silove D, Stelle Z, Mollica RF. Detention of asylum seekers: assault on health, human rights and social development. *Lancet*, 2001, vol. 357: 1436-37.

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

7. World Health Organisation. *Migrations Internationales, santé et droits humains*. Geneva, WHO, 2005.

8. Lamara F. *Migration et santé publique dans l'Union européenne: une mise en chantier qui se fait attendre*.

In: Chauvin P, Parizot I, eds. *Santé et recours aux soins des populations vulnérables*. Paris, Editions Inserm, 2005, p. 305-321.

In all, **835 undocumented migrants were questioned in seven countries:** Belgium, Spain, France, Greece, Italy, Portugal and the United Kingdom.

Volunteers from Médecins du Monde missions (social workers, doctors, nurses, psychologists, support workers, etc.) or, in a few rare cases, from partner organisations, conducted the survey.

The survey's intermediate findings were shared and discussed with all the MDMs during a working day to let everybody contribute to the analysis.

Context and survey centres in each country

Belgium

→ **202 people** questioned at two *Médecins du Monde* programmes and two partner organisations

→ The MDM programmes were:

- a “generalist” mission for homeless people in Brussels and its environs at a Centre d’Action Sociale Urgente (CASU, Emergency Social Action Centre), 12 people surveyed, 1,730 medical visits in 2005
- a “specialist” mission at a polyclinic for people with no access to care, 145 people surveyed, 501 medical visits in 2005

→ 45 people answered the survey at the two organisations, which were:

- *Zorgwonen*, an organisation caring for vulnerable people living with HIV
- Aide Info Sida via the referral centre for people with HIV, based at Saint Pierre hospital in Brussels.

Access to health care in Belgium?

Belgium's system is based on health insurance and social assistance (to guarantee financial accessibility). Health insurance still requires patients to pay 25 to 45% of their medical expenses. Destitute people with a medical assistance card can have 100% of their expenses met. The rest must make an annual contribution based on income.

Drugs are divided into five categories with different co-payment levels depending on their therapeutic benefits.

The system is complex, with three regions: Flanders, Wallonia and Brussels, itself divided into three parts. The federal, regional and community levels share authority. Many people remain outside the system as a result of this complexity. Asylum-seekers must go through a Centre Public d’Action Sociale (CPAS, Public Social Action Centre), of which there are no less than 19 in Brussels and its metropolitan area alone, to obtain the right to health care.

The law of 8 July 1976 on the CPAS recognised undocumented migrants' right to free health care if they are without means. They can take advantage of AMU (“*Aide Médicale d’Urgence*”, Emergency Medical Aid). A medical certificate confirms whether the situation is an emergency. AMU concerns both prevention and cure and can be given to walk-in patients at clinics. The term “emergency” is misleading because AMU is supposed to cover all pathologies whether they are emergencies or not. It pays for all expenses except psychiatric hospital treatment, drugs that are not normally reimbursed, such as tranquilisers and sleeping pills, eyeglasses and prosthetic devices, in particular dentures.

In actual practice, implementation of the law depends on each CPAS.

HIV screening is free for AMU beneficiaries (for everyone else, prices range from 10 to 30 euros, but some organisations offer the test for free). Everyone is entitled to free antiretroviral drugs (undocumented migrants must have AMU).

Spain

→ **201 people** questioned at five *Médecins du Monde* programmes

→ These were five social and medical assistance centres (CASSIN, *Centro de Atención SocioSanitaria a INmigrantes*) for migrants having difficulty obtaining health care:

- Tenerife, 63 people surveyed, 1,048 medical visits in 2005
- Bilbao, 54 people surveyed, 565 medical visits in 2005
- Valencia, 33 people surveyed, 1,343 medical visits in 2005
- Madrid, 30 people surveyed, 526 medical visits in 2005
- Seville-Málaga, 21 people surveyed, 1,499 medical visits in 2005⁹

Access to health care in Spain?

Spain's 1978 constitution and 1986 health care law recognise “the right to health protection and assistance for medical care for all Spanish citizens and foreign nationals residing on Spanish soil.”

The public health care system, “*assistencia sanitaria*”, is free and financed by taxes. Patients, except those suffering from chronic diseases, must contribute 40% towards the price of drugs.

For health care access, patients must have either a social security card (connected to work) or the health care card (for those who cannot afford to pay into the system or have no papers): the latter must be registered on the local civil register¹⁰. Foreigners registered on the rolls of the town where they reside are entitled, regardless of their status, to the same rights to free health care as Spanish citizens (general law 4/2000 of 11 January 2000). In practice, some regional governments drag their feet in implementing the law.

What's more, since 2003 the law has allowed the police access to the local registers. As a precaution, then, many foreign nationals do not register and consequently have no access to health care. They do not have the health care card and are only entitled to emergency treatment (necessary due to an accident or serious illness). The only exceptions are minors and pregnant women, who are entitled to the same care as Spanish citizens with national health insurance.

HIV screening and anti-retroviral treatments are free with either the health care or social security card.

France

→ **152 people surveyed** in four *Médecins du Monde* programmes

→ They were four Centres d'Accueil, de Soins et d'Orientation (CASO, Reception, Treatment and Orientation Centres), open to anyone having difficulty obtaining health care:

- Paris, 50 people surveyed, 8,595 medical visits in 2005

- Lyon, 49 people surveyed, 3,668 medical visits in 2005

- Saint Denis, 42 people surveyed, 5,236 medical visits in 2005

- Marseille, 11 people surveyed, 5,729 medical visits in 2005¹¹

Access to health care in France?

France's health insurance system is based on the idea "from each according to his or her means, to each according to his or her needs."

Basic health insurance was mainly connected to occupation status through the Social Security net but in 1992 the "Aide Médicale Départementale et d'Etat" (State and Departmental Medical Aid) was set up for those who are unable to pay into the system.

Since the "Couverture Maladie Universelle" (CMU, Universal Health Coverage) was created in 2000, anyone legally residing in France for at least three months has been entitled to basic health coverage (which covers approximately 65% of expenses).

If the person's monthly income is under 587.13 euros¹², well below the poverty line in France (774 euros¹³), he or she is entitled to additional coverage ("CMU complémentaire", or supplementary CMU) and exempt from any additional expenses.

Asylum-seekers are entitled to basic social security and CMU (including supplementary) as soon as they file their request for asylum.

"Aide Médicale Etat" (AME, State Medical Aid) is intended for undocumented migrants who have resided in France for at least three months and whose monthly revenues are below the same level as for supplementary CMU. They are covered for free, without having to incur any expenses, for all care except prostheses.

Undocumented migrants who have resided in France for less than three months can go to the hospital for free in order to obtain "emergency treatment without which the vital prognosis would be in jeopardy or might lead to a serious and lasting change in the health of the patient or of a child about to be born" (decree of 16 March 2005). HIV tests are free, anonymous and therefore accessible to all. AME and CMU provide for access to anti-retroviral treatments.

9. This figure only includes medical visits, not social or psychological consultations.

10. General Law 47/2000 on the Rights and Freedoms of Foreign Nationals in Spain and their Social Integration Article 12 – The right to health assistance:
1 - "Foreign nationals located in Spain and registered with the administrative service of the municipality where they customarily reside are entitled to health assistance in the same conditions as those enjoyed by Spanish citizens."

11. This figure only includes medical visits. We have not taken social or psychological consultations into account here.

12. From 2005 to July 2006 the threshold in France was 587.13 euros. It rose to 598.23 euros in July 2006.

13. In 2003, the poverty line for a single person was 774 euros a month (60% of the median income). Source: 2005-2006 report of the Observatoire national de la pauvreté et de l'exclusion sociale en France.

Greece

→ **112 people surveyed** in two *Médecins du Monde* programmes

→ They were two reception and treatment *policliniques*¹⁴ open to anyone having difficulty obtaining access to care:

- Athens, 58 people surveyed, 13,590 consultations in 2005
- Salonika, 54 people surveyed, 3,363 consultations in 2005

Access to health care in Greece?

Greece did not have a national health care system until 1983.

However, since the 1990s the system has been partially re-privatised and decentralised to regional and local structures. As a result, for example, nine in 10 dentists practice in the private sector. The number of public dispensaries is on the rise.

Three hundred health insurance organisations offer over 40 different kinds of coverage.

Insured patients must contribute 25% towards the price of drugs (except in the case of some chronic pathologies). Asylum-seekers are entitled to the same access to health care as Greeks as long as they can prove their status, which is difficult early in the process.

Since a law was passed in 2001, it has been nearly impossible for undocumented migrants to have access to health care outside life-threatening hospital emergencies.

HIV testing is free in public hospitals and screening centres. The need for anti-retroviral drugs is considered a life-threatening emergency.

However, undocumented migrants have no access to anti-retroviral drugs.

Italy

→ **136 people surveyed** in five cities in *Médecins du Monde* and partner organisation programmes

→ For the MDM programmes:

- In Rome, 72 people surveyed
 - at a walk-in university clinic intended for undocumented migrants
 - and at a mobile unit for homeless people managed with the Saint Egidio community.
- In Milan, 33 people surveyed at an MDM mobile unit offering treatment to mostly homeless people, 3,057 medical visits in 2005.

→ For the partner organisations:

- In Florence, 17 people surveyed at a multi-partner centre for prostitutes, 189 consultations in 2005
- In Siena, 7 people surveyed at a walk-in clinic for undocumented migrants, 230 consultations in 2005
- In Brescia, 7 people surveyed at a health care centre for foreign nationals.

Access to health care in Italy?

Italy's national health care service, which dates back to 1978, is financed by contributions from the entire population based on residence. Local health care agencies manage the organisation and distribution of treatment.

Payment exemption systems for registration in the national health care system are provided for asylum-seekers and people with very low incomes.

Undocumented migrants and minors are guaranteed free health care in hospitals for essential¹⁵ and emergency¹⁶ treatment, pregnancy, compulsory immunisation and infectious disease treatment (according to legislative decree no. 286 of 25 July 1998).

Access to HIV screening is free and anonymous for all. Anti-retroviral treatments are distributed at hospitals.

14. *Policliniques* = citizens' clinics

15. Essential treatment refers to treatment for pathologies that pose no immediate threat, but that might jeopardize the patient's life or health in the long term.

16. Emergency treatment is treatment that is impossible to postpone or delay without putting the patient's life or health in danger.

Portugal

→ 17 people surveyed in one Médecins du Monde programme

→ It was a mobile unit in Lisbon that mostly cares for homeless people living alone, 1,861 visits in 2005.

Access to health care in Portugal?

Portugal's national health care system has existed since 1979. The constitution guarantees the right to health protection through a universal national health care service. Treatment is accessible to all in local dispensaries and public hospitals. The system is financed by taxes based on residence.

Privatisation has been under way since 1989. Major differences between regions have been reported.

Patients must pay one to three euros for medical consultations and drugs, depending on their classification on a scale of therapeutic usefulness. They are also required to pay two to nine euros for emergency hospital care. Some people may be exempted.

The system is legally accessible but in practice gives rise to many problems, in particular for homeless people and others outside the social mainstream, who often linger in doctors' and hospital waiting rooms without anyone taking care of them. That is probably due, among other reasons, to a critical doctors shortage and lack of information about rights.

In order to obtain the national health care card, foreign nationals, including undocumented migrants, must prove (with two witnesses) that they have resided in the country at least 90 days, but they are not covered 100%. Exemptions are possible for people without means.

Undocumented migrants residing in Portugal for less than 90 days must pay for all their care unless their condition poses a threat to public health, for example in the case of contagious diseases such as tuberculosis, HIV and STIs. Although patient information is not passed on to the police, undocumented migrants are often afraid to seek treatment because they fear it will be.

All residents, regardless of their status, have access to HIV screening and anti-retroviral treatments.

United Kingdom

→ 15 people surveyed in the Médecins du Monde and partner organisations' programme

→ The survey started just as "Project: London" - a health care access project for migrants, homeless people and sex workers - was getting under way in January 2006. As of 30 March 2006, just 35 people had received treatment, which accounts for the low number of individuals questioned for the survey. *Casa de la Salud*, an organisation that mainly helps people from Latin America, and the *Dadihiye Somali Development Organisation*, which assists migrants from Somalia, distributed the questionnaires.

Access to health care in the United Kingdom?

The United Kingdom's system is based on the dual principle of universality and fairness. Taxes finance over 80% of the national health care service. Access to general practitioners is free for anyone who signs up on their patients list (undocumented migrants are signed up at the GP's discretion). Patients must go through a GP for access to a specialist (at the hospital only). They must contribute nine euros towards the payment of prescription drugs; the exemptions are minors under 16, pregnant women, mothers of children under one year old, people receiving unemployment benefits and minimum revenue, diabetics and people suffering from some other pathologies. People on low incomes can request exemption from prescription fees. Their request is assessed according to several criteria (household income, savings, etc).

Since April 2004, undocumented migrants have been entitled to health care only from GPs, and not second-line care from specialists and hospitals.

However, some treatment is free for everybody: emergency care, family planning, some mental illnesses, sexually transmitted diseases **but not HIV**, other contagious diseases, SARS, etc.

A private, pay-as-you-go medical system is currently growing.

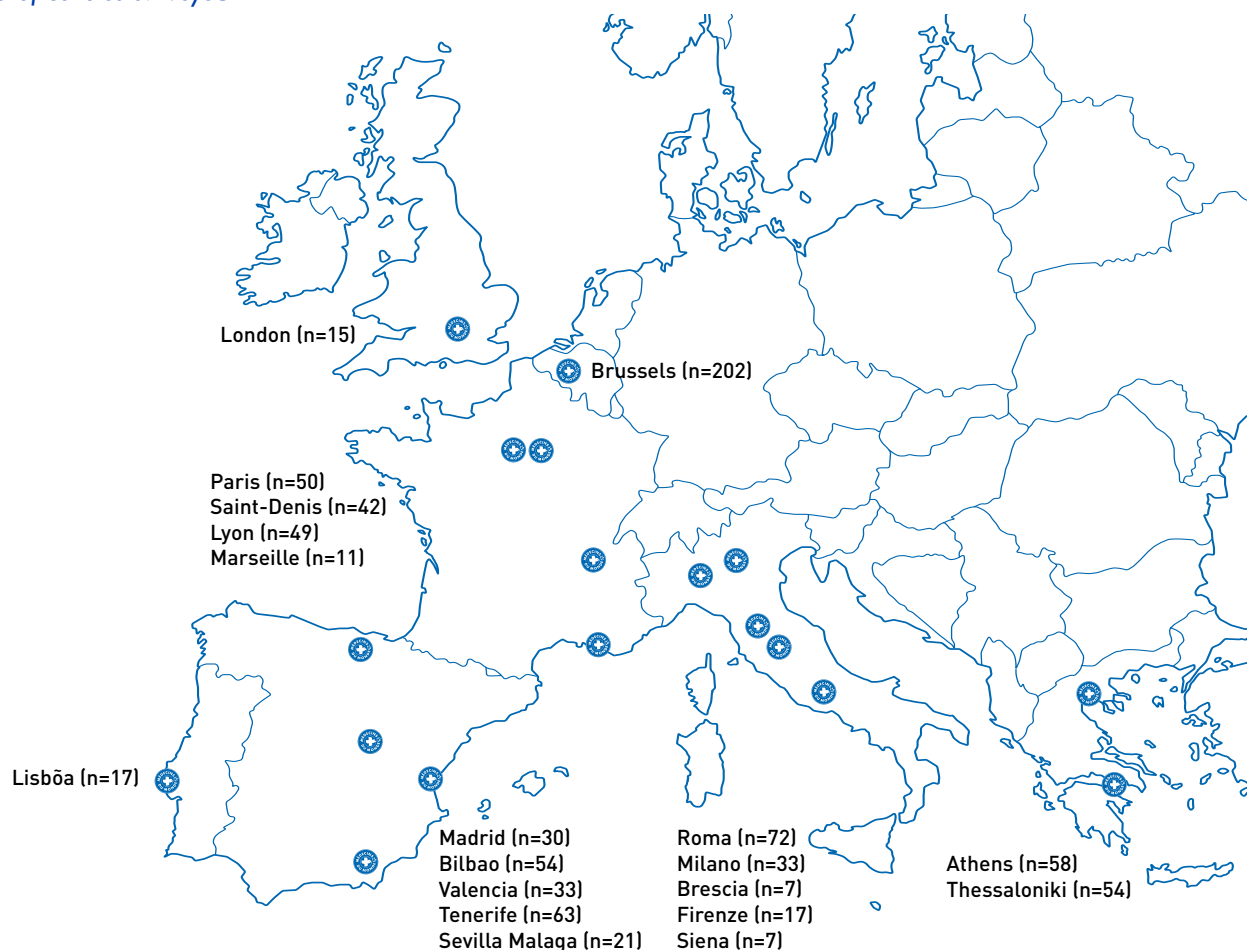
Undocumented migrants are not entitled to care for pregnancy or HIV except for the test and psychological counselling afterwards. However, patients registered with a GP do receive free treatment for opportunistic infections.

Table 1. Missions participating in the survey and number of people questioned by country

	NUMBER OF MISSIONS	NUMBER OF PEOPLE SURVEYED	% OF PEOPLE SURVEYED IN THE TOTAL SAMPLE
Belgium		202	24.2%
Specialists Brussels	3	145	17.4
Partner organisations Brussels		45	5.4
CASU Brussels		12	1.4
Spain		201	24.1%
CASSIN Tenerife	5	63	7.5
CASSIN Bilbao		54	6.5
CASSIN Valencia		33	4.0
CASSIN Madrid		30	3.6
CASSIN Seville-Malaga		21	2.5
France		152	18.2%
CASO Paris	4	50	6.0
CASO Lyon		49	5.9
CASO Saint-Denis		42	5.0
CASO Marseille		11	1.3
Italy		136	16.3%
Rome	5	72	8.6
Milan		33	4.0
Florence		17	2.0
Brescia		7	0.8
Siena		7	0.8
Greece		112	13.4%
Athens Policlinique	2	58	6.9
Salonika Policlinique		54	6.5
Portugal		17	2.0%
Lisbon	1	17	2.0
United Kingdom		15	1.8%
London	1	15	1.8
Total	21	835	100%

Given the low number of people questioned in the United Kingdom and Portugal, the data collected in those two countries has not been used for the international comparisons in this document (unless otherwise noted), but they have been included in the total sample for overall analysis.

Figure 1. Map of centres surveyed



MDM teams in the Netherlands and Germany did not take part in collecting the quantitative data for this survey¹⁷. MDM Netherlands gathered testimonials.

Below we describe health care access conditions in the Netherlands and Germany.

The Netherlands

Before 2006, the Netherlands had a health insurance scheme open to all legal residents below a certain income level that covered current expenses (free access to general practitioners, who could make a referral to a specialist). People with incomes above that level had to obtain insurance from private companies. Universal coverage for the most expensive and long-term care could obtain supplementary coverage, though at an additional cost. Parliament passed a reform that entered into force on 1 January 2006: the Dutch must now pay 90 euros a month into an insurance scheme that covers most health care. A complex system of reimbursements for society's poorest member has been set up, requiring them to fill out forms every month. Insurance companies have created health care networks (a single hospital of reference, etc.). Not all people have access to cutting-edge care (for cancer, for example).

A medical organisation specifically dedicated to asylum-seekers takes care of them and has offices in asylum-seekers' intake centres.

Undocumented migrants' health care access has been problematic since 1998, when they were denied access to all public services. The law of 1 July 1998 entitled undocumented migrants to "necessary medical care". Professionals decide whether the care is essential. By and large, all care that health insurance might cover is considered necessary. However, dentists are often reluctant to treat them.

A special, €5-million-a-year fund (*the Koppelings fund*) has been set up for undocumented migrants in cases of life-threatening emergencies, infectious diseases, pregnancy, neonatal care and mental pathologies that pose a threat to society.

The fund pays for HIV screening and access to anti-retroviral drugs **but** in practice health care professionals as well as the people concerned are seldom aware of their existence.

17. MDM Germany started a health care access programme for undocumented migrants in autumn 2006.

Germany

It is hard to describe Germany's system because so many differences exist between the various *Länder*. However, basic health insurance is mandatory (the only people not covered are undocumented migrants, free-lance workers and students who have exceeded a set number of years in the university system). Contributions are based on income. Direct payment by the insurer is widespread.

Since the system was reformed in January 2004, recipients of social benefits have had to pay 10 euros a quarter for their health care. In addition, they are required to make a financial contribution towards their prescription drugs and the use of therapeutic equipment.

Germany is the only country studied that does not grant asylum-seekers the same health care access as nationals. Asylum-seekers do not have the same rights until they have lived in the country for 36 months. In the meantime, they only have access to emergency care, care relating to pregnancy, compulsory vaccinations and preventive medical examinations.

Undocumented migrants are entitled to hospital access only in cases of intense pain, a medical emergency or pregnancy. They also have access to compulsory vaccinations and preventive medical examinations (law of 1 November 1993). However, since 1 January 2005, administrative staff members have been required to immediately report the presence of undocumented migrants to immigration officials if they find out about them in the course of carrying out their duties. As a consequence, undocumented migrants are reluctant to go to the hospital even in the event of an emergency and would rather turn to organisations.

The German system does not pay for treatment of pathologies such as HIV for undocumented migrants.



I. Demographic characteristics

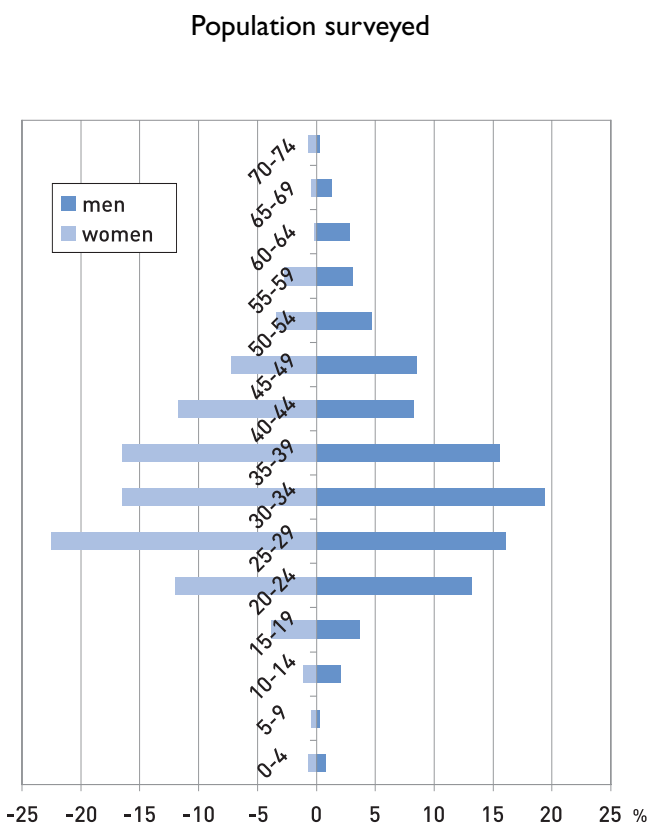


1. Age and sex

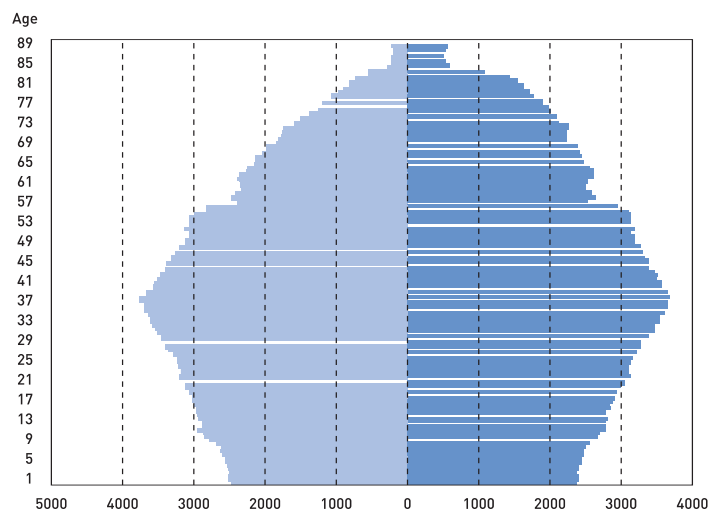
The total survey sample included 835 people, 53.4% men and 46.6% women (M/F gender ratio = 1.13) aged 0 to 72 years old (average = 33.9 years).

