Access to healthcare for people facing multiple vulnerability factors in 27 cities across 10 countries. Report on the social and medical data gathered in 2013 in eight European countries, Turkey and Canada

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

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"I am a lesbian. I had a forced marriage which is why I'm pregnant. I had to flee for my life. At the hospital here they gave me an estimate for the cost of my delivery of €5,000 to €12,000." MdM UK, London, 2014.

May 2014

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Contents

Executive summary

This Doctors of the World – Médecins du monde (MdM) report presents the analysis of data collected in 27 cities in 10 countries: eight European countries, together with Turkey and Canada.

In 2013, this data covered 18,098 people (16,881 of whom were in the eight European countries) and 31, 067 contacts (29,400 of whom were in the eight European countries), 17,393 medical consultations (15,799 in the eight European countries), leading to 23,697 different diagnoses which were recorded and coded (21,913 of which were in the eight European countries).

This year we wanted to reiterate the need for unconditional access to both antenatal care for pregnant women and to essential childhood vaccinations, neither of which are currently universally guaranteed. This amounts to a denial of rights which goes against basic human rights, international conventions and respect for the fundamental principles of public health.

The results for 2013 show that, among the **353 pregnant women seen**, **close to 70% had had no access to antenatal care before coming to one of our health centres and over 40% received care too late, i.e. after the 12th week of pregnancy**. At their first medical consultation, **the doctors considered in over 70% of cases that the individuals required urgent or semi-urgent care. Thus two thirds of pregnant women and their unborn children seen by Doctors of the World (MdM) were put at risk.**

In 2013, 1,703 children attended one of the European centres and were recorded on the database, i.e. 10.4% of patients. **Of these, at best only half had been vaccinated against tetanus, hepatitis B, measles and pertussis (whooping cough). In some countries this rate was less than 30%, well below vaccination coverage rates for the general population of around 90%.**

As the general population faces rising poverty, some political parties are taking advantage of the situation to target destitute migrants who are easy scapegoats.

At the same time, in many countries, groups which were already vulnerable before the crisis (undocumented migrants, asylum seekers, drug users, sex workers, destitute European citizens and homeless people) are seeing a deterioration or even removal of the safety nets and social networks which provided them with basic support. Health coverage systems are being eroded, leaving the patient to bear a growing proportion of the costs, despite their lack of financial resources; and this at a time when an ever larger number of vulnerable people are in increasing need. **This injustice challenges the very foundation of social solidarity in Europe and must be strongly opposed.**

Non-governmental organisations (NGOs) and service providers offer solidarity, but ultimately it is the role of governments themselves to ensure that vulnerable groups are protected. Yet some seem to forget this when faced with the pressure of short-term economic decisions and austerity measures. Vulnerable people need more protection in these times of crisis, not less.

Almost half the patients seen by Doctors of the World have permission to reside in Europe. For people from both the EU and beyond who do not have permission to reside, the situation is even more difficult.

A number of studies have shown the importance of identifying previous experiences of violence among migrant populations. **In 2013, 76.3% of people asked reported having had at least one violent experience.** The majority of these were migrants from the Middle East and asylum seekers. The types of violence most frequently reported were hunger and having lived in a country at war. **Almost 20% of people reported having experienced violence in the country where they were surveyed.**

Over a **quarter of patients seen by MdM felt that their general state of health was poor or very poor**. **However,** personal **health only represented 2.3% of the reasons cited for migration**, a figure close to

that seen in previous years. **These figures demonstrate once again how unfounded the rhetoric is against migrants, accused of coming to take advantage of European healthcare systems.**

Almost two thirds of patients had no coverage for healthcare charges when they first came to our centres.

The three barriers to access care most frequently cited by patients were financial problems (25.0%), administrative problems (22.8%) and lack of knowledge or understanding of the healthcare system and of their rights (21.7%). **These results clearly contradict the myth that migrants come to Europe for the purpose of using healthcare services.**

As healthcare professionals, and in accordance with the codes of ethics for medical professionals, we demand the right to provide care to all patients, irrespective of their administrative status, ethnic origin or financial resources.

We call for the establishment of national, universal healthcare systems built on solidarity, equality and equity and open to everyone living in the European Union (EU).

With regard to particularly vulnerable groups, such as children and pregnant women, these systems must allow unconditional access to antenatal and postnatal care, national vaccination programmes and paediatric care.

In times of crisis, access to care must be strengthened.

2013 in figures

18,098 patients seen in 27 towns and cities in 10 countries, 8 of which were European countries together with Canada and Turkey.

31,067 consultations of which 17,393 were medical consultations

23,697 diagnoses

For the 353 pregnant women

Amongst the pregnant women seen in the 8 European countries:

- 66 % had no access to antenatal care
- 43 % had received care too late
- 70 % required urgent or semi-urgent care according to the doctors
- 32 % lived in accommodation harmful to their health
- 89 % lived below the poverty line
- 36 % reported poor levels of moral support
- 64 % did not have the right to reside
- 84 % had no health insurance

In Istanbul, 100% of the pregnant women seen had no healthcare coverage.

In Montreal, one pregnant woman in two had a tourist or short stay visa but 95% had to bear all their health costs.

For the 1,703 children seen in Europe

35 % had been vaccinated against hepatitis B (except in Greece where the figure is 58%)

At best, 50% had been vaccinated against pertussis and measles.

On average 70% had not been vaccinated, or did not know if they had been vaccinated, against hepatitis B, measles or pertussis.

For all the people seen in the 8 European countries

44% were women

The median age was 32

95% were foreign nationals

93% were living below the poverty line

11% had no fixed abode

35% declared their accommodation as harmful to their health or that of their children

16% could never count on someone and were thus completely isolated

51% had migrated for economic reasons, 31% for political reasons and 23% for family reasons

Only 2.3% had migrated for health reasons

46% had the right to reside in Europe

38 % were or had been involved in an asylum application

Three quarters (76.3%) of the patients who were questioned on the issue reported that they had been through at least one violent experience

77% of men and 42% of women had lived in a country at war

47% of men and 27% of women had suffered from hunger

10% of women had reported suffering assault and 6% had been raped

20% of acts of violence had been perpetrated since the victim's arrival in the survey country

Health status

63% had a deteriorated state of health

26% perceived their health to be poor or very poor

28% said their mental health was poor or very poor

34% had at least one chronic illness

30% had at least one health problem which doctors deemed to require treatment but which had never been treated before their consultation with MdM

Barriers to accessing healthcare

65% of the people seen in Europe had no healthcare coverage whatsoever

The barriers to accessing healthcare most often cited were financial hardship (25%), administrative problems (23%) and lack of knowledge or understanding of the healthcare system and of their rights (22%).

22% gave up seeking medical care or treatment during the course of the year

17% had been denied care on at least one occasion over the last year

5% had experienced racism in a healthcare setting during the course of the year

61 % of patients without permission to reside said they restricted their movement or activity due to fear of arrest

Context: the impact of the crisis on healthcare systems

A growing body of scientific evidence has recently been produced on the precise effects of the economic crisis on population health. However, only the very early effects of the crisis are apparent thus far, as health data is published with a delay of several years[1].

The documented effects of the crisis and austerity measures throughout Europe

The proportion of people at risk of poor mental health increased by over 3 million in the EU between 2007 and 2011. Housing and job insecurity have predominantly been responsible for this increase[2]. The number of suicides[3] among people under the age of 65 has risen in the EU since 2007[4]. The high vulnerability to mental health problems among the most disadvantaged people may be explained by factors such as feelings of insecurity and hopelessness, poor education, unemployment, indebtedness, social isolation and poor housing[5]. Recent HIV outbreaks related to intravenous drug use in Greece and Romania have interrupted a positive trend of decline in the number of new HIV infections related to drug use[6]. The proportion of people reporting a good or very good health status significantly decreased, especially among people with a low income[7]. Among patients seen in Doctors of the World open health centres in 2013, 27.6% declared they were in poor or very poor mental health.

Strong social protection mechanisms have been shown to mitigate some of the negative effects recession has on health[8]. But in many countries, people's contributions to public healthcare coverage and/or their share of out-of-pocket payments have increased[9]. Bulgaria, Greece, Portugal, Romania and Slovenia increased employer and employee contributions to statutory health insurance. In many other countries[10], users' charges for health services have been introduced or increased, in response to the crisis and to bring down the budget deficit in public health insurance plans or for health services.

Public healthcare services, especially emergency wards, often remain the only place from which some people can access healthcare.

People having to deal with a range of vulnerability factors already faced major health inequalities before the crisis hit Europe. Yet many harm reduction programmes with drug users underwent cuts in the recent years (e.g. Portugal[11], Greece, Spain, Romania and Hungary) and the stigmatising policies in some countries clearly led to an opposite 'harm induction' effect with consequent higher Hepatitis C (HCV) and HIV prevalence[12]. Examples of such policies are the criminalisation and incarceration of sex workers or drug users and obligatory HCV or HIV screening. These all raise the threshold for testing and treatment

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1 Karanikolos M, Mladovsky P, Cylus J, Thomson S, Basu S, Stuckler D, Mackenbach JP, McKee M. Financial crisis, austerity, and health in Europe. *Lancet* 2013; 381: 1323–31.

2 Based on Eurofound analysis of Europe quality of life surveys (EQLS). See: *Impacts of the crisis on access to healthcare services in the EU*. Dublin: Eurofound, 2013.

3 Karanikolos M, Mladovsky P, Cylus J, et al. *op. cit*.

4 Sources: WHO Mortality Database and Eurostat, 2013.

5 Impact of economic crises on mental health. Copenhagen: WHO Europe, 2011.
Stuckler D, Basu S. *The Body Economic: Why Austerity Kills*. New York: Basic Books, 2013.

6 Collective. *European Drug Report. Trends and developments.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2013

7 Collectif. *Impacts of the crisis on access to healthcare services in the EU*. Dublin : Eurofound, 2013

8 Stuckler D, Basu S. *The Body Economic: Why Austerity Kills*. New York: Basic Books, 2013.

9 Mladovsky P, Srivastava D, Cylus J, Karanikolos M, Evetovits T, Thomson S, McKee M. Health policy responses to the financial crisis in Europe. Genève: WHO & European Observatory on Health Systems and Policies, 2012, Policy Summary n. 5.

10 Armenia, Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, Netherlands, Portugal, Romania, Russia, Slovenia, Switzerland and Turkey.

11 For instance, see EATG (2014), The impact of economic austerity on the HIV response in Portugal: a community perspective

12 Collective. *Who is paying the price for austerity?* Amsterdam: Correlation Network (Policy paper), newsletter 03/2013

and render people more vulnerable with, obviously, no improvement for their health. Cuts were also seen for harm reduction services and low threshold health services that support sex workers[13].

Homelessness is increasingly being criminalised through anti-begging fines (e.g. Spain, the Netherlands)[14]. Discriminatory practices are sometimes used to prevent homeless people from accessing social services and shelter[15].

Finally, the elderly are also increasingly hit by the crisis and austerity measures. In 2013, the Organisation of Economic Cooperation and Development (OECD) recognised and highlighted the importance of public healthcare services to provide support to the most vulnerable elderly at a time when cuts are being made to pensions[16]. The number of retired people facing problems accessing care has escalated rapidly, especially for those who live in remote areas or those with poor medical coverage. That is why MdM Portugal has introduced, for example, the "Viver Saudável" project, in which neighbourhood health centres and mobile programmes provide support to the elderly in Lisbon, Porto and Evora. With over 15,000 home visits a year, this programme offers medical care and other activities to improve the quality of life for the destitute elderly.

Impact on women's and children's health

In times of economic crisis, pregnant women and children should be specifically protected through social welfare. This is not what we have seen. According to official figures a quarter to a third of the Greek population is now without any health coverage at all. As a consequence, uninsured pregnant women have to bear the full costs for their antenatal care and delivery (around €1,300), which has become impossible for the average family. Greece has suffered a huge drop in its number of live births and the number of stillbirths increased by 21.15 % from 2008 to 2011[17].

Financial barriers preclude a growing number of children from accessing essential healthcare services such as vaccination; some national legislations also hinder children from accessing vaccination and medical follow up, when their parents are undocumented.

Policies based on fear and intolerance instead of evidence based policies

Healthcare systems should be efficient and financially sustainable. In order to be efficient, they have to cover the whole population, leaving no gaps; in particular they should not exclude from the system people confronted with multiple vulnerability factors. In times of crisis, especially when crisis hits as harshly as it has in Spain and Greece, most people start fearing what tomorrow will bring for themselves and their family. In times such as these, some stakeholders and extremist groups enter into their political machinations by feeding increasingly on these fears. Solidarity is then quickly replaced by exclusion and rejection and scapegoating become widespread, with the exploitation of the legitimate fears of the people in Europe as they are confronted by a bleak present with high unemployment rates, cuts in salaries and not much hope for a better future.

For instance, in **Spain**, adult undocumented migrants have been excluded from essential healthcare since Royal Decree-Law 16/2012 came into effect in September 2012. Undocumented pregnant women and

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13 Jakobsson P. *Sex work in Europe: the legal landscape and a rights-based way forward*. Amsterdam: Correlation Network, 2013.

14 Collective. *On the Way Home? Monitoring Report on Homelessness and Homeless Policies in Europe*. Brussels: FEANTSA, 2012

15 European Parliament resolution of 16 January 2014 on an EU homelessness strategy (2013/2994(RSP))

16 OECD. *Pensions at a Glance 2013: OECD and G20 Indicators*. Paris: OECD Publishing, 2013.

17 Simou E, Stavrou M, Kanavou E, Koutsogeorgou E, Roumeliotou A. *Association between birth rates and selected socio-economic indicators in a time of economic crisis: the case of Greece*. Athens: Department of Epidemiology and Biostatistics, National School of Public Health, in press.

children were explicitly not concerned by this new law, yet they too have been frequently denied access to essential services since the decree came into force[18]: the political message on exclusion of undocumented migrants was stronger than the law.

When discussing the right to free circulation of persons across the EU, some UK politicians invoked the danger of 'benefit tourism'. In reality, mobile EU citizens are net contributors to national social welfare systems and the expenditures associated with their healthcare are very small relative to the size of total health spending in the host countries[19]. Nevertheless, the UK Department of Health is planning to extend and create new NHS charges for visitors and migrants. The proposed measures will include extra prescription fees, charging for emergency care and higher rates for using opticians and dentists from March 2015 onwards. It is expected that these changes will add new barriers for migrants to access healthcare. Even before these measures are put into place legally, the political message of restricting migrants' access to care leads to greater confusion among health professionals, refusal of even primary care and a general lack of understanding among migrants about what care they can access.

In **Belgium**, an 'urgent medical care' scheme theoretically allows undocumented migrants to access essential healthcare services (both preventive and curative). But in Antwerp, the country's second biggest city, the social welfare centre has been extremely restrictive in its interpretation of national law for many years. Local authorities are clearly convinced that by restricting care, they will be able to regulate migration flows, a policy tool proven to be unethical and ineffective.

In **Greece**, the brutal attacks and hate crimes against ethnic minorities that we described last year are far from over. In 2013, MdM Greece has dealt with several minors who were witnesses to acts of racist violence towards their parents or who were victims themselves.

[18] Collective. Un año de exclusión sanitaria, un año de desobediencia. Madrid: Yo Sí Sanidad Universal, Campaña de desobediencia al Real Decreto-Ley 16/2012, 2013.

[19] Juravle C, Weber T, Canetta E, Fries Tersch E, Kadunc M. Fact finding analysis on the impact on Member States' social security systems of the entitlements of non-active intra-EU migrants to special non-contributory cash benefits and healthcare granted on the basis of residence. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2013

Some positive changes in national policies

In 2013, some governments also took positive steps to protect the most vulnerable; measures that are rare and so all the more noteworthy!

In **Sweden**, undocumented migrants and their children used to only have access to emergency care that was billed afterwards. In July 2013, a new law came into force that allows all children to access public healthcare free at the point of delivery. Undocumented adult migrants have obtained the same rights as asylum seekers: they can access healthcare "that cannot be postponed", ante and post natal care, family planning, termination of pregnancy and dental care "that cannot be postponed", provided that they pay the €6 fee for every visit to a doctor or dentist. Many healthcare professionals are still unaware of these changes. Furthermore, the law is not always correctly applied: migrants are sometimes asked to pay more than they should, or are denied access to care. The major problem is that migrants often cannot know what will be considered as care "that cannot be postponed", especially as each medical doctor will have her/his own interpretation of these criteria. Nevertheless, the new law is a major step forward in allowing the most vulnerable to seek medical care when they need to.

In **France**, the income threshold for applicants to free healthcare was raised, thereby granting an additional 600,000 patients access to full healthcare coverage. The same threshold is also valid for State Medical Aid (AME) for undocumented migrants. Additionally, the 30 Euros entrance fee to State Medical Aid for undocumented migrants, introduced by the previous government, was repealed in 2012.

In Germany, people who had lost their health coverage have had to pay 5% interest on their debt (payment for their health coverage) since 2007, if they wanted to regain their health coverage. According to the law of August 2013, they "only" have to pay 1% interest and now stand a chance of being exempt from their debts.

Introduction to the 2013 survey

In 2006 and 2008, the Doctors of the World (*Médecins du Monde – MdM*) European Observatory on access to healthcare[20] conducted a survey which focused specifically on undocumented migrants[21]. The survey was based on samples of patients in a number of European countries[22]. In 2012, the International Network Observatory presented data collected from all the patients who attended MdM health centres, rather than just undocumented migrants, in five European cities (Amsterdam, Brussels, London, Munich and Nice) [23]. Last year, the 2013 report (based on data collected in 2012 in 14 cities across seven European countries) focused on the barriers to accessing healthcare and the living conditions of people excluded from healthcare systems in Europe in times of crisis and rising xenophobia[24]. All the reports produced by the MdM International Network Observatory on access to healthcare are available at: www.mdmeuroblog.wordpress.com.

This year, we are pleased to present this report with analyses of routinely collected data from 27 towns and cities in ten countries: Antwerp and Brussels in Belgium; the canton of Neuchâtel including La Chaux-de-Fonds in Switzerland, Munich in Germany; Athens, Mytilene, Patras, Perama and Thessaloniki in Greece; 11 cities in Spain (Almeria, Malaga, Seville, Bilbao, Madrid, Palma de Mallorca, Zaragoza, Toledo, Tenerife, Valencia and Alicante); Amsterdam and The Hague in the Netherlands; Nice and Saint-Denis in France; London in the United Kingdom; and, for the first time, Istanbul in Turkey and Montreal in Quebec[25].

Thus, gradually the coverage of the routine data that is collected and analysed is being extended throughout the MdM international network. The generic medical and social questionnaires are reviewed each year to improve the quality of the data and analysis produced. Such analysis is intended to be a "statistical testimony", a snapshot of the situation of those living at a severe social disadvantage who have been encountered in MdM's various programmes in Europe and wherever an MdM association exists (with a Healthcare and Advice Centre). Countries where people are dealing with escalating, multiple vulnerability factors often only have one option for healthcare: those offered, for free and unconditionally, by non-governmental organisations such as ours.

With all their imperfections and biases, these analyses are crucial and highly instructive as they provide information on the living conditions, health status and access to care for the most vulnerable; those people who never appear in public statistics and very rarely in academic research on public health.

[20] In 2011 the European Observatory was renamed the International Network Observatory.

[21] Chauvin P, Parizot I, Drouot N, Simonnot N, Tomasino A. *European survey on undocumented migrants' access to health care.* Paris: Médecins du monde European Observatory on Access to Health Care, 2007, 100 p.

[22] Chauvin P, Parizot I, Simonnot N. *Access to healthcare for undocumented migrants in 11 European countries*. Paris: Médecins du monde European Observatory on Access to Health Care, 2009, 154 p.

[23] Chauvin P, Simonnot N. *Access to health care for vulnerable groups in the European Union in 2012*. Paris: Médecins du monde International Network Observatory on Access to Health Care, 2012, 23 p.

[24] Chauvin P, Simonnot N, Vanbiervliet F. *Access to healthcare in Europe in times of crisis and rising xenophobia: an overview of the situation of people excluded from healthcare systems*. Paris: Médecins du monde International Network Observatory on Access to Health Care, 2012, 46 p.

[25] Throughout this document, countries are cited in alphabetic order by their official international code, according to European recommendations (*Interinstitutional Style Guide*, EU, Rev. 14 / 1.3.2012). Quebec is thus cited under the code "CA" for Canada. In all the countries, we note that the data expresses the average results through different programmes for those cities associated with the network (between one and eleven, according to the country).

Methods

Each patient who had a consultation through one of the MdM programmes associated with the International Network Observatory in 2013 was interviewed using at least one of three, standardised, multilingual questionnaires (social questionnaire, medical questionnaire and medical re-consultation questionnaire(s)).

In the following analyses, the proportions presented relate to all the responses given (unless stated otherwise). The proportion of missing data is systematically indicated when it exceeds 10%. Missing data is related to one of the following three situations: either the question was not asked in certain countries (who decided to adapt the common questionnaires); or the issue was not raised by certain programmes or volunteers (relating to certain issues, such as for example violence); or (but more rarely) the interviewee preferred not to answer the question.

The following abbreviations are used throughout this report:

- BE (Belgium) for Antwerp and Brussels
- CA (Canada) for Montreal (Quebec)
- CH (Switzerland – Confédération Helvétique) for the canton of Neuchâtel and La Chaux-de-Fonds
- DE (Germany – Deutschland for Munich
- EL (Greece – Ellada) for Athens, Mytilene, Patras, Perama and Thessaloniki
- ES (Spain – España) for Almeria, Malaga, Seville, Bilbao, Madrid, Palma de Mallorca, Zaragoza, Toledo, Tenerife, Valencia and Alicante
- FR (France) for Saint-Denis (in the suburbs of Paris) and Nice
- NL (Netherlands – Nederland) for Amsterdam and The Hague
- TR (Turkey) for Istanbul
- UK (United Kingdom) for London

A summary of the programmes and locations surveyed

MdM have been working to improve access to healthcare and human rights protection since 1980. We are an international aid organisation that provides medical care and aims to improve access to healthcare for people all over the world facing numerous vulnerability factors.

Through our national programmes we work mainly with homeless people, drug users, destitute European citizens, sex workers, undocumented migrants, asylum seekers and Roma communities. In addition to the medical care we offer, **we collect data on the main social determinants of health and the patients' health status to raise awareness about the difficulties they face**. We provide patients with information about healthcare systems and their rights in relation to accessing care.

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

In **Belgium,** routine data were collected during medical, social and psychological consultations which take place during the day at the two Healthcare and Advice Centres (*Centres d'accueil, de soins et d'orientation – CASO and COZO*) in Brussels and Antwerp. These free consultations provide access to care for vulnerable individuals, regardless of their administrative status. The aim is also to reintegrate people into the mainstream healthcare system, by providing them with information about their rights and helping them to exercise these rights. These consultations are provided by volunteer health professionals (general

practitioners, psychologists, etc.) and non-medical volunteers (reception staff, interpreters, etc.). Paid social workers assist the patients throughout the process of seeking health coverage. Medicines can be provided free of charge where patients do not have the necessary resources to acquire them.

In **Switzerland**, in the canton of Neuchâtel, MdM provides social welfare advice and nurse-led consultations. These are provided by the Health and Migration Network (*Réseau Santé Migrations – RSM)* in La Chaux-de-Fonds and are aimed mainly at migrants. MdM also provides nurse-led consultations at centres for asylum seekers.

In **Germany**, open.med, in partnership with Café 104[26], an organisation in central Munich, offers free medical consultations and social welfare advice for people without health insurance, such as vulnerable European citizens (including German nationals) and undocumented migrants (the requirement for officials to report all undocumented migrants to the Federal Office for Migration and Refugees effectively means the latter have no access to the healthcare system and the only option available to them is accident and emergency services). The issue of access to rights and the public healthcare system is dealt with by social workers.