Three-quarters of them were 20 to 44 years old. The average age was 34 (34.5 for women and 33.5 for men). Women accounted for a greater share of the older patients: 12.6% were over 50 compared to 7.7% of the men.¹⁸

Chart 2. Age pyramid of the survey population by sex



The 25-member European Union in 2005¹⁹



The survey population's demographic profile, especially the breakdown by sex, varied widely depending on the country. The activities of the Médecins du Monde centres that participated in the survey partly account for those differences²⁰. The Belgium sample was the only one where women (60.9%) outnumbered men (39.1%).

18. The age pyramid by sex has differences on the borderline of statistical significance ($p=0.07$).

19. Source: EPC/European Commission, 2005.

20. For example, with regard to the distribution by sex, the 17 individuals questioned at the mobile unit for homeless people in Portugal included just one woman; the Portuguese data are not useable by themselves.

Table 2. Distribution by sex and country

	Men (%)	Women (%)	Total (N)
Belgium	39.1	60.9	202
Spain	60.3	39.7	201
France	52.0	48.0	152
Italy	60.0	40.0	136
Greece	54.5	45.5	112
Total	53.4	46.6	832

The average age of those surveyed was highest in France and Belgium (37) compared to 30 in Great Britain and 32 to 33 in Italy, Spain, Portugal and Greece.

Only the centres in Greece, Belgium and Spain included people under 18 in the sample: 20 (17.9% of the sample) in Greece, 7 in Belgium (3.5%) and one in Spain. The Spanish sample contained no patient over 60.

Table 3. Distribution by age quintile according to the survey country (in%)

	Belgium	Spain	France	Italy	Greece	Total
0-4 years old	0.5				4.5	0.7
5-9 years old	0.5				1.8	0.4
10-14 years old	1.5				8.9	1.6
15-19 years old	1.5	5.5	2.0	2.9	8.9	3.8
20-24 years old	6.5	18.5	9.3	12.5	16.1	12.5
25-29 years old	11.4	23.5	19.2	27.9	17.9	19.6
30-34 years old	19.9	16.0	17.2	24.3	8.0	17.8
35-39 years old	22.9	17.5	15.2	12.5	7.1	16.1
40-44 years old	15.9	8.5	11.3	8.8	1.8	10.1
45-49 years old	7.5	6.0	10.6	4.4	11.6	7.8
50-54 years old	4.0	3.5	6.6	4.4	1.8	4.0
55-59 years old	5.5	1.0	2.6	1.5	4.5	2.9
60-64 years old	1.5		3.3		3.6	1.4
65-69 years old	1.0		1.3	0.7	1.8	0.8
70-74 years old			1.3		1.8	0.5
Total	100% (n=201)	100% (n=200)	100% (n=151)	100% (n=136)	100% (n=112)	100% (n=832)

Table 4. Distribution by age (over 16 years old) according to the survey country (in%)

	16-24 years old	25-39 years old	40-49 years old	> = 50 years old	Total
Belgium	8.2	55.6	24.0	12.2	100
Spain	24.0	57.0	14.5	4.5	100
France	11.3	51.7	21.9	15.2	100
Greece	28.0	39.8	16.1	16.1	100
Italy	15.4	64.7	13.2	6.6	100
Total of the sample	16.6	55.1	18.4	9.9	100

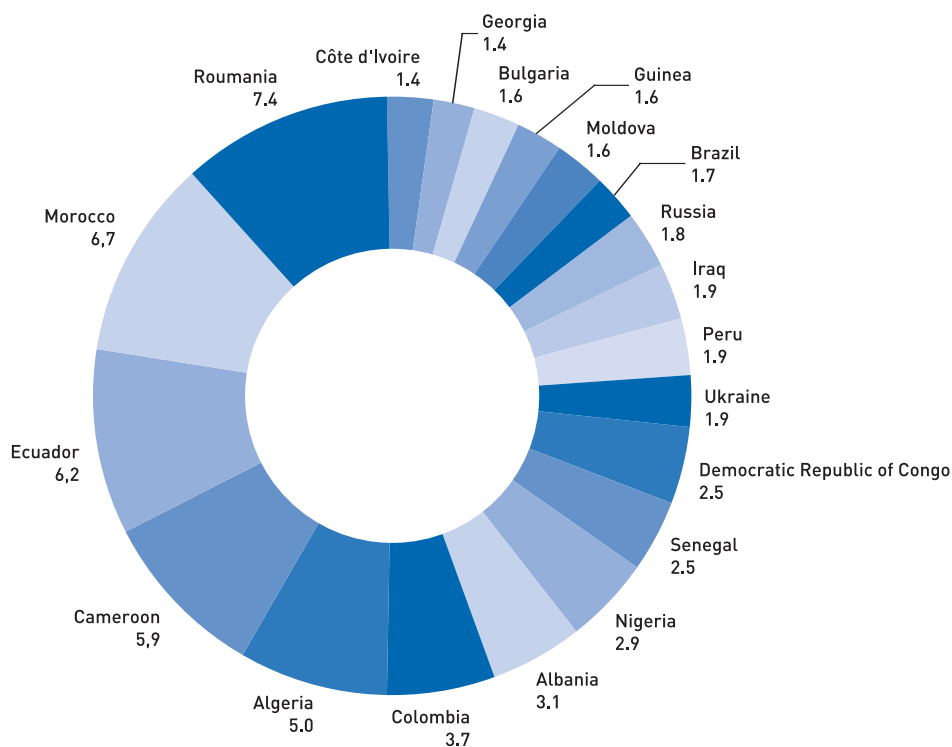
2. Geographical origin

The surveyed individuals come from a very wide range of geographical origins: **85 different countries were counted**.²¹

Nearly one in three comes from a country in sub-Saharan Africa (29.9%) - primarily Cameroon, Nigeria, Senegal and Democratic Republic of Congo - and **one in four (24.9%) from a country in the Americas**: 23.8% from Latin America, in particular Ecuador, Bolivia and Colombia, and 1.1% from the Caribbean (Cuba and Haiti). Some **22.3% are from European countries** outside the European Union (mainly Romania and Albania, but also the countries of ex-Yugoslavia), 13.5% from the Maghreb (especially Morocco and Algeria), 5.5% from the Near or Middle East (Iraq and Afghanistan for the most part) and 3.9% from Asia (primarily the Philippines, India and Bangladesh).

In decreasing order, the sample's most heavily represented countries are Romania (7.4%), Morocco (6.7%), Ecuador (6.2%), Cameroon (5.9%), Algeria (5.0%), Colombia (3.7%), Albania (3.1%), Nigeria (2.9%), Democratic Republic of Congo and Senegal (2.5% each). Some 11.5% of the women are Ecuadorian and 10.4% Romanian; 10.6% of the men are Moroccan. The **10 most heavily represented nationalities account for nearly half the total sample (46%)**.

Chart 3. Countries of origin: the 20 most frequently mentioned countries (in%)

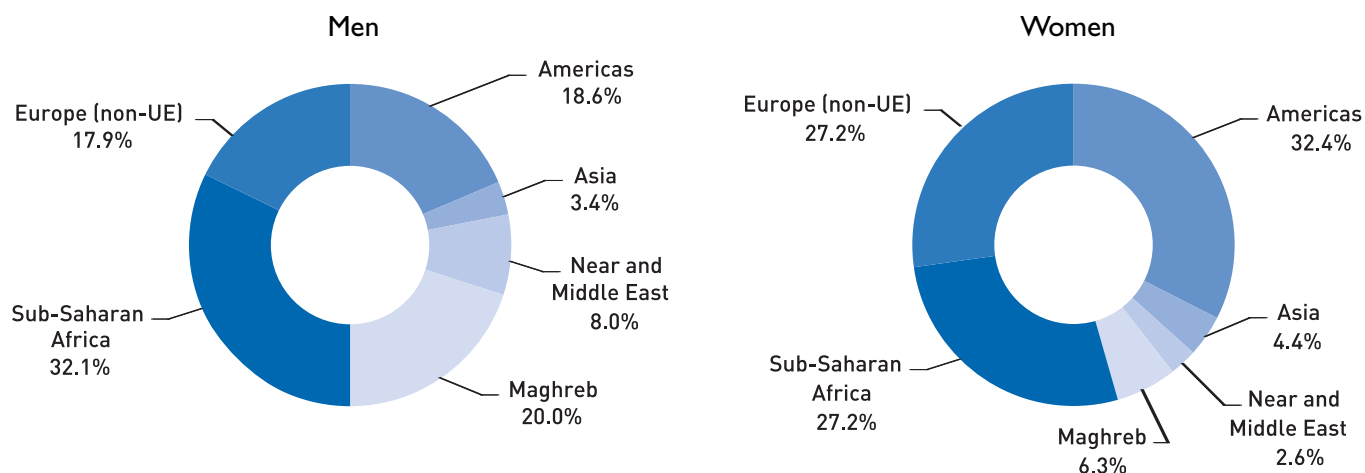


Men's and women's emigration figures differ for all the countries of origin, so it is not surprising to observe significant differences according to sex with regard to the respondents' geographic origin.

In the total sample, **the men come most often from sub-Saharan Africa (32.1%) and the Maghreb (20.0%)**, whereas **the women are predominantly from Latin America (32.4%), Europe (outside the European Union) and Sub-Saharan Africa (27.2% for each of these two areas)** ($p < 0.001$).

21. The nationality of 13 persons was not recorded.

Chart 4. Distribution of men and women according to the continent of origin (in%)



Similarly, the history of migration patterns peculiar to each European country leads to substantial differences (statistically significant) in the patients' origins.

Table 5. Distribution (in%) by continent of origin according to survey country

	Belgium	France	Spain	Greece	Italy	Total
Europe (non-UE)	14.5	15.9	10.9	47.7	34.8	22.3
Sub-Saharan Africa	32.0	49.7	22.8	18.9	25.9	29.9
Maghreb	12.0	25.8	14.0	5.4	9.6	13.5
Near/Middle East	2.5	2.0	0.5	23.4	6.7	5.5
Asia	7.0	0.7	0.0	4.5	4.4	3.9
Americas	32.0	6.0	51.8	0.0	18.5	24.9
Total	100% (N=200)	100% (N=151)	100% (N=193)	100% (N=111)	100% (N=135)	100% (N=822)

Belgium and France are the oldest, most popular destinations for migrants from sub-Saharan Africa because of the historic ties between those former colonial powers and the countries of West and Central Africa²².

More recently, Portugal has become an emigration destination, in particular for migrants from Portuguese-speaking Africa. Spain, because of its location, is a country of passage (or a destination) for African immigration, while cultural and historic ties with Latin America explain (at least partly) why the majority of those surveyed (51.8%) are from that region. Nearly half the people questioned in Greece (47.7%) come from countries in Europe outside the European Union; the sub-Saharan immigrants are often there because they are on the way to other European Union countries.

Activities specific to the centres surveyed also account for the differences observed.

Approximately half the patients questioned in France come from sub-Saharan Africa (49.7%), but that overall percentage conceals major regional disparities. The CASO (Reception, Treatment and Orientation Centre) in Marseille mainly accommodates people from the Maghreb and the CASO Paris reports an increase in Chinese patients although their figures are not reflected because they could not be interviewed due to a lack of interpreters during the survey.

Most of the individuals surveyed in Belgium are from sub-Saharan Africa (32.0%) and the Americas (32.0%). The high incidence of Latin Americans is a consequence of focused outreach to that particular community.

22. For a documented summary and map of migrations, see Wihtol De Wenden C. Atlas des migrations dans le monde. Paris, Autrement, 2005, 80 p.

2. Social situation



The surveyed individuals' various social situation indicators reveal the precariousness of their plights in the areas about which they were questioned, including housing, family status, employment and financial resources.

1. Housing conditions

Most surveys in Europe show that foreign nationals' housing situations are less favourable than those of the host countries' citizens in terms of both occupancy status and comfort²³. Undocumented migrants come across even greater obstacles in access to housing, including low or unsteady incomes, lack of documents legalizing residency in the host country, discrimination and abusive practices on the part of landlords, lack of the right to social housing, weak social networks, fear of disclosure, etc. In addition to the precariousness of housing with close relatives, forced overcrowding, and poor facilities and hygiene, undocumented foreign migrants often live in undesirable areas that can be detrimental to their health and well-being²⁴...

As a result, **the surveyed individuals often live in precarious housing situations**. Less than half the sample (48.4%) say they have a "permanent" address - despite the fact that the definition of "permanent housing" is very wide (wider than in the usual national statistical surveys²⁵) for the purposes of this survey because it corresponds to the use of a private, perhaps shared domicile but also to housing by close relatives if the surveyed individual considers the housing stable on the day of the survey.

Some 40.0% of those questioned say they live in precarious housing (with relatives or friends, in a squat with water and electricity, caravan, hostel, etc.). Lastly, 11.5% have no housing at all: they sleep in the street, hostels, squats without water or electricity or emergency housing.

"I live with other people and can't always ask them to take my special diet into account when they prepare meals."

Excerpt from an MDM Netherlands interview with S., 52, diabetic:

” *"I'm diabetic, and what's hard for me is that, because of my illness, I have to take a lot of things into consideration, like meals for example. I live with other people and can't always ask them to pay attention to my special diet when they prepare meals. I really depend on them and asking them to cook special meals for me or to take my diet into account costs extra money. I try to stay on my diet, but it's really hard and I can't really manage to do it."*

In a finding similar to representative surveys on homeless populations²⁶, **homeless men often outnumber homeless women**: nearly one man in five is in that situation (18.2%), compared to 4.0% of women ($p < 0.001$). Conversely, 56.2% of the women surveyed live in permanent housing, compared to 41.6% of the men ($p < 0.001$).

23. For France for example, see INSEE. *Les immigrés en France*. Paris, INSEE, 2005.

24. Braunschweig S, Carballo M. *Health and Human Rights of Migrants*. Geneva, International Centre for Migration and Health, 2001.

25. The definition of housing situations differs widely from one country to the next. For example, most of the national surveys consider people living with friends or relatives "without a permanent residence" or even, in some countries, "homeless". For example, see Avramov D, ed. *Coping with homelessness: issues to be tackled and best practices in Europe*. Ashgate Publishing, 1998.

26. For example, see Marpsat M. *Un avantage sous contrainte : le risque moindre pour les femmes de se trouver sans abri*. *Population*, 54 (6) : 885-932.

Table 6. Housing situation of men and women (in%)

	Men	Women	Average
Permanent housing	41.6	56.2	48.4
Precarious housing	40.2	39.8	40.0
Homeless	18.2	4.0	11.5
Total	100%	100%	100%

“I have to move around a lot because my friends can’t help me anymore and it’s time to find a new place to live...”

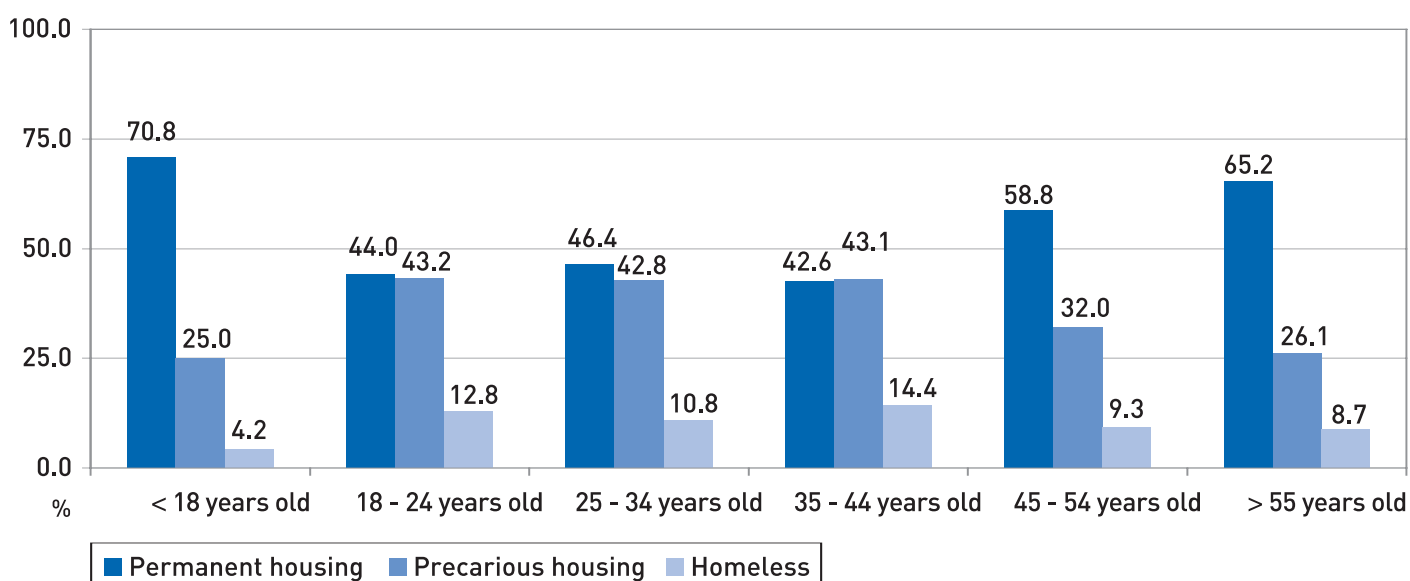
Excerpt from an MDM Netherlands interview with K., 42, from Ghana:



“My name is K., I’m married with four children. My wife and children live in Ghana. I left Ghana to earn a living and provide for my family. It’s very hard because I have no job or income. I haven’t had a permanent residence since arriving in the Netherlands in 1999. I have to move around a lot because my friends can’t help me anymore and it’s time to find a new place to live...”

The housing situation for those between 18 and 44 years old is more critical. Most people over 55 have housing (65.2% live in permanent housing and 26.1% in precarious housing). Six minors under 18 live in precarious housing²⁷ and one is homeless²⁸.

Chart 5. Housing situation according to age (in%).



Differences observed between countries are probably partly due to certain centres’ specific outreach and appeal but also to migration conditions - in particular whether the migrant came alone or with family - and to migratory groups’ differing from one country to the next.

27. Some are very young. One is only two years old (Belgium), two are 10 years old and the others are 13, 14 and 17.

28. He is a 17-year-old Albanian boy living in Greece (with relatives or friends) without means.

Table 7. Housing situation according to survey country (in%)

	Belgium	Spain	France	Greece	Italy	Average
Permanent housing	54,5	31.7	39.9	69,8	56,8	48,2
Precarious housing	36.5	56,8	52,0	20.8	26.5	40.3
Homeless	9.0	11.6	8.1	9.4	16.7	11.5
Total	100% (n=200)	100% (n=199)	100% (n=148)	100% (n=106)	100% (n=132)	100% (n=817)

2. Family status

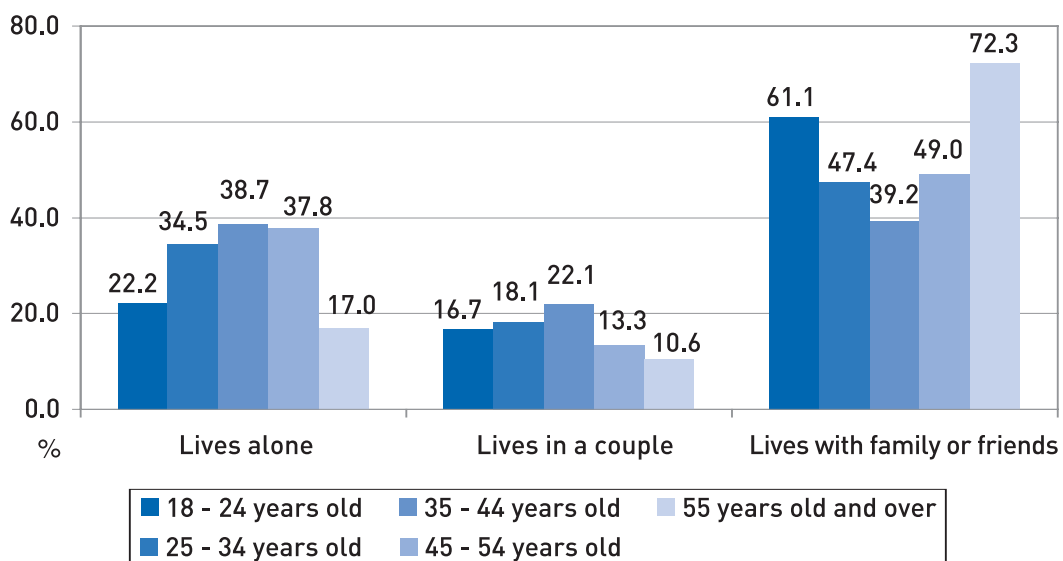
Half the people surveyed live with relatives or friends (50.6%), 32.2% live alone and 17.2% live in couples. Women living in couples outnumber men by two to one (23.0% compared to 12.2%), whereas **more men live alone than women** (37.2% compared to 26.4%) ($p < 0.001$).

Table 8. Family situation of men and women (in%)

	Men	Women	Average
Live alone	37.2	26.4	32.2
Live in couples	12.2	23.0	17.2
With family or friends	50.6	50.7	50.6
Total	100% (n=435)	100% (n=383)	100% (n=818)

There is a significant relationship between family status and the individuals' age ($p < 0.001$). The number of people living alone or in couples increases with age, peaking in the 35-44 age bracket (38.7% of these people live alone and 22.1% in couples) and decreases above it. Conversely, **the number of people living with families or friends is highest at the upper and lower ends**, also peaking in the same 35-44 age bracket (39.2% compared to an average of 50.6% for the entire sample). All the minors surveyed live with relatives or friends except one, who lives alone.

Chart 6. Family situation according to age (in%).



Significant differences also exist from one survey country to another. In particular, more of the people questioned in Belgium and France live alone: 41.5% and 36.9%, respectively.

Table 9. Family situation according to survey country (in%)

	Lives alone	Lives in a couple	Lives with family, friends	Average
Belgium	41.5	24.5	34.0	100% (n=200)
Spain	30.7	20.6	48.7	100% (n=199)
France	36.9	11.4	51.7	100% (n=149)
Greece	15.6	6.4	78.0	100% (n=109)
Italy	25.8	17.4	56.8	100% (n=132)
Total	32.0	17.3	50.7	100% (n=821)

Family and housing situations are also directly related to each other ($p < 0.001$). **Nearly three-quarters of the homeless people live alone (73.4%)**, and just 2.1% are in couples. A higher percentage of people in precarious housing (31.4%) also live alone. Conversely, most people with a permanent address live with family or friends (55.7%).

Table 10. Family situation according to type of housing (in%)

	Lives alone	Lives in a couple	Lives with family, friends	Average
Permanent housing	23.2	21.1	55.7	100% (n=393)
Precarious housing	31.4	16.5	52.1	100% (n=328)
Homeless	73.4	2.1	24.5	100% (n=94)
Total	32.3	17.1	50.7	100% (n=815)

Nearly half the people surveyed have children (46.8% of those 15 and older). One minor has children: a 16-year-old Ecuadorian woman interviewed in Belgium.

The parents surveyed have an average of 2.5 children (between one and 10 children for the total sample), **but nearly three-quarters do not live with all of them (73.2%)**, either because the children are now on their own, the parents are divorced or separated, or the surveyed individuals' social situation keeps them from doing so²⁹. The number of children living with the people surveyed varies from 0 to 6, with an average of 0.8.

Table 11. Average number of children (whether or not living with those surveyed) according to age

	Average number of children	Average number of children living with them
16 - 24 years old	1.3	0.8
25 - 39 years old	2.0	0.7
40 - 49 years old	2.7	0.7
50 years old and over	3.9	0.9
Overall average	2.5	0.8

In distinguishing between people living with all their children and those living with some or none of them, a significant difference between men and women emerges. **Women living with all their children outnumber men (31.1% of the women over 15 with children compared to 19.5% of the men, $p=0.02$)**.

29. These are the hypotheses we have put forward, although this information was not directly collected in the questionnaire.

Likewise, and as might be expected, more of the youngest people (presumably having the youngest children) live with all their children ($p=0.08$), although *not* the majority: **more than half the parents under 25 (52.2%) do not live with all their children**. Only approximately one-fourth (26.5%) of parents under 40 live with all their children, and 72.5% live with some or none of them.

Table 12. Persons living with all their children according to age (in%)

	16-24 years old	25-39 years old	40-49 years old	50 years old and +	Average
Live with all their children	47.8	29.7	25.9	13.6	26.8
Do not live with all their children	52.2	70.3	74.1	86.4	73.2
Total	100% (n=23)	100% (n=158)	100% (n=81)	100% (n=66)	100% (n=328)

Slightly over one-fourth (26.0%) of the people surveyed live with at least one child, whether or not their own; the number of children in the surveyed individuals' household ranges from 0 to 10. The majority (66.4%) of those living with children have a stable address, but **nearly one-third live in precarious housing (31.3%)** and 2.4% (five people among the 211 concerned) are homeless.