> Gisela is a 55-year-old German woman. "*The first time I heard about Doctors of the World was on the TV. I was amazed to realise that there were lots of other people without health insurance".* In May 2013, Gisela came to MdM. She hadn't seen a doctor for four years. After losing her job, she had become severely depressed. *"I was constantly frightened, especially about losing my flat. I couldn't even manage to pay the 500 Euros a month for my health insurance".* The MdM doctor examined her and ordered a blood test which showed she was severely anaemic. At a follow-up appointment the doctor, suspecting an auto-immune disease, referred her to hospital where she was denied access due to her lack of health insurance. The hospital asked for a payment guarantee of €200. Eventually, following an appeal by MdM, she was admitted to hospital for two weeks. On leaving hospital, follow-up appointments were provided free of charge by an MdM volunteer doctor. She has now made an application for her health insurance to be reactivated, after having been informed by MdM about the new law in Germany (as of August 2013)[27]. If there is no progress, the MdM team will help Gisela to regain her health insurance.
>
> MdM Germany – Munich – January 2014

In **Greece**, the economic and social situation and the severity of the austerity measures are having serious consequences on vulnerable populations accessing healthcare. MdM is stepping up its work in the country in response to these huge needs. In 2013, an analysis was conducted of some of the medical and social data from the five centres[28] in Athens, Patras, Perama, Thessaloniki and Mytilene (on the island of Lesbos). These facilities provide primary healthcare and psychological support to anyone without access to the national healthcare system. Medicines are also provided free of charge. In Mytilene, medical, psychological and legal assistance is offered to migrants arriving on the island by boat and requiring international protection. Patras also receives large numbers of migrants.

In **Spain**, MdM manages health and social care centres for immigrants (CASSIM), the main aim of which is to integrate people into the mainstream health and social care facilities. To this end, the teams run awareness-raising and health promotion campaigns, as well as training and information events for professionals working in public healthcare facilities, and training courses with and for intercultural

[26] Café 104 – http://cafe104.maxverein.de

[27] Prior to the law of August 2013, individuals who lost their health insurance had to pay 5 % per month interest on their debt (contributions) going back to 2007. From now on, they will pay 1 % interest per month.

[28] In 2013, in Athens only around 3% of patients were included in the database analysed in this report; in Thessaloniki it was around 13%, in Patras 50%, in Perama 57% and in Mytilene 91%.

mediators. For the 2013 Observatory report, the questionnaire was given to 130 patients at the CASSIM centres in Tenerife[29], Zaragoza, Bilbao, Seville, Malaga, Madrid, Alicante and Valencia over the course of three weeks in December. The questionnaires were also given out in Mallorca, Almeria and Toledo. The responses to the 130 questionnaires were incorporated into the analysis, even though they did not result from routine data collection over the whole year, as was the case in the other countries

In **France**, MdM has established, since 1986, specially tailored facilities to respond to the needs of the most excluded groups (especially those without adequate health coverage and/or with minimal financial resources). These facilities are, in 2013, the 20 Healthcare and Advice Centres (*Centres d'accueil, de soins et d'orientation – CASO*) in France. They offer social welfare and medical consultations, as well as assistance for individuals seeking to access the mainstream healthcare system. The data from the CASO in Saint-Denis and Nice were analysed for the International Network Observatory report.

In the **Netherlands**, MdM runs a weekly advice clinic for undocumented migrants in Amsterdam and The Hague. People are provided with information about their rights and directed towards health professionals in the mainstream healthcare system, especially general practitioners, in order to guarantee continuity of care.

In the **United Kingdom**, MdM runs a healthcare and advice centre in east London where volunteers, doctors, nurses, support workers and social workers offer primary healthcare to excluded groups, especially migrants and sex workers. A large part of the centre's work involves helping patients to register with a general practitioner, the entry point to the healthcare system.

In **Canada**, MdM runs a general medicine clinic in Montreal for migrants facing difficult situations. Migrants without health insurance (adults and children) are welcomed, cared for and offered guidance by the medical and non-medical volunteers. The Canadian data included in this report comes from the Montreal Migrants project.

In **Turkey**, a Turkish association, ASEM (the Association for solidarity and support for migrants) manages a socio-medical centre in partnership with MdM, for those without access to public healthcare facilities in Istanbul. These are mainly asylum seekers, refugees or foreigners without documents. In this centre, the patients are also given information on their health rights, although they have very few legal avenues for treatment that is free or at little cost.

> Ahmed, aged 7, consulted the ASEM centre with his father in September 2012 for a genital malformation. He has already undergone seven operations but they have proved unsuccessful. The doctor at the centre directed him to the university hospital. A surgical intervention was scheduled for 16th December 2012. Once more the surgery failed. In 2013, Ahmed suffered from urinary retention together with high fever and pain. He was therefore once again sent to the emergency room at the university hospital where he was hospitalised for 53 days. ASEM picked up the hospital bill and paid €880, before obtaining a new surgery. This rate was obtained by the United Nations High Commission for Refugees (UNHCR) on request from ASEM. Indeed, this is the rate applied to Turkish people without social security; the rate for migrants is twice as high. The next surgery is planned for February 2014. Again ASEM will assume the costs for this new operation with the same "benefits" as before.
>
> MdM Turkey – Istanbul – 2013

[29] In Tenerife 25 surveys were handed out over the course of 2013.

Statistics

This report contains data in three different types of proportion.

The proportions by country are all *crude proportions* and include all the survey sites (irrespective of the number of cities or programmes[30]).
The total proportions were calculated for the eight European countries[31] and are, for the most part and unless otherwise indicated, *weighted average proportions* (WAP) i.e. the global proportion if all the countries had contributed for the same number of patients; this allows actual differences between countries to be corrected and they then each have the same weight in the overall total. Where there are significant differences between this *weighted average proportion (WAP)* and the *crude average proportion (CAP)*, the latter (which does not account for the relative contribution of countries with low numbers) is sometimes also given for information purposes.

For pregnant women, only the crude average proportions (CAP) have been given, due to the low figures[32] (for the same reason, the proportions for each country will be cited with due caution as they refer to fewer than 100 women, and usually only a few dozen).

When referring to children, we have usually used weighted average proportions (WAP), which are given by default (so not specified). However, when certain figures are also low, the crude average proportions (CAP) are given (and the type of proportion is then always specified).

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

Standard statistical tests were used for some comparisons: mainly the Chi-squared test or Fisher's exact test when the figures were low. All the statistic tests were performed on the crude unweighted figures using the SAS software (v. 9.2, SAS Institute Inc., Cary, NC, USA). Let us note that a $p < 0.05$ denotes a statistically significant difference.

[30] Within one country, if a programme in one city sees ten times fewer patients than another programme in another city, the former will count for one tenth of the latter.

[31] Data for Quebec and Turkey are not included in these totals.

[32] The same is true for the questions on violence, which were not systematically talked about with the patients.

Numbers surveyed

This report is based on the analysis of data from 18,098 individuals, of whom 1,755 were children and 353 were pregnant women. Of those surveyed 34.5 % were women.

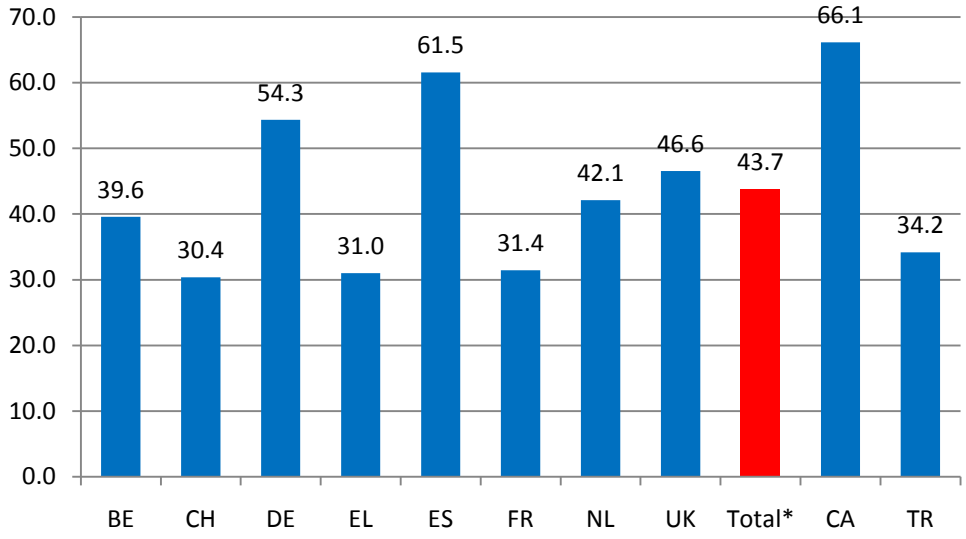
Table 1. Number of patients and survey periods by country.

Country	N° of patients	% of total	Survey period
BE (2 cities)	2 382	13.2	01/01/2013-31/12/2013
CA (1 city)	204	1.1	01/01/2013-19/12/2013
CH (1 city)	237	1.3	03/01/2013-30/12/2013
DE (1 city)	520	2.9	04/01/2013-27/12/2013
EL (5 cities)*	3 430	19.0	01/01/2013-31/12/2013
ES (11 cities) **	130	0.7	02/12/2013-26/12/2013
FR (2 cities)	9 002	49.7	01/01/2013-26/12/2013
NL (2 cities)	133	0.7	03/01/2013-19/12/2013
TR (1 city)	1 013	5.6	02/01/2013-19/12/2013
UK (1 city)***	1 047	5.8	01/01/2013-20/12/2013
Total (27 villes)	18 098	100.0	

** In Greece, a very small percentage of the patients was recorded in the database in at least two of the five cities (16 % of patients recorded in total)*
*** In Spain, 105 files relate to three weeks of activity in ten of the 11 cities and 25 cases were recorded during 2013 for the Canaries*
**** In London, the medical consultations were interrupted for a period of five months between 14/05/2013 and 21/10/2013.*

In total **31,067 consultations (29,400 consultations, 15,445 of which were medical consultations, were recorded in the eight European countries)** were analysed **and 23,697 different diagnoses were reported by the volunteer doctors (21,913 of which were in the eight European countries).**

Figure 1. Proportion of women per country surveyed.



**Average total proportion in eight European countries*

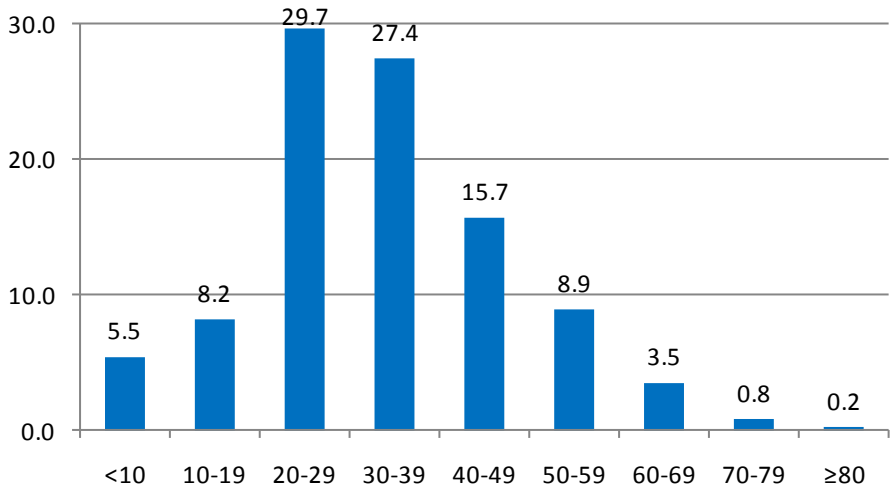
A high proportion of women were recorded in German and Spanish centres. Indeed, in Germany, MdM offers women clinics twice a month. In Spain, the MdM teams are mobilised on gender equality and have a proactive approach towards women.

The average age of the patients seen by MdM was 33.1 (median = 32). Half of the patients were between 24 and 42. Only the Spanish centres included in the survey did not receive children.

Table 2. Age distribution of patients: mean, median, country interquartile range, years.

	Mean	*Minimum*	*Lower quartile*	*Median*	*Higher quartile*	*Maximum*
BE	33.2	0.0	26.0	33.0	43.0	86.0
CH	30.5	0.0	22.0	29.0	39.0	67.0
DE	36.2	0.0	23.0	36.0	51.0	85.0
EL	29.4	0.0	18.5	26.0	38.0	87.0
ES	40.2	18.0	29.0	38.0	51.0	84.0
FR	33.8	0.0	26.0	32.0	41.0	85.0
NL	38.2	0.0	29.0	39.0	48.0	78.0
UK	35.9	0.0	27.0	35.0	43.0	102.0
Total 8 countries Europe	*33.1*	*0.0*	*24.0*	*32.0*	*42.0*	*102.0*
CA	34.9	0.0	27.0	33.0	45.0	77.0
TR	30.7	0.0	25.0	30.0	35.0	69.0

Figure 2. Population distribution per age group.



Focus on pregnant women

A total of 353 pregnant women were seen for consultations in 2013, 285 of whom were in the eight European countries taking part in the survey (mainly in Belgium, Germany and France), representing 5.7% of patients (6.2% in Europe). The average age of the pregnant women was 27.6 and **3.2% of them were minors** – the youngest was 14 years old.

The lowest proportion of pregnant women consulting of all the women consulting was in Greece and France (1.6% and 2.3% respectively): in Greece because the majority of those consulting are Greek or European (and their access to care remains, despite the crisis, relatively better than for those who are from outside of Europe) ; in France because access to care remains globally quite good for pregnant women in the public domain – in the mother and child protection services and at hospital – whatever their status and health insurance coverage (although around two pregnant women are seen a month in consultations in each of the two CASOs included in the survey).

> Anthéa, a 34 year old Greek woman, was admitted to a public maternity ward in a hospital after the birth of her child. She had no health insurance or income. Neither she nor her husband have a job. She informed us that the staff at the clinic had refused to issue a birth certificate "as the hospital bill was unpaid". This is against the law. MdM intervened to ensure that the family would receive the document, in accordance with the law that guarantees the right of every child to have a legal existence.
>
> MdM Greece – Athens – 2013

Conversely, this proportion is particularly high in Munich, the Netherlands and Montreal: between 20% and a quarter of women who consulted were pregnant.

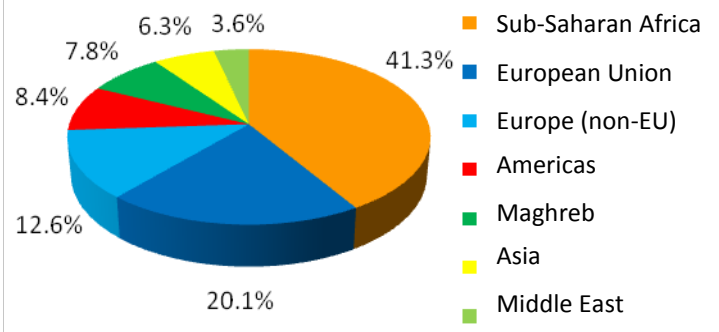
Table 3. Numbers of pregnant women by country and as a percentage of total women seen.

	N° pregnant women	% of total	% of total n° of women
BE	94	26.6	10.1
CA	28	7.9	22.8
CH	6	1.7	8.3
DE	57	16.2	20.2
EL	17	4.8	1.6
ES	5	1.4	6.3
FR	65	18.4	2.3
NL	14	4.0	25.0
TR	40	11.3	11.6
UK	27	7.7	5.6
Total	353	100.0	5.7

In the eight European countries surveyed, **almost all the pregnant women seen (94.7%) were foreign nationals, mainly originating from sub-Saharan Africa (41.3%), the EU (20.1%) and European countries outside the EU (12.6%).**

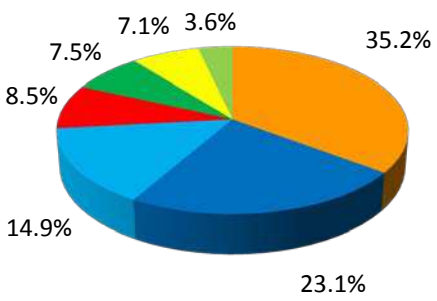
Figure 3. Geographical origin of pregnant women in the two populations analysed.

In the 8 European countries



Response rate = 94.1%

In the 10 countries surveyed



Response rate = 97.9%

For their housing conditions[33], **52.5% of pregnant women seen were living in temporary accommodation; a third (32.3%) of them were living in conditions they considered harmful to their health and 4.8% were homeless**.

We should stress that for these three indicators, the housing conditions of pregnant women were in no way better than those of all the women who consulted.

In Istanbul, the situation for pregnant women was even more uncertain (62.5% were living in temporary accommodation) although it was better in Montreal (21.1% of women were in temporary accommodation but none of them were reported to be homeless).

> Adjoua, 28, from Benin was three months pregnant when she first went to the CASO. She was homeless and had had no antenatal care. We contacted the SAMU Social so that she would be allocated a room in a hostel. During her pregnancy she was accommodated in two different hostels, meaning she had to change maternity hospital. After the birth of her daughter she returned to her hostel room, despite the fact that it had a serious damp problem: the walls of the room were covered in mould, with water running down and it was difficult to breathe in the room. At three weeks old, her daughter was admitted to hospital for a week as an emergency case. It was not until three weeks later that she was offered an alternative room.
>
> MdM France – Saint-Denis – Juin 2013

Very few of these women were engaged in an activity that provided them with an income (16.8%) and **the vast majority (89.1%) were living below the poverty line**[34]. A similar proportion of pregnant women had a job in Istanbul and Montreal.

[33] Response rate = 92.1%

[34] Response rate = 64.6% and 45.3% respectively (the poverty line of the survey country is applied). It should be noted that the financial resources reported by the patients do not take into account the number of people living with them: if we were to ask them about this, the number of people living below the poverty line would be even higher and, in all probability, would in fact be all of them.

Among the pregnant women surveyed, 41.8% reported having one or more minor children[35]. Of these women, **44.3% were living apart from one or more of their minor children** (38.5% were living apart from all their minor children). These figures were very different in Montreal (where 2/3 of pregnant women were living with their children) and Istanbul where almost all of them were living with all their children.

> Macire, 28, is originally from Kenya: "*I arrived in Germany a year ago. I came here with my two children (aged seven and three) to join my boyfriend who is a German citizen. Shortly after I arrived in Germany, I realised that I was pregnant. I didn't know what to do about the pregnancy: our income was very low and I had no health insurance. Unfortunately, we couldn't afford it. As I wasn't working I would have had to pay the full monthly contributions. I had my first antenatal consultation at open.med and since then I have been going back every month to attend the pregnant women's clinic. They gave me a booklet with all the information about my pregnancy. At the moment they are trying to find a health insurance plan for me that I can afford. Open.med has really helped me to realise I can be a mother again. Even though the future is uncertain, I do have hope now. I hope I'll have my own health coverage before my due date. I'm worried that the bill for my delivery will be very high".*
>
> MdM Germany – Munich – January 2014

Although the figures are low (only one third of pregnant women were asked about their moral support in the eight European countries, i.e. 94 women), it is important to stress that **36.2% of pregnant women declared they received a low level of moral support, and of these close to 10% had none at all**.

An analysis of the administrative status of the 285 pregnant women who attended consultations in the eight European countries[36] shows that **63.7% had no right to reside: of these 15.8% were EU nationals and 47.9% were nationals of non-EU countries.**

Table 4. Administrative status of the pregnant women interviewed in the 8 European countries.

	n	%
No residence permit requirement (nationals)	16	6.0
For EU nationals		
No permission to reside*	42	15.8
No residence permit required *(in the country less than 3 months)*	14	5.3
Permission to reside *(adequate financial resources and valid healthcare coverage)*	6	2.3
For non-EU nationals		
No permission to reside	127	47.9
Asylum seeker	20	7.5
Tourist, short-stay or student visa	16	6.0
Valid residence permit	14	5.3
Residence permit for another EU country	5	1.9
Work visa	3	1.1
Humanitarian protection	2	0.8

* in the country for more than three months, without sufficient financial resources and/or healthcare coverage
Response rate: 88.4%.

[35] Response rate = 65.8 %
[36] Response rate = 88.4 %

> Lisa, 33, is from Mongolia. She has just been refused asylum and is now considered as an undocumented migrant. Before she received a negative answer for asylum, she had been able to access the public healthcare system. After two failed medical termination of pregnancy, she went back for a third time to the hospital which had carried out the procedures. She was suffering from upper abdominal pain and vomiting.
> The gynaecologist was unwilling to see her unless she paid several hundred Euros. Lisa and her boyfriend turned to MdM who told them about the new law on undocumented migrants which contains the right to obstetric care and pregnancy termination.
> Two weeks later, Lisa's boyfriend returned to the hospital with the information about the new law on undocumented migrants. No one at the reception was aware of the law. Eventually, Lisa received a bill for €45 for the visit and pregnancy termination procedure.
>
> MdM Sweden – Stockholm – 2013

Of the pregnant women surveyed, 7.5% were in the process of claiming asylum, 34% were or had at some point been involved in an asylum claim[37] and, of these half had been refused asylum

In the eight European countries, there were twice as many EU nationals not authorised to stay amongst the pregnant women than amongst all the women (14.9% versus 6.3%, $p<10^{-6}$).

> Selma, a 27 year old Afghan woman, went to the public maternity hospital as she was about to give birth. The hospital administration department refused her access as she did not have all the necessary papers, in particular no healthcare insurance. MdM's social department was informed by one of her compatriots. We contacted the hospital who told us, "There is nothing we can do, because she is undocumented". MdM's President called the hospital director, who denied the existence of this incident. A few hours later, after passing out in front of the hospital, Selma was admitted to the hospital to give birth.
>
> MdM Greece – Athens – 2013

As a result of their precarious administrative situation, **almost half of the pregnant women (45.1%)** in the eight European countries **restricted their movements to varying degrees for fear of arrest**; sometimes (18.3%), frequently (18.3%) or very frequently (8.5%). This creates a significant additional obstacle to accessing antenatal care

Pregnant women are in this situation more often than all the women together, or a little more often (45.1% versus 34.7%, p=0.09).

In Montreal (where, as we have seen, women are in a very different administrative situation) only 20% were afraid to move around. In Istanbul, on the other hand, this fear was stated by close to 9 women in 10 (pregnant or not) of whom half replied often or very often.

Regardless of their administrative status, **83.5% of pregnant women seen by MdM had no healthcare coverage**[38]. In most countries this means that they have to pay for their care, except, for example, in France where antenatal care is available free of charge for all women, regardless of their healthcare coverage and, theoretically, their administrative situation. Similarly, in Spain pregnant women without permission to reside are supposed to be provided with antenatal and postnatal care, as well as care during their delivery, the same as any other woman.

[37] Response rate = 66.0 %

[38] We have aggregated women with no healthcare coverage and those who are only entitled to use emergency services, which indicates that they do not have access to healthcare and have no healthcare coverage.

Pregnant women have poorer healthcare insurance than all the women interviewed by MdM, 80% of whom have no healthcare coverage. The total lack of health coverage on the day of their first consultation specifically relates to pregnant women in the French and Belgian centres[39] (over 90% of cases in these two countries).

Proportionally, they also more often have open rights in another country than other women (6.3% versus 2.6%, p<0,001). Finally, less than 10% have full or partial coverage for their healthcare (4.6% and 3.8% respectively).

Table 5. Medical care coverage for pregnant women and women in general in the programmes in the 8 European countries.

	n	% of pregnant women*	n	% of all women**
No coverage / all charges must be paid	156	65.8	3 205	80.1
Access to emergency services only	42	17.7	258	6.5
Open rights in another European country	15	6.3	103	2.6
Full healthcare coverage	11	4.6	234	5.9
Partial healthcare coverage	9	3.8	149	3.7
Access on a case by case basis	4	1.7	37	0.9
Free access to general medicine	0	0.0	12	0.3
Second line treatments for a fee	0	0.0	2	0.1

*Response rate = 83.2%, ** Response rate = 69.2%

> Nina, a Moroccan woman who was 7 months pregnant, applied for a residence permit in April 2013. She went to the social security services to obtain a health insurance card. As she had no valid foreigner identification number (NIE) and no work and was not able to register as a co-beneficiary (she was not married), the social security services refused to issue the card on the pretext that she had applied for her residence permit after 24 February 2012. The health centre's administrative department later sent her back to the social security centre to "sort out the problem with the card". One day Nina felt unwell and went to the emergency room where the doctor was very concerned about her condition. Not knowing what to do, she sent Nina to MdM where they both learnt that pregnant women have the right to access care regardless of their administrative situation. The doctor found out about the procedures at MdM and promised to pass on the information to the administrative staff at the health centre. Nina was then able to provide the necessary documents and obtain "medical assistance for special circumstances".
>
> MdM Spain – Castilla La Mancha – June 2013

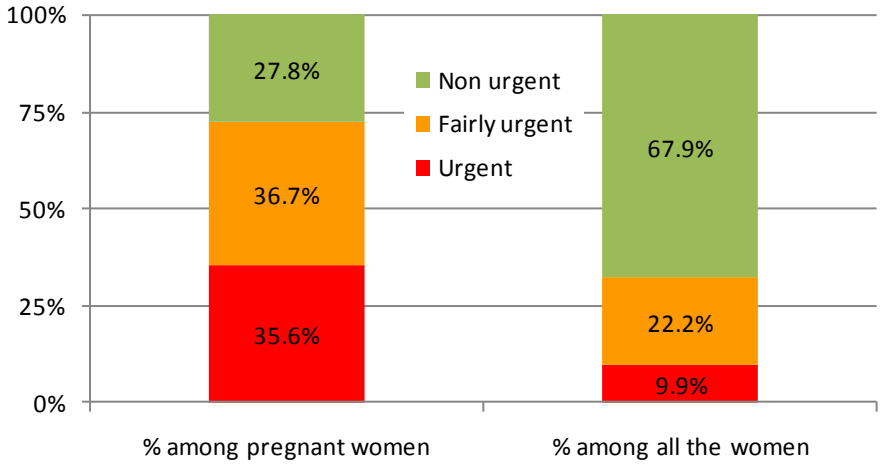
Among the pregnant women in the eight European countries, **65.8% had not had access to antenatal care when they came to our free health centres and,** according to the doctors, **42.8% received care too late, that is after the 12th week of pregnancy**[40].