In other words, 132 (31.1%) of the 425 children living with persons surveyed live in precarious housing and 20 (4.7%) have no permanent address (those children are from three families surveyed in Belgium and two in France).³⁰

Table 13. Surveyed individuals living with children broken down according to the number of children living with them and to their housing situation (in%)

Number of children	Permanent housing	Precarious housing	Homeless	Total
1	62.9	34.8	2.2	100% (n=89)
2	71.4	27.1	1.4	100% (n=70)
3	71.4	28.6	0	100% (n=35)
4	62.5	37.5	0	100% (n=8)
5	66.7	33.3	0	100% (n=3)
6	66.7	0	33.3	100% (n=3)
8	0	100.0	0	100% (n=2)
10	0	0	100.0	100% (n=1)
Average	66.4%	31.3%	2.4%	100% (n=211)

30. One 36-year-old man from Democratic Republic of Congo interviewed at the specialists' centre in Brussels stated that he is homeless but lives with 10 children.

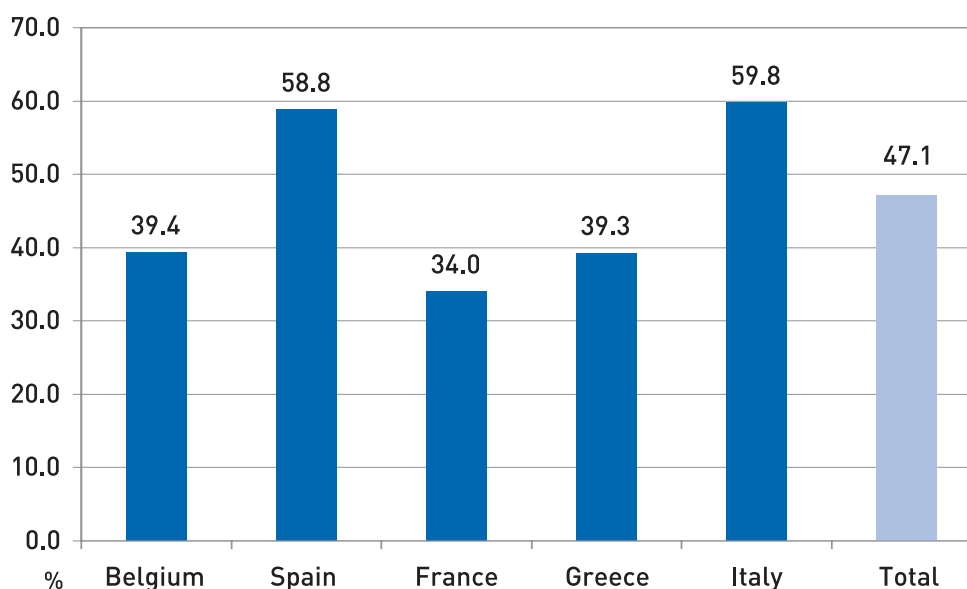
3. Employment

The surveyed individuals' job situations also reflect their precariousness. **Nearly half** of those 16 years old or over³¹ **have a job** (47.1%); there is no significant difference between men and women.

France, Greece and Belgium are where the least amount of surveyed people have a job: only 34.0% in France, 39.3% in Greece and 39.4% in Belgium have a job.

Nearly 60% have a job in Italy and Spain (59.8% and 58.8%, respectively), where undocumented labour and the informal sector are generally more developed than in France and Belgium³² (especially in traditional industries such as farming, construction, hospitality, catering and seasonal tourism, but also emerging ones like homebound assistance³³). It is possible, consequently, that such activities are more easily declared by the persons surveyed compared to other countries.

Chart 7. Proportion of people surveyed with a job, according to the survey country (in%).



“The only jobs I found had awful working conditions. I’ve even been offered work as a prostitute.”

Excerpt from an MDM Spain interview with a 50-year-old woman from Uruguay:

“Political conditions in Uruguay in 2004 made it impossible for people to leave the country. I had the necessary papers for living in Spain because I have Basque and Galician ancestors. I have a university degree and good work experience. That’s why I thought, for the good of my children and my own, a better future awaited me in Spain. I knew it wouldn’t be easy at the age of 49, but I was healthy enough to start a new life. I decided to come alone at first and leave my children with their father with the idea of bringing them over once my situation was stable.

I got on a plane and arrived in Tenerife on 25 January 2004 with 50 euros in my pocket. I found a job as a kitchen aid even though I have no experience in that area. Eight months later I got in touch with some people from Galicia and could finally afford a ticket to go there. Even though I’m South American and my ancestors came from Spain, I was treated the same as any other immigrant from Morocco or sub-Saharan Africa... The only jobs I found had terrible working conditions. I’ve even been offered work as a prostitute. With help from various NGOs (Medicos del Mundo was the first NGO I knew), I obtained the necessary information for papers, health insurance, aid, services and the personal and emotional support you often need when you’re in a borderline situation. Those groups helped me cope with many of the administrative hurdles I stumbled over; complications getting the health card, problems with my papers, which were often rejected when I requested services (...)

31. No minor under 16 in the sample works.

32. Tapinos G. Immigration et marché du travail. L’Observateur de l’OCDE, no. 19, December 1999.

33. Garson JP. Où travaillent les clandestins? L’Observateur de l’OCDE, no. 219, December 1999.

4. Income

It is difficult to use the question about the survey household's income because of the high refusal rate (or frequency of missing data) in some countries, owing primarily to the centres' experience and practice of this question. Some centres (in Greece and France for example) systematically ask all their patients this question, whereas in other countries the fact that obtaining medical coverage depends on means makes the question eminently sensitive and biased (in Belgium for example).

Overall, 55.7% of those surveyed answered this question, and among the respondents the average disposable monthly income is €205 per consumption unit³⁴. The (declared) income is zero for 22.4% of the people who answered the question and half the individuals surveyed reported a monthly income per consumption unit below €145.

For the reasons mentioned above, the no-answer rate is high in Spain (84.4% of those surveyed did not answer), Belgium (82.7%) and Portugal (58.8%) and **income data is usable only in France** (62.5% answer rate), **Greece** (67.0% answer rate) **and Italy** (83.1% answer rate). In those three countries, the responses must nevertheless be interpreted with the usual caution because of their declarative character (deliberate or involuntary omission of income from undeclared, undocumented or illegal activities, occasional financial help, lack of knowledge about the income of other household members, etc.).

Table 14. Income per consumption unit (CU) of persons answering the question about income in France, Greece and Italy

	France	Greece	Italy
Median monthly income per CU	€50	€118	€135
Average monthly income per CU	€133	€171	€172
% of people with no income	39.2%	14.7%	7.1%
% of people below the poverty threshold (Eurostat 2004)	97.3%	92.6%	98.0%
N	95	75	113

The poverty threshold chosen is the same as the one Eurostat calculated in 2004³⁵, corresponding to 60% of the median income in each of the countries. According to that definition, 92.6% of the persons questioned in Greece, 97.3% in France and 98.0% in Italy live below the poverty threshold (in 2005-2006). The 2001 poverty rates were 21% in Greece, 19% in Italy and 12% in France.³⁶

Almost everybody surveyed lives below the poverty threshold in the three countries where the question could be processed (the rest have incomes close to that level).

“I don't want to steal”

MDM Portugal described the situation of a 24-year-old Moroccan man:

” *This young man has a very weak constitution. He talked to us about his situation with a sense of humour. Two years ago, he told us, he and a group of friends, who he has already lost sight of, climbed into a boat full of people in Morocco and landed in Spain “without any problems”. He spent approximately one year in Spain, picking fruit and working in the construction industry. At one point he was jobless for a month or two, so he came to Portugal. He entered Portugal with someone he knew. He has been in the country for a month. The police, which is always checking his papers, is what he complains about most. Now he's unemployed and living in the streets. He says he does not like having to do odd jobs, “parking cars”, in order to eat, and he has no bad habits. “I don't want to steal,” he says. He still goes to the “vans” [that hand out free meals] for dinner.*

34. The number of consumption units in a household was calculated by applying a standard scale: the household's first adult represents one unit, the other adults 0.7 and the children 0.5.

35. Respectively, €762 per consumption unit (ICU) in France, €442/ICU in Greece and €635/ICU in Italy (Eurostat data for a single-person household, 2004 estimates).

36. Guio AC. Pauvreté monétaire et exclusion sociale dans l'UE25. Eurostat, Statistiques en bref, 2005, n° 13.

5. Administrative status

The amount of time spent in the survey country without a residency permit varies widely, ranging from one month to 24 years; the average is two years. The median is 13 months, which means that half of those surveyed have lived in the country without authorisation for less than 13 months.

France has the highest proportion of people present for over 10 years (3.8%): individuals who, victims of the iniquity of French law, can not be expelled but they also cannot obtain a residency permit.

In the entire sample, **22.2% of those surveyed have received an order to leave the country.** That figure is highest in Belgium (40.6%). By and large, the longer they stay in the country without authorisation, the higher the chances they will receive an order to leave. More men than women have received such an order (26.7% compared to 16.8%, $p=0.001$).

Table 15. Length of unauthorised residence according to country (in%)

	Belgium	Spain	France	Greece	Italy	Total
Under 3 months	3.3	20.1	13.0	20.2	7.6	12.7
3-6 months	10.6	23.3	27.5	19.2	7.6	17.6
7-12 months	10.0	25.2	22.1	27.3	25.4	20.6
1-3 years	41.1	26.4	21.4	20.2	46.6	31.4
4-10 years	34.4	5.0	12.2	12.1	9.3	16.0
over 10 years	0.6	0	3.8	1.0	3.4	1.7
Total	100% (n=180)	100% (n=159)	100% (n=131)	100% (n=99)	100% (n=118)	100% (n=714)

“They found out we had applied for asylum in Greece and expelled us here (...). They can’t understand that we’ll be killed if we go back to Afghanistan.”

Excerpt from an MDM Greece interview with a 28-year-old woman married to a man 14 years her senior and mother of a two-year-old girl.



She is from a village near Kabul, Afghanistan.

“I lived with my parents and never had any problems. Until I was 23, I was engaged to a man 10 years older than me. His father is the political chief of my village. That man behaved very badly. He was jealous and often beat me. At a political meeting three years ago, I met my husband, who was the head of the rival party. When I told my fiancé that I wanted to break off our engagement, he flew into a rage and swore he’d kill me. At first I didn’t believe him, but when strangers beat up my brother and husband we decided to leave.

We wanted to go to England, where I have relatives. On some friends’ advice, we decided to go by way of Turkey and Greece, paying some “friends”.

The first part of the journey was a nightmare. We changed buses several times and sometimes they put us in trucks. After a week we reached the Turkish coast across from Greece. Then, three weeks later, they put us in a little boat. There were around 50 of us and they told us that we’d be in Greece the next day. The crossing was at night and they told us it was completely safe.

But it was November and it was very cold and the sea was rough. Six hours later, a Greek coast guard vessel forced us to disembark on an island called Kos. They gave us food and warm clothes and asked us if we wanted to request political asylum. Unfortunately our friends had given us bad advice and we said yes.

We were on Kos for 10 days before going to Athens, where we stayed for six months. Then we paid people of another nationality who took us to Patras and promised to send us to England by way of Italy and France. A week later, they hid us in a truck and the next day we arrived in Bari, Italy. We took the train from there to the border, which we walked across at night. In France, we were driven by car to Dijon, where

we hid for around 20 days.

Twenty days later, they put us in a truck and drove us to Calais. Then we took the train and reached England at last.

I thought that was the end of the nightmare. We lived with my aunt and uncle in London. My daughter was happy, and my uncle took care of getting our papers in order.

Three months later, we were walking down the street minding our own business when the police stopped us during a routine check. As long as somebody was taking care of our papers, they told us, we had nothing to worry about.

But there was a problem, a serious one... They found out that we had applied for asylum in Greece and they expelled us from the UK to Greece [following the Dublin II procedure³⁷]. The Greeks told us that once we left the country our request for political asylum was no longer valid and that we had to leave Europe and go home. They couldn't understand that we'd be killed if we went back to Afghanistan."



37. The community regulation (343–2003 of 18/02/2003, called Dublin II because it followed the Dublin Convention) stipulates that only one State processes the asylum request: the country that issued a visa or that the applicant entered in the "Dublin zone", in other words the EU Member States plus Iceland and Norway.



3. Access to health coverage

Different countries have different names for the documents entitling their bearers to health coverage. It might be called a health card, social security card, *health care system card*, *medical help card* or *certificate*. For simplification's sake, and to make reading this report easier, we have chosen to use the term *health coverage*.

The various European countries' laws regarding undocumented migrants' access to health care coverage vary widely. Some are highly restrictive and entitle them to almost no rights (for example in Greece), whereas others are more generous.

We want to emphasize that everyone living in a country must have effective access to appropriate prevention and treatment. In Europe, that means health care coverage that is free for the most vulnerable populations, i.e., those without the financial means to meet their health care expenses. As the European Social Charter states in article 13, "*anyone without adequate resources has a right to social and medical assistance*".

1. Theoretical health coverage rights

Among the persons questioned, **78.3% are theoretically, according to the law, entitled to health coverage**, with no significant difference based on sex. The figure masks major disparities between the survey countries - and most of those surveyed live in countries where legislation on this point is the most favourable for undocumented migrants.

Greece is a special case because under the law undocumented migrants have no right to health coverage, with the exception of a few particular situations (perinatal care and treatment of certain infectious diseases). Only 6.9% of those surveyed are theoretically entitled to health coverage.

In three countries, the persons questioned are theoretically entitled to health coverage including access to free treatment: Belgium, Italy and, to a lesser degree, France where 10% of the population surveyed does not have that right.

- In **Belgium**, "*Aide Médicale Urgente*" (AMU, Emergency Medical Assistance) is theoretically recognized as a right for all undocumented migrants with inadequate resources and a health condition that a doctor has certified as requiring emergency care. AMU pays for all the treatments listed in the national health insurance scheme.
- In **Italy**, all undocumented migrants theoretically have access to "emergency" or "essential" care in public or approved hospitals as well as to preventive medicine programmes and services relating to pregnancy and childbirth (upon presentation of a special health card issued by all hospitals, even if the patient has no proof of identity). If they declare themselves to be destitute when the health card is issued (without having to provide proof), they must pay a contribution towards the cost of certain medical treatments. However, pregnant women, children under 6 and persons over 75 are entitled to free emergency care and treatment.
- In **France**, undocumented migrants have access to "*Aide Médicale Etat*" (AME, State Medical Assistance) if their income is below €587 (in 2005) but only if they can prove that they have resided in the country for at least three months and have a home address³⁸. AME pays the entire contribution towards medical treatment and the cost of a public hospital stay with a total advance of the expenses. Only dental prostheses and eyeglasses are not covered.

³⁸ Applying for AME requires proof of address. All the patients unable to provide proof in their name (rent receipt, electricity bill, etc.) must provide an administrative domiciliation.

In Spain, 70.4% of the persons questioned are entitled to health coverage but those not on the municipal registers on the day of the survey were not counted as potential beneficiaries. That figure appears lower than in Belgium, Italy and France but basically reflects issues of registration on the municipal registers³⁹.

Registration with the municipal authorities is necessary to obtain the health card granting free access to care in Spain. That procedure does not require legal residence but since 2003 the other administrations (including the police) have been able to obtain data from municipal files, which dissuades some undocumented migrants from registering⁴⁰. Treatment given as part of the national health service is free.

In Portugal, entitlement to health coverage requires presenting a certificate attesting residence in the country for at least three months, which can be issued based on oral statements by two people (whoever they may be) regardless of their administrative status on Portuguese soil. But people who have been sentenced to a jail term lose that right, which means health care access problems for foreign nationals just out of prison. Holders of the social security card issued by the national health service must pay part of the costs. Some people, including those without means, can be exempted from paying a contribution towards their health care, but they must be able to understand and follow complex procedures.

In the United Kingdom⁴¹, undocumented migrants' access to free health care is limited to primary care (general medicine consultations, emergency care, treatment for certain infectious diseases and severe psychiatric pathologies). These people have no free access to additional tests (including screenings), specialised care and pharmaceutical expenses.

You have to look poor to receive health coverage.

Testimonial gathered by an MDM doctor in Belgium:

” At first glance, she didn't look anything like somebody in a difficult situation. With her nice clothes and hair, she could have been taken for the head of a department. When you speak to her, the illusion is replaced by sadness, even compassion.

“Everything hurts, I don't know who I am anymore.” Period. And her face hardened. She seemed to be hiding something when I introduced myself to her. Oh, it's just a mobile phone. At first I didn't understand why she looked so embarrassed, but anyway...

Her husband died when she was 37. Six years ago she had to flee armed conflict in the Caucasus, leaving her family and job as a primary school teacher. She's been wandering across western Europe ever since. Health problems eventually caught up with S., who walked into the MDM office. By now we've lost count of how many times she's been in to see a doctor, and the reason is always different. She lives alone in a space negotiated by a friend. The only thing she owns is her mobile phone. Her friend loans her clothes when she has a doctor's appointment.

When asked why she hasn't applied for emergency medical assistance, S. replies, “They asked me to give them my home address but I have no papers and so I'm not entitled to housing. And the friend who negotiated the lease doesn't want any problems.”

S. lost the only theoretical right she had to access to State health coverage because of technicalities. And that's not all. During her last appointment with the CPAS⁴² social worker two years ago, she was considered 'not indigent enough for emergency medical assistance'. The reason: 'You're too well dressed and you can even afford a mobile phone!' Now I understand.

S. no longer believes her life will get better and continues her ordeal in silence, amidst total indifference.

She has a neoplasm on her neck...

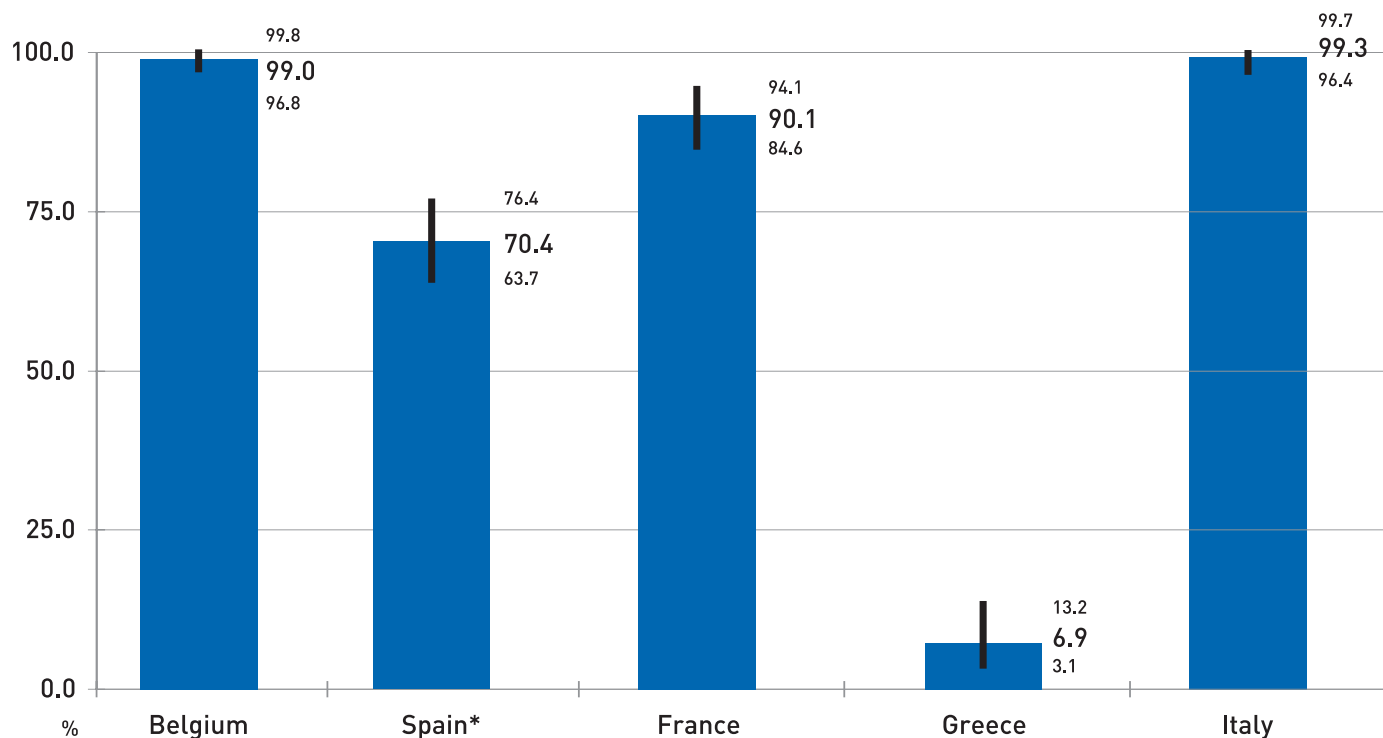
39. The surveyors in Spain and France therefore interpreted the issue of a theoretical entitlement to health coverage differently. In Spain, foreigners who have not registered at city hall were considered illegal, whereas in France those who failed to carry out the necessary procedures but could have health coverage if they did were deemed as theoretically having access to health coverage. The absence of domiciliation in France was considered an obstacle.

40. L'accès des étrangers en situation irrégulière au système de santé. The working documents of the Senate, no. LC I 60, March 2006.

41. Specific data unreported due to the low number of people surveyed

42. CPAS: Centre Public d'Action Sociale

Chart 8. Proportion of people surveyed theoretically entitled to health coverage by country



* In Spain, 100% of the people are theoretically entitled to health coverage if they've registered with the municipal authorities, which is a prerequisite for obtaining the health card providing free access to care. The chart above shows that just 70.4% of the persons questioned are entitled to health coverage because individuals who were unregistered on the day of the survey were not considered potential beneficiaries.

Note to the reader: the chart gives the proportion observed in the sample (wide bar) and the confidence interval at 95% (black line) for each country. For example, 90.1% of the persons surveyed in France are entitled to health coverage, and the statistical confidence interval of the percentage observed ranges between 84.6% and 94.1%.

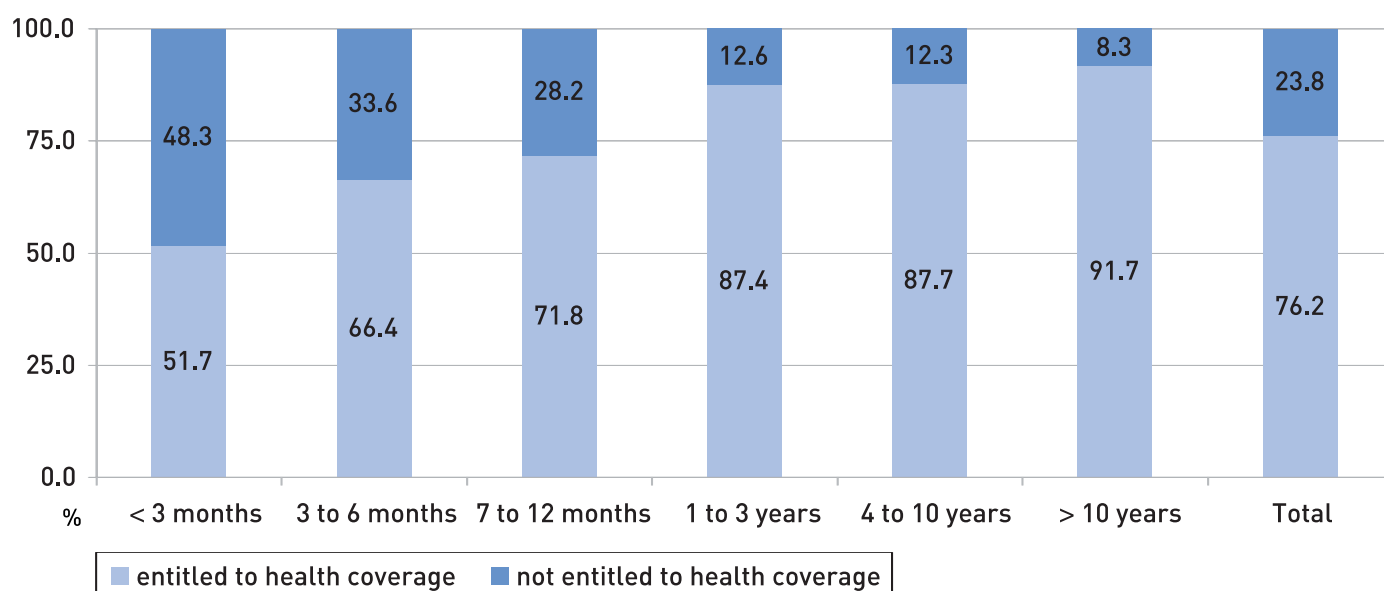
The possibility of entitlement to health coverage is strongly correlated with the length of time lived in the host country: people who are theoretically entitled have lived longer in the country on average than the others (37.5 months and 23.2 months⁴³, respectively, $p < 10^{-6}$).

It also differs significantly depending on the length of unauthorised residence in the host country.

- **Nearly 90% of the persons questioned residing in the host country without authorisation for over one year are entitled to health coverage.**
- Only 66.8% of those residing in the host country less than one year are entitled to such coverage: one-third of "illegal" immigrants, then, have no way of accessing health care during the first year of residence.
- **That proportion falls to 48.3% during the first three months of unauthorised residence in the host country.**

43. Respective medians: 29 and 12 months.

Chart 9. Proportion of persons theoretically entitled to health coverage depending on length of unauthorised residence in the host country.



2. Effective access to health coverage: the obstacle of information

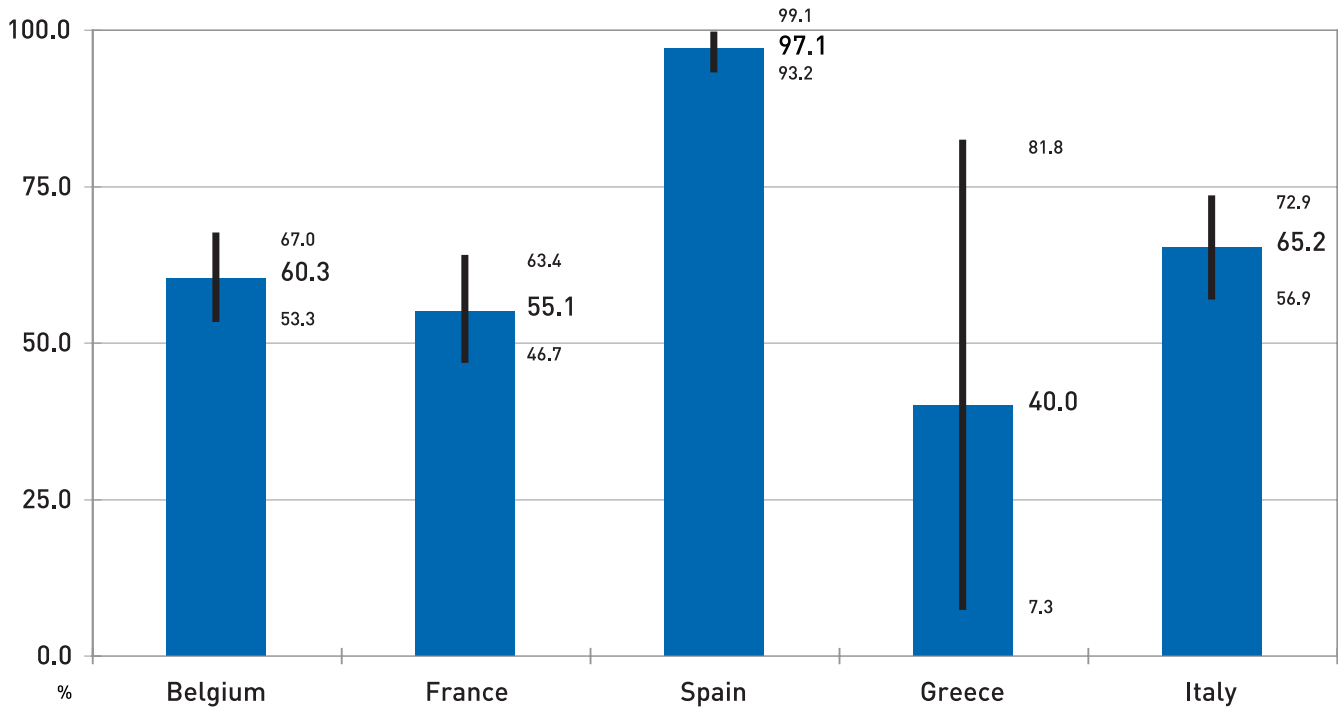
Having a theoretical right to health coverage does not automatically mean that people know it or that they have actually been able to take advantage of that right. The survey brought to light significant differences between countries.

In all the survey countries, **only two-thirds of the people theoretically entitled to health coverage are aware of that right** (67.8%). On the day of the survey, 32.2% of those questioned were uninformed about their right to health coverage.

Spain is the survey country where the persons questioned are the best informed about their right to health coverage (nearly all the theoretical beneficiaries). In Italy, approximately one-third of the beneficiaries do not know that they are entitled to health coverage. That figure rises to 40% in Belgium and 45% in France. **In Belgium and France, then, the right to health coverage seems poorly known particularly often.** The number of persons surveyed in the United Kingdom and Portugal was too low to interpret the data (the confidence intervals are extremely wide). In Greece, the point is moot because the overwhelming majority of those surveyed have no rights.

Most people aware of their right (76.9%) have begun taking the necessary steps to obtain health coverage in practice.

Chart 10. Proportion of persons aware that they are entitled to health coverage (among the theoretical beneficiaries) by country.



Note to the reader: the chart gives the proportion observed in the sample (wide bar) and the confidence interval at 95% (black line) for each country. For example, in Belgium, 60.3% of the people theoretically entitled to health coverage are aware of that right, and the statistical confidence interval of that percentage observed ranges between 53.3% and 67.0%.

Nearly half (43.5%) the people potentially entitled to health coverage have not begun taking the necessary steps to obtain it, mainly because they lack information and help with completing the procedures involved.⁴⁴

Awareness of one's rights is a necessary pre-condition for obtaining them. That is why the dearth of information about the right to health coverage observed in Italy, Belgium and France is a serious matter.

“He thought he was no longer entitled to consult a doctor for free”

MDM United Kingdom testimonial about a 42-year-old man from Democratic Republic of Congo whose application for asylum was rejected:

” After demonstrating against the government, R. was imprisoned for his political activities. Fearing for his life, he escaped from jail. With help from friends, he used somebody else's passport to leave the country. It took him two to three months to plan his departure from the time he escaped from prison and the day of his flight. In January 2000, R. arrived in the United Kingdom by way of France. He had flown to Paris before taking the bus for Dover, where he asked for political asylum the day he arrived. The journey from DRC to the United Kingdom took two days. He was in touch with someone living in London and went there the next day. R. should have made another appointment within two weeks after his first request, but didn't. His request for asylum was rejected in September 2002. The organisation following his case at the time did not support him. Now R. has a new lawyer and together they're trying to gather fresh proof for another request. However, it's really difficult to get in touch with people in DRC and to ask them to send proof without putting their lives in danger. He receives no assistance from the government and survives only with help from friends and churches. He's happy if he receives 30 pounds a month. R. has been in the United Kingdom for over six years now and his undocumented situation makes him anxious and depressed. .../...

44. 23.1% of the people aware that they are entitled.

In 2001, a friend helped him register with a GP and he went there. Since in September 2002 he had been told that he would receive no help from the government, he thought he no longer had the right to consult a doctor for free and that he had to pay for his care.

We told R. that he could still see a GP even though his request for asylum failed. We checked to see if he was on the list of the GP in question and since he was, we advised him to go back and assured him that he wouldn't have to pay for the appointment. Since R. lacks self-confidence and speaks English poorly, we also arranged for him to have a Linguala interpreter through the local health authority to help him at the GP's.

R. was sent to us by Praxis⁴⁵, which gave him support. They helped him fill out a request for psychological assistance through a medical foundation for the care of torture victims.

When I asked R. what he thought of the help we were offering him, he gave me this answer: 'Whatever the doctor does, the fact that he takes an interest in my pain really makes me feel good.'

Most patients seldom have an opportunity to be listened to and at the same time they have a tremendous need to ease their pain. Taking an interest in their problems and giving them the time and space to be listened to is part of the help we provide.

Since we saw R. in 2006, he has had an appointment with his GP and told us that he has received all the care and treatment he needs. He has already scheduled another appointment. An organisation has helped him obtain a residence permit because he can claim amnesty. He's waiting to hear from the Home Office.

We asked him what he thought our help. This is what he told us:

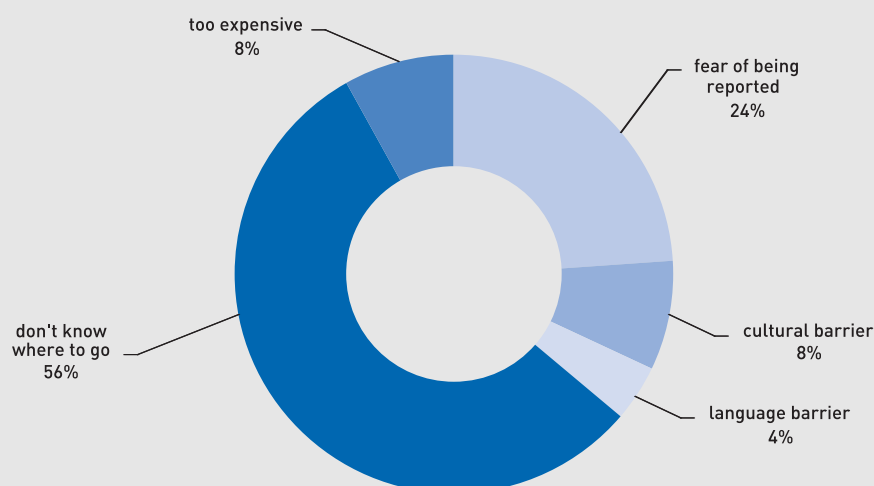
'It helped me a lot. I don't know if I would've had access to care today. I feel relieved. I was worried about becoming ill and not being able to see a GP. Even if you go to the hospital they ask you if you have a GP and what his name is. If you've got one it's much better. It really helped me.'

Another example of the lack of information: childhood immunisation

Lack of information about access to free health care is also glaring with regard to childhood immunisation.

- Only a slim majority (53.5%) of the population concerned by this issue (and that answered the questions about immunisation) knows their child is entitled to free vaccination⁴⁶ and/or where they can obtain information about it (51.5%).
- The main obstacles to immunisation reported in the survey include lack of knowledge about where it is available (56%) and fear of being reported to the authorities (24%).

Chart 11. Obstacles to immunisation



45. Partner organisation

46. In Italy, half the people concerned know that immunisation is available for payment but only four people answered the question.

Fear of arrest runs high even when having children immunised, as comments that MDM Netherlands gathered from a 20-year-old from the Philippines attest:



E. registered her child at the town hall, so she received a call from the public health service to have vaccinations performed. She really had to look for the place to have her child immunised. She recalls being careful because the fear of being arrested was omnipresent. 'But fortunately today my child is vaccinated,' she told us.

3. Effective access to health coverage: the obstacle of administrative procedures

On the day of the survey, nearly half the people who had begun taking steps to obtain health coverage had no document effectively entitling them to free care (44.6%). There is no correlation with the length of residence in the host country or the person's age and sex.

The proportion varies widely from one country to another. **The situation is best in Italy and, to a lesser degree, Spain**, where 97.4% and 80.0%, respectively, of the people who have started taking the necessary steps have received a document entitling them to free care.

It is much more critical in France and Belgium, where only a minority of the people who have started taking steps to obtain health coverage were successful on the day of the survey (18.0% in France and 26.7% in Belgium). The situation is connected to many factors, in particular the complexity of administrative procedures. In France for example, it takes a relatively long time to process applicants' files. So does the time it takes to send the certificate by post (which is all the more problematic when the housing situation is precarious).

Whether they lack information about their rights, or because the administrative procedures have produced no results or are still under way, 69.4% of theoretical beneficiaries do not actually have (on the day of the survey) access to health coverage entitling them to free treatment in the mainstream health care system. Stated otherwise, **less than one-third of potential beneficiaries effectively have access to health coverage**.

In the entire sample, an average of just **24.0% of the persons surveyed actually have health coverage**.

4. Who does not take advantage of health coverage, even though they are entitled to it?

What characterises the people who, although theoretically entitled to health coverage in the mainstream system, have not obtained the certificate proving that they have that right? There are **no significant differences according to sex, family status or employment situation**. With regard to age, **people 55 years old and older are in a critical situation**: just 10.0% are in possession of a certificate entitling them to health coverage (that proportion is approximately one-third for adults in other age groups⁴⁷).

Among the theoretical beneficiaries, **homeless individuals are the least likely to obtain a certificate entitling them to health coverage**: just 25.4% of homeless persons have obtained it, compared to 31.7% of the people living in precarious housing and 31.8% of those who have stable housing. That difference underscores the importance of being settled, a necessary condition for obtaining rights in several countries.

The amount of time spent in the host country without a residence permit is another factor. Among the theoretical beneficiaries, **the people with the least coverage are those who recently arrived (or who have recently lost their residence permit) and those who have been settled the longest**.

47. None of | | children concerned has a document entitling them to health coverage..

Some 75.0% of the people living in the host country without a residence permit for less than a year have been unable to obtain the right to health coverage. The figure rises to 84.9% when the unauthorised stay is four years or longer (significantly, $p < 0.001$). That probably reflects a **selection bias**. Among the people who have been in the host country more than four years (which MDM sees much more rarely), most of those who still visit free clinics have no health coverage. Otherwise, they would already have joined the mainstream system.

To conclude this part of the report, we will compare access to health coverage and the individuals' health. Just 24.0% of the people surveyed have health coverage entitling them to free mainstream health care (meaning outside humanitarian organisations). That figure is probably higher among people with particular health issues, but many of them still have no health coverage. Some **43.8% of the surveyed individuals suffering from chronic conditions are not actually covered**. When health problems are not chronic, that figure rises to 59.1%.

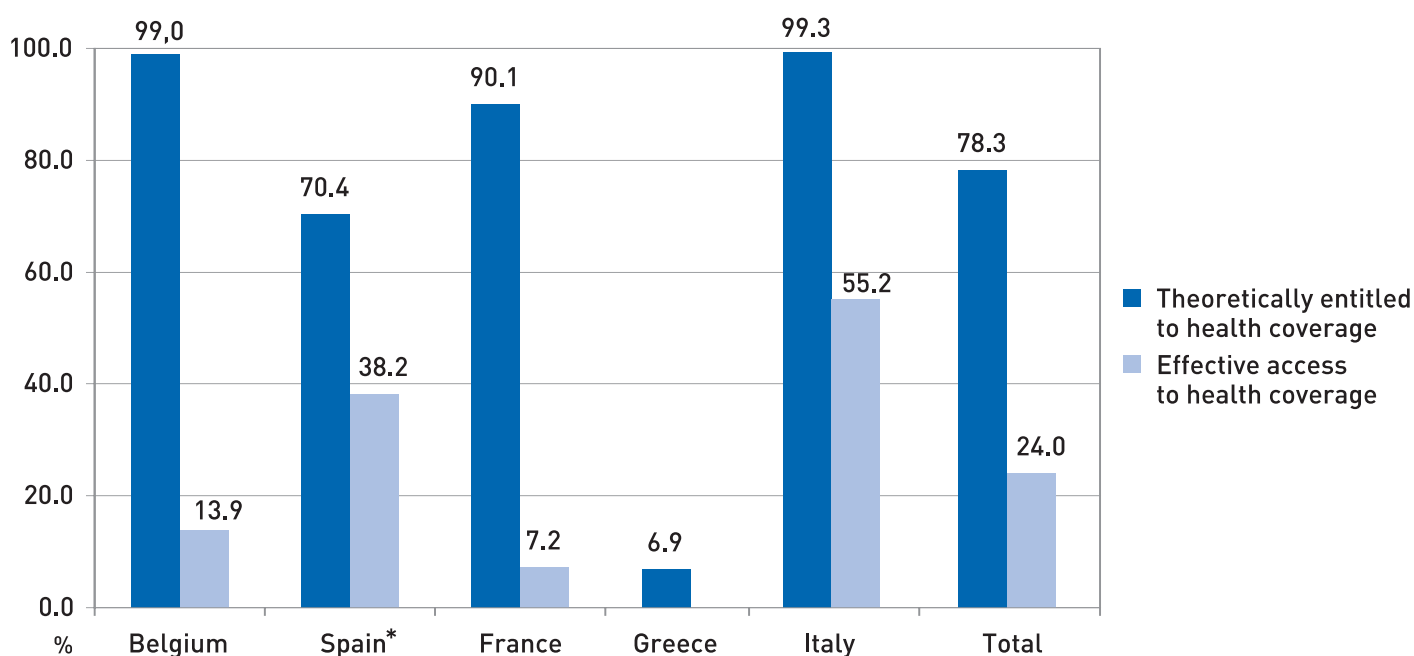
5. Summary by country

Differences between countries (following charts) must be analyzed with caution. The case of Greece is hard to interpret because of extremely wide statistical confidence intervals. The proportion of people theoretically entitled to health coverage there is extremely small and the proportion of those who actually have it is, consequently, based on a very limited number.

The other four countries that stand out are:

- **Belgium and France, where only a tiny minority have been able to effectively claim their right to health coverage:** 13.9% in Belgium (CI95% = [9.7–19.3]) and 7.2% in France (CI95% = [4.3–13.5]);
- **Spain and Italy, where theoretical beneficiaries who have been able to claim that right are more numerous:** respectively, 38.2% in Spain (CI95% = [31–45.4]) and 55.2% in Italy (CI95% = [47.1–63.8]).

Chart 12. Proportion of people entitled (theoretically) to health coverage and of people who actually have access to it (in%)



* Reminder: In Spain, 100% of the people are theoretically entitled to health coverage if they've registered with the municipal authorities, which is a prerequisite for obtaining the health card providing free access to care. The chart above shows that just 70.4% of the persons questioned are entitled to health coverage because individuals who were not registered on the day of the survey were not considered potential beneficiaries.

Overall, then, several types of countries can be said to exist:

1. Countries where almost all the undocumented persons are theoretically entitled to health coverage but only a tiny minority of those surveyed actually take advantage of that right: **Belgium** and **France**;
2. Countries where almost all the undocumented persons are theoretically entitled to health coverage and a sizeable proportion take advantage of it (but never more than half the theoretical beneficiaries): **Italy**, **Spain** and **Portugal** (although the number of people surveyed is too small to accurately estimate how many exercise their rights);
3. The **United Kingdom**, where undocumented persons only have access to consultations with a GP and other treatments (including complementary examinations and treatments) are usually not covered.
4. **Greece**, where theoretical rights are the most restricted and the least accessible in practice (none of the few theoretical interviewed beneficiaries have access in practice).



4. Health



1. The most recent request for care: reasons and recourse

This question does not concern 38% of the people surveyed because they stated that they have not felt ill (37%) or did not answer (1%).

When they felt ill, slightly over three-quarters of the people surveyed saw a doctor or dentist (76.0%) and 19.5% did not consult anybody.

The other types of recourse to treatment are anecdotal (even if recourse to traditional practitioners might have been under-declared, as it is the case in every survey where the main focus is the recourse to modern medicine).

Table 16. Types of recourse during the most recent request for care

	%(n=517)
Did not consult anybody	19.5
Saw a doctor or dentist	76.0
Saw a nurse	1.2
Saw a traditional practitioner	0.4
Saw a neighbour, friend, relative	3.9
Phoned a doctor in the home country	0.8
Saw a doctor in the home country	1.0

* several answers possible

“I’m forced to ring up a doctor friend in Ukraine”

Excerpt from an interview by MDM Belgium:

”

“When I’m not feeling well, I’m forced to ring up a doctor friend in Ukraine. I describe my symptoms to her (by telephone) and she tells me what medicine to buy at the pharmacy... which I’m not reimbursed for.”

The most recent health problem⁴⁸ broken down by system reveals the preponderance of five main types:

- digestive (20.1% of the problems mentioned and 12.0% of the people),
- musculoskeletal (13.7% and 8.1% respectively),
- respiratory (10.0% and 6.0% respectively),
- gynaecological (8.8% and 5.3% respectively)
- the “general and non-specific” category (which covers a miscellaneous group of symptoms and diseases⁴⁹) accounts for 15.3% of the problems mentioned and 9.1% of the people.

48. The doctors used the International Classification of Primary Care (ICPC) to encode the health problems.

49. This category groups together all the diseases and symptoms that cannot be classified by system or organ group according to the overall logic of the ICPC.

For example it includes:

- general symptoms (fever, pain),
- general characteristics (in particular risk factors),
- infectious diseases (tuberculosis, measles, chicken pox, etc., when they are not classifiable as diseases of the liver – viral hepatitis – or of the immune system – HIV infection for example),
- cancer when the original cancer is not diagnosed,
- multiple traumas, system side effects of drugs, non-pulmonary and non-coetaneous allergies, etc.

Table 17. Most recent health problem mentioned, by system

	Proportion of all the problems mentioned (n=503) %	Frequency in the survey population (n=835) %
Digestive	20.1	12.0
General and non-specific	15.3	9.1
Musculoskeletal	13.7	8.1
Respiratory	10.0	6.0
Gynaecological	8.8	5.3
Neurological	6.8	4.1
Psychological	6.0	3.6
Cardiovascular	4.4	2.6
Dermatological	3.6	2.2
Metabolic, endocrinal, nutritional	3.0	1.8
Ophthalmological	2.8	1.7
Pregnancy, childbirth and family planning	2.0	1.2
Urinary	1.8	1.1
Ear	1.0	0.6
Male genital system	1.0	0.6
Blood, hematopoietic and immunological system	0.6	0.4

On a more detailed level, 27 diagnoses account for half of the most recent health problems reported. The following table shows their frequency.

Table 18. Distribution of the top 27 most recently mentioned health problems

	n*	% of the survey population (n=835)
HIV infection⁵⁰	33	7.1
Abdominal pain	25	5.4
Headache	24	5.2
Flu	13	2.8
Asthma	12	2.6
General pain	12	2.6
Tooth or gum S/C**	12	2.6
Back S/C	10	2.2
Genital pain in women	9	1.9
Acute stress reaction	8	1.7
Fever	8	1.7
HBP without complications	7	1.5
Insulin-dependant diabetes	7	1.5
Drug abuse	6	1.3
Benign genital tumour in women	6	1.3
Loin S/C	5	1.1
Knee S/C	5	1.1
Dorsal-lumbar pain without irradiation	5	1.1
Menstrual pain	4	0.9
Dysuria or painful miction	4	0.9
Epilepsy	4	0.9
Viral hepatitis	4	0.9
Urinary calculus disease	4	0.9
Cough	4	0.9
Gastric disorder	4	0.9
Peptic ulcer	4	0.9
Acute angina	4	0.9
Total	243	52.5

*raw ICPC coding, without grouping

** S/C: symptoms or complaints

50. The high prevalence is partly due to the fact that some of the individuals were previously diagnosed with HIV and also because two survey sites in Belgium were focussing on helping HIV infected persons – see paragraph IV. 5. HIV infection

In all, **70.8% of the people affected by a health problem took drugs prescribed by a doctor, 13.2% resorted to self-medication and 15.9% had no care.** No statistical correlation has been observed between the treatment used and the fact that a request for free care was rejected.

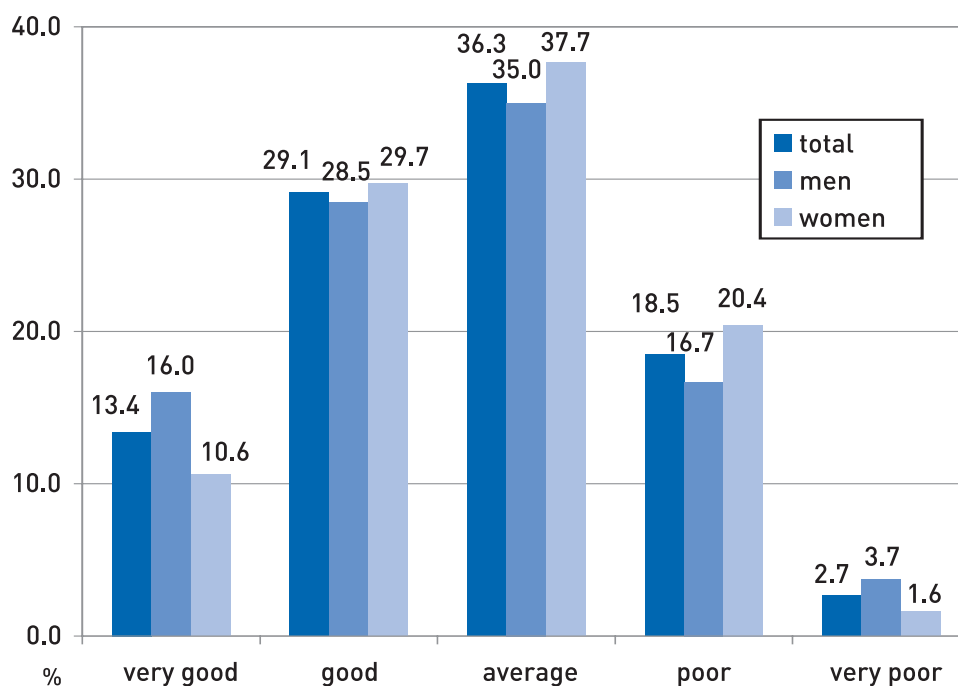
Some 85.5% of the respondents who took drugs acquired them in the survey country, 2.9% in their home country and a tiny minority (1%) in a third country.