[39] This can be explained by the fact that in France and Belgium, patients with permission to stay are referred for the most part directly to the common law healthcare system before any medical consultation.

[40] Response rate = 60.7% and 50.9% respectively.

When the women first presented for a medical consultation, **the doctors considered that over 70% of them required urgent (35.6%) or semi-urgent care (36.7%);** i.e. **more than twice as often as all women** (72.2% versus 32.1%[41], $p<10^{-6}$).

Figure 4. Frequency of treatment deemed urgent by doctors (at the first consultation).



Pregnant women in Turkey

In Turkey, 40 pregnant women attended ASEM – MdM's Istanbul health centre, which represented 11.3% of all the pregnant women seen in 2013. They were all from sub-Saharan Africa[42]. They had an average age of 28.8 and 62.5% of them lived in insecure housing[43].

> Eve, a 30 year old Ugandan patient undocumented and unemployed, went for a consultation at the ASEM health centre supported by MdM. She was 8½ months pregnant. From there she was sent for her antenatal care at St Georges hospital.
> One weekend, suffering from contractions, she called the ASEM team who sent her to the Sisli Etfal public hospital, as the obstetrical department is not open 24 hours at Saint Georges hospital. She gave birth the same evening by caesarean. The next day, the hospital finance department asked her to pay for her care, over €7,000. The ASEM team then tried to negotiate with the finance department to pay in eight instalments. The spokesperson's answer: "There is nothing to discuss, I've already called the police".
> During the night, the mother, the person accompanying her and the new-born were placed in custody at Sisli. The ASEM team were informed and tried in vain to contact the United Nations High Commission for Refugees (UNHCR) lawyer. The mother, the person accompanying her and the new-born were then taken to the detention centre at Kumkapi. They were imprisoned there for a week. Their release was subject to an asylum application, probably supported by UNHCR. The child's birth has still not been officially recorded. Indeed, the public hospital refused to give a medical report on the birth until the medical fees have been paid.
>
> MdM Turkey – Istanbul – 2013

[41] Response rate = 63.2% and 50.4% respectively
[42] Response rate = 82.5%.
[43] Response rate = 80 %.

For their administrative situation[44], over a third of the pregnant women seen in Turkey were undocumented migrants (34.4%) and 28.1% were involved in an asylum application. All of them had to pay 100% of their healthcare costs.

When the women first presented for a medical consultation, doctors considered that 30.0% of pregnant women had received care too late, that is after their twelfth week of pregnancy. 70.0% of them had had no access to antenatal care and doctors considered that 80.0% of them required urgent care.

Pregnant women in Canada

In Quebec, 28 pregnant women attended consultations at the MdM Montreal centre, which represented 7.9% of the pregnant women seen in 2013. They were all foreigners[45] and had an average age of 29.6. Close to 80% of them lived in stable housing[46] (78.9%). Only 10% of them were undocumented. Many of them (45.0%) had a tourist or short stay visa. However, 95% of them had to bear all healthcare costs.

Doctors considered that close to half of pregnant women had received care too late[47], that is after their twelfth week of pregnancy and that all of them required care quite urgently.

> Dalisay, from the Philippines, came to Canada a year ago to work. A few weeks after her arrival, she discovered she was pregnant. When she told her employer about her pregnancy, her work contract was revoked. Dalisay was left jobless, homeless and without access to healthcare. She had a consultation at MdM Canada as she had had no antenatal care. She planned to give birth at home with a midwife, but due to complications she had to deliver at the hospital. Dalisay is still unemployed and has to pay over €6,500 for the birth.
>
> MdM Canada – Montreal – December 2013

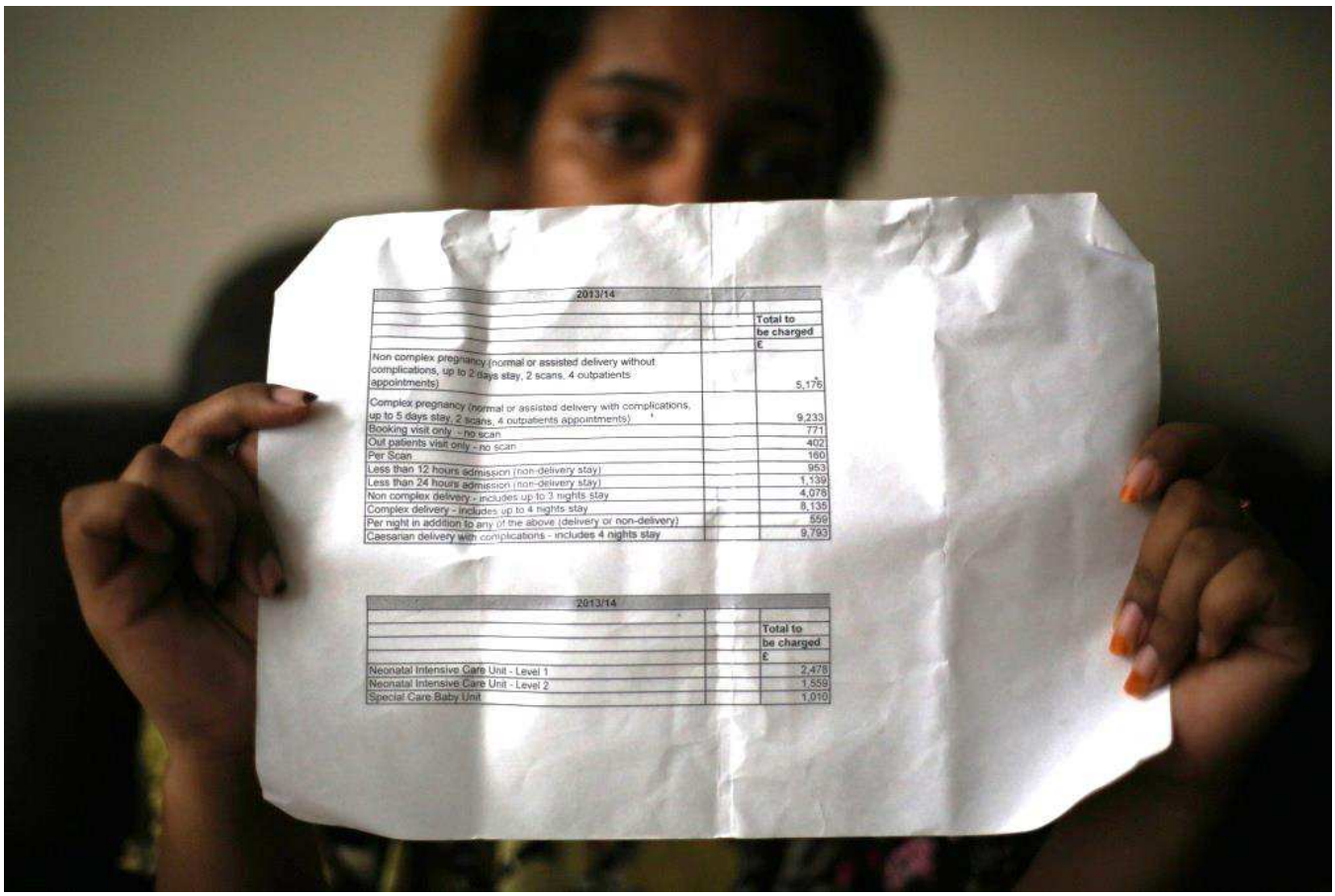
[44] Response rate = 80%.
[45] Response rate = 71.4%.
[46] Response rate = 67.9%.
[47] Response rate = 17.9% and 25% respectively

Refusal to issue birth certificates to babies of women unable to pay

The MdM teams are now providing assistance where the authorities have refused to issue a birth certificate, despite the fact that having their existence recognised is a fundamental right for all human beings. Patients' stories from Belgium, Greece and Turkey demonstrate the downward spiral which is triggered by an obsession with recovering costs, even when this is contrary to basic human rights.

Should we be in a situation in Europe where children whose parents are unable to pay for their delivery do not legally exist? How can we tolerate such unacceptable practices? We demand that the European institutions and governments guarantee legal existence for every child.

> Maritza, a 33 year old Armenian woman, has been living in Belgium for seven years. Initially, she survived by doing casual work. However, she then started to suffer from psychiatric problems (anxiety). Having applied for leave to remain on medical grounds, for a few months she received basic services and medical assistance from the Public Social Welfare Centre (*Centre public d'aide sociale* – CPAS). When her application for leave to remain on medical grounds was eventually rejected, this medical care ceased.
> Maritza came to the MdM centre when she was six months pregnant for antenatal care and care during her delivery. She also asked to see a psychiatrist for her anxiety. She should have been eligible for Urgent Medical Care (*Aide Médicale Urgente* – AMU) specifically for undocumented migrants and provided by the CPAS. No longer able to work or pay for her rent, Maritza was taken in by fellow Armenians. The CPAS asked for written evidence of her living arrangements, proof of identity and evidence from her hosts of their income. Hosts are always very reluctant to provide this sort of documentation. The CPAS therefore decided that this counted as a refusal to cooperate. Her request for AMU was rejected, because it hadn't been possible to complete the paperwork. However, it was possible to refer Maritza immediately to the "Child and Family" centre for her antenatal care. She gave birth in early spring. She was admitted to hospital, but since she had still not been granted AMU and despite being in labour for 21 hours, she was discharged the day after the birth. In addition, the hospital refused to provide the record of birth needed to register the child with the local authority. Intervention by MdM's social welfare service ensured that the document was issued.
>
> MdM Belgium – Antwerp – 2013



© Giorgos Moutafis – Estimate of between €4,930 and €11,720 for a hospital delivery, MdM UK, London 2014

Focus on childhood vaccination

A total of 1,703 patients who were minors attended one of the European centres taking part in the survey, representing 10.4% of the patients who provided their age (97% of patients).

Table 6. Number of minors by country and proportion of all the patients seen.

	N° of minors	% of Europe total	% of the Europe population
BE	257	15.1	10.9
CH	23	1.4	10.0
DE	79	4.6	15.7
EL[48]	713	41.9	21.2
FR	608	35.7	6.9
NL	5	0.3	3.8
UK	40	2.3	3.8
Total Europe	1 703	100.0	10.4
CA	13	-	-
TR	39	-	-
Total	1 755		-

Of these children, 1 568 were seen by a doctor. As might be expected, four groups of medical problems were identified to account for 50% of the diagnoses: respiratory tract infections (31%), vaccinations (7%), digestive problems (6%) and dental issues (5 %). To these main diagnoses can be added general symptoms (3%), psychosomatic problems (3%), other respiratory disorders (3%), skeletal problems (3%), ear infections (3%), rashes (2.6%), skin infections (2.5%) and other skin problems (2.4%); all of these combined accounted for 75% of diagnoses. However, some serious and chronic diseases were also found; for example, insulin-dependent diabetes (n=14), cardiovascular disease (n=27), epilepsy (n=13), metabolic abnormalities (n=7), and even one case of AIDS and another of pulmonary tuberculosis.

Remarks on methodology

This year data on vaccination was only collected for children. With this change, which had been discussed with the field teams beforehand, the response rate on questions of children's vaccination status are useable (unlike previous years) even though they vary enormously from one country to the next t. The response rates are identical for all antigens: that is to say, for a given patient questions about vaccinations were filled in systematically, in approximately equal proportions

In contrast: half of doctors coded "vaccinated = no" then "vaccinated = done" (which was how the questionnaire was designed: if we find the child has not been vaccinated, then we vaccinated him/her) while the other half coded it "vaccinated = yes" (because they were about to do it) then "vaccinated = done". The latter were therefore recoded as "no". In the future, we will have to make it clear that we want the vaccination status on arrival, before the consultation and possible vaccination.

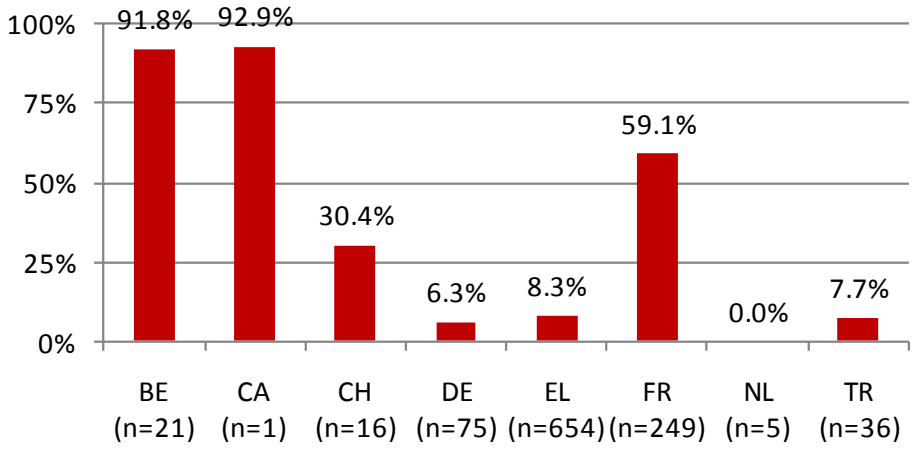
The missing data rate is very low in Germany, Greece, the Netherlands (but they only saw five children) and Turkey. In France, these questions were only asked for half of the children (the data analysed for 249 respondents should therefore be interpreted with caution) and in Switzerland for 70% of children (but the final figures are low). The final figures for respondents do not exceed 75 individuals except in three countries for which we will give more detailed information (in Germany: n=75, in Greece: n=654, in France: n=249); in all other countries the numbers are too small for the details to be meaningful.

[48] Only around 13% of children who attended a consultation at the five Greek clinics have been recorded in the database analysed here.

Therefore, to compare the vaccination coverage between countries, we will only use those for which we have responses for more than 75 children.

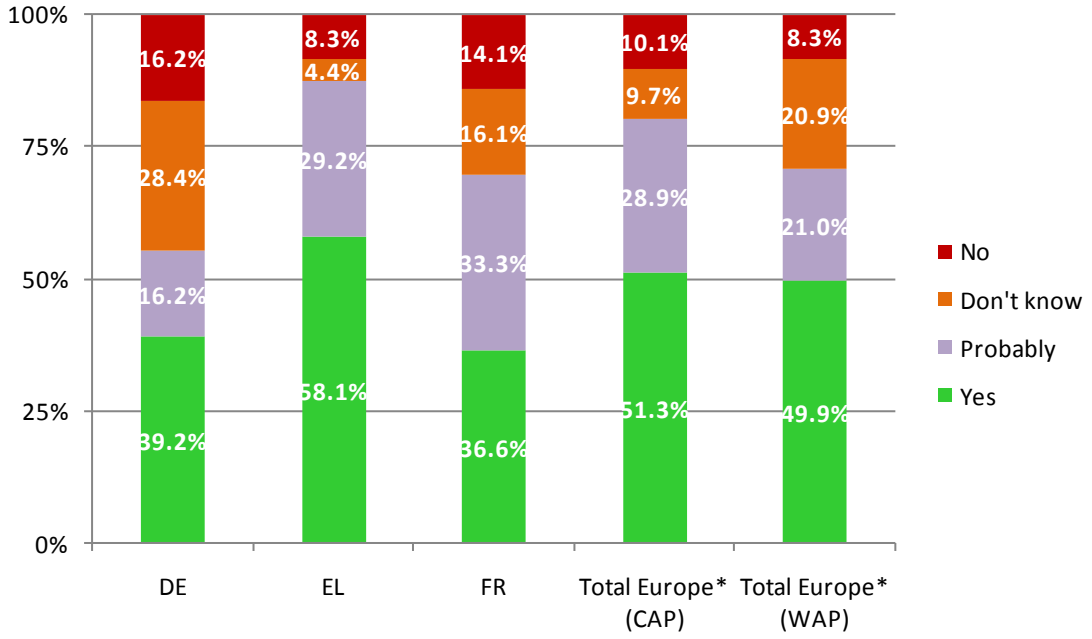
As might be expected, the vaccination coverage for tetanus is the one most often asked about on the one hand and the one that is least often known on the other (9.7% of respondents answered "don't know" of the total in the six European countries where the question was asked and 0% in Turkey).

Figure 5. Missing data rate on vaccination questions regarding children in the survey country: the example of tetanus (the number of respondents is given in brackets).



In the six European countries for which we have immunisation data (Spain does not see children and in London the question was not asked), **only one in two children had been vaccinated against tetanus** (49.9% weighted average proportion); at worst, just 36.6% of children had been vaccinated against tetanus. One third of children had definitely not been vaccinated against tetanus or did not know whether they had (which amounts to the same thing in terms of a formal vaccination indicator) and 21% had probably been vaccinated but this could not be established for certain (which similarly means they must be re-vaccinated owing to the potential seriousness of the disease).

Figure 6. Vaccination coverage against tetanus amongst minors.



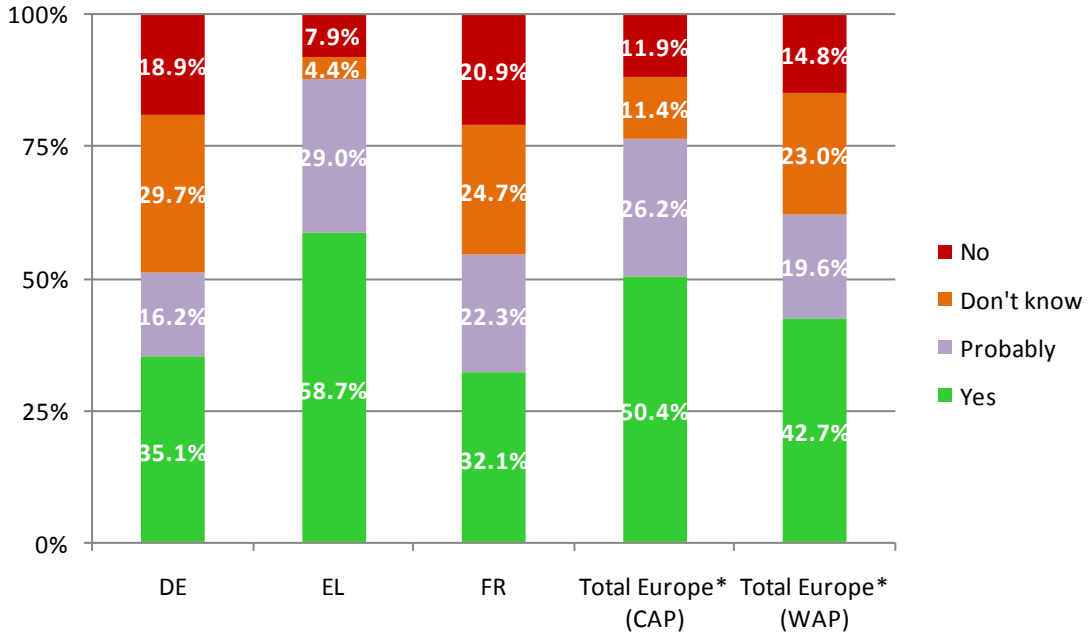
**Total including BE, CH, DE, EL, FR and NL*

It should be noted that the vaccination activity carried out within MdM programmes nevertheless remains the exception rather than the rule: only the Greek centres and the one in Munich vaccinated children[49].

The vaccination rates against **hepatitis B** were even lower: **Greece was an exception (where 58.7% of children were vaccinated), but the rate was no more than 35% in the other countries where the question was asked**. Again, vaccination carried out in MdM programmes is seldom written down in the questionnaires by the doctors.

[49] To clarify, 5,596 children were seen at the five Greek centres and 5,327 vaccinations were given. Our database only includes around 13% of the children seen in Greece. These figures do not include the 7,654 children seen by the mobile units where 3,261 immunisations were given.

Figure 7. Vaccination coverage against hepatitis B amongst minors.



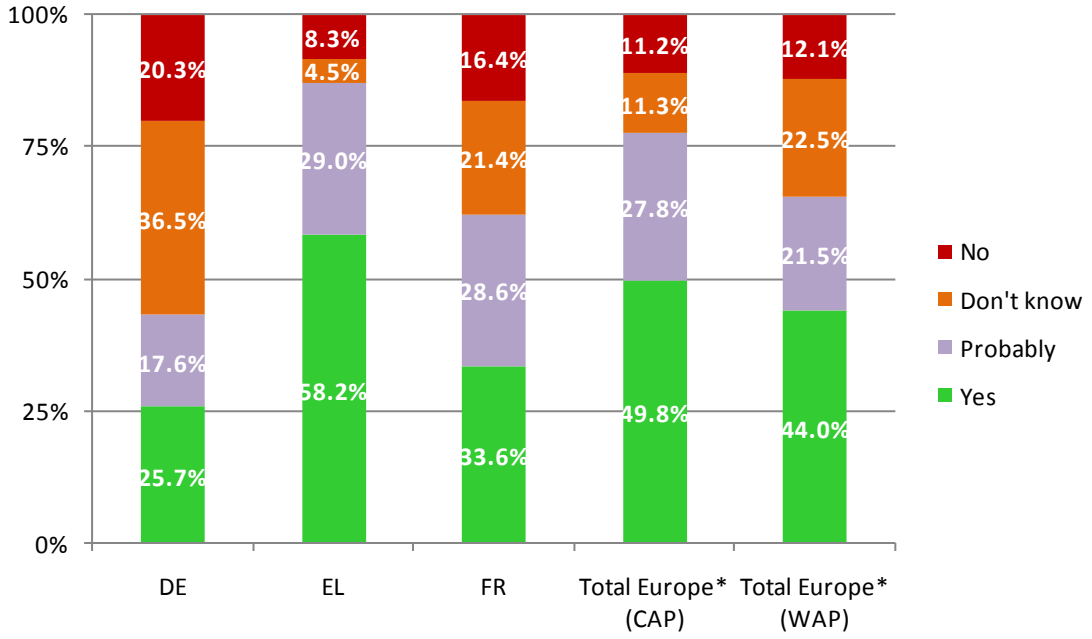
**Total including BE, CH, DE, EL, FR and NL*

The majority of European countries have followed the World Health Organisation (WHO)[50] recommendation to incorporate this vaccine into national vaccination programmes. In these countries, vaccination coverage in the general population is around 93%[51]. A number of countries do not currently require children to be vaccinated before the age of 2 or do not have systematic programmes, including the United Kingdom, Denmark and Sweden.
In France, although the hepatitis B vaccination is not given systematically, it is still highly recommended for all infants as well as a booster for all children aged under 16[52]. The immunisation coverage rate for the general population is gradually rising after the drop in the 1990s (the immunisation coverage with 3 doses was 74% at 24 months in 2011 in the mother and child protection centres and 61% at the same age in 2010 in the private sector[53]).

The rates for **pertussis (whooping cough) and mumps, measles and rubella (MMR)** vaccinations were almost the same as for hepatitis B. **At best, one in two children has been vaccinated against pertussis (at worst 33.3%) and the same proportion had received the MMR vaccine (at worst 25.7%).** Yet, in the majority of countries participating in the survey, vaccination coverage for pertussis and measles at the age of two years has reached (and often exceeded) 90% in the general population[30] (with respective averages of 95.3% and 93.5% in OECD countries in 2009)[54].