2. Perceived health and current health problems

By and large, the few available surveys show that migrants' health differs from that of the host countries' populations, but the explanations are many. Their living conditions (housing, work, social isolation, etc.) expose them to bigger health risks. For example, most undocumented migrants accept work (out of economic necessity and fear of drawing attention to themselves, losing their jobs or being expelled) exposing them to many occupational illness and accident hazards, in particular toxic substances, long working hours, communication problems and limited supervision and protection, especially since they mostly are unaware of their rights⁵¹. Furthermore, there is a "selection" by migration, in the sense that healthy people are usually those who voluntarily leave their countries of origin⁵².

In the entire population surveyed, 21% of the respondents perceive their health as poor or very poor. As usual in surveys on the perception of health, women feel that theirs is slightly worse than men's.

Chart 13. Perceived health according to sex



51. World Health Organisation. *Migrations Internationales, santé et droits humains*. Geneva, WHO, 2005.

Carballo M, Siem H. Migration, Migration Policy, and AIDS. In: Haour-Knipe M, Rector R, eds. *Crossing Borders: Migration, Ethnicity and AIDS*. Bristol, Taylor & Francis, 1996.

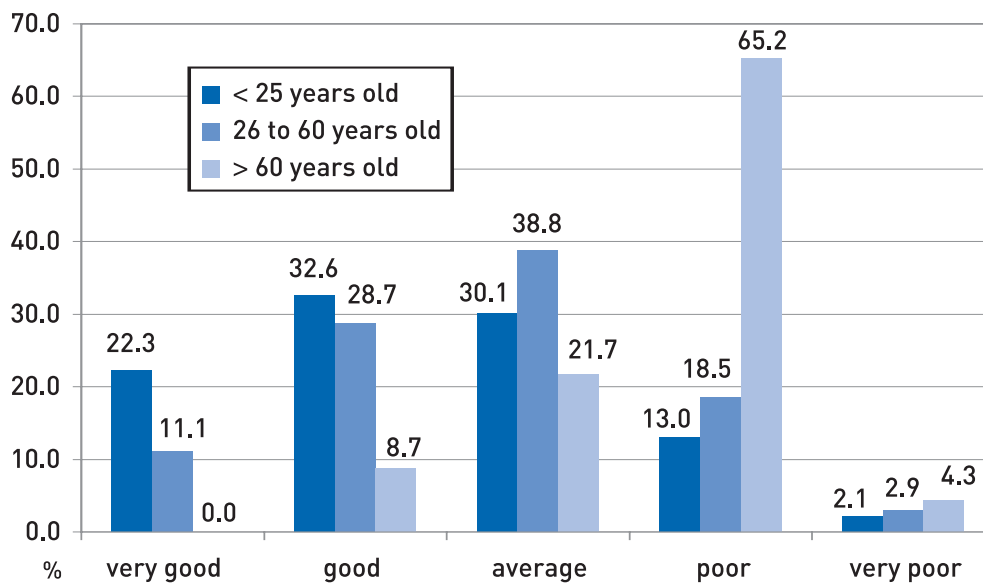
52. Khlal M, Darmon N. Is there a Mediterranean migrants mortality paradox in Europe? *Int J Epidemiol* 2003; 32: 1115-8.

Uitenbroek DG, Verhoeff AP. Life expectancy and mortality differences between migrant groups living in Amsterdam, The Netherlands. *Soc Sci Med* 2002; 54: 1379-88.

Razum O, Zeeb H, Akgun HS, Yilmaz S. Low overall mortality of Turkish residents in Germany persists and extends into a second generation: merely a healthy migrant effect? *Trop Med Int Health* 1998; 3: 297-303. Powles J. The best of both worlds: attempting to explain the persisting low mortality of Greek migrants to Australia. In: Caldwell J, Findley S, Caldwell P, Santow G (eds). *What we Know about Health Transition: the Cultural, Social and Behavioural Determinants of Health*. Canberra: Health Transition Centre, 1990, pp. 584-94.

Perceived health naturally deteriorates with age. However, **15% of the persons surveyed in the youngest age group (under 25) say that their health is poor or very poor, a proportion that reaches 69% in those over 60.**

Chart 14. Perceived health according to age group



On the whole, the individuals surveyed declared an average of 1.2 health problems per person. The main three areas they mention are digestive, mental health and musculoskeletal disorders, as well as gynaecological problems for women (mentioned by 16% of them).

Asylum-seekers, refugees and undocumented migrants whose application for asylum has been rejected often report a high prevalence of mental health problems. They have often endured tremendous shock and trauma, including the death of family members, torture and physical and emotional violence⁵³...

“Both his arms were tied to the wall and he was kicked, punched and hit with an iron bar.”

MDM Italy tells the story of a young man from Democratic Republic of Congo:



A. was born in Democratic Republic of Congo in 1975 and attended trade school to become a mechanic. Later he worked on boats in Kinshasa’s river port. His job was to load and unload freight. A. lived with a woman and had two children with her. His troubles started in September 2002, when he was arrested. Well before then, his boat had been hijacked to carry weapons and combatants to the north, where there was a war. One day, when the boat was going from Kinshasa to Equator Province, rebels attacked and captured it. Everybody aboard fled into the forest. A. saved his life by hiding in the bush. Later he returned to Kinshasa with refugees leaving the war zone. Two months after arriving in Kinshasa, he and everybody else working on the boat were arrested. He was tried and sentenced to 10 years in prison. A friend of his father was able to obtain his release in November 2003. A. was tortured during his incarceration. Both his arms were tied to the wall and he was kicked, punched and hit with iron bars. He was incarcerated in a windowless room with many other prisoners. There was no air or light. He saw prisoners leave the room and never come back. When A. left prison, he hid at a friend’s home for two days, the time it took for him to prepare his documents, and the friend put him on a plane for Italy. He arrived at Milan Malpensa airport the next day. A. requested political asylum in December 2003. He lived on the street for two months before being sent to a hostel. He has lost touch with his wife and children.

53. Kirmayer LJ. Le dilemme du réfugié. *Evol Psychiatr* 2002; 67: 743-63.

“He told us he’s not sure of his age but that he thinks he’s 24. He doesn’t know when or how he arrived in Portugal.”

MDM Portugal tells this story about a young man from Guinea:

” He showed up in bad shape. His speech was garbled. He told us he’s not sure of his age but that he thinks he’s 24. He doesn’t know when or how he arrived in Portugal but he’s always slept in the same spot, in the doorway of the Ministério da Marinha next to Terreiro do Paço. Everybody there knows him. The only time he’s not there is when he has ‘attacks’ and goes to the psychiatric unit at Júlio de Matos Hospital, where he frequently returns.

For food he goes to the vans [distribution of meals], whose locations and hours he knows for the whole week. When he wants to see a doctor he goes to the Medicos do Mundo mobile unit or Santa Maria Hospital. He tells us that he can’t remember obtaining a residence permit and says he “doesn’t need one”.

“She was locked up in a big room with other women, (...) they were beaten, tortured and abused.”

MDM Italy tells this story about a 32-year-old woman from Democratic Republic of Congo:

” N. was born in Gemena (Democratic Republic of Congo) in 1974. She is married and has two children. The first child was born in the Central African Republic in 2002 while she was fleeing from Congo. The second one was born in Milan in 2005.

In 2002, they lived in Gemena, an area that the rebels recaptured. She was pregnant then.

N. was locked up in a big room with other women, separate from the men. There were 200 people in the room. They were beaten, tortured and raped.

Two weeks after their incarceration, 70 inmates escaped, including N. and her husband. They walked for days to the border with the Central African Republic, around 100 km from Gemena.

They reached Bangui, where they stayed for several months. That’s where N. had her first child.

The delivery wasn’t easy and she had to have a caesarean. Later the baby suffered from severe after-effects. Two months later they set out for Mombassa (Kenya) by truck. From there they went to Turkey, where they lived for one year.

Then they boarded a boat for Italy.

The crossing wasn’t easy. They had no food or water during the trip. The Italian navy rescued them and took them to LAMPEDUSA.

N. suffered a lot from the sea voyage, but not as much as her child, who was having convulsions by the time they reached Italy.

They were taken to the hospital in Palermo.

They asked for political asylum in July 2004.

Two months after arriving in Italy, they were brought to a shelter in Milan where they have remained together. N. has been traumatised by her ordeal. She is currently undergoing psychotherapy. She only speaks with her husband and children and spurns all other contact.

There is always a chance that “illegal” migrants’ living conditions in the host country (fear of arrest or of being reported, social and economic vulnerability, stigmatisation, discrimination, exploitation, difficulty thinking about the future, language and cultural barriers, lack of social networks, etc.) might weaken their psychological health.

“She is developing increasingly severe signs of depression. She is pregnant and becoming more and more withdrawn”

MDM France tells this story about a young mother from Albania:

” I met this mixed couple at CASO [MDM Reception, Treatment and Orientation Centre] around two weeks after they arrived in France. She is Albanian and he is Macedonian. Their youngest daughter, who was three years old at the time, was with them. Their eldest daughter, who was six, stayed at the shelter with the other children. The youngest one clung to her mother and refused to be apart from her, even for a moment. They fled Macedonia after a five-year ordeal that they describe as hell: repeated death threats, violations of their home day and night by men who pointed their guns at Mr A’s temple in front of the children, shouting threats, yelling insults and asking them for money. Mrs A could hardly ever leave the neighbourhood without being insulted and roughed up. When she went into labour, the hospital refused to admit her because she is Albanian and she had to pay a bribe to give birth in the hospital stairwell. .../...

The police took her in for 'questioning' several times. During one of those 'interrogations' she was raped. This woman and her family have endured repeated violence all their lives because her father is a political activist in Kosovo. She got married and went to Macedonia, whereas her family fled to France, where they obtained political asylum.

To escape their ordeal they decided to flee to France as well. They trekked through the mountains with their daughters, cold, hungry and witnessing several people die of exhaustion.

They lived in a temporary shelter before obtaining a room with mildewed walls in a 'hotel' unfit for habitation. They were unable to cook and went to meal distribution centres.

Mrs A developed increasingly severe signs of depression. She was pregnant and becoming more and more withdrawn. Two and a half years went by before they obtained a negative response to their request for political asylum. They filed another request, which was rejected approximately six months later.

Meanwhile, they moved into two rooms in an accommodation centre.

They had to leave the shelter when their last request for asylum was rejected. Now they have a three-month-old baby. They are being followed by an organisation that has found them decent housing.

Mrs A's depression got worse and she was rushed to the emergency room of a psychiatric hospital, where she spent three months. She felt hopeless and was prone to fits of violence. An application for a residence permit for medical reasons was filed. The response was positive and she obtained it for one year.

Her husband still had no documents. He obtained legal aid and had to wait six months before seeing a lawyer. Mrs A gradually started enjoying life again. She found a few hours of work cleaning houses every week, which matters a lot to her even though she is trained as a secretary.

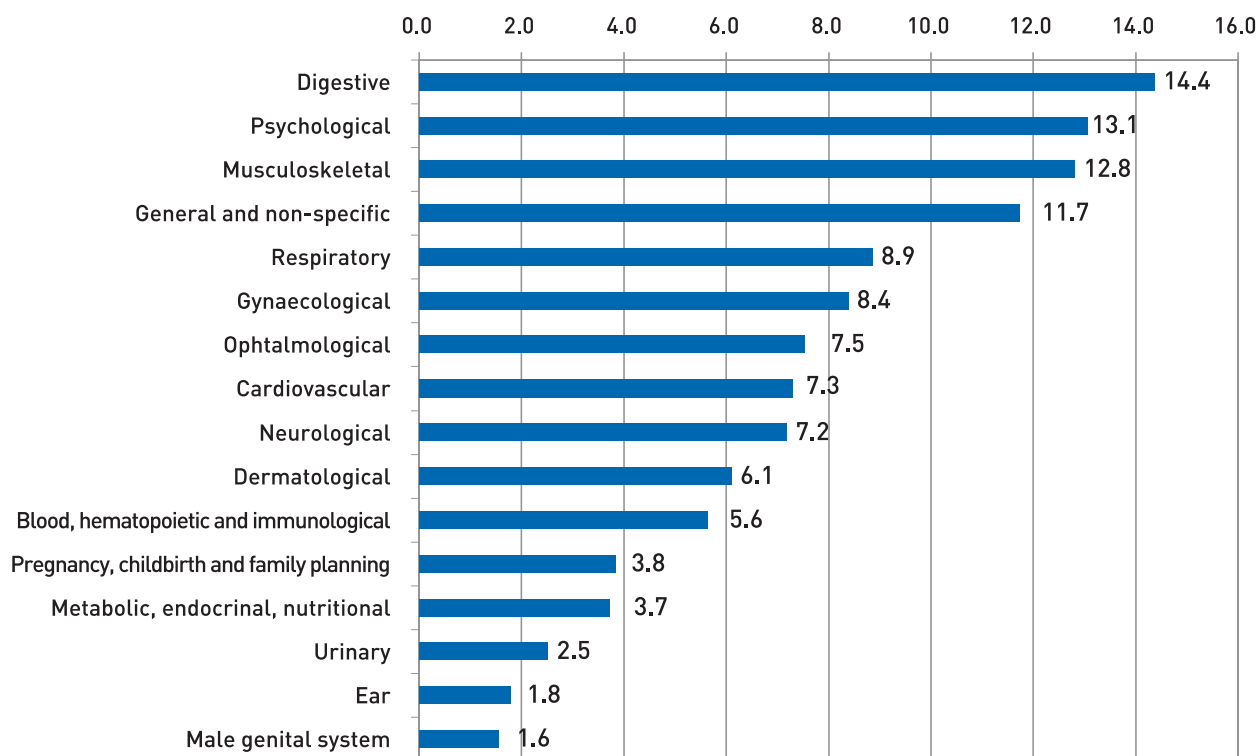
She was completely demoralised after a meeting with a lawyer who told her that the chances of getting papers were extremely slim. Mrs A must prove that she has a full-time job, but that is impossible because of her current state of health. Now her mood is fragile again.

Table 19. Health problems mentioned by system

	Proportion of the problems mentioned (n=998) %	Frequency in the survey population (n=835) %
Digestive	12.3	14.4
Psychological	11.3	13.1
Musculoskeletal	11.0	12.8
General and non-specific	10.1	11.7
Respiratory	7.6	8.9
Gynaecological	7.2	8.4*
Ophthalmological	6.5	7.5
Cardiovascular	6.3	7.3
Neurological	6.2	7.2
Dermatological	5.2	6.1
Blood, hematopoietic and immunological	4.8	5.6
Pregnancy, childbirth and family planning	3.3	3.8**
Metabolic, endocrinal, nutritional	3.2	3.7
Urinary	2.2	2.5
Ear	1.5	1.8
Male genital system	1.3	1.6***

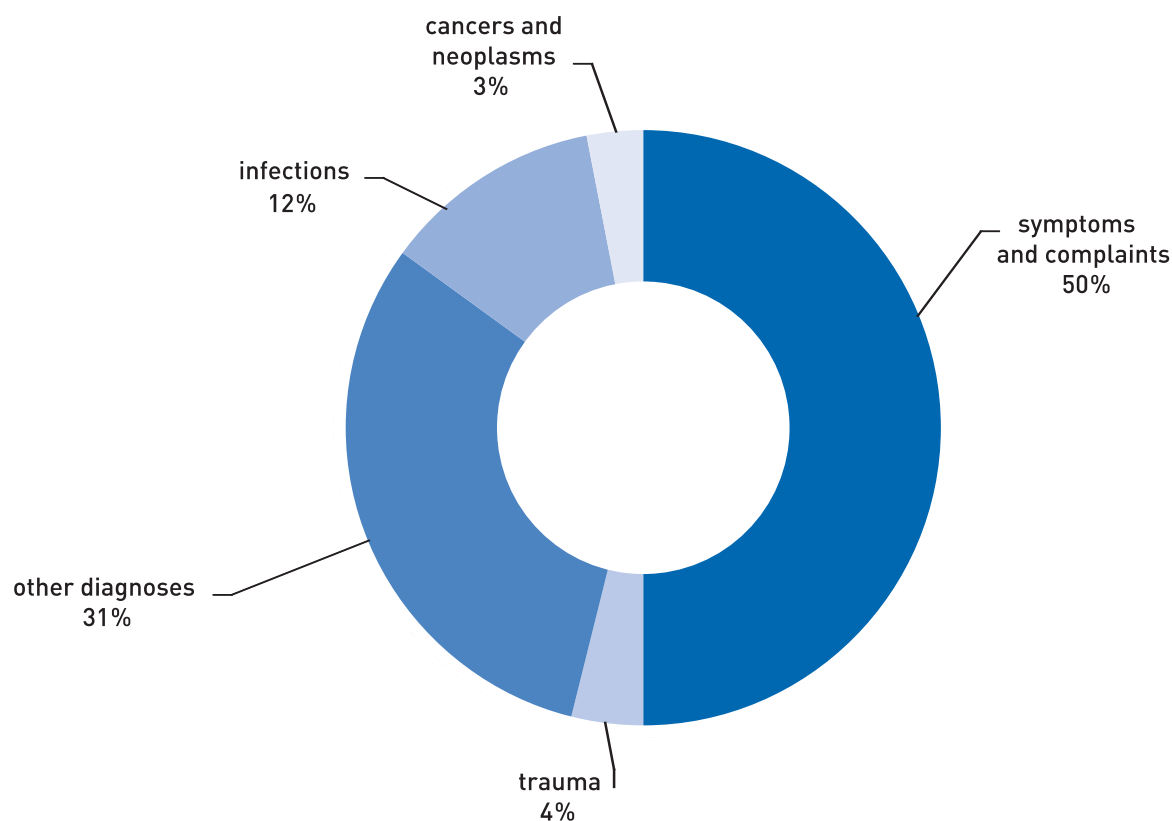
*15.9% of the women **8.4% of the women ***3.3% of the men

Chart 15. Health problems mentioned by system (frequency in the survey population in%)



According to the ICPC grouping, **half the health problems mentioned are symptoms and complaints (without a final diagnosis)**. Infections (all causes combined), cancers and traumas together account for nearly 20% of the problems mentioned (it should be pointed out that the ICPC groups together a wide range of diseases with broadly varying degrees of seriousness).

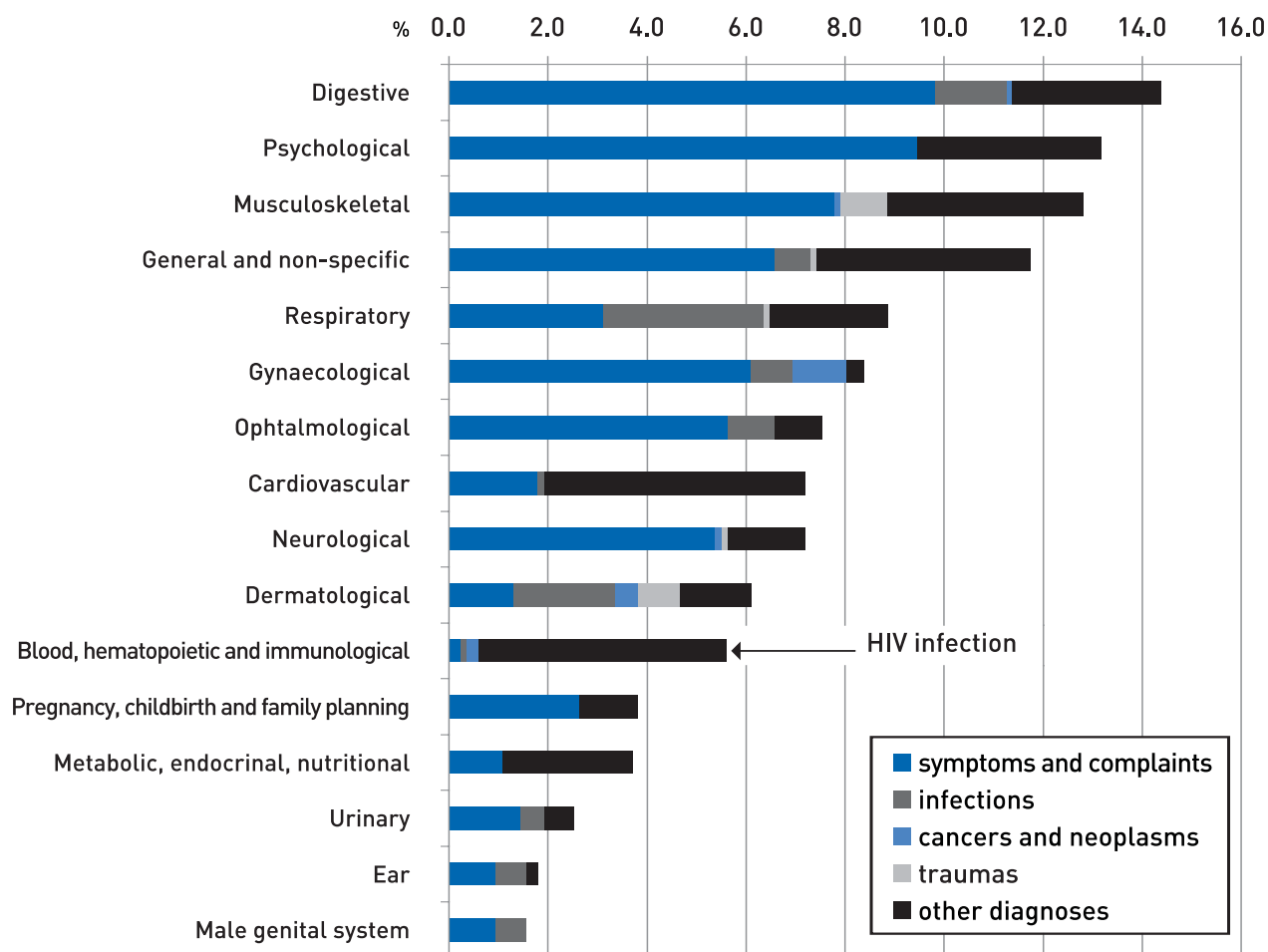
Chart 16. Health problems mentioned by type (frequency in the survey population in%)



Comparing the previous two indicators (type of problem and system involved according to the ICPC) shows that “non-finalised diagnoses” (recorded and encoded as symptoms) often involve the digestive, muscle-skeletal, neurological and psychiatric spheres; in other words, areas where obvious symptoms are common (especially pain) and for which only ongoing, rather than occasional, care can lead to a diagnosis.

Most of the immunological and haematological pathologies involve HIV infection.⁵⁴

Chart 17. Health problems mentioned by type and system (frequency in the survey population in%)



On a more detailed level, **27 health problems account for slightly less than half (45.7%) of all the problems mentioned⁵⁵**. They include a high rate of abdominal, musculoskeletal and gynaecological pain, symptoms of anxiety and depression, symptoms of infection (cough, fever) and serious infections (HIV, viral hepatitis).

54. It might seem odd that the HIV infection rate is so high in the diagnoses without being able to perform additional tests. This is explained by two complementary reasons:

- some patients know about their HIV infection, which was previously diagnosed
- this is especially true since two survey sites are HIV clinics.

In this type of survey, the actual HIV rate remains unknown (see chapter IV-5. HIV Infection).

55. Approximately one-third (32.8%) of the problems mentioned are purely declarative on the part of the surveyed individual.