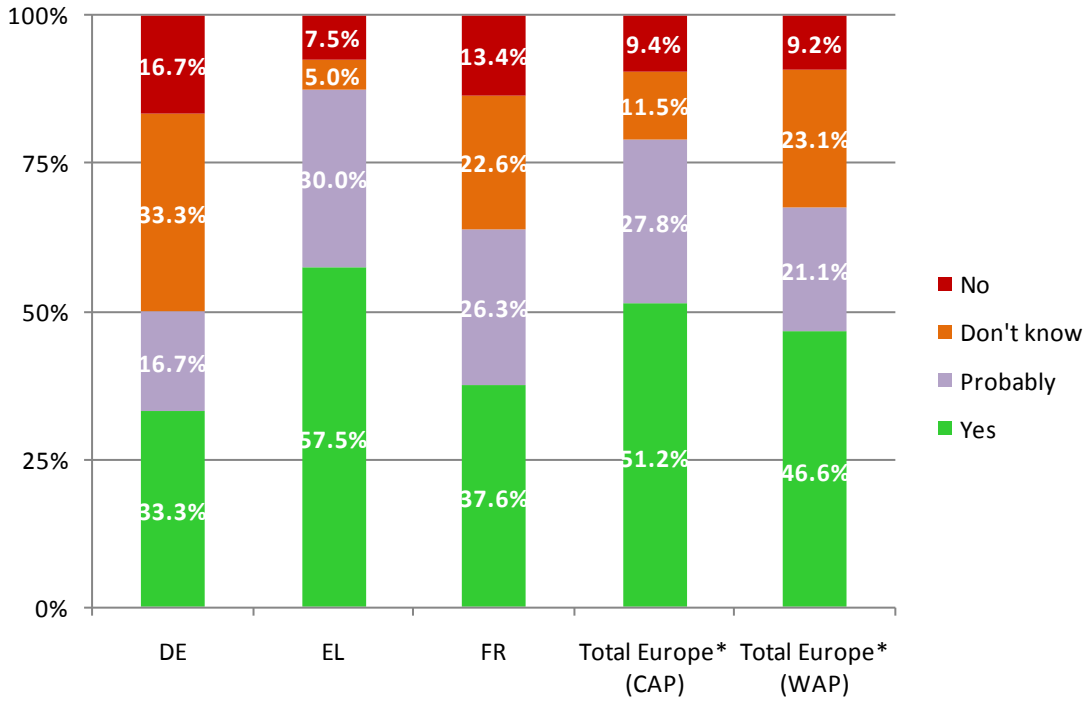
50 De Franchis R, Marcellin P, et al. EASL International Consensus Conference on Hepatitis B. *J Hepatol* 2003; 39: S3-25.
51 OECD (2011), "Childhood vaccination programmes", in Health at a Glance 2011: OECD Indicators, OECD Publishing.
52 The Public health council (HCSP) recommends that "All children or adolescents aged 16 or under, who have not previously been vaccinated, should be offered immunisation against hepatitis B when going for a medical consultation or check-up". (Ministry of Health and social affairs: *vaccination calendar and immunisation recommendations 2013*. Paris, 2013, p. 14.)
53 Fonteneau L, Guthman JP, Levy Bruhl D. *Estimation des couvertures vaccinales en secteur libéral à travers l'échantillon généraliste des bénéficiaires en France – 2004-2009*. Saint-Maurice : Institut de veille sanitaire, August 2010, 14 p.
54 OECD. Childhood vaccination programmes. in Health at a Glance 2011. Paris : OECD publications, 2011.

Figure 8. MMR Vaccination coverage among children.



**BE, CH, DE, EL, FR and NL (No data for ES and UK)*

Figure 9. Pertussis vaccination coverage rate among children.



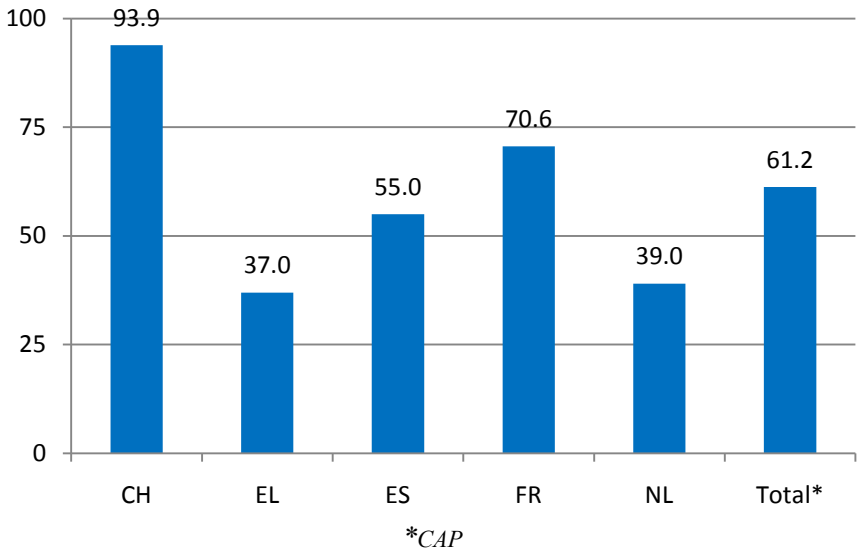
**BE, CH, DE, EL, FR and NL (No data for ES and UK)*

> Anton, 5, and his family left Bulgaria in 2013 and moved to Munich. *"To start with, the whole family had healthcare coverage through my work, but I lost my job and since then we've had no healthcare coverage. When Anton had a fever we took him to open.med for the first time. We were also concerned about an issue with his skin pigmentation and the fact that his hands were swollen",* his mother said. The open.med team gave him an appointment with a dermatologist who diagnosed "genetic dysmorphia" and recommended a genetic test. Neither his parents nor MdM could pay for this very expensive text. The MdM paediatrician asked for Anton's immunisation record, but his parents had never seen such a record and were unable to say what vaccinations Anton had already had. MdM also asked them about their health insurance status in Bulgaria. Even if Anton was able to obtain medical care in Bulgaria, his parents didn't have a European Health Insurance Card. *"I hope open.med will be able to help us get healthcare coverage in Germany so we can take Anton for the genetic test".*
>
> MdM Germany – Munich – January 2014

Knowledge of where to go for vaccinations

Patients asked about vaccination for their children were also asked whether they knew where to go for vaccinations. **Almost 40% (39%) did not know where to go to get their child vaccinated**. After Switzerland (where virtually everyone knew), France was the country where people were most well-informed about where to go for vaccinations.

Figure 10. Knowledge of where to go for vaccinations (for minors).



**CAP*

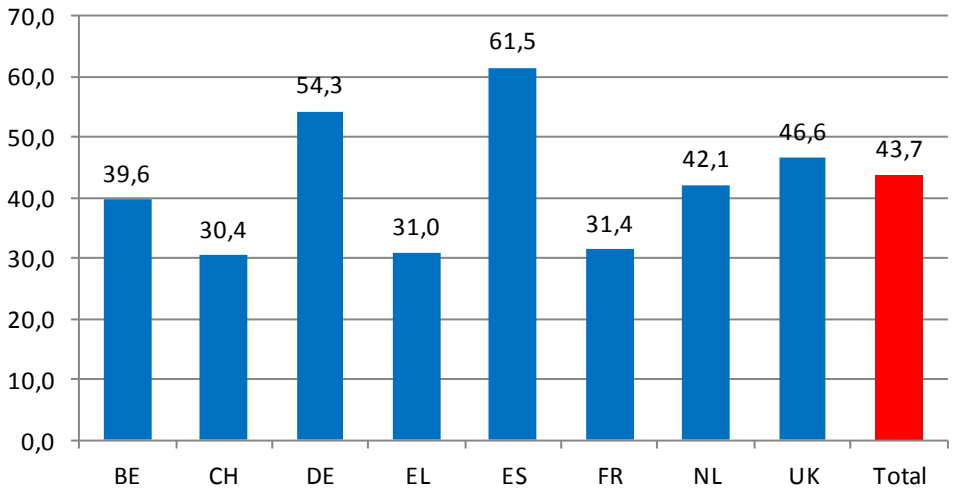
Demographic characteristics

Sex and age

43.7% of all the patients seen in the European centres in 2013 were women.

The average age of the patients seen was 33.1 years (median = 32). Half of the patients were between 24 and 42 years old.

Figure 11. Proportion of women by country surveyed.



Nationality and geographical origin

In 2013 approximately 240 million international migrants were identified around the world, of whom six in ten live in developed countries[55].

Based on the total population, international migrants represented around 3.2% of the global population in 2013, compared to 2.9% in 1990. Of these international migrants, only one third moved from a developing country to a developed country, whilst the other two thirds moved from one developing country to another or between two developed countries[56]. Estimates of the different migrant populations around the world are presented in the following table.

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

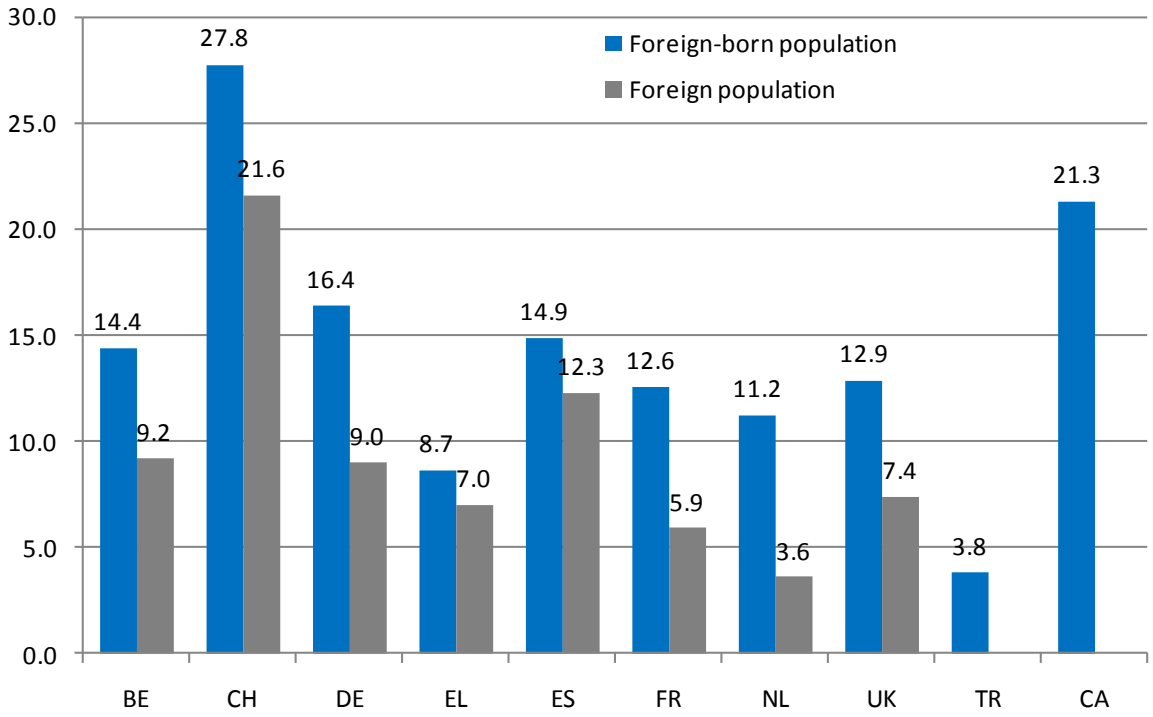
[56] UNDP. *Human Development Report 2013. The Rise of the South: Human Progress in a Diverse World*. New York: UNDP Editions.

Table 7. Estimation of the different migrant populations of the world.

Migrant categories	Population estimate (stock)
Internal migrants	740 million (2009)
International migrants	240 million (2013)
Migrant workers	100 million (2010)
International students	2,1 million (2003)
Migrants internally displaced in the same country	51 million (2007)
Refugees	15.2 million (2009)
Asylum or refugee status seekers	838 000 seekers in 2009
Travellers (tourism or business)	922 million in 2008
Victims of human trafficking	800 000 people a year (2006)

Source: WHO/IOM (2013). Health of Migrants. The way forward. Report of a global consultation. Madrid, Spain, 3–5 March 2010.

Figure 12. Proportion of the total population foreign born or foreign by country in 2010.



Source: OECD, 2012.

Remarks on methodology
According to the United Nations definition, an immigrant is a person born in a country other than the one in which s/he resides (this therefore includes foreign-born nationals, i.e. with the nationality of the country where they currently reside).

Foreign or immigrant populations should not therefore be confused: a foreigner can be born in the country where he resides, an immigrant may have been naturalised. The label of immigrant is a permanent one (an individual continues to belong to the immigrant population, even if he acquires the nationality of the country of residence). The geographic origin of an immigrant is defined by his country of birth and not by his nationality at birth.

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

For MdM however, only nationalities are recorded.

A substantial majority of patients seen by MdM programmes and centres were foreign citizens (95%).

In Montreal, Americans (47.8%) and sub-Saharan Africans were the most numerous but the question was only asked half the time. In Istanbul, 87% of patients came from sub-Saharan Africa and 9% from the Middle East[57].

In the eight European countries covered by this report[58], the patients were from sub-Saharan Africa (29.4%), Europe (EU: 14.9%; non-EU: 7.4%), Middle East[59] (12.6%), Maghreb (12.0%), Asia (as a whole, 9.7%) and the Americas (essentially Latin America: 8.9%). **European Union citizens therefore ranked in second place, after migrants from sub-Saharan Africa.**

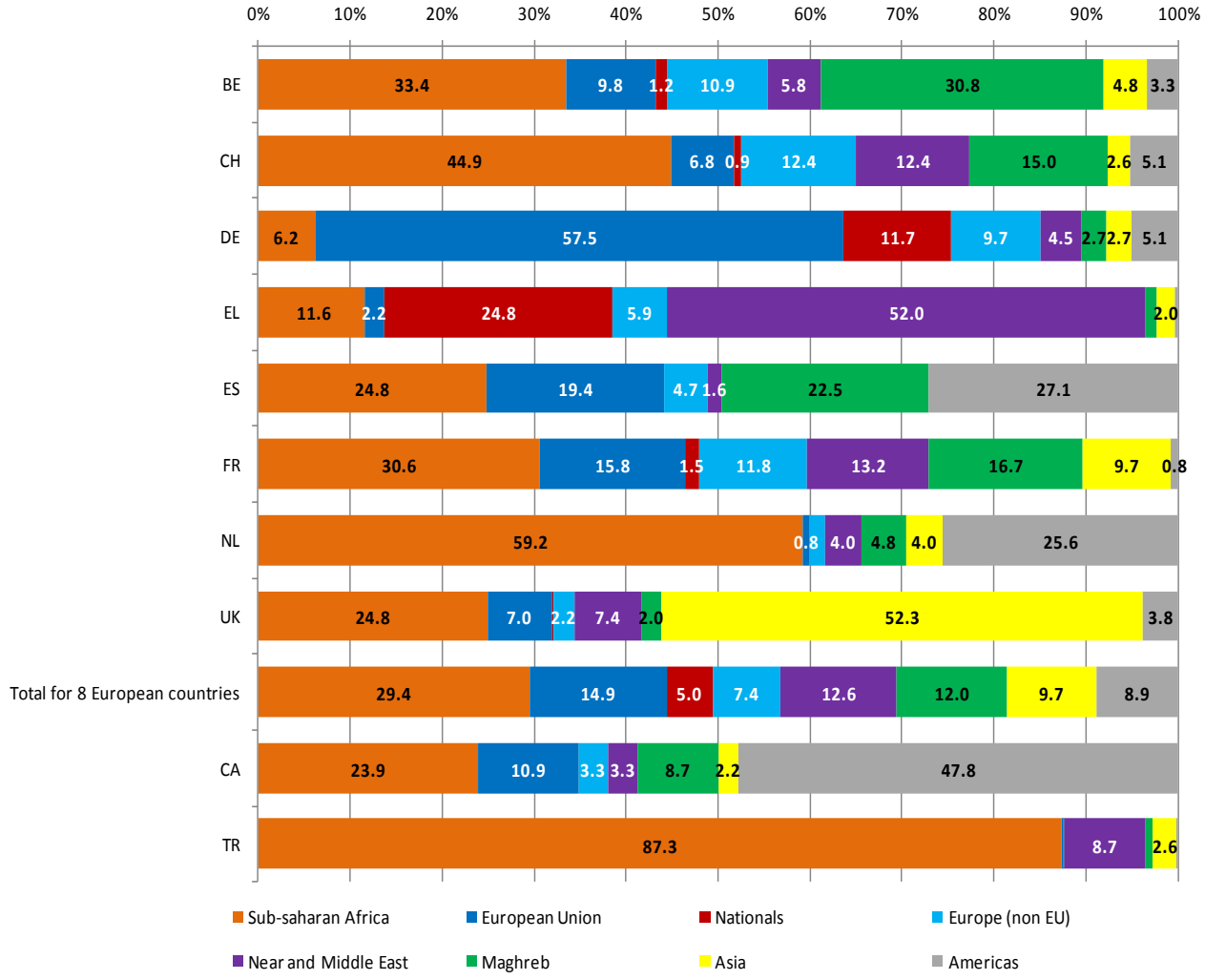
European averages of course cover major disparities between one survey country and another (as we have seen every year) depending on the migratory movements specific to each of them, which themselves are dependent on their own historical context (especially for the former colonial nations) and their geographic location.

[57] Respective response rates: CA=45.1%, TR=77,0 %

[58] Respective response rates : BE=97.9%, CH=98.7%, DE=99.0%, EL=98.6%, ES=99.2%, FR=89.3%, NL=94.0%, UK=98.5%, CA=45.1%, TR=77.0%

[59] For the purposes of this report, Middle East comprises Afghanistan, Egypt, Iran, Iraq, Jordan, Kazakhstan, Kurdistan, Kuwait, Lebanon, Pakistan, Palestine, Syria, the United Arab Emirates and Yemen.

Figure 13. Patients' geographical origins by country surveyed.



Although the African continent (including the Maghreb) remains the top place of origin for patients seen in Belgium and France and Asia for patients seen in London, it has been noted that the nationalities the most frequently encountered do not always respond to this "weight of history".

Indeed at the health centre in Saint-Denis, in **France,** the three most common nationalities were Romanian, Pakistani and Indian; in Nice the patients were mostly from the Maghreb and sub-Saharan Africa (even if the five following ones were former African colonies). In **Belgium**, most people attending the MdM centres originated from Morocco, Guinea and the Democratic Republic of Congo (but six of the ten top nationalities were French speaking). In the **Netherlands**, there were more Nigerians and Ghanaians than Surinamese people. In **London**, people from the Indian subcontinent (Bangladesh and India) were still the largest group, followed by Filipinos. In **Munich**, the largest group were Bulgarians, followed by Germans and Romanians. In **Greece**, the largest numbers of patients were Afghans, followed by Greeks and Syrians, among whom there has been a large increase this year (last year they were the tenth nationality).

Table 8. Top ten most frequently recorded nationalities, by country.

Belgium	Switzerland	Germany	Greece	Spain	France	Netherlands	United Kingdom	Canada	Turkey
Morocco (545)	Nigeria (26)	Bulgaria (190)	Afghanistan (1151)	Morocco (24)	Romania (1031)	Nigeria (35)	Bangladesh (165)	Mexico (16)	Senegal (155)
Guinea (137)	Eritrea (17)	Germany (60)	Greece (838)	Romania (19)	Pakistan (873)	Ghana (22)	India (117)	Haiti (15)	DR Congo (106)
DR Congo (137)	Afghanistan (15)	Romania (59)	Syria (530)	Nigeria (8)	India (575)	Surinam (13)	Philippines (108)	Algeria (8)	Cameroon (88)
Algeria (123)	Algeria (14)	Serbia (22)	Albania (173)	Cuba (6)	Tunisia (514)	Brazil (5)	Uganda (99)	Cameroon (4)	Nigeria (71)
Cameroon (113)	Morocco (13)	Poland (14)	Somalia (170)	Guinea (6)	Cote d'Ivoire (512)	Colombia (3)	China (76)	DR Congo (4)	Cote d'Ivoire (50)
Nigeria (65)	Gambia (10)	Hungary (10)	Sudan (64)	Senegal (5)	Mali (470)	Egypt (3)	Nigeria (63)	France (4)	Uganda (33)
Romania (63)	Guinea-Bissau (8)	Mongolia (10)	Bangladesh (59)	Honduras (4)	Morocco (417)	Ecuador (3)	Vietnam (43)	Cote d'Ivoire (3)	Somalia (29)
Afghanistan (62)	Georgia (6)	Afghanistan (8)	Eritrea (57)	Nicaragua (4)	Algeria (370)		Romania (39)	Cuba (3)	Afghanistan (23)
Senegal (62)	Portugal (6)	Croatia (8)	Bulgaria (52)	Venezuela (4)	Moldavia (351)	-	Pakistan (30)	Madagascar (3)	Guinea (21)
Bulgaria (46)	Tunisia (6)	Iraq (8)	Pakistan (51)		Cape Verde (254)		Afghanistan (28)	Spain (3)	Ghana (19)

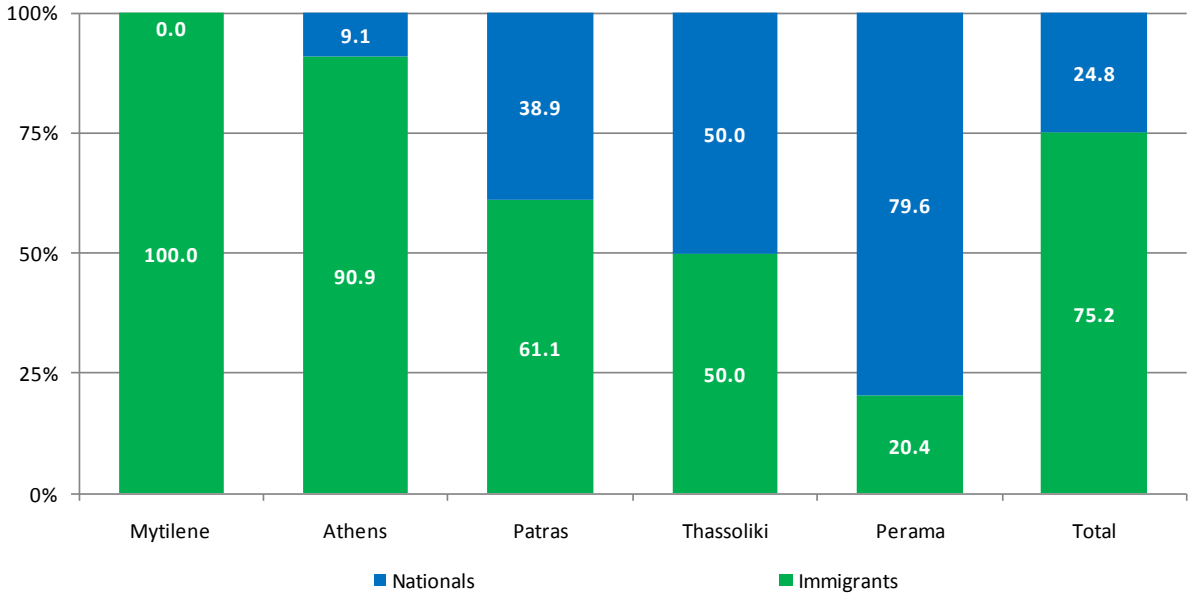
The proportion of patients originating from the Middle East increased significantly between 2012 and 2013, reflecting the political problems in that part of the world. The figures in 2013 were 30.8% in Belgium, 22.5% in Spain, 16.7% in France and 15% in Switzerland. In Greece, Syrians were the third most frequently recorded nationality in 2013 (15.5%) after Afghans (33.6%) and Greeks (24.4%)

In France, the inclusion of a second centre (Saint-Denis, in the suburbs of Paris), in addition to the one in Nice, explains why the proportion of people from the Maghreb and sub-Saharan Africa reversed between 2012 and 2013. In 2012 the figures in Nice were 36% from Maghreb compared with 19.9% from sub-Saharan Africa. This year, the total for the two centres resulted in a larger number of people from sub-Saharan Africa (31%), considerably ahead of the Maghreb (17%).

In Greece, the proportion of nationals remains the most significant of any country covered by the survey: **one quarter of patients seen in Greece were Greek**. The apparent reduction in 2013 compared with 2012 (when half of all the patients were Greek) is explained by the fact that a new centre was included in the survey which is attended solely by immigrants (Mytilene, which opened in 2013). **In Thessaloniki[60] and Perama, the majority of patients attending a consultation in 2013 were still Greek nationals** (50% and 79.6% respectively).

[60] Only 13% of patients seen in Thessaloniki were recorded in the database, and 57% in Perama, which largely explains the reduction in the proportion of Greeks seen.

Figure 14. Proportion of nationals and immigrants in the five Greek centres.



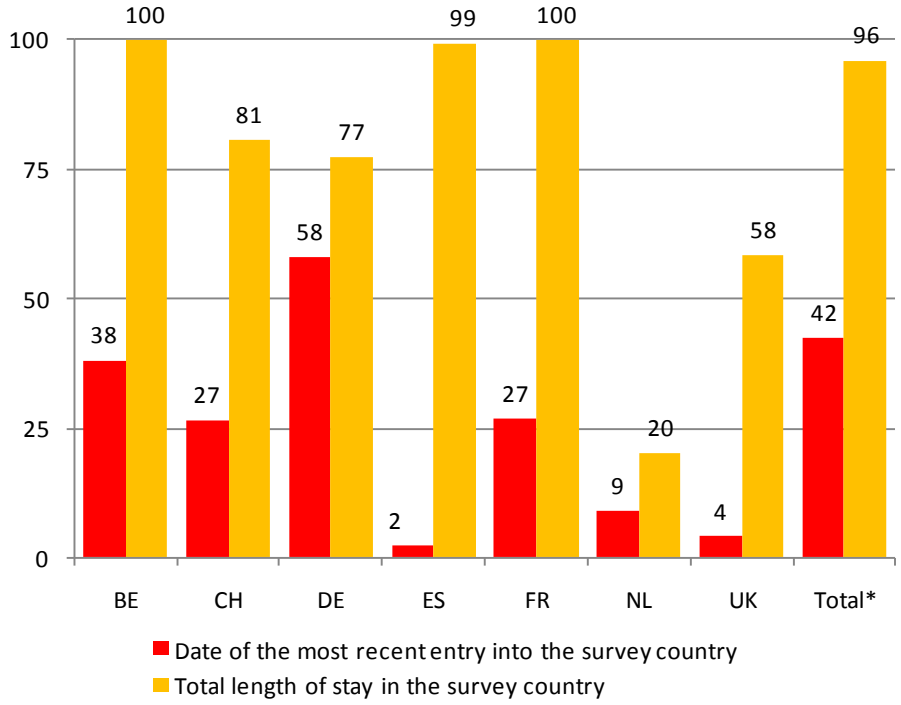
Length of stay by foreign nationals in the survey country

In its full version, the questionnaire asked two variables successively: the date of the last entry into the survey country (which in some countries determines a person's administrative rights to access healthcare) and the total duration of residence (all periods of residence together) in the survey country.

These questions were not asked in Greece and Canada.

The first question was significantly better filled in, even though response rates in Belgium (62%) and Munich (42 %) suggest caution should be used in interpreting the results. The response rate to the second question was especially low and only useable for the Netherlands. It was not asked in Belgium or France, and hardly at all in Spain. The response rate in Switzerland and Germany was lower than 30% and 40% in London. Discussions need to be held on whether the question should remain on the form in the future: this low completion rate is probably due to the fact that MdM teams find it hard to calculate (as some people have had several periods of residency).

Figure 15. Missing data rate for the two questions on length of stay.



*CAP

On average in the 8 European countries, non-national patients had been living in the country for nearly 3 years (32.5 months); half of them had been there for between four months and three years. Patients had been living for the longest periods in Spain and London (average = 64 months, i.e. just over five years), the Netherlands (average = 87.8 months, i.e. just over seven years) and Belgium (average = 40.8 months, i.e. almost 3.5 years) compared with the other countries.

In Istanbul, patients have been there for a shorter length of time on average (11 months).

This illustrates once again that migration for the purposes of seeking healthcare is a myth, as the patients seen only presented at the centres after having lived in Europe for long periods.

Table 9. Distribution of length of stay for non-nationals (from the latest, most recent entry): mean, median, range and interquartile by country, in months.

	Mean	*Minimum*	*Lower quartile*	*Median*	*Upper quartile*	*Maximum*
BE	40.8	0.0	9.6	24.0	48.0	684.0
CH	20.7	0.0	2.4	6.6	12.0	300.0
DE	21.5	0.0	1.2	4.8	12.0	420.0
ES	64.0	0.0	12.0	48.0	96.0	408.0
FR	24.7	0.0	3.6	7.2	24.0	756.0
NL	87.8	4.8	24.0	60.0	120.0	420.0
UK	63.2	0.0	12.0	48.0	96.0	588.0
Total 7 countries	32.5	0.0	3.6	12.0	36.0	756.0
TR	11.2	0.0	2.4	6.0	12.0	144.0

Reasons for migration

As they are every year, the migrants were asked about their reasons for deciding to migrate. Multiple responses were possible.

Table 10. Reasons for migration by country.

	CH	DE	EL	ES	NL	UK	Total 6 countries (CAP)	CA	TR
For economic reasons	28.2	65.9	69.9	60.0	41.9	38.1	48.1	11.4	60.4
For political, religious, ethnic or sexual orientation reasons	23.6	4.6	40.2	4.8	31.0	28.5	23.7	22.7	38.6
To join or follow someone	18.2	31.8	3.8	22.4	14.0	10.7	15.2	31.8	3.8
Because of family conflict	10.0	3.5	2.9	5.6	13.2	7.2	6.7	0.0	4.0
To escape war	16.4	5.8	8.4	5.6	6.2	4.7	6.0	0.0	24.3
To safeguard children's future	0.0	4.6	2.1	10.4	2.3	2.1	3.1	0.0	0.9
To study	1.8	3.5	0.8	1.6	1.6	4.9	3.6	27.3	2.6
For personal health reasons	**3.6**	**4.1**	**2.5**	**6.4**	**0.8**	**0.9**	**2.3**	**0.0**	**0.5**
Other	9.1	11.3	2.5	4.0	2.3	15.6	11.2	11.4	1.9
Total*	110.9	135.0	133.1	120.8	113.2	112.8	119.9	104.5	137.0
Response rate	*46.8*	*94.3*	*9.2*	*96.2*	*97.0*	*95.0*	-	*21.6*	*77.2*

* *Multiple responses were possible: in France the question was not asked, in Belgium one patient in seven was meant to be asked, in Greece the response rate was very low (9.2%), as it was also in Canada (21,6 %) .*

As in 2012, in the **European countries**, **the reasons most often cited were, overwhelmingly, economic reasons** (48.1%), **political reasons** (23.7% in total + 6% 'to escape from war') **and family reasons** (whether to join or follow someone: 15.2%, or to escape from family conflict: 6.7%)[61].

In **Turkey, political reasons** came out top (38.6%).

In **Canada**, two reasons accounted for the majority of answers: to join or follow someone (31.8%) and to study (27.3%).

Health reasons were extremely rare (2.3% in Europe, which is a similar rate to that reported in 2008 and 2012[62], 0% in Canada and 0.5% in Turkey). In countries where access to healthcare is particularly difficult for people whose residence status is precarious (Germany and Switzerland), the rate of migration for health reasons, although still very low, was among the highest[63] (4.1% and 3.6% respectively). In London only 0.9% of people gave health as a reason for migration, demonstrating once again that the discourse against migrants said to come to take advantage of the British healthcare system is without foundation.

[61] These values are crude average proportions (CAP) to ensure that comparisons could be made with the 2012 data.

[62] In 2008 and 2012, 6 % and 1.6 % respectively of those surveyed cited health as one of their reasons for migration.

[63] We are not taking the figure for Spain into account where the patients seen in 2013 had been in the country for the longest, meaning that the immigrants who had lived there the longest had access to healthcare at that time, which is no longer the case if they are undocumented.

Victor, 56 is Romanian: "*I was born in 1958 and grew up in B. in Romania. I got married and had two children. As I was no longer able to find any work in my country, I decided to come to Germany to work. I arrived in May 2008 and found work in the construction industry. I worked long hours every day but didn't know that my employer was legally obliged to pay for my healthcare coverage. In 2012 I started to suffer increasingly from muscle pains so I decided to go to MdM. Soon afterwards the pain became much worse, especially in my leg. Although I continued to go to work, it was difficult because I was physically very tired. In May 2013, I went back to open.med. The doctor told me I needed urgent treatment and sent me to hospital. I was diagnosed with a herniated lumbar disc and was operated on immediately. After spending 11 days in hospital, I was dreading the bill. It came to €4,000. I turned to MdM for help and they contacted several welfare organisations and sent me to one which helps people like me (Caritas). I was hugely relieved to learn that I wouldn't have to pay for the cost of the operation. The doctor at the hospital told me that patients usually need some physiotherapy sessions after surgery, but with no healthcare coverage this wasn't an option for me. Luckily, open.med was able to organise some physiotherapy sessions for me during which I was given exercises I could do at home. I gradually began to recover".*

MdM Germany – Munich – January 2014

Living conditions

It must be noted, as every year, that the vast majority of people who came to consult at the MdM programmes cumulated a range of social vulnerability factors that were determinants of their deteriorated health status.

Housing conditions

Overall, in the seven countries where the question was asked, **62.4% of patients were living in unstable or temporary accommodation**[64] (this was particularly common in Switzerland and the Netherlands).

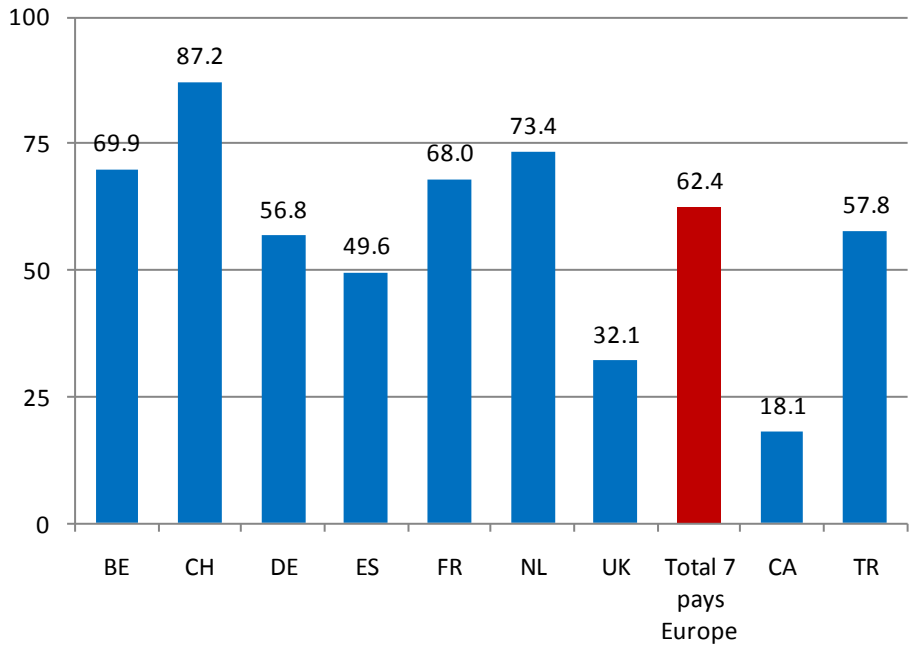
This proportion stood at 18.1% in Montreal and 57.8% in Istanbul[65].

One third (34.8%) of those surveyed deemed their housing was affecting their health or that of their children.

Housing appears to pose the least risk to health in Munich and London.

Of the patients seen by MdM programmes, 11% are homeless (20% among men) and 7% had been provided with accommodation by a charity or other organisation (15% of women), while 5% were living in slums and 3% in squats.

Figure 16. Proportion of patients living in unstable or temporary accommodation by country.

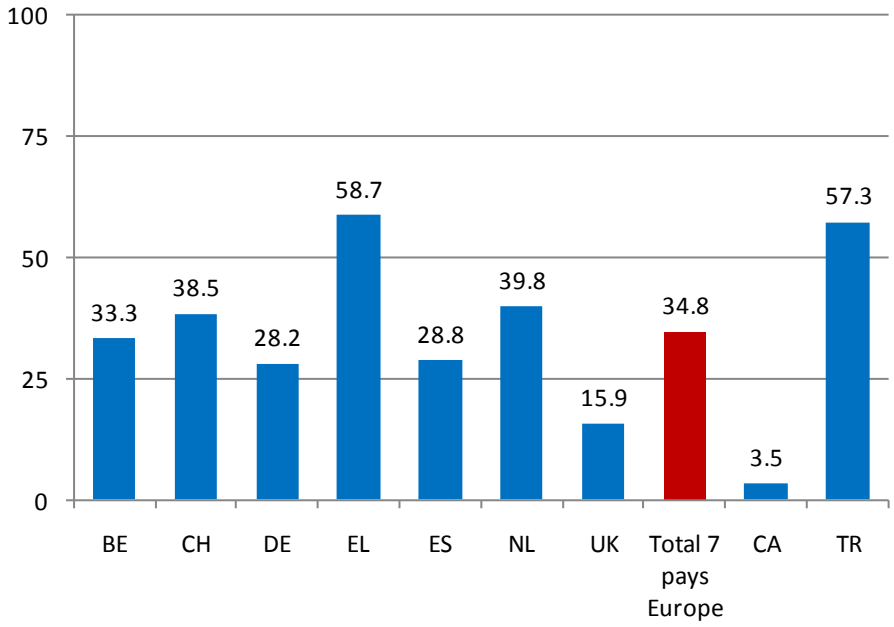


[64] The question was not asked in Greece. Here, the notion of unstable accommodation was given by patients when they were not sure they would be able to stay where they were living – it is their own perception of the instability of their housing which is of significance.

[65] Respective response rates = 40.7 % and 73.2%.

> Christian, 47 years old, is Belgian and spent a year living on the streets of Brussels. He suffers from a severe form of Type 1 diabetes. "*How did I take care of myself on the streets? I did my own wound dressing in the disabled toilets because there was room in there. I could sit down, take off the dressings and put on new ones or wash the original ones. I dried them under the hand dryer. My blood sugar was stable. If you don't have anything to eat or you're eating less than before, your sugar levels are OK, they hold up quite well. My blood glucose level was perfect, no problem, and I wasn't doing anything for it for a change* [laughs]. *As far as my health was concerned, MdM listened to me and supported me. One day I went to the hospital, I was feeling faint because of the diabetes and the pain in my feet. I already owed them €250, so when I went there they threw me out. I walked and walked to try and ease the pain, I walked all night".*
>
> MdM Belgium – Brussels – January 2014

Figure 17. Proportion of patients living in accommodation they deem harmful to their health or that of their children, by country.



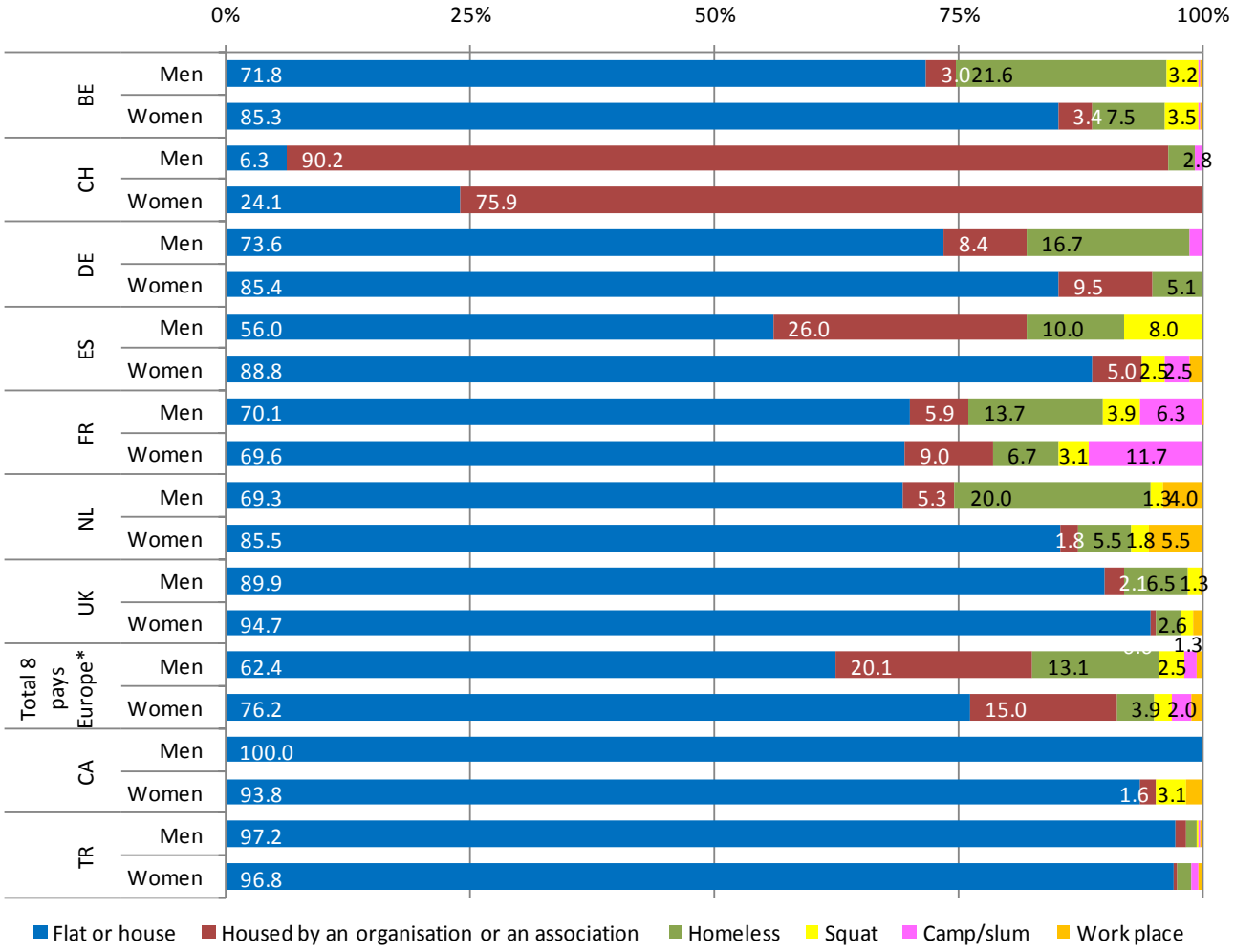
A third (34.8%) of those questioned deemed their accommodation to be harmful to their health or that of their children.

Housing in Munich and London appears to be the least harmful (the rates for Belgium and Greece are given for information purposes but the response rates are particularly low in these two countries).

In Istanbul, this proportion reached 57.3%[66]. In Montreal, the question was only put to 28.4% of patients and only 3.5% of them described their housing as being harmful to their health.

[66] Response rate = 72.9%.

Figure 18. Type of housing by country and by gender.



Close to three quarters of the patients lived in a flat or a house (which were by no means always stable accommodation and furthermore could also be overcrowded); **11% were homeless (20% for men) and 7% were housed by an organisation or association (15% for women)**, whilst 5% lived in a camp/slums and 3% in a squat.

In Montreal 94.4% lived in a flat or house; in Istanbul this figure was 97.1%[67]. Only 1.2% (n=9) of people were homeless in Istanbul.

[67] Respective response rates = 43.6% and 74.0%.

Administrative situation

The majority (56.5%) of people seen at the MdM centres in the eight European countries do not have permission to reside: 48.6% are non-EU citizens and 7.9% are EU citizens (who have been in the country for over three months and do not have adequate financial resources and/or valid health insurance). Most of the EU citizens are Romanians, Bulgarians, Poles and Slovakians but the figure also includes Dutch, Spanish, Portuguese and Italian nationals, among others.

Table 11. Administrative status by country.

	BE	CH	DE	EL	ES	FR	NL	UK	Total	CA	TR
No permission to reside	63.2	15.4	8.5	23.8	53.5	67.8	90.2	61.5	48.6	29.7	51.5
EU citizen with no permission to reside[1]	15.9	2.1	30.9	2.4	8.5	5.7	2.3	1.1	7.9	-	-
Total without permission to reside	*79.1*	*17.5*	*39.4*	*26.2*	*62.0*	*71.9*	*92.4*	*62.7*	*56.5*	*29.7*	*51.5*
No residence permit requirement (nationals)[2]	1.8	0.9	12.4	47.1	3.1	5.1	0.8	0.5	8.8	3.3	1.9
Asylum seekers (application or appeal ongoing)	6.3	69.7	3.0	13.0	1.6	7.5	5.3	16.7	15.5	7.7	22.0
Valid residence permit	3.5	7.3	4.7	5.6	19.4	5.7	0.8	2.3	6.2	6.6	2.2
EU national staying for less than three months (no residence permit required) [3]	2.3	1.3	20.1	2.8	1.6	2.5	0.0	0.7	3.9	1.1[4]	20.0[4]
Visas of all types[4]	2.5	1.3	10.2	0.4	5.4	2.5	0.0	6.2	3.6	35.2	1.2
EU national with permission to reside[5]	1.8	0.9	6.5	4.3	6.2	1.1	0.0	1.8	2.8	-	-
Residence permit from another EU country	1.8	0.4	1.8	0.0	0.0	2.2	0.0	0.1	0.8	0.0	0.0
Specific situation conferring right to remain	0.0	0.0	1.4	0.0	0.0	0.0	0.0	4.5	0.7	13.2	0.7
Subsidiary / humanitarian protection	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.3	0.1	1.1	0.1
Total with permission to reside	*20.1*	*81.6*	*60.4*	*73.2*	*37.2*	*28.1*	*6.8*	*33.1*	*42.5*	*67.0*	*28.1*
Don't know	0.8	0.9	0.2	0.6	0.8	0.0	0.8	4.2	1.0	2.2	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	98.9	79.9
Data missing	*6,5*	*1,3*	*5,4*	*86,5*[6]	*0,8*	*28,7*	*0,8*	*7,4*		*55,4*	*26,5*
N° of respondents	*2227*	*234*	*492*	*463*	*129*	*6057*	*132*	*969*		*91*	*745*

[1] Without adequate financial resources and/or health coverage
[2] In France and Greece, children who are foreign nationals do not require a residence permit and are therefore included in this category
[3] Or equivalent situation (recent immigrants)
[4] Tourism, short-stay, student, work
[5] Adequate financial resources and valid healthcare coverage
[6] In the case of Greece there is too much missing data for it to be analysed.

This average proportion of people without a residence permit covered wide disparities from one country to the other. Greece (26.2%[68]), Switzerland (17.5%) and Germany (39.4%) had the lowest figures. In contrast, 92.4% of patients seen in the Netherlands[69], 79.1% of those seen in Belgium and 71.9% of those seen in France[70] were in this situation.

In Germany, 30.9% of patients were EU nationals who did not have permission to reside, due to a lack of adequate financial resources or valid health insurance (compared with an average rate of 7.9% in the other countries). In addition, **20.1% of patients were EU nationals who had arrived in the country less than three months ago** (compared with fewer than 3% in the other countries) and 6.5% were EU nationals with permission to reside. Germany was the country with the largest number of EU citizens (excluding German nationals).

In Spain, 19.4% of patients were non-EU nationals with a valid residence permit (compared with fewer than 7% in most other countries). This is due to mass unemployment and economic problems in the country (which have primarily affected immigrants).

In Switzerland, a significant majority of patients were asylum seekers (69.7%), in contrast to the other countries surveyed (asylum seekers represented 16.7% of the total in London and less than 10% in most other countries). One of the two programmes is actually aimed at asylum seekers housed in three reception facilities in the canton of Neuchâtel and accounted for 68% of the patients.

In London, 61.5% of those coming to the centre were foreign nationals who did not have permission to reside and 16.7% were asylum seekers.

> Muenda, 35, is a Ugandan who fled to Kenya in 2005. Involved in support for an opposition party and fearing for his life, he sought asylum in Kenya but was returned to Uganda where he was then imprisoned. He eventually managed to escape and travelled to the United Kingdom. In 2011, he fell ill. "*I had a problem when I was in prison in Uganda which was diagnosed as chronic prostatitis. I don't have enough money here to pay for private medical care, so I went to the hospital. I was feeling unwell; I was weak and when I arrived I could hardly walk. When I got there they asked me for the name of my GP...and told me they couldn't help me. They just gave me paracetamol. So I borrowed money from my friend and went to see a private doctor who sent me to hospital for my prostate, liver, kidneys and bladder to be scanned and a blood test to be taken. The total cost of these tests was around €454 but I didn't have enough money. I asked the doctor to leave out one of the tests. I had an infection and I needed to go to hospital. Then the private doctor gave me a prescription for medication which I couldn't afford. Living without the medication, knowing that I had a prescription which would make me feel better was like a living hell. In 2012, I went to MdM. I was losing blood and had lost weight. The MdM doctor gave me a prescription and medication free of charge. I felt much better. I took the medication for 21 days but the infection had spread. It took a year for MdM to help me register with a GP, after two rejections....My father and brother died and I couldn't go to their funerals. When they sent me away from the accident and emergency department, despite the fact that I was so ill, it was as though they were saying to me, go away and die".*
>
> MdM United Kingdom – London – September 2013

[68] The missing data rate is particularly high in Greece (86.5%)!