Table 20. Health problems mentioned

	Proportion of all the problems mentioned (n=998) %	Frequency in the survey population (n=835) %
Dorsal-lumbar*	4.4	5.3
Depression*	4.3	5.2
HIV infection	3.7	4.4
Headache	3.1	3.7
Eyesight	2.7	3.2
Epigastric pain and gastric disorders*	2.8	3.3
Pain and other genital and menstrual S/C women*	2.5	2.9
HBP without complications	1.8	2.2
Anxiety	1.7	2.0
Acute stress	1.7	2.0
Asthma	1.6	1.9
General pain	1.6	1.9
Sleeping disorders	1.6	1.9
Fatigue	1.4	1.7
Tooth or gum S/C**	1.4	1.7
Abdominal cramps and pain	1.3	1.6
Fever	1.2	1.4
Viral hepatitis	1.1	1.3
Eye S/C (except eyesight)	0.9	1.1
Insulin-dependant diabetes	0.9	1.1
Sterility	0.8	1.0
Cough	0.8	1.0
Sinusitis	0.7	0.8
Drug abuse	0.7	0.8

*after grouping together all the compatible codes in the ICPC

**S/C: symptoms and complaints

Over two-thirds of these health problems (69.9%) have been declared chronic and less than one-third (30.1%) are currently being treated. An average of 47.1% say they have at least one chronic health condition. Only half (50.4%) are currently undergoing treatment for all their chronic illnesses, whereas 49.6% have at least one untreated chronic disease. There are no significant differences with regard to sex, age and length of unauthorised residence in the host country.

Having health coverage increases people's chances of receiving care for all their chronic diseases (RR = 1.71, CI95% = [1.28 – 2.29]). However, that does not guarantee everyone that all the treatments are paid for: just 65.8% of the people with this type of document have all their chronic diseases treated (compared to 38.5% of people without that document, p<0.001).

Nearly half the people reporting more than one health problem (46.7%) have suffered from a delay in their recourse to treatment. A comparison of the most frequent disorders among those who stated or did not state delayed treatment shows no notable difference: in other words, people suffering from serious or chronic conditions (in particular depression, HIV infection, diabetes, viral hepatitis and HBP) receive treatment no later than those who report less serious disorders or undiagnosed symptoms (fatigue, fever, joint pain, etc.). **There is no correlation between the condition's seriousness and quicker recourse to treatment, which is particularly alarming** because delayed treatment can have grave consequences in the case of some pathologies.

“He asked me several questions during the visit but didn't examine me. He didn't even look at the lump I felt in my breast”.

MDM Netherlands interview with M., 43, from Ghana:

” *“A month ago I saw a GP because I felt a lump in my breast and was very worried. The doctor would help me only if I paid in advance. He asked me several questions but didn't examine me. He didn't even look at the lump in my breast. I was a nurse in Ghana and know how to deal with medical problems. That's why I thought it was really odd that the doctor did not correctly examine me and that made me angry. At the end of the appointment he gave me a prescription. I didn't go to the pharmacy. I don't think the prescription would've done me any good because it was not based on a proper medical examination. I don't trust that doctor. The way he treated me made me feel sad. I decided not to go back to him and to look for another one.”*

There is no significant correlation between obtaining health coverage and seeking care sooner (for health problems on the day of the survey). Nevertheless, there is a slight difference: 53% of the people having that health coverage have delayed treatment, compared to 45.1% of those without ($p=0.2$). At first glance this result might seem surprising, but it shows that **obtaining a card for access to free care does not mean all the obstacles to that access are lifted**. Some doctors are reluctant to treat undocumented persons⁵⁶.

Furthermore, **the fact that people with free access to the mainstream health care system drop in to centres run by Médecins du Monde or other organisations underscores the fact that such a right is a necessary but insufficient condition for an effective equality of access to treatment for all the vulnerable persons residing in European countries.**

56. See chapter V.2. The refusal of health professionals to treat patients

3. Addictive behaviours

In the entire population surveyed, **10% of the individuals have an alcohol abuse or dependency problem** (CI95% = [7.8-12.6]⁵⁷). There is no age correlation, but the problem is more widespread among men than women: 15.2% compared to 3.0% (RR = 4.9, CI95% = [2.5 – 9.4], $p < 10^{-6}$). The rate varies significantly depending on the country ($p < 10^{-6}$): it is lower in Spain and higher in Italy. For comparison's sake, for example in France, “problematic” alcohol consumption affects 13.8% of the male population and 5.0% of the female population⁵⁸.

Table 21. Prevalence of male alcoholism by country

	%	Confidence Interval (CI) 95%
Italy	32.1	31.0 - 64.2
Belgium	12.8	6.3 - 22.3
France	9.6	3.9 - 18.8
Greece	8.7	2.4 - 20.8
Spain	7.8	3.6 - 14.3
Average	15.2	11.7 - 19.3

Moreover, **21.6% of the people surveyed abuses or are dependent on tobacco** (CI95% = [18.6 – 24.8]). That figure tends to decline with age, but not significantly. This is more often the case with men, with smaller differences between sexes than for alcohol: 30.2% and 12.2%, respectively (RR = 2.5, CI95% = [1.8 – 3.4]). The gap is particularly wide in Belgium; it is also significant in France and Greece but not in the other countries, especially Spain.

For comparison's sake, according to 2002 or 2003 OECD data, 35.0% of the total population smokes every day in Greece, 28.6% in France, 28.1% in Spain, 27.0% in Belgium, 26.0% in the United Kingdom, 24.2% in Italy and 20.5% in Portugal⁵⁹.

Table 22. Male smoking per country: Male/Female relative risk estimates

	Relative Risk (RR) M/F	Confidence Interval (CI) 95%
Belgium	11.4	3.5 - 36.9
France	2.1	1.1 - 4.6
Greece	2.7	1.3 - 6.5
Italy	0.8	0.3 - 2.0*
Spain	1.5	0.9 - 2.5*

* insignificant (which means that the risk of smoking is statistically insignificant for men and women)

Note to reader: in Greece, men's risk of smoking is 2.7 times higher than it is for women with a confidence interval (CI) of 95% ranging between 1.3 and 6.5.

Abuse or dependency on both alcohol and tobacco is less frequent: 3.4% (CI95% = [2.2 – 4.8]). The rate for men is three times higher than for women ($p=0.01$). The low number of people concerned makes it impossible to draw comparisons between countries after adjusting for sex.

The estimated prevalence of drug abuse is 5.2% (CI95% = [3.7 – 7.0]) and, once again, more likely to concern men (8.5%) than women (1.5%): RR = 5.7, CI95% = [2.3 – 14.5], $p < 10^{-4}$. Figures for young people are also higher: 9.2% of the under-25s and 4.2% of 26-60 year-old. No cases were observed among people over 60.

57. CI = Confidence Interval; RR = Relative Risk

58. Delta test estimate: Guilbert P, Gautier A, eds. *Baromètre santé 2005, premiers résultats*. Paris, INPES, 2006, 170 p.

59. Source: EcoHealth OECD 2005.

The observed prevalence of drug abuse is significantly higher in Italy and significantly lower in Belgium (including after adjusting for age); there is a connection to the specific populations of the different centres surveyed. Co-dependency on drugs and alcohol was observed in 19 cases (2.3% of the total sample) and 3.4 times more often in men ($p=0.04$).

Table 23. Drug abuse per country

	%	Confidence Interval (CI) 95%
Italy	18.8	10.9 - 29.0
France	5.0	2.0 - 10.0
Spain	4.2	1.8 - 8.1
Greece	2.4	0.3- 8.4
Belgium	1.0	0.1 - 3.5
Average	5.2	3.7 - 7.1

The observed prevalence of medication drug abuse is still lower, ranking from 2.2% and 3.3% (depending on whether the missing data is taken into account; they might then be understood as negative answers). The low number of people concerned makes comparison by sex and country irrelevant. Only six cases of co-dependency on both alcohol and medication drugs was reported (0.7% of the total sample).

4. Access to HIV screening and treatment for HIV infection

In all the countries surveyed, HIV screening is theoretically available and free for anybody on demand. However, in the sample surveyed, 54.2% of the people questioned were unaware of that fact. The proportion differs significantly depending on the country.

- It is, significantly, **the worst in Greece**. The result can be seen as an effect of the denial of the right to health care largely affecting the undocumented migrants in that country: the general rule is that they have no right to care, so the few exceptions to that rule (in this instance access to free HIV screening) are, understandably but unfortunately, poorly known.
- It is **the most favourable in France**, where the persons surveyed are the best informed about the availability of free screening (even though most are poorly informed about the possibility of obtaining health coverage): 59.0% are aware of that right, a figure that rises to 68.8% in Paris (where several major poster and information campaigns about screening have taken place).

Table 24. Frequency of unawareness of HIV screening by country

	%	Confidence Interval (CI) 95%
Greece	83.7	74.2 - 90.8
United Kingdom	66.7	29.9 - 92.5
Portugal	64.7	38.3 - 85.8
Italy	63.0	54.2 - 71.1
Belgium	50.3	42.8 - 57.8
Spain	47.2	40.1 - 54.4
France	41.0	32.9 - 49.5
Average	54.2	50.6 - 57.8

“Every year I give myself a test for my birthday. It’s only normal, with my husband ...”

MDM France tells this story about a young woman from Senegal:

” *F. pushed open the office door accompanied by the receptionist. As she was sitting down and taking off her coat, I explained the survey’s goals and thanked her for participating. She stopped me with a wave of her hand. ‘This is the first time I’m going to talk. Do you mind?’ I put down my pen and pushed the questionnaire away. F. started talking about her life over there [in Senegal], her voice was lively and lifeless by turns. Lively when she talks about her life as an actress, her children and a beautiful easy life. Lifeless when she talks about excision, her eldest daughter’s gift for saving her from that torture, the organised ‘disappearance’ of the smallest children and a violent, womanising husband who refused to let her have a career. ‘Actress? Prostitute is more like it!’ He verbally and physically abused her, dragging her body over barbed wire and threatening her: ‘if you come home I’ll put out one of your eyes!’ F. summed up her life as quietly as breathing, and perhaps to breathe. Getting back to the reason she came in, hepatitis C combined with syphilis, I brought up the topic of an HIV test. She had already had them, but didn’t know it’s free in France. In Senegal, she said, “every year I give myself a test for my birthday. It’s only normal, with my husband...” What about life in France? F. concludes our meeting with these words: “Here people help us, but our road must be made wider so that undocumented people can be treated without fear. It’s necessary to forge respect, not fear. We hide as if we were animals.”*

An even higher rate of people are unaware where they can have an HIV test: 62.3% of those surveyed.

That figure is significantly higher in the United Kingdom⁶⁰, Greece and Italy and significantly lower in Spain. In France, it is located in the general average.

Table 25. Rate of unawareness of HIV screening centres by country

	%	Confidence Interval (CI) 95%
United Kingdom	88.9	51.8 - 99.7
Greece	86.4	75.0 - 94.0
Italy	74.5	65.1 - 82.5
France	66.7	58.0 - 74.5
Portugal	61.5	31.6 - 86.1
Belgium	60.3	52.8 - 67.6
Spain	46.2	39.1 - 53.4
Average	62.3	50.6 - 57.8

The situation regarding treatment is similar: **63.1% of the people surveyed do not know that free HIV treatment is available.** That figure is significantly **higher in Greece** (none of the persons questioned knew it) and significantly **lower in Spain**.

In the United Kingdom, the question is moot because undocumented people with HIV have no access to free treatment.

60. Since treatment is not free (see below), there is no HIV screening information campaign directed at undocumented persons.

Table 26. Rate of unawareness of free HIV treatment by country

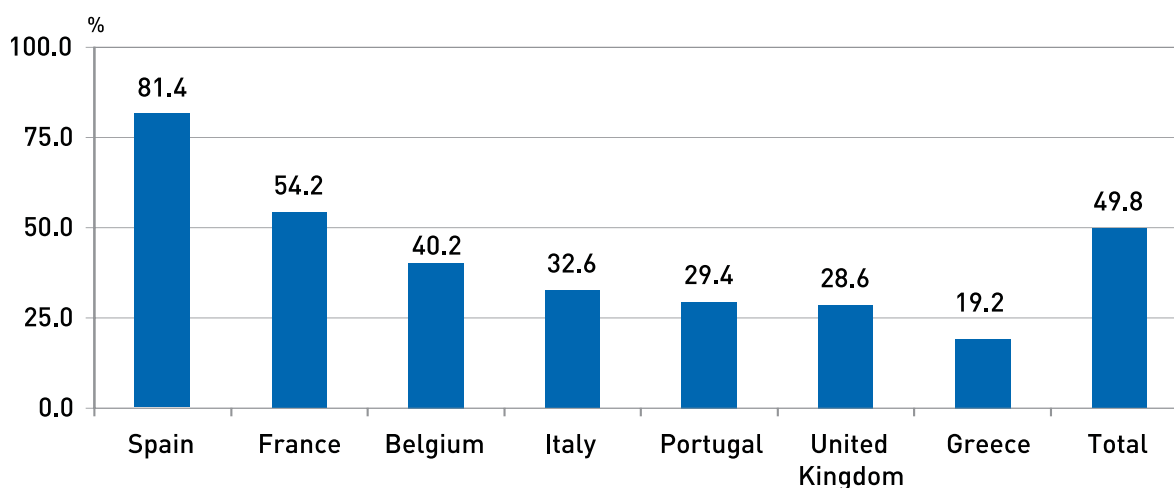
	%	Confidence Interval (CI) 95%
United Kingdom	*	
Greece	100,0	93.4 - 100.0
Portugal	73.3	44.9 - 92.2
Italy	68.2	58.5 - 76.9
France	67.9	59.3 - 75.7
Belgium	59.8	52.1 - 67.1
Spain	49.2	42.1 - 56.4
Average	63.1	50.6 - 57.8

* there is no free treatment in the United Kingdom

Those rates are particularly high in light of the finding that **nearly half the people surveyed have already wanted to take an HIV test (49.8%)**; there is no lack of interest in screening, far from it.

Significant differences exist depending on the country. In Spain, most of the people surveyed (81.4%) have already wanted to take an HIV/AIDS test; in France, slightly over half have (54.2%). The figures fall to 40.2% in Belgium, 32.6% in Italy, 29.4% in Portugal, 28.6% in the United Kingdom and 19.2% in Greece.

Chart 18. Proportion of individuals wanting to take an HIV test by country



Several factors might account for the differences between countries, although the survey did not identify them:⁶¹

- Perception of the risk of being infected might be different (in particular depending on the migratory groups);
- Information policies (and awareness of what's available) also have an impact on demand for screening;⁶²
- Differences observed partly reflect the activities of the centres taking part in the survey (for example in Belgium, the desire for screening is higher among individuals surveyed at partner organisations that care for people living with HIV: 64.4% compared to 40.2% for all the people questioned).

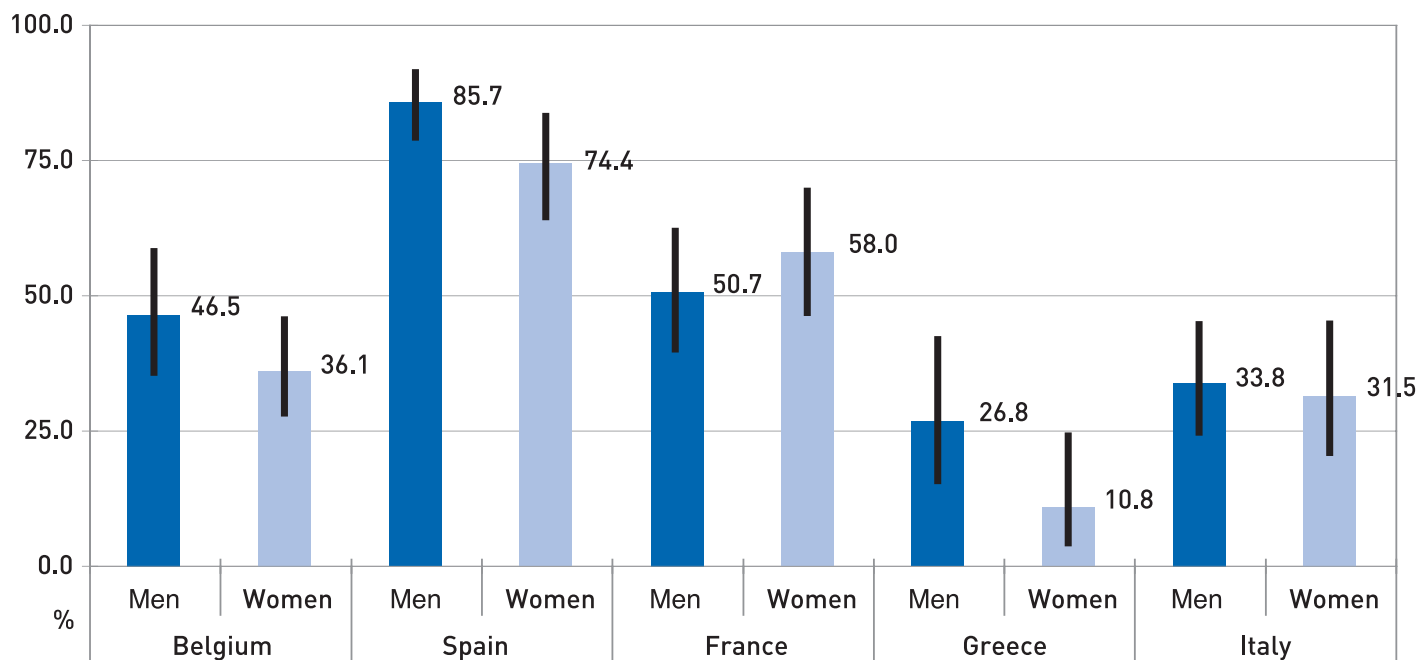
In the survey population as a whole, **the desire for screening is significantly higher in men (53.4%) than women (45.4%, p=0.03) and declines with age** (just 23.5% among people over 60 but the differences are insignificant).

Differences by gender and country are insignificant because of the low number of people surveyed (the chart below shows the width of confidence intervals).

61. Clarke K, Broring G, eds. *HIV/AIDS Care and support for migrant and ethnic minority communities in Europe. Woerden: AIDS & Mobility, 2000.*

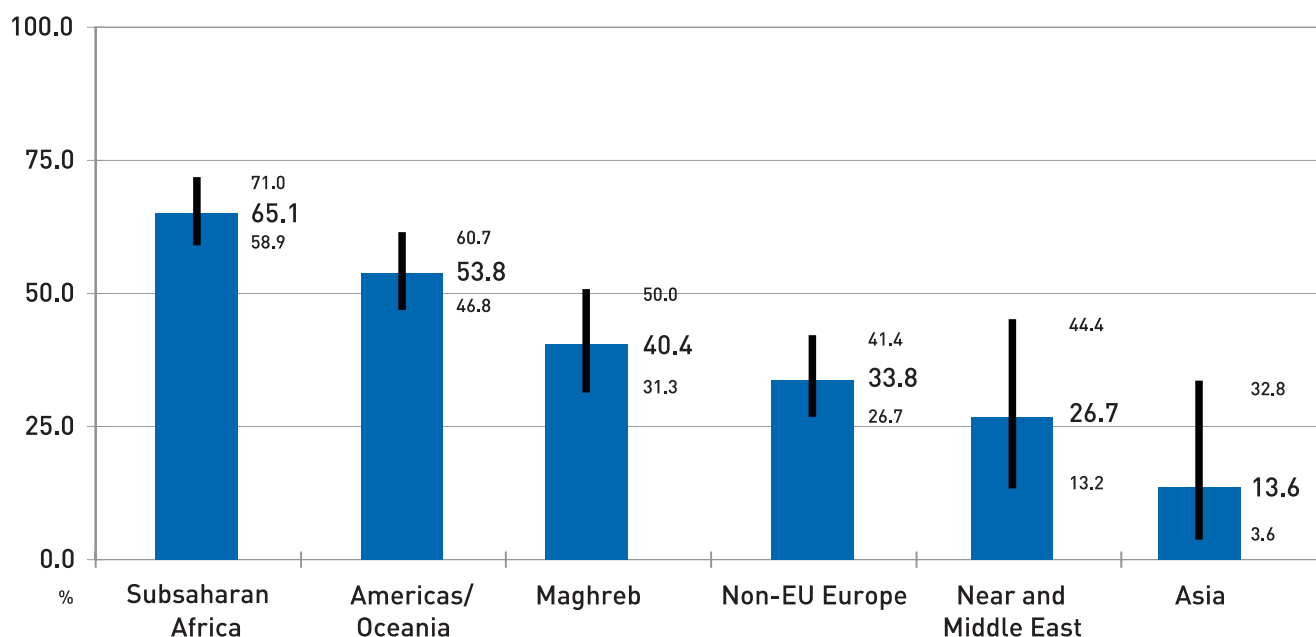
62. Matic S, Lazarus JV, Donoghoe MC, eds. *HIV/AIDS in Europe: moving from death sentence to chronic disease management. Geneva, WHO, 2006, 298 p*

Chart 19. Prevalence of the desire for HIV testing by country and sex



The desire to have an HIV test differs significantly depending on the respondents' continent of origin ($p < 10^{-6}$). It is **highest among Africans** (65.1%, significantly more than the average for the sample as a whole) and lowest among Asians; North Africans, Middle Easterners and Europeans are in the middle, but in every case only a minority say they have already wanted to take an HIV test.

Chart 20. Prevalence of the desire for HIV testing by continent of origin



Note to the reader: the chart gives the proportion observed in the sample (wide bar) and its confidence interval at 95% (black lines) for each country. For example, 40.4% of the people from the Maghreb have wanted to take the test and the statistical confidence interval of that percentage ranges from 31.3% to 50.0%.

The overwhelming majority of people who wanted to be screened for HIV have been able to take the test (85.4%) but 14.6% have not⁶³. Practically no obstacle to finding out the result was observed in the survey: 99.7% of the people who took the test know the result (only one person stated the contrary).

63. No significant difference between men and women.

The reasons why the other half of the population never wanted to take the test overwhelmingly involve the feeling of not needing to know or not feeling concerned by the issue. The issue of obstacles to treatments (unawareness that they are free or perception that they must be paid for) is mentioned in 10% of the cases. It seems that the overwhelming majority trust in the results' confidentiality – at least that is not an obstacle to testing (only eight people said they believed the results would not be kept secret).

Other — and fortunately exceptional (less than 1% of the population surveyed) — situations were observed: tests in which the persons did not know they were being screened (mentioned by five persons who say they were involuntarily and unwittingly tested), unawareness of the existence of treatments (nine people), never heard of AIDS (eight people).

Table 27. Reasons why an HIV test was never wanted

	% (n=385)
Don't feel the need	64.4
Fear of results	11.4
Don't know that treatment is free	5.5
Know no treatment is free	4.2
Not concerned	2.9
Don't know that treatment exists	2.3
Fear of lack of confidentiality	2.1
Never heard of AIDS	2.1
Tested unknowingly	1.3
Don't know where to go	1.3
Too expensive	1.0
Never had the opportunity	0.5
No answer	0.5
Don't know that the test is free	0.5

5. HIV infection

In the sample as a whole, there is an extremely high prevalence of HIV infection: 5.7% (CI95% = [4.3 – 7.5]), with no significant difference between men and women. The figure is accurate only insofar as people know (and declare) their HIV status. The actual number is probably higher: people who do not know they are carrying the virus that can cause AIDS or choose to conceal the fact are not considered HIV-positive (this is not a prevalence survey in the “epidemiological” sense of the term).

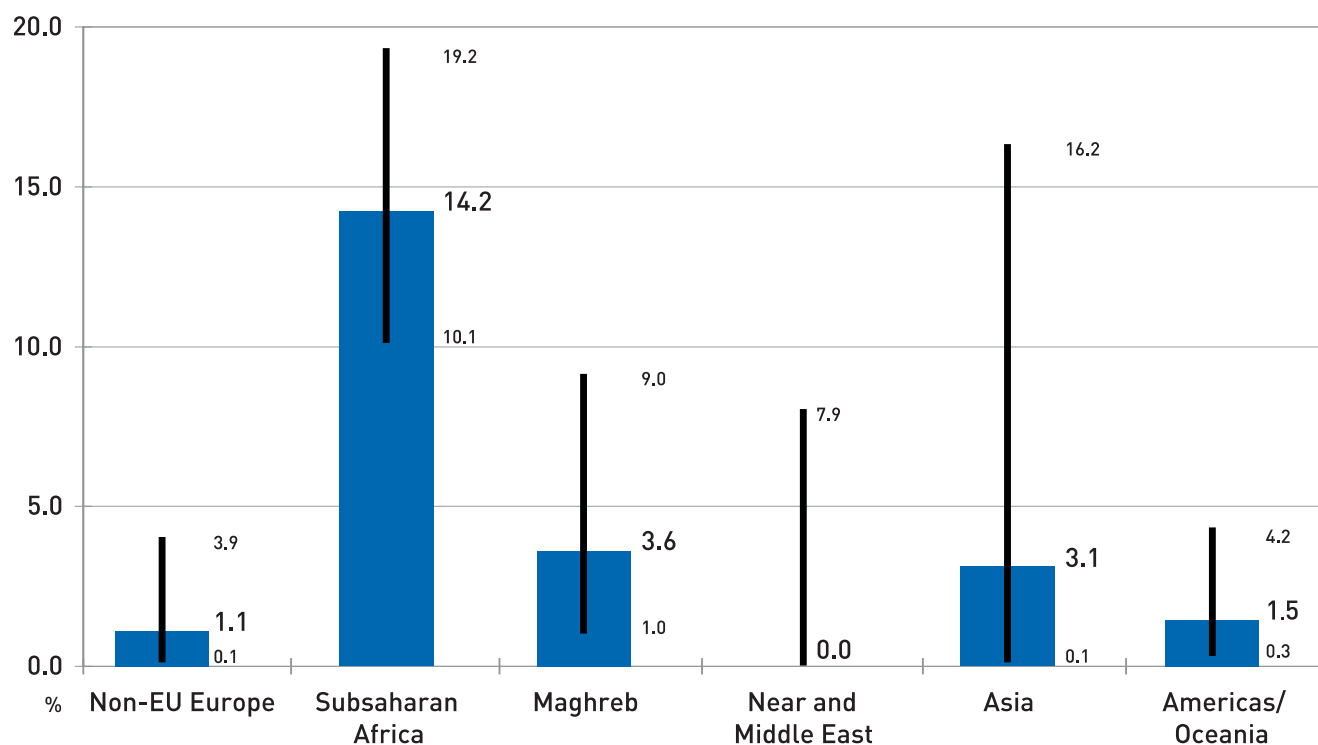
The very high prevalence also stems from how the sample was compiled – and in particular the fact that in Belgium part of the survey was conducted in organisations for foreign nationals with HIV/AIDS. Thirty of the 48 HIV-positive people in the sample are receiving free treatment (and were questioned) on those Belgian organisations' premises. **In the rest of the sample, the prevalence of HIV is half as high (2.3%) but still particularly elevated.** As a point of comparison, the annual incidence of new HIV infections is approximately 68 per million inhabitants in the European Union⁶⁴, or roughly 1% of the total population.

A significant relationship ($p < 10^{-6}$) to the continent of origin has been observed: **people from sub-Saharan Africa have a particularly high prevalence (14.2%)** and no cases have been observed in individuals from the Near and Middle East. However, low numbers make the confidence intervals particularly wide for Asia and, to a lesser extent, the Near and Middle East.

64. EuroHIV. HIV/AIDS Surveillance in Europe. Mid-year report 2005. Saint-Maurice: Institut de veille sanitaire, 2006, n°72.

For sub-Saharan Africa, people with HIV infection are from Cameroon (nine cases), Rwanda (seven cases), Democratic Republic of Congo (five cases), Burundi, Côte d'Ivoire, Ghana (two cases each), Burkina Faso, Cap Verde, Guinea, Guinea Bissau, Niger, Nigeria, Senegal and Togo (one case each). For America, the countries are Ecuador, Peru and El Salvador (one case each); for Asia, Kazakhstan (one case); for Europe (non-EU), Romania and Serbia (one case each).

Chart 21. Prevalence of HIV infection by country of origin



People with HIV have health coverage more often than the others (93.8% versus 76.0%, $p < 0.01$)⁶⁵ and almost all of them (also 93.8%) have seen a doctor for the condition.

Over nine in 10 HIV-positive patients have been offered treatment (90.9%), and 42.5% have taken it, but half the HIV-positive people declined to answer the question. If only those who did are taken into account, the figure rises to over 80% (but the numbers are small: approximately 20 individuals in the entire survey population...).

Fewer people declined to answer the question about taking ARV treatments (14.6%), which is easier to interpret: **at least two-thirds of the people with HIV (64.6%) – and up to 75.6% if those who did not answer the question are taken into account – are taking an ARV treatment⁶⁶.** The reasons mentioned for not taking the treatment include difficulty following the treatment regimen and a refusal of treatment (four people did not answer this question).

“I couldn’t touch a cup or anything else because she was afraid of my HIV infection.”

MDM United Kingdom tells this story about a 48-year-old woman from Uganda with HIV:

” A. arrived in the United Kingdom in 2003. She was diagnosed HIV-positive in her home country. All her brothers and sisters have died of AIDS, leaving her alone to look after their children as well as her own. “I started taking antiretroviral drugs (nevirapine) in my country, but they work better here. I think they must be fake in my country. Sometimes I spent all my money on the drugs and couldn’t afford food. Sometimes I had to borrow 90,000 Ugandan shillings (30 pounds) a month. Very few people in my country can afford the drugs. They’re only free for pregnant women. I was depressed and lost interest in everything. When I couldn’t find money for the medicine, my friends told me to prostitute myself or sell drugs. I didn’t come to the United Kingdom to take advantage of the social security system. I just wanted to start all over again and have a decent, better life. .../...

65. Just one person with HIV is not entitled to health coverage in the survey population and has not seen a doctor for the condition.

66. The questionnaire did not make it possible to relate this figure to the exact denominator of people with HIV and who have received doctor’s prescriptions for ARV drugs.

A friend helped me come to the United Kingdom. I stayed with her here but she turned on me because she thought I was going to die at any moment. I couldn't touch a cup or anything else because she was afraid of my HIV infection. I didn't do any cooking in her house. She told me, 'If you die, what am I going to do?' She thought I was going to contaminate her. I hoped she would understand and console me but she didn't. She introduced me to a man who wanted to have sex with me in exchange for a job."

A local women's help organisation sent A. to see us after the hospital refused to give her treatment because she wasn't registered with a GP.

The team located a doctor who agreed to see her, but she was reluctant to go alone because she was afraid of being reported and expelled. A team member went with her to help her register. Unfortunately, she did not receive a good welcome from the person in charge. That person's hostility made A. panic and afraid of being reported. She thought the person had recorded details about her life to report her.

Our team volunteer said, "I tried to reassure A. that the person in question had not recorded information about her and that we would try and find another doctor. A. was still worried and upset but I managed to reassure her enough so that she wanted to seek out other doctors."

We eventually located another doctor where she could feel comfortable. We went with her again. The registration procedure went smoothly and A. seemed happy with the outcome.

A few months later, we decided to contact A. to make sure she had seen a doctor, because that's vital for her. We found out that she never went to see the doctor after the initial registration. We offered to accompany her once again to the doctor's. She agreed and we made an appointment.

The appointment went well. Now we hope that A. will feel self-confident enough to see the doctor on her own.

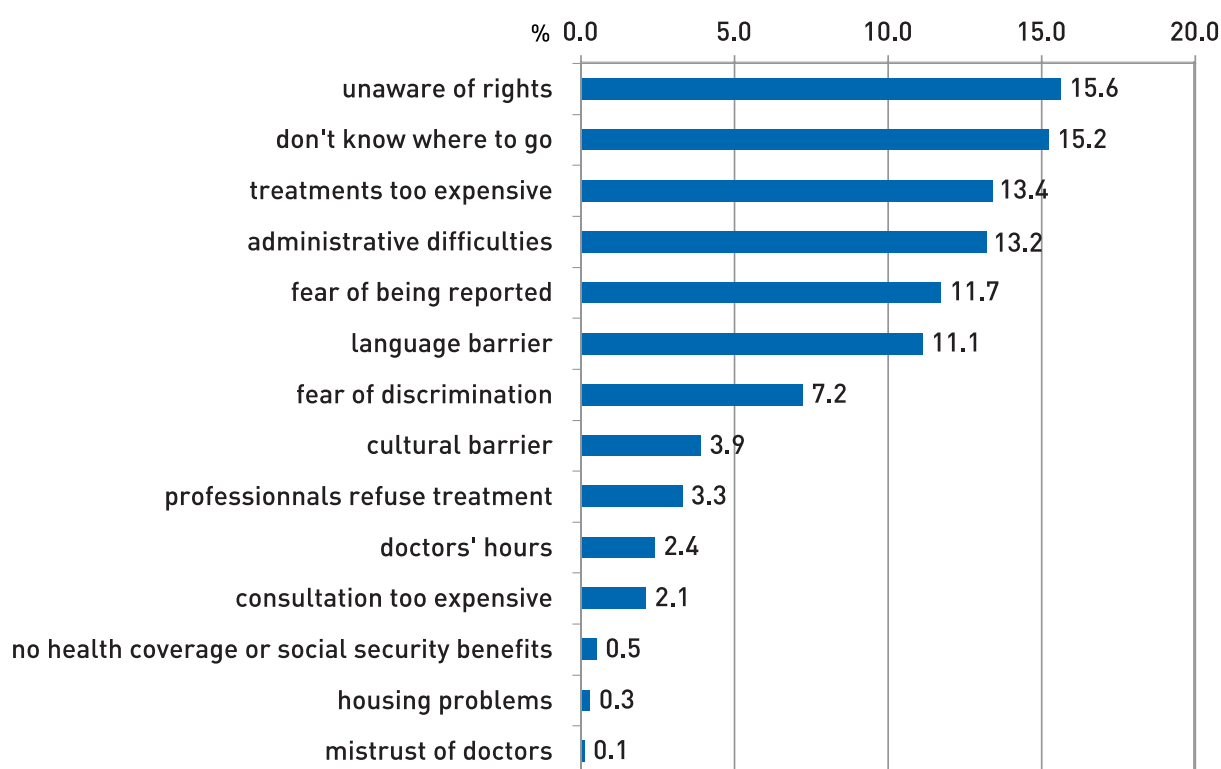


5. Obstacles to access to and continuity of treatment

1. Obstacles voiced by patients

A question about obstacles to treatment access and continuity had many answers. In all, 751 reasons were mentioned. The most frequent were **unawareness of rights, not knowing where to go for treatment, the treatments' cost, administrative difficulties, fear of discrimination and of being reported and language and cultural barriers.**

Chart 22. Frequency of the main obstacles to access to treatment (in% of obstacles mentioned)



The doctor reluctantly agreed to see J. for a single appointment, but didn't want to provide an interpreter.

MDM United Kingdom tells this story about a 27-year-old man from Iraq:

” J. was a victim of the chemical bombardments in Hallabjah, Iraq when he was eight or nine years old. “Now I have health problems requiring continuous treatment because of those attacks,” he says. In 2003, he fled Iraq after war broke out with the United Kingdom and the United States. He feared for his life because of his cousin's activities in the area.

“Before the war, my cousin helped the old Iraqi regime and killed local Kurds. When new Kurdish and Iraqi groups took over the province, I thought my life was danger because of my family ties. My whole family was wiped out and I fled to Syria before the US and UK armies captured Baghdad.

One of my relatives paid somebody to get me out of Iraq but I didn't know where I'd end up. I travelled in the back of a truck that dropped me off on the outskirts of London. I had no idea where I was or where to go to ask for asylum. The police found me, with other people, and advised me to go to the Home Office in Croydon to request asylum.

That's what I did. While my request was being reviewed, I lived in a small room in south London and ate every day. I had regular access to a doctor and received psychological counselling from an organisation. .../...

In 2005, my application for asylum was rejected and I found myself without assistance for housing and treatment. The rejection of my request for asylum left me without means. Fortunately, friends let me stay with them but they were constantly moving and that had an impact on my health.

While staying with some friends in Walthamstow, I needed help for eye problems that were caused by the chemical attack in Iraq.

I prefer living in the United Kingdom because I feel safer here but I think I was healthier in Iraq, where my family could easily pay for my care. The chemical attacks' emotional impact and my relatives' deaths mean that I need psychological as much as medical help. A psychological support organisation put me in touch with "Project: London", where I went to explain my difficult situation."

A GP's receptionist told him his registration was temporary and that he had to find another doctor now. But J. needed an emergency appointment in order to visit the hospital for his eye problems. A team member spoke with the receptionist and the doctor to explain the situation's urgency. The doctor reluctantly agreed to see J. for a single appointment but didn't want to provide an interpreter.

The "Project: London" team went to the doctor's appointment with J. Then we found another doctor who agreed to register him and offered the services of an interpreter. J. was very happy with the service provided and with the location, which was close to where he lived.

Since J. came to "Project: London", he has been directed to an eye hospital. Research about his ophthalmological problems started at the same time as regular treatment provided by his doctor. He is still undergoing treatment for his psychological problems.

"I explained to them that I didn't have any insurance and couldn't pay the bill."

Excerpt from an MDM Netherlands interview with a 21-year-old woman from the Philippines:

”

"When I was pregnant, my friends helped me find a midwife to help me take care of myself and examine me regularly. I had to pay her for all the consultations in advance. I was able to afford it because I had a steady job. I was satisfied with the care I received, it made me feel good. I wanted to have my baby at home and had already arranged everything with the midwife. A deposit I had already paid was enough to cover the costs of childbirth at home, but I had to go to the hospital because of complications. I really didn't want to go because I knew it would be too expensive. But I had no choice: I had to go. I left the hospital as soon as possible. The admission and care cost €3,000. I didn't have any health coverage and couldn't pay the €3,000 right away so I went back to the hospital to talk about my situation with the financial department. I explained to them that I didn't have any insurance and couldn't pay the bill. The hospital helped me. They drew up a payment schedule of €200 a month. That's still a lot for me but I'm satisfied with how they dealt with my problem.

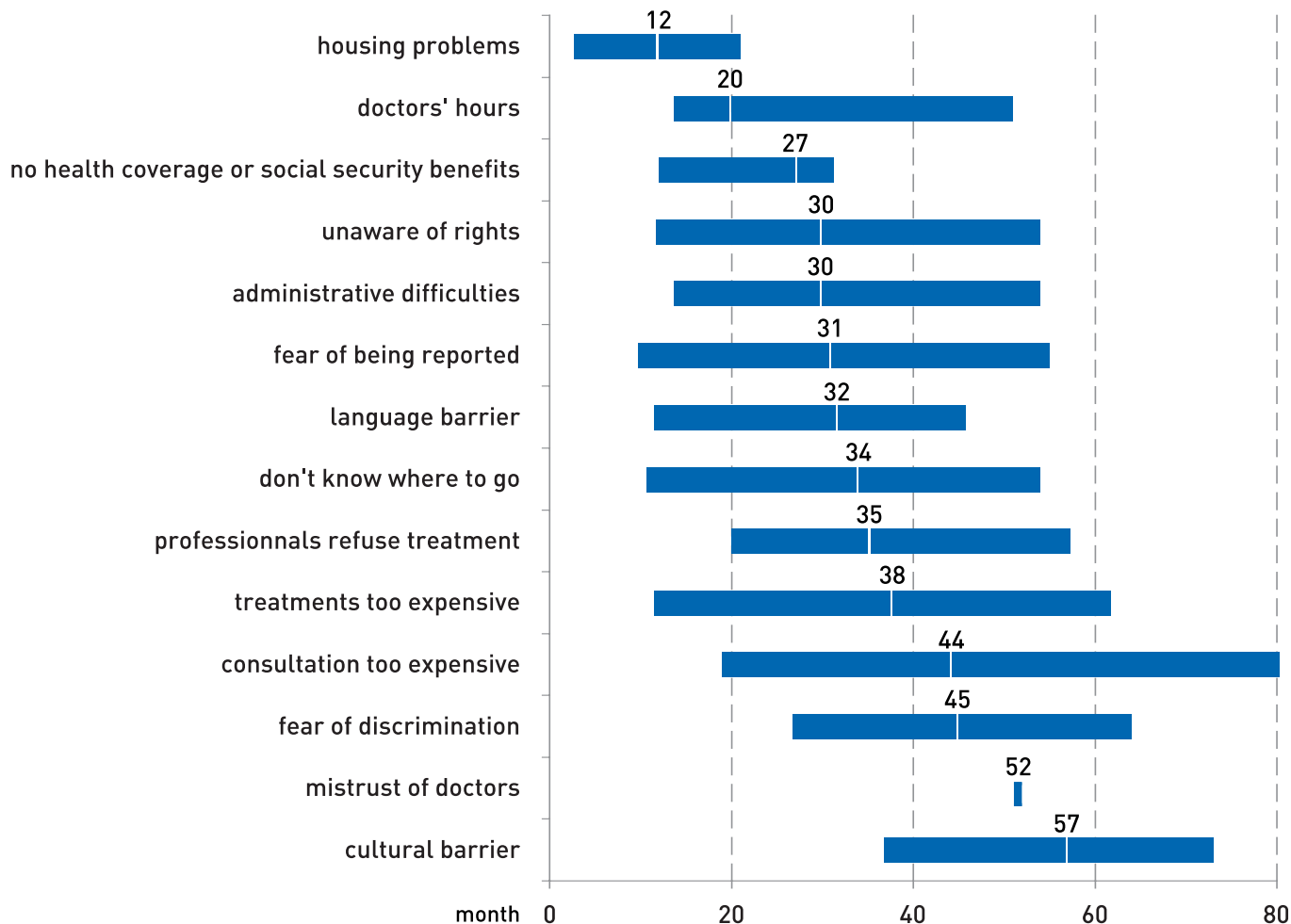
What matters most now is my baby's health and my own. If my baby or I get sick I can arrange things with my boyfriend. He's legal and has his own doctor. If anything happens to me or my baby, I think I can go see a doctor. In fact I have to see him soon because my baby needs help. He's sick right now. His skin has broken out in pimples. But my boyfriend isn't here right now and I can't go to the doctor without him. I have to wait for him to come back and we'll go together.

Things always get better when you can afford health care and medicine. The medical staff can help you better. Not having papers is no longer an obstacle then."

A correlation exists between the length of time spent in the host country and the kinds of obstacles mentioned. People who have been residing in the country for a median of 3.5 years or longer mention cultural barriers, the cost of appointments and treatments and fear of discrimination, whereas fear of being reported, administrative difficulties, unawareness of rights and housing problems are associated with shorter median periods of residence (but from one to more than two years all the same).

In other words, **the main obstacles to access to treatment change with the number of years of unauthorised residence in the host country.** At first those barriers mainly involve housing issues, doctors' working hours, lack of health coverage, fear of being reported to the authorities and not knowing where to turn for treatment. During the first few months, cultural differences are not mentioned as such. The cultural barrier is not experienced as an obstacle to access to treatment until several years have passed in the host country (after the other obstacles have been more or less removed). Financial obstacles (cost of treatments and consultations) persist for years after arriving in the host country.

Chart 23. Length of residence in the host country by type of obstacle in access to treatment (median and quarter in months)



Note to the reader: the chart gives the median length of time and the quarter lived in the host country of individuals mentioning each obstacle for each reason. For example, the median length of residence of people mentioning a housing problem as the obstacle to access to treatment is 12 months (and 50% of those residing between three and 21 months) in the host country. Cultural barriers, fear of discrimination, lack of trust in doctors (mentioned by just one person) and the high cost of consultations seem to be obstacles that persist after long periods of residence (a median of 40 months).

As we have seen, no significant correlation exists between a delay in recourse to treatment and having health coverage, but it appears to be connected to two of these obstacles. **Among barriers to treatment access and continuity, people who delay treatment mention health professionals' refusal to treat them more than the others (7.4% compared to 1.1%, $p < 0.001$) and health care services' opening times (6.1% compared to 2.2%, $p = 0.02$).** Patients also voice fears of being reported or arrested by the police and would rather not go to a doctor or the hospital.

“I put off the appointment because I was scared of the police and didn’t want to end up in the hospital.”

Excerpt from an MDM Netherlands interview with a 21-year-old woman:



“Once, I had to go to the hospital. I had internal bleeding. I think I waited too long. I was in pain but afraid to see a doctor. It ending up turning into an emergency and I had to go straight to the hospital. I put off the appointment because I was scared of the police and didn’t want to end up in the hospital.

At around 10 o’clock one night, I got very sick and had internal bleeding. But I was afraid of going to the hospital because I didn’t know exactly what to do and how it would go for me, or if the hospital would ring the police. Everybody at home was scared. I eventually took a cab to the hospital at around noon the next day. I didn’t take an ambulance because that would’ve been too expensive. The doctor said that if I had waited another three minutes chances are I would’ve died. But what could I do, besides put it off? The doctor told me that next time I shouldn’t be scared of going to the hospital, there’s no connection with the police, they don’t deal with registration problems or anything else like that. They didn’t call the police. A lot of people don’t know that and so they don’t know where they can and cannot go.

I received good care at the hospital but now I’m stuck with a big bill. I had to make an arrangement with the hospital for the payments. Today I feel fine but I’m very worried about how much my medical care costs.”

2. Refusal of care by health professionals

During the most recent health problem, **11.1% of the people concerned experienced a refusal of care by health professionals** (no matter what the health coverage situation)⁶⁷. The refusal rate observed in the survey differs significantly from one country to another ($p < 10^{-6}$): **in Belgium it is higher than the average rate and in Spain it is lowest.**

Table 28. Health care professional treatment refusal rate by country

	%	Confidence Interval (CI) 95%
Belgium	15.0	9.5 - 22.0
France	10.6	5.2 - 18.7
Greece	10.3	3.9 - 21.2
Italy	7.5	3.1 - 14.9
Spain	6.4	1.3 - 17.5
Average	11.1	8.3 - 14.3

In all, 44 health problems were refused care. **Some cases were emergencies** (in particular fractures and burns but also pregnancies and personality disorders), **serious illnesses** (insulin-dependent diabetes, viral hepatitis) **and infectious diseases** (sinusitis, pneumonia).

67. No significant difference observed between men and women or depending on age.

Table 29. Most recent health problems that met with a refusal of care

	n
Musculoskeletal symptoms	7
Gynaecological symptoms	5
Diffuse pain	3
Fractures	3
Anxiety	2
Insulin-dependent diabetes	2
Pregnancy	2
Flu	2
High blood pressure	2
Chronic alcoholism	1
Asthma	1
Other symptoms	1
Burns	1
Abdominal pain	1
Fatigue	1
Infectious gastroenteritis	1
Haemorrhoids	1
Viral hepatitis	1
Headaches	1
Pneumonia	1
Acute sinusitis	1
Cardiovascular symptoms	1
Personality disorders	1
Benign tumours	1
Drug abuse	1

Being refused care during the most recent health problem **occurs twice as frequently when the patients do not have an effective, recognised right to health coverage** (13.0%, $p=0.04$) as when they do (6.2%), but the proportion is high in either case.

Why do health care professionals refuse to treat patients with health coverage? Several factors may be involved, and they are not mutually exclusive.

First, it cannot be ruled out that a small number of patients were refused care *before* obtaining their health coverage (if they did so shortly before the survey⁶⁸). Second, it is possible that several of them do not know what types of treatment structures they have access to (when their health coverage provides access to only a part of the structures) and they may have gone to “the wrong place”; or they may be unaware that their health coverage does not cover the care requested (for example in Belgium the “*Aide Médicale Urgente*” does not pay for psychiatric treatment and in Great Britain foreign nationals without papers have access to care from GPs but not to hospitals, which perform supplementary examinations and specialised treatments).

68. The survey did not ask when patients were refused treatment in relation to when they obtained health coverage.

The high rate of people who have been refused care also has to do with the reluctance of some professionals. In France for example, some doctors refuse (directly or in a backhanded way) to see patients receiving AME (“Aide Médicale Etat”), in large part because the system is not computerised (which might make the procedures more complicated), but also because health professionals do not know much about it yet. That is what a 2006 *Médecins du Monde* France survey of 725 GPs showed: 37% of them refuse to see AME beneficiaries.⁶⁹

A public organisation using “testing” methodology recently conducted another survey in France estimating that 41% of specialists (outside hospital outpatients clinics, but including some primary care specialists, see below) in a department of the Ile-de-France region refuse to treat patients who have health coverage specifically for the destitute⁷⁰: 39% of dentists, 41% of paediatricians, 44% of gynaecologists and 50% of psychiatrists compared to “only” 4.5% of GPs.⁷¹ In those conditions, access to private doctors for AME beneficiaries – who are in even more precarious situations – is probably even more difficult. Also, some professionals in the survey countries seem to be inadequately informed about undocumented migrants’ rights to health care.

By and large, **the scientific literature (in medicine or in public health) on treatment discrimination against migrants is surprisingly scarce in Europe: a search of the Medline® publications database turned up a mere three articles published since... 1992!** (only one of which has statistical data)⁷². That points up the importance of the data on the issue gathered and reported here.