[69] In the Netherlands, the programme is specifically geared towards undocumented migrants from outside of Europe.

[70] In Belgium and France, access to the public healthcare system remains highly complex for undocumented migrants, who can nevertheless benefit from personal healthcare insurance if they are destitute through AME in France and AMU in Belgium. The patients with permit to reside are mostly redirected before they attend a social or medical consultation.

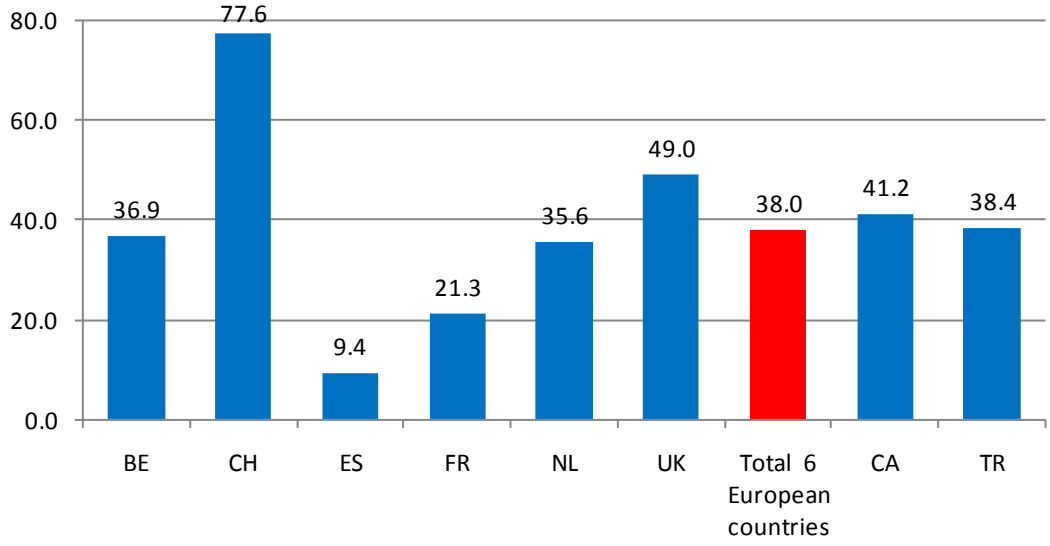
In Greece a quarter of the patients were Greek citizens[71].

In **Montreal**, around one third of patients had a visa (a student visa for the most part), one third had no permission to reside and the last third grouped together various situations for people with permission to reside.

In **Istanbul**, half of the patients had no permission to reside and around 20% were seeking asylum and 20% were recent immigrants.

Overall, in the six countries where sufficient numbers of patients were asked this question[72], **38% of them were or had been involved in an asylum application.** As we have seen, they were particularly numerous in Switzerland (77.6%) and account for almost half of the patients seen in London (49.0%). The French programmes were less concerned (21.3%) and the proportion was very low in Spain (9.4%).

Figure 19. Proportions of patients involved in an asylum application by country.



Only a very small minority of asylum seekers had been granted refugee status (between 2.1% and 4.1% depending on whether a crude or weighted average proportion is calculated), **while four out of ten had already been rejected (43.9%** crude average proportion calculated excluding people who have not yet submitted their applications).

The proportion of those rejected is highest in Belgium (77.3% of the 565 respondents), as well as in the Netherlands (31 of 47 respondents) and Spain (6 of 11 respondents). They were, respectively, 31.1% in France, 26.0% in Switzerland, 24.2% in London as well as 23.8% in Germany (5 of 27 respondents) and 11.1% in Greece (6 of 59 respondents).[73]

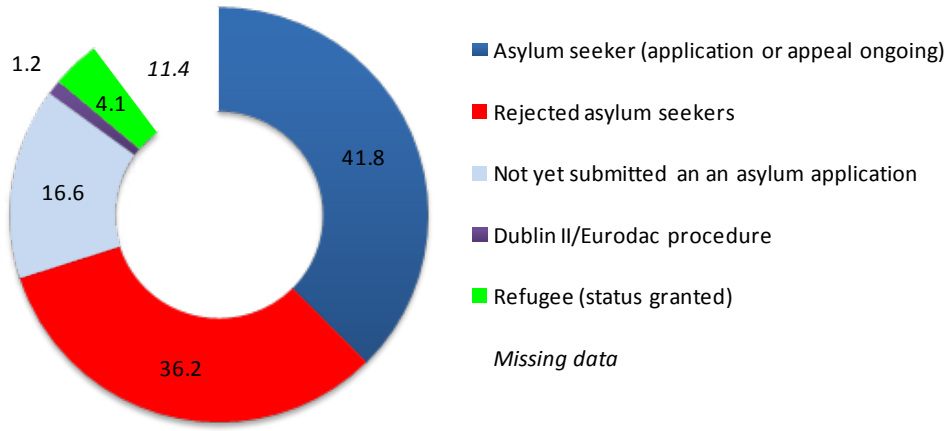
[71] It should be noted again that only 13% and 57% of patients were recorded at the two centres which saw the most Greek nationals, meaning the rate is significantly reduced.

[72] Global response rate = 55.3 % (respectively BE=71.5%, CH=96.2%, ES=98.5%, FR=66.1%, NL=99.2%, UK=55.3%). Response rates in Germany (DE=14.0 %) and Greece (EL=4.6%) prevent specific use of the data but have been included in the totals.

[73] The response rates to this question (filtered by the preceding one) were excellent (89% on average and never less than 84%) but it is the preceding ones that should be taken into account.

Finally, those affected by the Dublin II/Eurodac regulation are rather few (between 1% and 2%, but up to 4.3% in the Netherlands, 3.4% in France and 2.1% in Belgium). Of course in Greece there should have been the greatest number but the question was not asked with enough frequency.

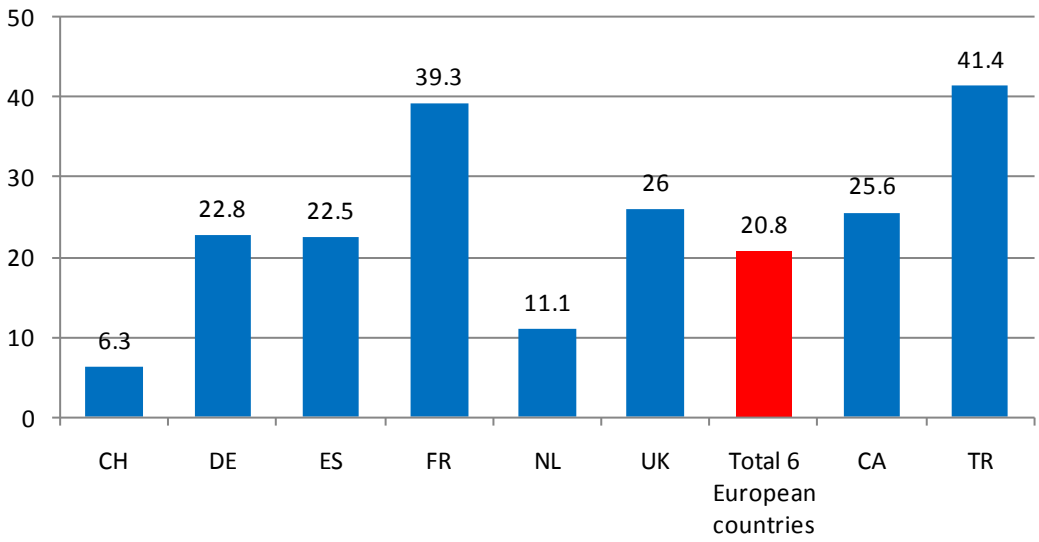
Figure 20. Situation for asylum seekers (at the beginning of monitoring).



Work and Income

A slim majority of people attending MdM centres in Europe had no permission to reside and therefore did not have permission to work. **It is therefore unsurprising that only 21% of them reported an activity to earn a living** in the six European countries[74].

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

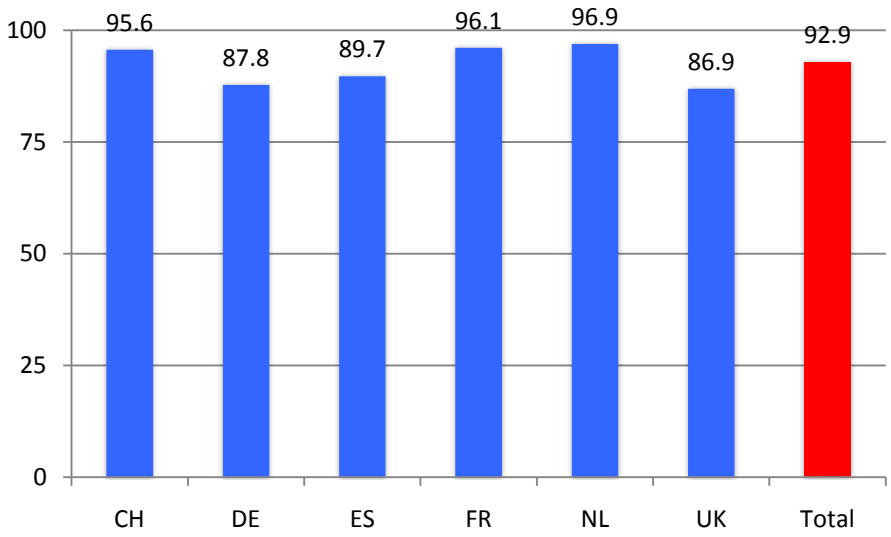


[74] Response rate: CH=87.8%, DE=93.5%, ES=99.2%, FR=71.3%, NL=94.7%, UK=96.0%, CA=40.2%, TR=73.4% respectively

This proportion was twice as high in France and twice as low (at least) in Switzerland and the Netherlands. In Montreal and Istanbul, 25.6% and 41.4% of patients respectively declared that they had an activity.

Almost all of the people surveyed in the six European countries (93%) were living below the poverty line[75] (on average, over the past three months, taking into account all sources of income).

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



[75] We did not calculate how many persons lived on the financial resources of the respondent. If they were included, the percentage of people living below the poverty line would be much higher and may actually represent all the patients seen by MdM.

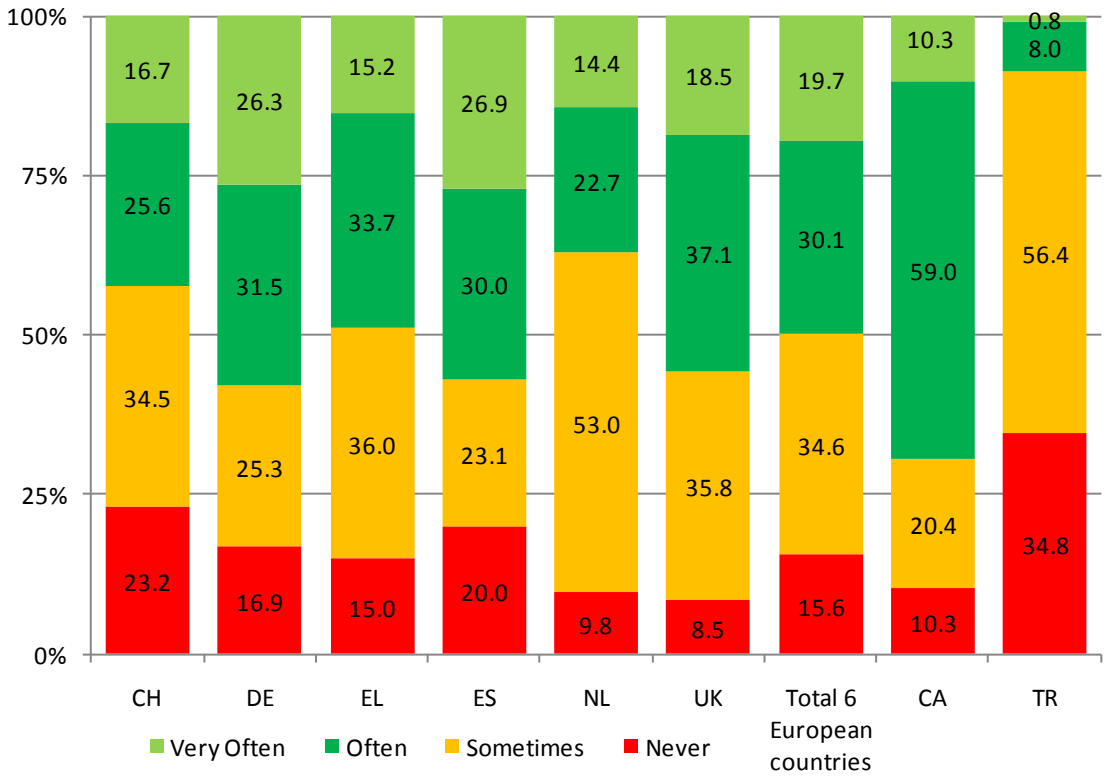
Emotional support

When asked about moral support[76], **15.6% of patients seen in the 6 European countries replied that they never had anyone they could rely on for emotional support or whom they could turn to in case of need.** One third (34.6%) only sometimes had someone they could rely on. **Overall, one in two people said they could rarely or never rely on support if they needed it.**

In Montreal, the question was not often asked (80.9% of data were missing).

In Istanbul, 81.2% of patients were isolated[77]: 34.8% said they could never rely on anyone for moral support and 56.4% said they could do so only occasionally.

Figure 23. Availability of emotional support by country.

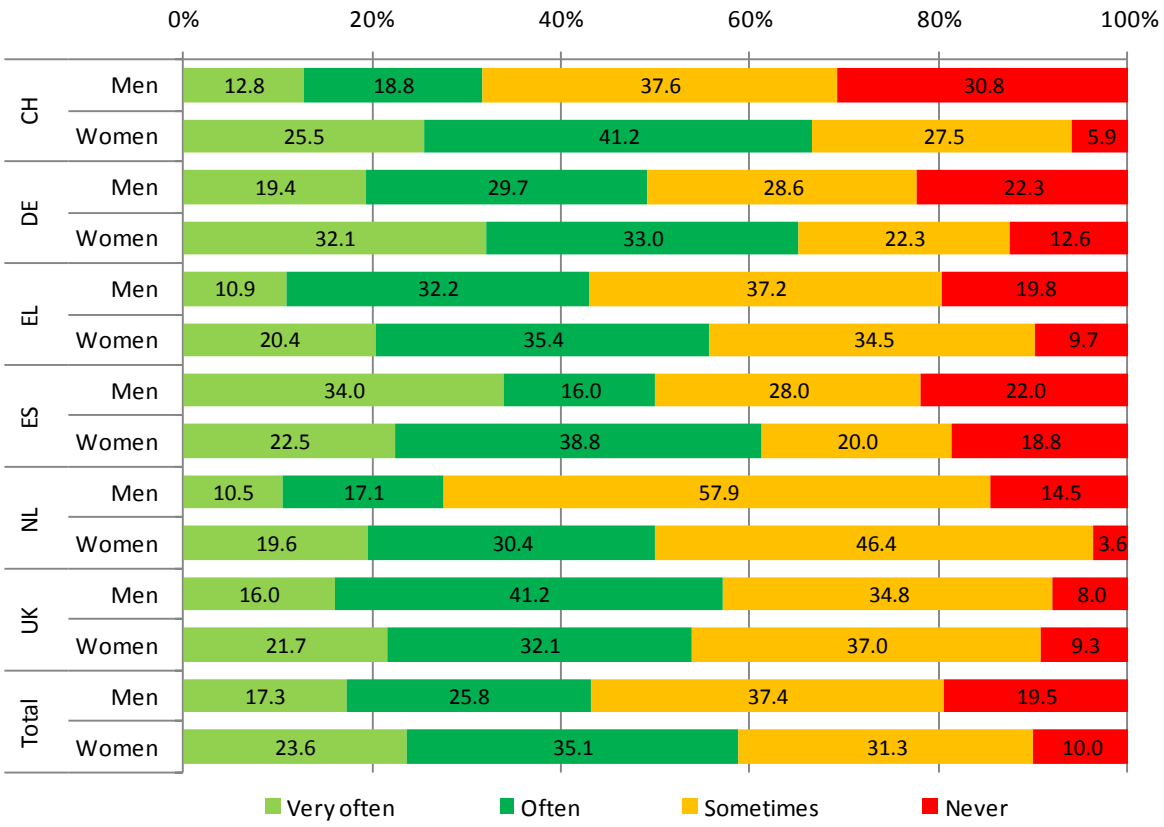


In all the European countries (except in London), men were significantly more isolated than women. Overall, 56.9% of men had emotional support only sometimes or never, compared with 41.3% of women ($p<10^{-6}$).

[76] The question was not asked in Belgium or France. The response rate in Greece was very low: 14.3% like in Canada 19.1%).In other countries the response rates were as follows: CH=70.9%, DE=75.2%, ES=100.0%, NL=99.2%, UK=86.0%, TR=72.7%.

[77] Response rate = 72.7%

Figure 24. Emotional support by gender.



> Hélène is Belgian: "*I took several casual jobs in order to get by and ended up working 15 hours a day. I was falling asleep at work from exhaustion. I was starting to lose my strength... I had serious health problems and I gradually had to stop working. I had to spend all my savings to survive. I was so exhausted I no longer had the energy to do the things I needed to do....Fortunately, I met someone who helped me to rebuild the fabric of my life – social, administrative and medical – and to find the support I was entitled to. I just didn't have the energy any more to find information, apply for things and sort out things like unemployment benefit, health coverage and all that....*"
>
> MdM Belgium – Brussels – January 2014

Experiences of violence

A number of studies have shown the importance of identifying previous experiences of violence among migrant populations, taking into account their frequency[78] and their impact on the mental and physical health of the victims, including in the long term, many years after the original episode.

Experiences of violence were rarely raised spontaneously by the patients during their consultation and there are not always outward signs that lead one to detect it. Conversely, patients have usually been quite open, in all studies, to such a line of questioning in the systematic examination of past violent experiences (provided, of course, adequate time had been taken to address these issues), whatever their origin, culture or social environment (the same is true for detecting domestic violence[79]). Patients understand, accept and are very supportive of routine questions about these issues. Reticence to ask these questions comes mostly from the doctors who bear the responsibility: reluctance, lack of information, lack of time and medical misconceptions[80].

In a context where stigmatisation of 'foreigners' is one of the main obstacles to a better awareness of the situation of exiles fleeing torture and political violence[81], and also knowing the countries of origin and the conditions experienced by migrants during their journey to the destination country, it is important to listen attentively to accounts of previous experiences of violence.

Not asking about this past medical history runs the risk of missing psychological problems (depression or post-traumatic stress disorder[82]), and it also entails the risk of misdiagnosis or diagnostic errors when faced with unexplained physical disorders[83]. It can also hinder the detection of sexually transmitted infections arising from sexual violence. It is therefore a real opportunity for the patients and an issue of good medical practice (and responsibility). We can also cite female genital mutilation which women concerned will not speak about spontaneously, nor would it be identified by a GP unless there was specific focus on it; the same is also true for domestic violence...

However, as in previous years, **these issues are still seldom raised and so violence remains rarely screened by the MdM programme teams:** less than 15% of patients were questioned on this issue, at any time during their first consultation or follow up.

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78 Baker R. 'Psychological consequences for tortured refugees seeking asylum and refugee status in Europe'. In: Basoglu M., ed. *Torture and its consequences*. Cambridge, Cambridge University Press, 1992, pp. 83-106.

79 Bradley F, Smith M, Long J, O'Dowd T. Reported frequency of domestic violence: cross sectional survey of women attending general practice. *BMJ* 2002; 324: 271.
Chen PH, Rovi S, Washington J, et al. Randomized comparison of 3 methods to screen for domestic violence in family practice. *Ann Fam Med* 2007; 5: 430-5.
Garcia-Esteve L, Torres A, Navarro P, Ascaso C, Imaz ML, Herreras Z, Valdés M. Validación y comparación de cuatro instrumentos para la detección de la violencia de pareja en el ámbito sanitario. *Med Clin (Barc)* 2011; 137: 390-7
Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation. *Ann Intern Med* 2012; 156: 796-808.
Abrahams N, Devries K, Watts C, Pallitto C, Petzold M, Shamu S, García-Moreno C. Worldwide prevalence of non-partner sexual violence: a systematic review. *Lancet* 2014, in press (DOI: 10.1016/S0140-6736(13)62243-6).

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

81 Collective. *Soigner les victimes de torture exilées en France. Livre blanc*. Paris, Centre Primo Levi, May 2012, p.9.

82 Loutan L, Berens de Haan D, Subilia L. 'La santé des demandeurs d'asile: du dépistage des maladies transmissibles à celui des séquelles post-traumatiques'. In *Bull Soc Pathol Exotique* 1997; 90: 233-7.
Vannotti M, Bodenmann P. 'Migration et violence'. In *Med Hyg* 2003; 61: 2034-8.

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

As migrants form the majority of the people who receive support from the MdM domestic programmes, the meaning of **MdM's activities amongst these people and good quality primary healthcare are both dependent on taking into account this violence the patients have been facing.** It is therefore essential that the teams are sensitized and trained on this screening. They should systematically build networks to refer the victims, sometimes including providing specific care (although this is not always necessary as the needed care can often be provided through usual primary healthcare services).

Remarks on methodology

Teams were free to choose if they asked questions related to violence or not. This pragmatic choice obviously severely limits interpreting the data. The frequencies reported are in no way representative of the prevalence of violence amongst the patients seen. We cannot dismiss the fact that some teams (or some volunteers in the teams) may have chosen whom they asked about this issue. Conversely, some cases undoubtedly escaped the notice of the teams, as questions were not asked.

The other major limitation to our analyses arises directly from the previous point. The response rates are very imbalanced between the countries, and so *nearly 80% of the patients who had declared at least one type of violence were questioned in Greece,* the country where these questions were overwhelmingly the most often asked, due to the repeated acts of xenophobic violence[84] (10% in France, 4% in United Kingdom, 3% in Belgium, 2% in Munich and Switzerland, less than 1% elsewhere). Data is so scarce (especially when working on the types of violence) that it is not possible to give details by country, nor is it reasonable to weigh the average proportions.

As every year, not all the issues related to violence were addressed, which is logical given that we do not recommend asking the questions one by one but instead opening up the discussion on violence with each patient who may have experienced it him/herself or whose loved ones may have been affected; this approach encourages them to talk. Of course, this choice precludes a systematic approach and runs the risk of missing previous history that will not be spontaneously recounted. Luckily, this ultimately affects less than 10% of the patients questioned. The type of violence for which we got the most responses is the first one – "country at war" (n=2,928) – which is also the least "difficult" for the care giver and the person. The type least often reported is the confiscation of money or papers (n=2,743 individuals). Insofar as violence is asked about, sexual assault and rape were discussed as often with men as with women (in nearly 95% of cases), reflecting a major step forward.

This year, a line for "subject not discussed during consultation" was added to the end of the violence questionnaire. The response rate was extremely low and could not be used. It is suggested that this question be placed at the beginning of the violence questionnaire "if the issue was not discussed, tick the box and go to the next topic".

In 2013, 76.3% of people asked about this topic in the eight European countries reported having had at least one violent experience. The vast majority of people asked about violence were in Greece and, consequently, almost 80% of cases reported came from patients seen through the Greek programmes.

Migrants from the Middle East were disproportionately highly represented among the victims of violence: 72% of victims of at least one form of violence came from this region[85] compared with 3.6% of patients overall from other regions.

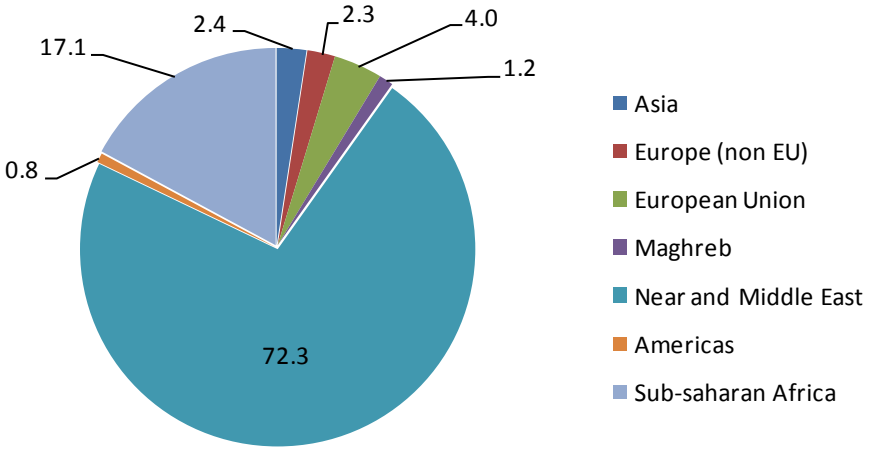
These types of violence affected both sexes and all ages (on average the victims were 27 at the time of the survey, and ranged in age from less than 1 to 86). 61% of people had no permission to reside (a similar proportion to that of the total population of patients seen in the eight European countries). **Asylum seekers,** as might be expected, **were disproportionately highly represented among** victims of violence (24.1% compared with 15.5% among the overall population, $p<0.001$).