“I’m very worried about this situation of rejection”

Example of a refusal to fill a drug prescription from MDM Netherlands:



K. went from Ghana to the Netherlands in 1999.

“My diabetes was diagnosed in Ghana 10 years ago. A lot of people in my family have diabetes, so I wasn’t surprised when the doctor gave me the diagnosis. I depend on the treatment and have to take tests on a regular basis... I’m very satisfied with the access to care by health professionals in the Netherlands, but I did have a negative experience obtaining my treatment: the pharmacy refused to fill my prescription. I didn’t receive my medicine. The chemist told me I didn’t have the papers [legal residence] and that therefore he couldn’t give me my treatment. She sent me away. When I went to the pharmacy with the prescription, the lady behind the counter asked me for my ID right away. I told her I didn’t have a residence permit. She looked for my name in the computer. When she couldn’t find it, she said she couldn’t help me. I was sent away in spite of my prescription. I was very angry at that situation. I had the doctor’s prescription on me. I don’t think it was right. This incident made me angry, frustrated and sad. When I was sent away, I left the pharmacy. I couldn’t insist on getting my treatment. I wondered what to do. In fact, the best thing is to go back to the Kruispost⁷³ clinic as fast as possible and ask the doctor what to do. I’m very worried about this situation of rejection.”

69. See the *Médecins du Monde* France Mission on this point: « Je ne prends pas ces patients », *Testing sur les refus de soins des médecins généralistes pour les bénéficiaires de la Couverture Maladie Universelle ou de l’Aide Médicale Etat dans 10 villes de France*. Paris, *Médecins du Monde*, November 2006, 43 p.

70. *The Couverture Maladie Universelle*

71. *DIES. Analyse des attitudes de médecins et de dentistes à l’égard des patients bénéficiant de la Couverture Maladie Universelle complémentaire : une étude par testing dans 6 villes du Val-de-Marne*. Paris, Fonds CMU, May 2006, 80 p.

72. Peretti-Watel P, Spire B, Lert F, Obadia Y; VESPA survey team. Seropositive people infected through intravenous drug use: a persistent vulnerability. *Rev Prat* 2005; 55: 2093-100. (in French)

Eshiett MU, Parry EH. Migrants and health: a cultural dilemma. *Clin Med* 2003; 3: 229-31.

Corretger JM, Fortuny C, Botet F, Valls O. Marginality, ethnic groups and health. *An Esp Pediatr* 1992; 36: 115-7. (in Spanish)

73. *A free clinic for people without insurance*.



Conclusion

Despite methodological challenges relating to the diversity of situations and types of programmes conducted by the field teams, the first *Médecins du Monde* European Observatory for Access to Health Care report proves that it is possible to unite around shared concepts and to obtain a common view of the health of the most vulnerable migrants, those undocumented, and the problems they encounter when seeking care.

During the survey we observed a lack of data about the situation of children. They are always the most vulnerable, whether in terms of exclusion, poverty and health. Fortunately, laws in the different European countries are generally favourable to health care access for minors regardless of their parents' administrative status. Yet the children that MDM teams met in the field often have no effective access to care. Their immunisation coverage is unsatisfactory. That is why in 2007 we will probably have to conduct a specific children's survey on how the European Union's institutions care for their health.

Now we must be able to use this survey's findings in order to improve public health policies in Europe so that they definitively remove obstacles to care tied to the administrative status of the people living on its soil. We must convince political leaders and our fellow European citizens that access to health care for people in precarious situations is a barometer of our democracies.

In 2006 the *Médecins du Monde* European network pursued its goal and activities in favour of effective access to health care for migrants and the protection of seriously ill people from expulsion from the European Union by setting up *Averroès*, a network of NGOs campaigning to improve the health of asylum-seekers and undocumented migrants through promoting, drafting and implementing common, binding, non-discriminatory legal standards in the Member States within the next five years.

Health care is a fundamental right that the European States have pledged to uphold in numerous international texts. Each State is responsible for promoting the health of everyone living within its borders, reducing health care social inequality and ensuring equal access to treatment.

In keeping with the commitments made in various international instruments, the Council of Europe has advised Member States to⁷⁴:

- “ (...)
- develop a coherent and comprehensive policy framework that:
 - **secures and promotes the health of persons living in insecure conditions;**
 - **protects human dignity and prevents social exclusion and discrimination;**
 - ensures supportive environments for the **social integration** of persons living in marginal situations or in insecure conditions;
 - strengthen and implement their legislation in order to **ensure human rights protection, social solidarity and equity;**
 - (...)
 - **develop comprehensive, effective and efficient health care systems** for a timely and adequate response to health care needs in order to **ensure equity and equal access to health care services**, taking into account health care needs and available resources, and to be able to identify, assess and treat health problems of persons living in marginal situations.”

When will the Council of Europe's recommendations become a reality?

Renewing the pledge to make health care a priority goal of the EU requires consideration of the range of fundamental rights which affect access to healthcare. Reducing social inequalities and ensuring that they are addressed consistently within the EU will lead to a better future for all.

74. Recommendations of the Committee of Ministers of the Council of Europe (Rec(2001)12) to the Member States on the adaptation of health care services to the demand for health care and health care services of people in marginal situations.

Health care charter for all foreign nationals residing in Europe



Considering that it would be unworthy to participate in a continent where protection of all its inhabitants' health is not a fundamental principle, *Médecins du Monde*, after this first European report, requests the European parliament, European Commission and Council of the European Union to agree on binding standards that compel each member country to guarantee effective access to health care for vulnerable people, and in particular migrants, regardless of their status.

In order to propose the first advances in this area, the 11 *Médecins du Monde* representations in Europe, based on the field experience of each of them,

→ proposes a charter for the health of all foreign persons residing in Europe,

→ requests that this charter be fully included in the European Union's next health care strategy plan.

Médecins du Monde International Network

Taking into account that the article 25 of the Universal Declaration of Human Rights recognizes that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care...",

Taking into account that the European Human Rights Convention refers explicitly to the Universal Declaration of Human Rights,

And on the basis of our medical field experience working with the most vulnerable populations living within the European Union as well as outside Europe,

We commit all the European Member States, which signed the European Human Rights Convention to take appropriate measures in order to ensure a collective guaranty for the right to effective access to health care and prevention for all foreign residents* in Europe.

Trough our actions, we have noted that the health conditions and the access to health care of migrants and particularly undocumented migrants and asylum seekers are below the ones of the general population.

We require all the European Member States, which signed the European Human Rights Convention to recognise the right, which can be used as evidence, to real access to health care and prevention** for each foreign resident on its territory.

We require all the European Member States, which signed the European Human Rights Convention to refuse any kind of discrimination regarding access to health care and prevention based on the residence-related administrative status of the migrant.

Therefore,

- We require all the European Member States, which signed the European Human Rights Convention to ensure access to health care and prevention for all foreign residents disregarding if their residency status are regular or irregular and to provide this service in the same conditions – for persons with equal resources – that it is provided for nationals.
- We require all the European Member States, which signed the European Human Rights Convention to ensure free medical care for pregnant women (delivery, ante natal, and post natal care) as well as for minors and all foreign residents whose revenues are below the poverty line***.
- We require all the European Member States, which signed the European Human Rights Convention to provide asylum seekers with appropriate medical care, taking into account the specific consequences of the political violence they may have been victims of in their countries of origin.
- We require all the European Member States, which signed the European Human Rights Convention to grant to each foreign person suffering from a serious illness, an autonomous residence permit or another authorisation conferring the right to stay and real access to health care, unless it can be proved that he/she can receive appropriate treatment and medical care in his/her country of origin.
- We require all the European Member States, which signed the European Human Rights Convention to ensure free and effective access to health care for all the foreigners retained, kept in retention centres or waiting areas on their territory.
- We require all the European Member States, which signed the European Human Rights Convention to recognize the right for one or several independent non-governmental organisations – especially medical and human rights organisations- to have permanent access to all reception and retention centres for migrants with irregular administrative status in Europe (waiting areas, retention centres).

A person is considered one country's **resident when he/she wished to set up its main residence in this very country. In practise, this excludes all the persons who stay in a country for tourist purposes.*

*****Access to health care** includes the medical check-up, the treatment and complementary tests that would have been prescribed.*

**** The **poverty line** equals 60% of a population's median revenue.*

Methodological recommendations



Several limitations emerged during the survey, and they should be corrected in subsequent studies that the *Médecins du Monde* European Observatory is planning to conduct. Public health survey methodology recommendations can be grouped as follows:

Denominator(s)

The denominator issue (in other words the reference population supposed to be addressed by such studies) is always crucial if we want to seriously answer two questions: to which populations do the observed frequencies refer? What extrapolations can reasonably be made based on the respondents' answers?

Each participating centre should keep an exhaustive count of “eligible” persons (undocumented migrants) that come in as well as an equally exhaustive count of respondents, non-respondents and the reasons they do not answer (refusal, lack of translators, emergency treatments, etc.)

Representativeness

By this we do not mean the respondents' representativeness in relation to all the undocumented migrants in the survey city or country, which is very hard (if not impossible) to estimate due to the lack of reliable statistics about that population but also because the people who visit free clinics are clearly different — by definition and by “essence” — from others since they are ill.

Rather, it refers to the representativeness of all undocumented persons visiting each centre. It does not matter whether the survey is exhaustive (all the eligible persons are supposed to be surveyed) or based on a sample (one in two, every other day, etc.); but the procedure must be systematic and the surveyors should have no possibility of choosing the person to survey (a regular visitor, a nice person, somebody with an interesting story to tell, etc.). Likewise, the surveyor must not exclude anybody (no matter how valid the reason: language barrier, mental or behavioural disorders, a new emergency patient, etc.). **The strategy of inclusion – exhaustive or based on a sample – must be absolutely systematic and any deviations must be recorded and described.** The survey protocol provides for survey inclusion and exclusion guidelines.

In the future, the number of centres taking part in the survey should be higher in order to expand the final sample size (which also helps to boost statistical reliability) and ensure a wider diversity of the populations surveyed. It would also be desirable to include as many European countries in the Observatory as possible.

Social situations

Describing the surveyed individuals' social situations is one of the Observatory's major goals. Three kinds of recommendations can be implemented to improve the description of the situations they experience:

I. Review and specify certain characteristics

In particular, the question about **housing** should be more in line with the (few) European standards that other groups propose (especially the European Federation of National Organisations Working with the Homeless⁷⁵). Some items from the *European Social Surveys* can also be included as European standards, even though standardisation has not been completed yet⁷⁶.

75. <http://www.feantsa.org/code/fr/pg.asp?Page=546>

76. <http://ess.nsd.uib.no/index.jsp?year=2003&country=&module=documentation>

The questions about employment should also be made more compatible between the Observatory's countries by emphasizing surveyor training to try and diminish information bias relating to the risk of under-declaring **undocumented labour** in some countries.

The question on income – if the decision is made to keep it in the surveys (which is highly recommended) – must be completely reworded and surveyors at centres in countries where that question is not part of the routine questionnaire must receive specific training about it. Despite the awkwardness and/or difficulty of asking such a question, it seems indispensable to measure **total income per consumption unit** of the person's household. That requires asking about the household's composition (number of adults and number of children) and total income, all sources combined.⁷⁷

2. Round out certain dimensions

Gathering data on socio-professional categories is out of the question (there is little Europe-wide standardisation of them and they are not very differentiating in this population), but it might be interesting to collect data on the individuals' **education level** (recent surveys have shown that it is rising among migrants, including undocumented ones, and this question is easy to ask) and the **activity sector**. The latter (in particular those that habitually use undeclared and/or undocumented labour: construction/public works, agriculture, services to people, restaurant, hotel, tourism, etc.) would help illustrate the hypocrisy of many European countries' immigration policies.

A question about **command of the host country's language** (oral and written) should be added. A question about whether the interviewee is "**expellable or not**" could be asked, but that would require giving surveyors training about the survey country's legislation, which cannot be envisaged everywhere.

It would be interesting to ask questions about migration routes and conditions but perhaps a specific survey instead of systematic questioning is the best way to go about that. Without going into the details about the "travel" conditions and methods (probably studied better qualitatively through first-hand accounts rather than statistical investigations), it would be worthwhile to ask questions about **migration for health care or health reasons** or to do systematic research on **violence suffered** in the home countries or during migration.

3. Directly asking how people feel

Questions about how the interviewees feel about at least two aspects of their social situation (by questioning all the individuals, without a screening question) should be asked: the **feeling of social isolation**, which is easy to gather with a single multiple-choice question (for example: "in general, would you say that you feel very alone, alone, surrounded or very surrounded?"⁷⁸); and **forced separation from children**, which can be determined directly by the question: "were you forced to be separated from your children to immigrate because of your situation?"

Diseases

ICPC coding is an interesting, fairly complete standardised method of collecting data on medical reasons and diagnoses. The main two advantages are that it is multilingual and recognised by the scientific literature and public health authorities. The main drawback is that, to our knowledge, no routine automated data analysis tools exist yet. That analysis, which is complicated and time-consuming, is still in the research and/or ad hoc programming sphere.

The classification of diseases (by distinguishing between "acute" or "chronic" in the survey) remains absolutely necessary. It **should probably be expanded to include criteria of seriousness** in order to round out the information collected through ICPC coding. Various criteria exist, from the most empirical (the treating doctor's comments, for example) to more standardised rapid assessment scales similar to those that emergency services use or that quickly estimate the risk of death or functional incapacity.

77. In our experience, considering the low income and frequency of situations of isolation (adult living alone with 0 to X children), it is not impossible to make that estimate.

78. See the SIRS (Inserm, 2005) and AME (Drees, 2007) surveys

Lifestyles

It seems hard to imagine dropping the focus on health-related behaviour such as drinking and smoking. However, asking questions about some low-prevalence behaviour (in particular drug abuse) is not worthwhile unless we can increase the number of people surveyed (frequencies below 5% are generally not conducive to statistical analysis of populations of under 1,000 people...).

But it would be worthwhile to examine other lifestyles or at least to make the proposal and discuss it in the steering committee, in particular certain dietary habits (the poor diets of people living in precarious situations is mentioned without always being really estimated), contraception, the use of condoms,...

Care

The Observatory's steering committee has focused on some areas that are probably no longer worth systematically recording (access to medicine, in particular sources of medicine) now that the first survey's findings are known.

However, it would probably be worth considering other information about care in future surveys, in particular the need for and recourse to additional examinations and the recourse to preventive care (women's cancer screening, for example). Distinctions could also be drawn between the need for and difficulty of access to primary and secondary care. With regard to the latter point, a prior definition is necessary so that all the countries agree on that distinction (in particular with regard to paediatric, gynaecological, dental and mental health care).

Surveys of specific populations

One of this survey's methodological lessons points up the difficulty, given the system used, of bringing together enough people to specifically question children and pregnant women (and, to a lesser extent, people with HIV).

Unless the number of people systematically included in a "general" survey (by increasing the number of participating centres in each country) drastically rises, the expected frequency of pregnancies and child patients will remain too low to use the data gathered from those populations.

Two populations – pregnant women and children – require special survey methods:

- for pregnant women: either routine data collection over a much longer period of time (with analyses aggregating several years), with all the problems that prolonged information migrant women;
- for children: the system must also be completely overhauled. The current survey includes a very small number of minors. On the basis of that fact, either the centres offering undocumented migrant children must be included, or the parents who come in to the centres (for their own problems) must be asked about their children (which was not done in this survey even though it had been planned).



European enquiry

Country: _____ City/town: _____ Programme : _____

Interviewer name(s): _____

1. File number: __ / __ / __ / __ 2. Interview date: __ / __ / ____ dd/mm/yyyy

General data

3. Date of birth: __ / __ / ____ dd/mm/yyyy or Age: __ years

4. Sex : 1 M 2 F

Administrative status/Immigration status

5. What is your nationality? _____

6. Do you belong to an ethnic group? (Optional question) 1 yes 2 no

If yes, which group? _____

7. When did you leave your country of origin? __ / ____ mm/yyyy

Or number of months: ____ months Or number of years: ____ years

8. When did you arrive for the last time in (country of enquiry)? __ / __ / ____ dd/mm/yyyy

9. Since how long have you been living in (country of enquiry) without authorization (in months)? ____ months

10. Have you been ordered to leave the country? 1 yes 2 no

Access to health cover

For the interviewer:

You must write on another page specific criteria to determinate if the person could have free access to health care (criteria won't be seized)

11. Regarding his/her administrative situation, could s/he have free access to health care? 1 yes 2 no

Questions 12, 13 and 14: Only if the person could have free access to health care

12. Are you aware, that regarding your administrative situation, you can have free access to health care in a health structure of common law or in the national health system? (Formulation to be chosen according to the country) 1 yes 2 no

13. Did you make any actions to get an health cover? 1 yes 2 no

14. If so, do you have the necessary documents (health card, certificate ...) to have free access to health care ? 1 yes 2 no

Access to prevention, health care and treatments

15. Who did you consult the last time you felt ill in (country of enquiry)?

- 1 didn't feel ill
- 2 didn't consult anybody
- 3 consulted a doctor / dentist
- 4 consulted a nurse
- 5 consulted a traditional practitioner
- 6 consulted a neighbour, friend, family member
- 7 or else: _____

16. Where did you consult?

- 1 at the hospital
- 2 in a private medical office
- 3 in an health centre
- 4 in an association / NGO
- 5 at the person's place of residence
- 6 at home
- 7 or else: _____

17. What was your health problem? _____ ICPC code ____

18. Were you refused care by health professionals during this last illness? 1 yes 2 no

19. How were you treated?

- 1 with prescribed or given drugs by doctor
- 2 self medication
- 3 didn't take any drugs/ was not treated

20. If you took medicines, where did you get them?

1 in the (country of enquiry)

2 in the country of origin

3 in an other country

Access to testing and treatment for HIV / AIDS

If screening is free:

21. Do you know that you are able to have free testing for HIV? 1 yes 2 no

If screening is not free:

21'. Do you know that you can have an HIV test for X euros? 1 yes 2 no

22. Do you know where you can go to make an HIV / Aids test? 1 yes Where _____ (without data capture) 2 no

If the treatment is free:

23. Do you know that someone in your administrative situation who is HIV positive can have free treatment? 1 yes 2 no

24. Have you ever wanted to have a test for HIV? 1 yes 2 no

25. If not, why? Several possible answers

1 afraid that the results won't be kept confidential 5 doesn't know that it will be possible to have free access to treatment

2 test is too expensive 6 fear of results

3 knows that there's no free access to treatment 7 doesn't feel he/she needs it

4 doesn't know that treatment exists 8 or else: _____

26. If yes, have you been able to do a test? 1 yes 2 no

27. If yes, do you know the result? 1 yes 2 no

Health problems / access to health care and treatment

28. What would you say about your health status in general? Would you say that it is ...

1 very good 4 bad

2 good 5 very bad

3 medium 6 doesn't know

29. 30. 31. What health problems or illnesses do you have presently? Are they acute or chronic? Are they treated?

29. Problem(s) :	ICPC	30. Pathology :	31. Current treatment:
-----	---	1 <input type="checkbox"/> acute	2 <input type="checkbox"/> chronic 1 <input type="radio"/> yes 2 <input type="radio"/> no
-----	---	1 <input type="checkbox"/> acute	2 <input type="checkbox"/> chronic 1 <input type="radio"/> yes 2 <input type="radio"/> no
-----	---	1 <input type="checkbox"/> acute	2 <input type="checkbox"/> chronic 1 <input type="radio"/> yes 2 <input type="radio"/> no
-----	---	1 <input type="checkbox"/> acute	2 <input type="checkbox"/> chronic 1 <input type="radio"/> yes 2 <input type="radio"/> no

Tick only if questions 29, 30 and 31 were told by the patient in his declaration (no doctor or nurse during the data collection):

1 based on patient's declaration

32. Should the patient have received treatment earlier for one or another of his health problem (evaluation by doctor or nurse)? 1 yes 2 no

33. Do you have any problem of abuse or addiction to ... (ICPC code):

Alcohol 1 yes = P15 2 no Medicines 1 yes = P18 2 no

Tabacco 1 yes = P17 2 no Other drugs 1 yes = P19 2 no

34. If the person is HIV positive: 1 code ICPC B90

35. Have you seen a consultant? 1 yes 2 no

36. Were you prescribed any treatment? 1 yes 2 no

37. If so, did you take this treatment? 1 yes 2 no

38. Do you take ARV treatments? 1 yes 2 no (but prescribed) 3 no (but not prescribed)

39. If you didn't take the prescribed ARV, why?

1 treatment is too expensive 4 difficulties to comply

2 fear of side effects 5 refuses the therapy

3 fear of stigmatization 6 else: _____

Obstacles to access to healthcare and follow-up

40. Generally, what are the main obstacles that you encounter regarding access to healthcare and follow-up? Several possible answers

1 consultation is too expensive 6 doesn't know where to go 11 fear of being reported

2 treatment is too expensive 7 language barrier 12 no obstacles

3 health services opening hours are not adapted 8 cultural barrier 13 else: _____

4 administrative difficulties 9 care refused by health professionals _____

5 lack of knowledge of rights 10 fear of discrimination _____

Specific questions on child immunization

Questions for the minor seen in consultation

41. Has the minor been immunized and is s/he up date for?

Each country must write here the list of different types of vaccines without changing the question n°, but must add i.e. 41 a: tetanus etc; and answer for each type

1 yes (with any document that confirms the vaccination) 3 no (sure that it is not made)

2 yes, normally (is sure about being vaccinated, but is unable to justify it with a document) 4 doesn't know

Questions 42, 43, 44, 45 and 46 are to be asked to each patient who has child or children

If vaccinations are free:

42. Are you aware that your child(ren) could be immunized for free? 1 yes 2 no

If vaccinations are not free:

42'. Do you know that you / your child(ren) could be immunized for X euros? 1 yes 2 no

43. Do you know where it is possible to have immunization made? 1 yes Where _____ (no data capture) 2 no

44. Have you ever wanted to have your child(ren) immunized in (country of enquiry)? 1 yes 2 no

45. If yes, were you able to? 1 yes 2 no

46. Why couldn't your child be immunized?

- 1 too expensive
- 2 immunization centres opening hours not adapted
- 3 doesn't know where to go
- 4 language barrier
- 5 cultural barrier
- 6 fear of being reported
- 7 refuses vaccines
- 8 child(ren) not at school : so, no need to be immunized
- 9 other: _____

Specific questions for pregnant women

47. How long have you been pregnant for? 1 ___ months 2 doesn't know

48. Have you had access to antenatal care during this pregnancy in (country of enquiry)? 1 yes 2 no

49. If so, how many times? ___

50. Was it free (according the country of enquiry)? 1 yes 2 no

51. If you did not get antenatal care (no consultation and three months pregnant minimum), why? Several possible answers

- 1 financial difficulties
- 2 administrative difficulties
- 3 lack of knowledge of rights
- 4 doesn't know where to go
- 5 language barrier
- 6 cultural barrier
- 7 care refused by professionals
- 8 fear of being reported
- 9 fear of discrimination
- 10 opening hours not adapted
- 11 has not free pregnancy monitory
- 12 didn't know she was pregnant
- 13 no obstacles
- 14 else: _____

52. Did you have an HIV/AIDS test during your pregnancy? 1 yes 2 no

Social status

53. Do you live: 1 alone 2 with a partner 3 with your family or friends

54. Do you have any children? 1 yes How many? ___ 2 no

55. If so, how many live with you at the present time? ___

56. Your accommodation is:

- 1 stable (Personal, shared, or stable accommodation with friends or family ...)
- 2 unstable or temporary (with family, friends, squat with water and electricity, caravan, hostel ...)
- 3 homeless (Street, shelter, squat without water and electricity, collective public accommodation...)

57. How many people live in your home? ___

58. Among them, how many children are there? ___

59. Do you have an activity to earn some money to live? 1 yes 2 no

60. How much money does your family have to live monthly, in euros? amount _____ € / month

Do you have anything to add?

“It’s necessary to forge respect, no fear”

F., MDM France patient, Lyon, february 2006



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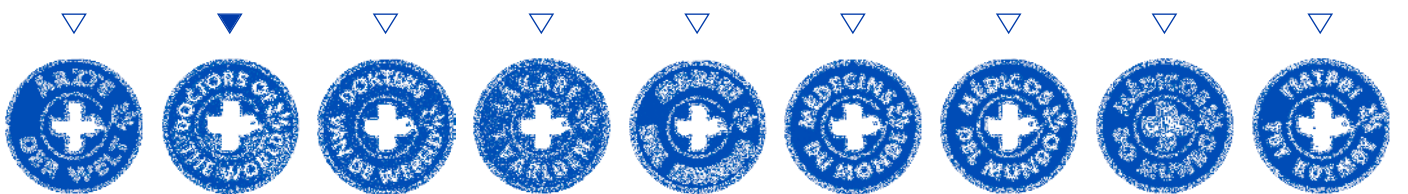
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