[84] In Greece, 20% of the men that reported acts of physical violence by police or armed forces (representing 28% of the people surveyed on this issue) have suffered them since their arrival in Greece.

[85] Afghans (65.5%), Syrians (29.9%), Iraqis (0.8%), Iranians (0.5%), Palestinians (0.5%), Egyptians (0.1%) and Yemenis (0.1%).

> Aicha, a 35 year old Cameroonian woman, went to the Migrant Health Network (Réseau *Santé Migrations – RSM)* with dental and gynaecological problems and abdominal pain. After two weeks of tests, she discovered she was pregnant and HIV positive. The father of her child didn't want any more to do with her, her sister had thrown her out and so she had nowhere to live and no money. We went with her to the Advice Centre for Victims of Offences (*Centre d'aide aux victimes d'infractions)*. Following long discussions, she explained that she had been a victim of trafficking and had been locked in a room for four months. She had managed to escape with the help of a client. She was provided with emergency accommodation and decided to initiate the process of filing a criminal complaint. The local social services assumed responsibility for her treatment and accommodation. She had an antenatal follow-up at the hospital and was given anti-retroviral treatment. She was also referred to a psychiatrist for psychological support.
>
> MdM Switzerland – Neuchâtel – September 2013

Figure 25. Geographical origins of victims of violence (in the 8 European countries surveyed).



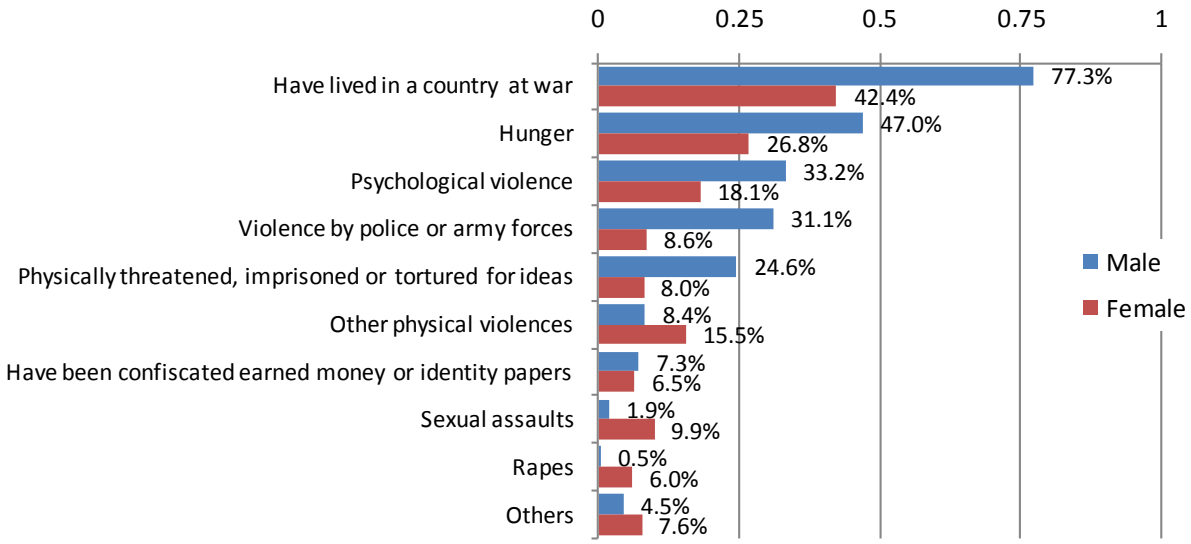
The types of violence most frequently reported were having lived in a country at war (cited by 77.3% of men surveyed and 42.4% of women) **and hunger** (47% of men and 26.8% of women).

Between a quarter and a third of men asked about violence reported violence perpetrated by law enforcement agencies, psychological abuse and/or having been threatened, tortured or imprisoned for their ideas.

Almost one in five women reported suffering psychological abuse.

Sexual assault was reported by 10% of women (compared with 2% of men) **and rape by 6%**. The youngest victims were children aged eight. **One third of sexual assault or rape was reported by men.** These victims (of both sexes) were not from the same geographical origins as the victims of violence in general. Incidents of sexual assault and rape were reported most often by people from sub-Saharan Africa (38.5%), the Middle East (25.3%) and Europe (both EU and non-EU) (22%), while the Middle East accounted for 72% of cases of violence in general.

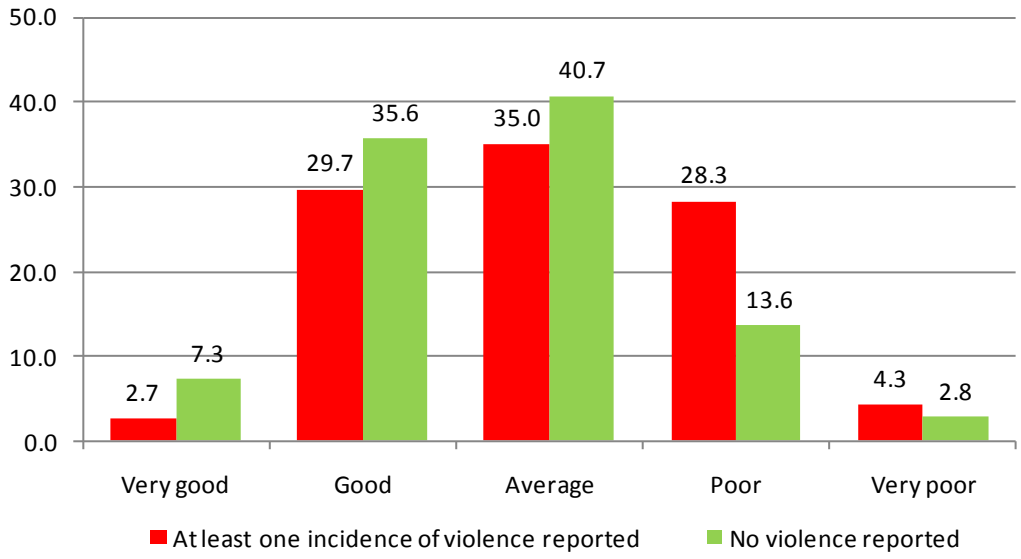
Figure 26. Rates of violence by gender (among patients surveyed on this subject in the 8 European countries surveyed).



*Other physical violence includes domestic violence

The perceived health status of victims of violence was significantly worse than that of other patients ($p<0.001$). **Indeed, the former were twice as likely to report poor or very poor health than the former** (32.6% compared to 16.4% respectively).

Figure 27. Perceived health status of victims of violence compared to patients reporting no violence (amongst the population questioned on this subject in the 8 European countries in the survey).



It is not unusual for people to suffer violence after having arrived in the countries surveyed: **almost 20% of the incidents of rape, sexual assault, other physical assault and having money or papers taken were reported to have taken place after the victims' arrival in the European country.**

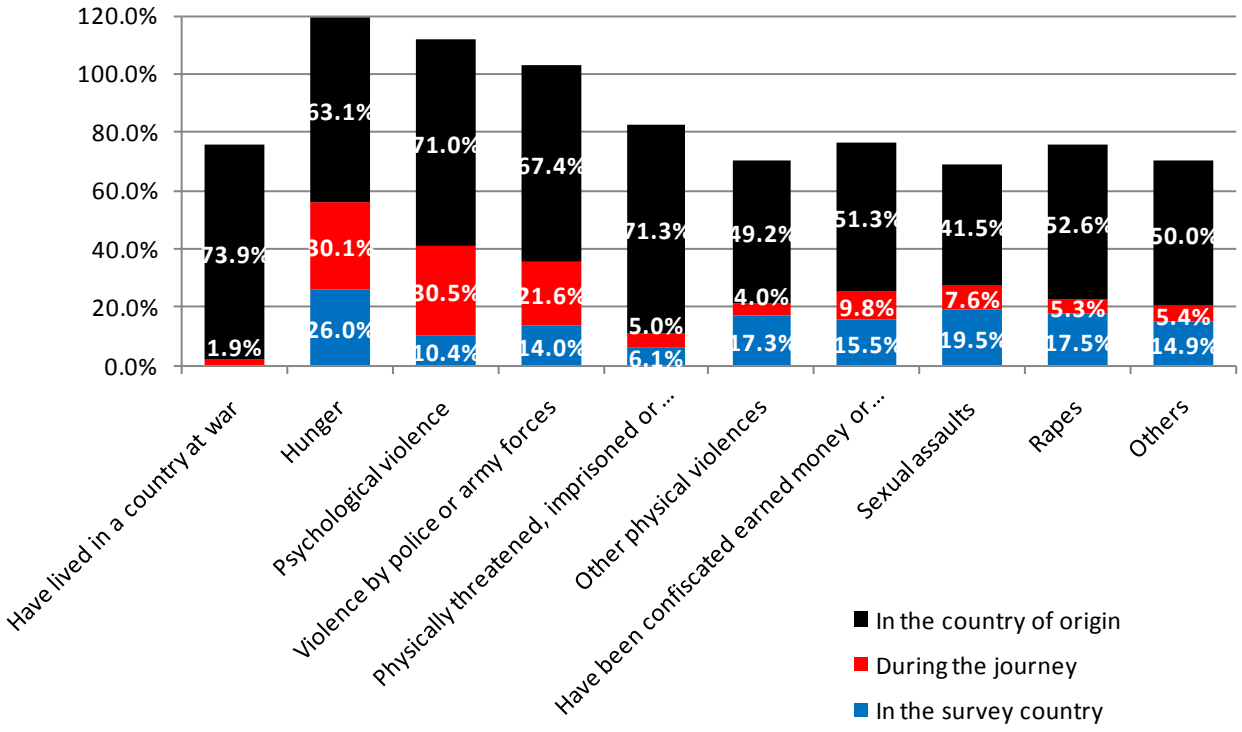
A quarter of people who had experienced hunger had experienced it in the host country.

Shaid is an Iranian migrant who was attacked at Metaxourgiou Square in Athens. "*I was walking in the street, talking on the phone, when three men dressed in black attacked me. They hit me. Then one of them put his arm round my neck and immobilised me and he tore my ear off with his teeth. I was bleeding and my ear fell on the ground. I didn't realise at first. A friend of mine saw me, came and picked me up. He found my amputated ear and took me to the hospital. I had surgery to reattach my ear but it was not successful. So they removed my ear. I was discharged from hospital two weeks later. I went to MdM and they helped me with changing my dressings. I would like to say to migrants who are leaving their countries that maybe it's better in their own countries. I saw no civilisation in Europe. No civilisation and no love*".

Following this incident and hospitalisation, Shaid's asylum process was interrupted because he could not get to Patras where he was expected for a second interview. Despite legal assistance, Shaid was arrested and received a deportation order to leave within 6 days...MdM has since lost contact with him[86].

MdM Greece – Athens – 2013

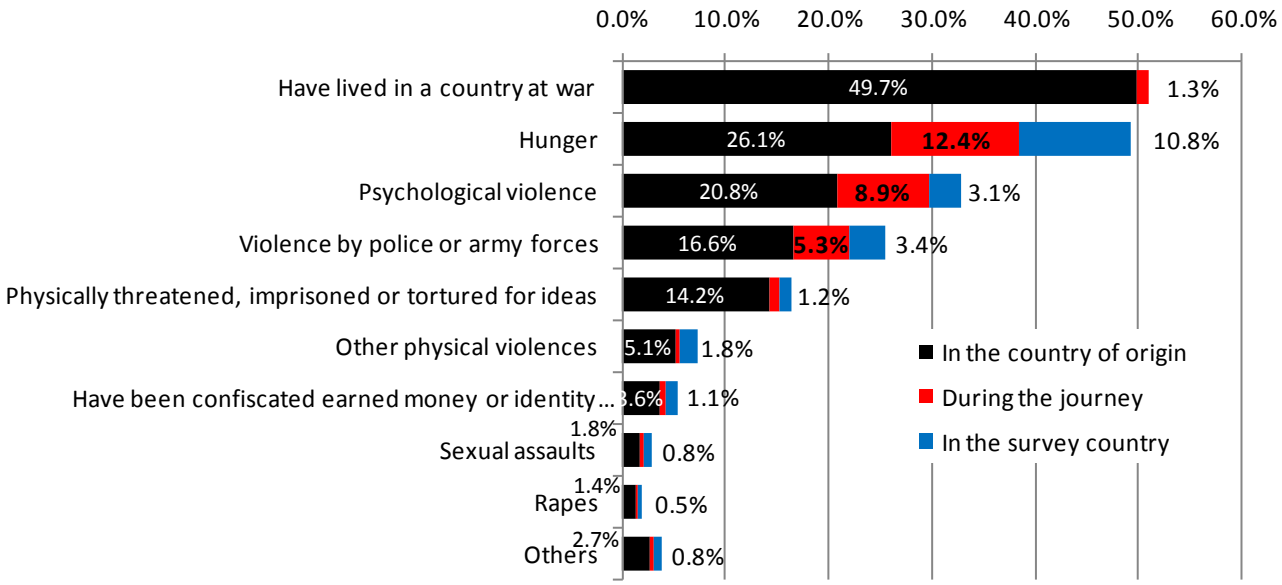
Figure 28. Proportion of violence during different stages of migration (in the 8 European countries surveyed).



Overall, in the host countries, 11% of people surveyed on this issue had suffered from hunger, 3% from violence perpetrated by law enforcement agencies and 3% from psychological abuse.

[86] See the video at: www.mdmeuroblog.wordpress.com

Figure 29. Rates of violence during different stages of migration (in the 8 European countries surveyed).



In Canada, questions about violence were not asked.

In Istanbul, the questions were routinely put to all the women who attended a consultation, or nearly all (response rate = 95.7% or n=970 respondents). In total, 15.7% of respondents had lived in a country at war, 9.2% had been threatened, tortured or imprisoned for their beliefs, 9.2% had been victims of psychological violence, 8.3% had been victims of violence at the hands of the law enforcement agencies, 0.5% of sexual assault and 0.5% of rape, 3.5% of other physical violence, 5.0% had had their money or papers confiscated and 7.1% had suffered from hunger. With only a few exceptions, no violence had been reported since arriving in the country.

Access to healthcare

Coverage of healthcare charges

Two thirds (64.5%) of patients seen in the MdM European centres had no healthcare coverage [87] when they first came to our programmes.

Table 12. Coverage of healthcare charges by country.

Variables	BE	CH	DE	EL	ES	FR	NL	UK	Total 8 pays	CA	TR
No coverage / all charges must be paid	89.9	14.9	0.0	61.5	0.0	92.3	20.3	94.1	46.6	86.4	99.2
Access to emergency services only	0.0	1.3	68.6	14.2	59.4	0.0	0.0	0.0	17.9	1.1	0.0
Full healthcare coverage	5.2	72.4	3.8	18.1	25.0	3.8	3.1	1.3	16.6	12.5	0.0
Partial healthcare coverage	0.4	9.6	4.0	6.0	4.7	2.8	76.6	0.1	13.0	0.0	0.1
Healthcare rights in another EU country	2.4	1.8	19.0	0.2	0.8	1.2	0.0	0.0	3.2	0.0	0.1
Access on a case by case basis	2.1	0.0	4.6	0.0	10.2	0.0	0.0	0.0	2.1	0.0	0.0
Free access to GP services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.7	0.5	0.0	0.5
Chargeable access to secondary healthcare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.1	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Missing data	*10.2*	*3.8*	*13.1*	*86.0*	*1.5*	*30.2*	*3.8*	*11.2*	*36.2*	*56.9*	*26.9*

In London, almost all patients (94.1%) had no healthcare coverage whatsoever when they came to the MdM clinic: at that point they had still been unable to register with a GP, the entry point to the healthcare system. This was in a political context where the government was increasingly questioning access to healthcare for undocumented immigrants.

The proportion of patients in this group was particularly high in France (92.3%) and Belgium (89.9%). These rates can be explained in part by the fact that the centres concerned (Nice, Saint-Denis, Brussels and Antwerp) mainly accept patients with no effective right of access to healthcare, while people who do have healthcare coverage are redirected to facilities within the public healthcare system. In theory, undocumented migrants in both countries have relatively favourable conditions of access to healthcare; in practice, however, administrative barriers and the time taken to process case files and applications for periodic renewal of access increase the frequency of situations and interim periods where they have no effective healthcare coverage.

In Greece, where the largest group of patients seen were Greek nationals, **almost two thirds (61.5%) had never had healthcare coverage or had lost it.** Foreign nationals without permission to reside had no

[87] We have aggregated the figures for people who have no healthcare coverage and those who only have access to emergency treatment.

rights to any healthcare coverage, while Greek nationals and foreign citizens with permission to reside had lost their healthcare coverage due to lack of contributions through their employment or their inability to pay for it.

In Switzerland, 72.4% of patients seen had full healthcare coverage. It was observed that these people were mainly asylum seekers, who have the right to health coverage during their application process (although the procedures involved can be complex and the context rather restrictive). The other patients seen either did not have or no longer had any (adequate or effective) form of healthcare coverage.

In Germany slightly more than two thirds (68.6%) of patients only had access to emergency healthcare and 19% had rights to healthcare coverage in another European country (which is in line with the high number of Europeans among the patients received, as noted above).

In Spain[88], almost 60% of patients seen also only had access to emergency healthcare.

In the Netherlands 76.6% of patients seen in Amsterdam and The Hague could not obtain healthcare coverage due to their irregular administrative status (although their treatment charges can be reimbursed to the healthcare provider on a case-by-case basis if the patient cannot pay).

In Canada and Turkey, the vast majority of those consulting had no coverage whatsoever for their health expenses.

Barriers to access healthcare

Only 24.5% of all patients surveyed reported that they had experienced no difficulty in accessing healthcare. This percentage is even smaller if the exceptional figures for Switzerland (where 84.8% of patients stated that they had experienced no difficulty in accessing healthcare) are not taken into account[89] : across all other countries, **only 15.9% of patients stated they had experienced no difficulty in accessing healthcare**. A further quarter (24.9%) had not tried to access healthcare. While some of these people may not have needed healthcare, others have undoubtedly internalised the various barriers to access healthcare to such an extent that they gave up seeking it.

As in our previous surveys, the three barriers most frequently cited by patients were: financial problems (25.0%) (a combination of charges for consultations and treatment, upfront payments and the prohibitive cost of healthcare coverage contributions); **administrative problems (22.8%)** (including restrictive legislation and difficulties in collecting all the documentation needed to obtain any kind of healthcare coverage, as well as administrative malfunctioning); and **lack of knowledge or understanding of the healthcare system and of their rights (21.7%)**. Since the first studies by the MdM International Network Observatory in 2006, nothing seems to have changed with regard to these problems: around one in two patients had no knowledge either of the healthcare system or of their rights and/or was at a loss when confronted with the administrative procedures of the host country. **These results clearly contradict the myth that migrants come to Europe for the purpose of using healthcare services.**

[88] It should be noted that since September 2012 between 750,000 and 873,000 migrants in Spain have lost their healthcare coverage. (Legido-Quigley, H., Urdaneta, E., Gonzales, A. et al., 'Erosion of Universal Health Coverage in Spain', *The Lancet*, Vol.382, No 9909, 14.12.2003, p. 1977.)

[89] The patients attending the Swiss centres were predominantly asylum seekers who have access to healthcare coverage during their application process.

Adama, 31, is originally from Kenya. He is an undocumented migrant. He came to the MdM clinic because he was experiencing chest pains spreading to his arm and frequent nausea. The MdM team referred him to a public healthcare centre. "*At the health centre, I showed the receptionist the papers explaining the new law on access to healthcare for undocumented people which MdM had given me. The receptionist then asked me quite a lot of questions: what was I doing in Sweden? Why had I come here? and other things. It was like being at the Immigration Office and it was really unpleasant. Then she told me I would have to pay €200 to see a doctor. This was in spite of showing her the paper about the new law. I knew that it should cost €6. Then I went to another health centre and paid €6 and they gave me an appointment with a doctor. The doctor gave me a prescription for two types of medications. At the pharmacy I had to pay €30".*

MdM Sweden – Stockholm – 2013

Figure 30. Rates of barriers to access healthcare in the 8 European countries.

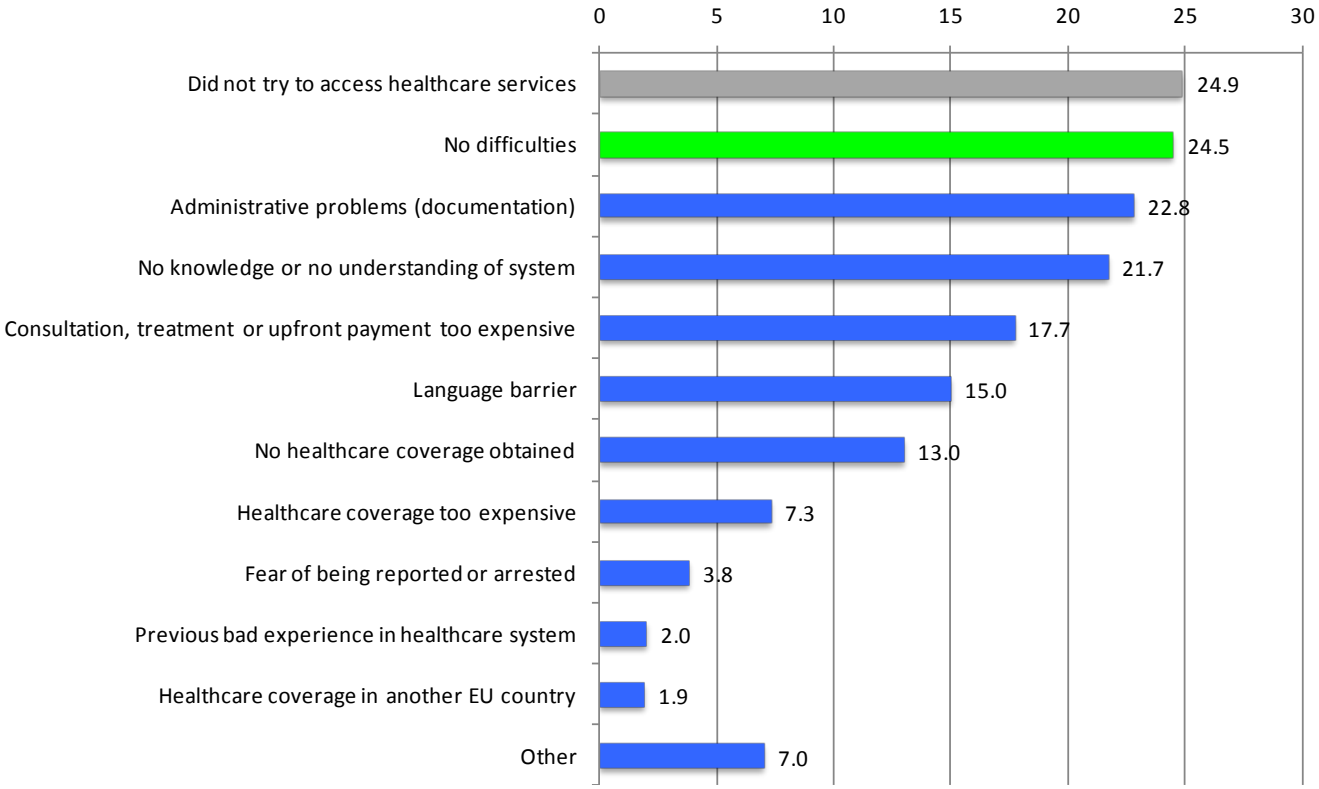


Table 13. Barriers to access to healthcare by country.

	BE	CH	DE	EL	ES	FR	NL	UK	Total 8 Europe countries	CA	TR
Did not try to access healthcare services	34.7	10.5	33.0	13.3	11.8	4.1	36.6	55.5	24.9	23.3	34.1
No difficulties	13.7	84.8	16.1	14.7	16.5	9.3	37.4	3.6	24.5	13.3	0.0
Administrative problems	10.1	0.0	15.7	21.1	38.6	37.0	10.7	49.2	22.8	13.3	28.4
No knowledge or understanding of the system	23.5	0.0	35.7	6.3	15.7	36.5	7.6	48.5	21.7	6.7	19.4
Consultation, treatment or upfront payment too expensive	24.5	3.1	52.6	26.4	17.3	6.6	9.2	1.6	17.7	30.0	53.7
Language barrier	1.1	1.6	44.1	10.2	13.4	28.8	0.8	20.1	15.0	0.0	48.6
No healthcare coverage obtained	13.0	0.0	5.0	7.4	47.2	15.7	2.3	13.6	13.0	16.7	8.6
Healthcare coverage too expensive	2.5	0.5	42.8	3.3	3.9	0.0	3.1	1.9	7.3	6.7	9.3
Fear of being reported or arrested	0.7	1.0	6.3	7.8	3.9	0.5	0.0	10.3	3.8	0.0	31.5
Previous bad experience in healthcare system	1.4	0.5	3.3	4.9	2.4	1.7	0.8	1.0	2.0	3.3	9.8
Healthcare coverage in another EU country	0.0	0.0	13.2	0.2	0.0	1.8	0.0	0.2	1.9	0.0	0.1
Other	9.4	1.6	12.3	22.5	3.9	0.2	1.5	4.4	7.0	0.0	0.4
Total*	134.7	103.7	280.0	138.0	174.8	142.4	109.9	209.9	161.7	113.3	243.9
*Response rate***	*11.6%*	*80.6%*	*92.1%*	*38.5%*	*97.7%*	*67.1%*	*98.5%*	*88.4%*	*53.4%*	*14.7%*	*73.3%*

*People could cite several barriers which explains why the total is > 100 %
**Response rates were particularly low in Belgium and Canada

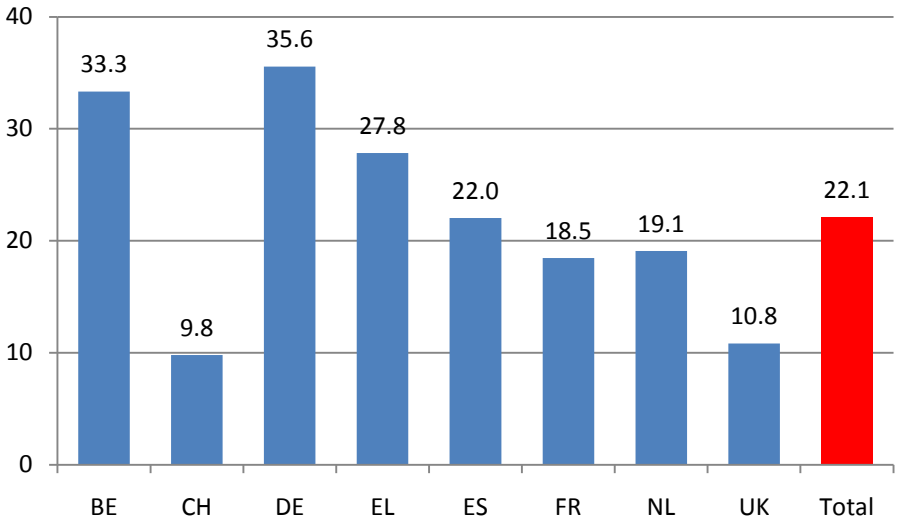
Giving up seeking healthcare

More than one patient in five (22.1%) said that they had given up trying to access healthcare or medical treatment in the course of the previous 12 months. As in previous years, Munich has the highest percentage (35.6%).

The frequency of people giving up seeking healthcare has significantly decreased in Spain (going from 52.0% in 2012 to 22.0% this year). Indeed, just after the new law/decree began to be applied restricting access to healthcare, many migrants gave up going to public health facilities. Then at the end of 2013, when the survey was carried out, some migrants knew that MdM could help them to access healthcare and they came to our programmes for this reason. Furthermore, it is possible that destitute patients (or those without permission to reside) had so internalised the restrictions applied to accessing healthcare in 2012 that they no longer reported (and/or no longer felt) these barriers to accessing healthcare as tantamount to giving up seeking care ...

Asylum seekers in Switzerland declared that they had rarely given up seeking healthcare, which is logical as the majority of them had healthcare coverage and they only very rarely reported any barriers in accessing healthcare.

Figure 31. Proportion of patients that gave up seeking healthcare by country.



The Greek and Belgian figures are given as an indicator and should be interpreted using utmost caution (they relate to 204 individuals and the question was asked in only 8.6% of cases in Belgium; they relate to478 patients with a response rate of 27.8% in Greece[90]).

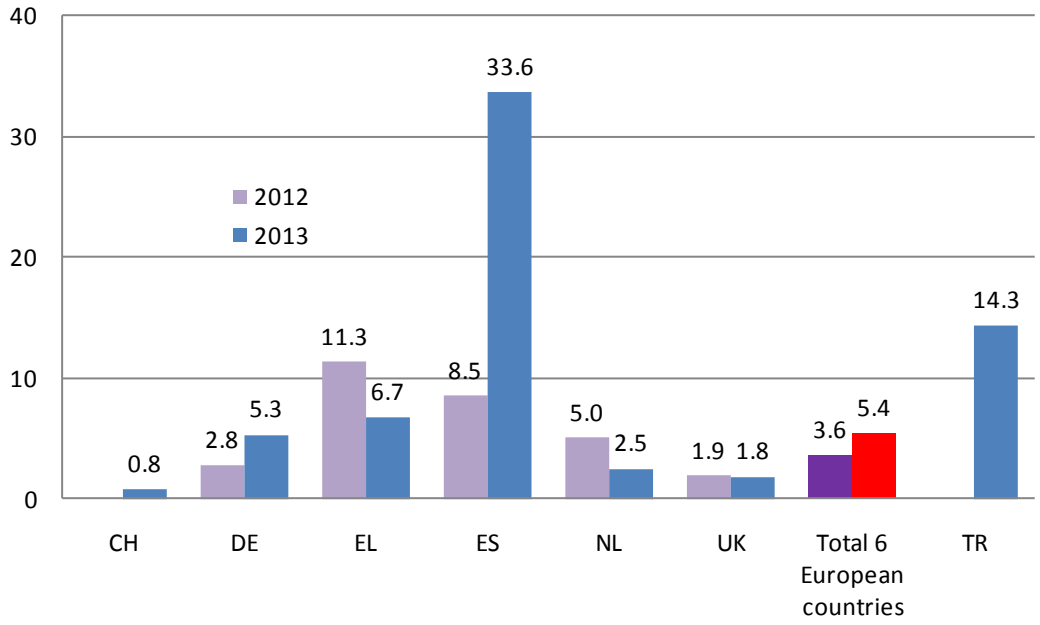
[90] Global response rate = 45.2 % (respectively BE=8.6%, CH=64.6%, DE=77.9%, EL=13.9%, ES=97.7%, FR=58.1%, NL=98.5%, UK=86.4%).

Racism in healthcare services

Fortunately, experiences of racism within healthcare services remain rare: an average (crude) of **5.4 % of the patients seen in Europe had faced this during the previous 12 months**[91]. The figures for Greece are based on only a very small proportion (13.9%) of those surveyed, specifically because many patients were Greek and were not asked this question, but also because when migrants are seen at Mytilene (which, of the five Greek centres, has the largest number of patients recorded in the database), they have just arrived in the country and have not yet had any contact with healthcare services.

In contrast, behaviour of this kind was frequently reported in Spain, where it has increased fivefold between 2012 (6.3%) and 2013 (33.6%, $p<10^{-3}$)[92]**.** We are witnessing a clear deterioration in the perception of migrants in Spain, as a result of political discourse at the highest government levels, who targeted migrants in the reform of the health system by claiming that their access to healthcare should be restricted, as they cost the health system too much money. Migrants have thus also become scapegoats in the economic crisis in Spain.

Figure 32. Proportion of patients who have been victims of racism in a healthcare facility over the past 12 months, by country.



*Crude average proportion (CAP)

In Istanbul, 14.3% of patients declared they had been victims of racism in a healthcare facility[93] (as seen before, 87.3% of patients seen in this country were from sub-Saharan Africa). In Montreal, the question was too rarely asked (to 11.3% patients) to be useable.

[91] This question was not asked in Belgium or France.

[92] Although the number of patients in Spain were very low in both 2012 (103 patients) and 2013 (130 patients).

[93] Response rate = 69.6%

Denial of access to healthcare

Denial of access to healthcare is defined as any behaviour by health professionals that results, directly or indirectly, in failure to provide healthcare or medical treatment appropriate to the patient's situation.

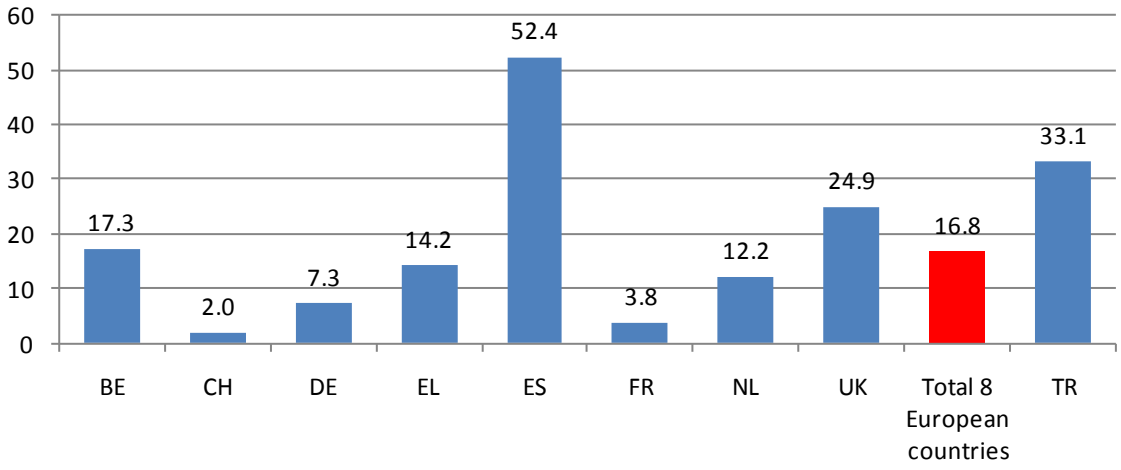
Denial of access to healthcare (over the previous 12 months) was reported by **16.8 % of patients seen by MdM in Europe.**

As in 2012, **denial of access to healthcare was most frequently reported in Spain**, by over half the patients (52.4%) surveyed. These patients – who expected to be treated as they had been before the changes introduced by the new legislation – discovered when they went to healthcare facilities that they no longer had any right of access to medical services.

Ranked second after Spain in this respect is London, where a quarter (24.9%) of patients was denied access to healthcare. The figures for Belgium, Greece and France should be interpreted with caution, given the low response rates in those countries (missing data rates stood at 91.8%, 86.1% and 63.3% respectively)[94].

> Alpha Pam, a 28 year old Senegalese man, had been living in Spain for eight years. He had been trying to see a doctor for six months, but had been turned away on seven occasions by a health centre and twice by a hospital. For this third and final attempt at the hospital, he even asked a friend to go with him, as he no longer had enough strength to walk on his own. Once there, he was seen for five minutes, but no chest x-ray or other examination were made. He died at his home, 11 days later, of tuberculosis which could and should have been diagnosed and treated when he first attempted to access medical treatment.
>
> MdM Spain – the Balearics – April 2013

Figure 33. Denial of access to healthcare rate over the past 12 months, by country.



In Istanbul, these denials of access to healthcare affected a third (33.1%) of patients.

In Montreal, the question was asked too rarely to be useable (87.3% of data missing).

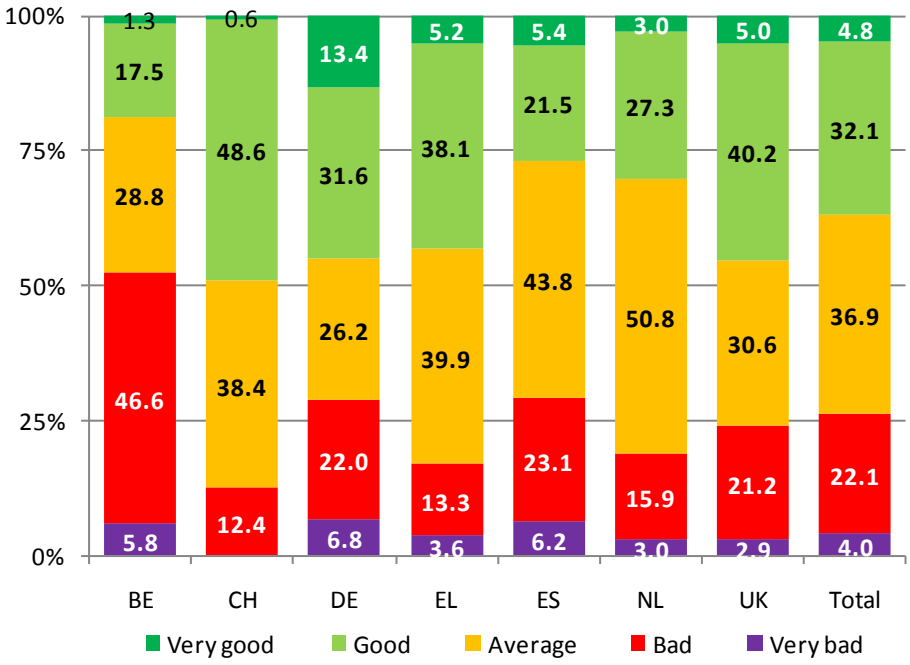
[94] In the other countries, the response rates were: CH=62.9%, DE=71.5%, ES=95.4%, FR=36.7%, NL=98.4%, UK=87.3%, TR=69.7%.

Health status

Self-perceived health status

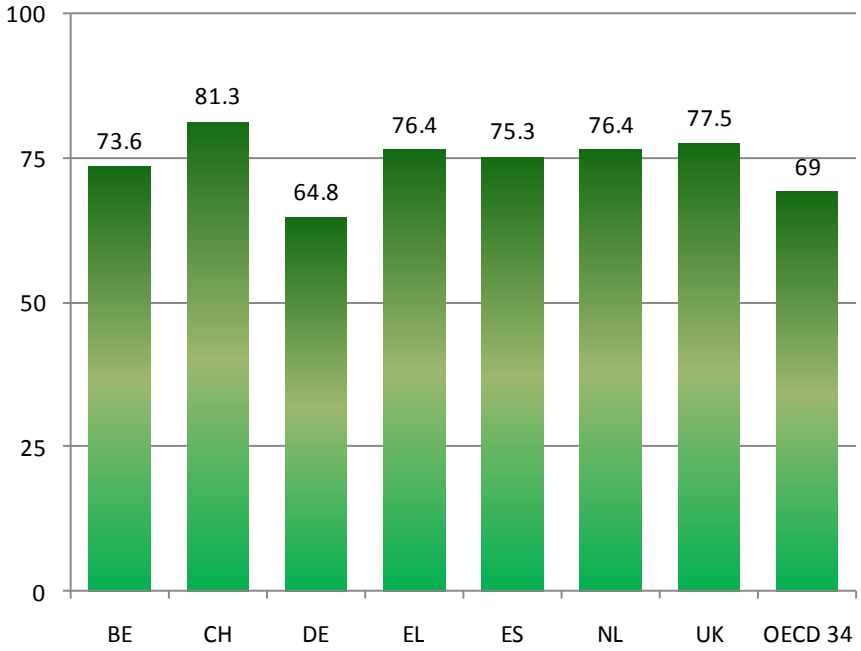
Almost two thirds (63.1%) of patients seen by MdM in Europe[95] perceived their health status as deteriorated. **Around a quarter of patients felt that they were in bad or very bad health**

Figure 34. Self-perceived health status by country.



[95] In the 8 European countries surveyed. See below for Montreal and Istanbul.

Figure 35. Proportion of adults in the general population declaring themselves to be in good or very good health by country in 2011.



Source: EU Statistics on Income and Living Conditions survey; OECD Health Data 2013.

Even though the population of patients studied is younger (their median age is 32), their health status is significantly worse than that of the general population in the eight European countries covered[96]. Compared to the adult population alone in each of these countries, **only 36.9% of patients met (which, it should be noted, included children) perceived themselves to be in very good or good health whereas in the general population the figures were 65% to 82 %**[97] (in 2011) [98].

In six countries (Switzerland, Germany, Greece[99], Spain, the Netherlands and the United Kingdom), patients were then asked questions on their perception of their psychological health as well as their physical health. **In general, the perceived psychological health of the people surveyed appeared even worse than their physical health: in total, 27.6% of patients stated that their mental health was bad or very bad.**

This applied particularly to Spain, where a rate of 40% for bad or very bad perceived mental health was reported (compared to 23.9% for bad or very bad physical health). In Switzerland too, 27% of patients felt that their mental health was bad or very bad, while 18.2% perceived their physical health as bad or very bad.

[96] In 2013, the median age of the population was, respectively, 42.8 in Belgium, 41.8 in Switzerland, 45.7 in Germany, 43.2 in Greece, 41.3 in Spain, 40.6 in France, 41.8 in the Netherlands and 40.3 in the United Kingdom

[97] OECD. *Health at a Glance: Europe 2013*. Paris: OECD Publishing, 2013.

[98] It is possible that since 2011 the self-perceived health status of the general population has worsened in the countries worst affected by the crisis but surely not by such large percentages (between 2010 and 2011, variations did not exceed 2% in the countries where they were the highest).

[99] The data for Greece should be interpreted with caution, in view of the high rate of missing responses (85% for the two questions on self-perceived physical and mental health).

Figure 36. Perceived physical health status by country.

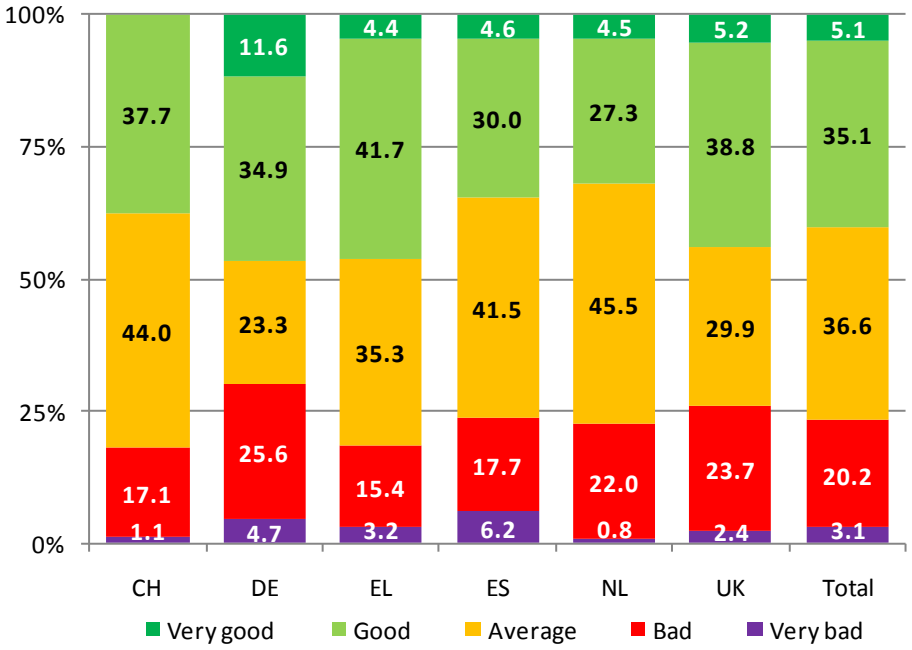
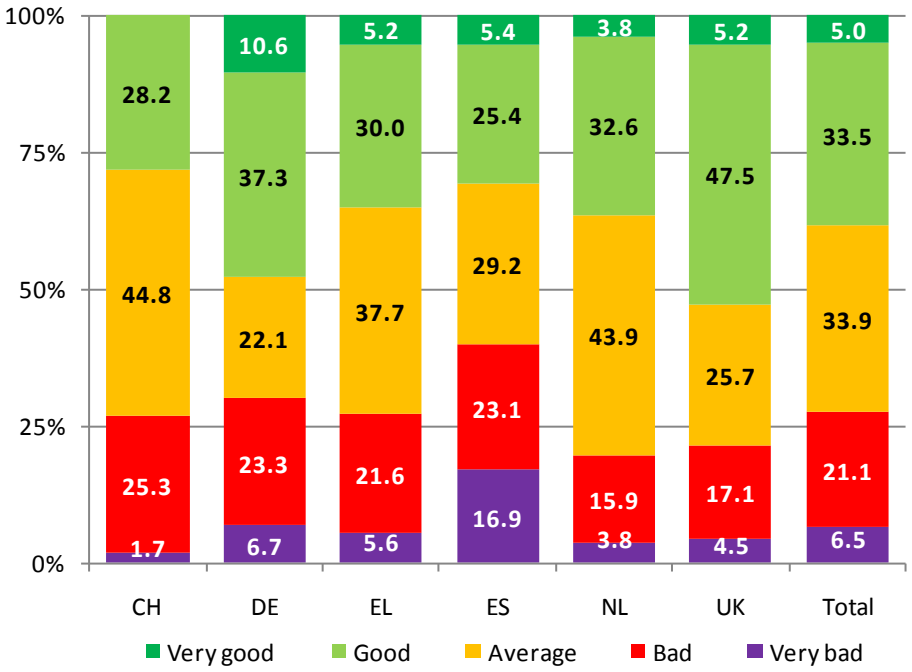


Figure 37. Perceived psychological health status by country.



The response rate for these perceived health indicators was too low (<15%) in Montreal to be useful.

In Istanbul, their distribution is unique. For general health, 69.4% of patients felt in good health (and 0.4% in very good health), a quarter perceived their health status as average and only 5.2% felt in poor health. On the other hand, this city had the greatest difference between global (or physical) health and mental health: indeed, **43.5% of patients deemed their psychological health status as poor and** 1.7% as very poor.

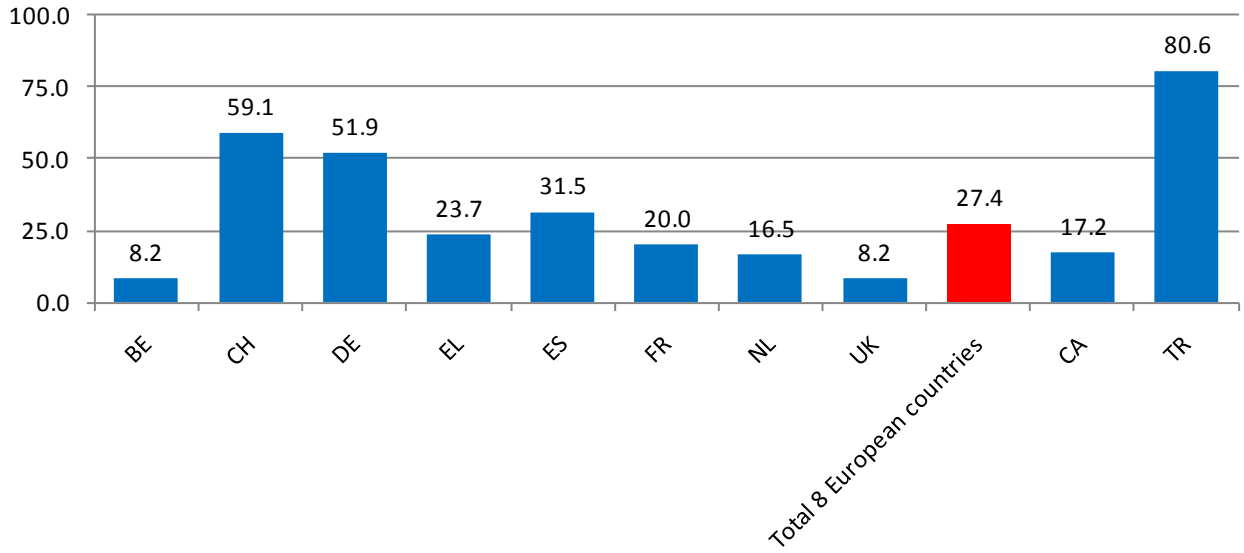
Chronic and acute health conditions

Health professionals[100] who saw patients for a consultation indicated, for each health problem (and each visit) the following: if they believed this problem arose from a chronic or acute health condition, if they thought treatment (or medical care) was necessary or only precautionary; if this problem had been treated or monitored before coming to MdM, and if, in their opinion, this problem should have been treated earlier.

Almost a third of patients (27.4 %) seen by a doctor in the European centres were diagnosed with at least one acute health condition.

In Montreal and Istanbul, 17.2% and 80.6% of patients seen respectively had at least one acute health condition.

Figure 38. Proportion of patients with at least one acute health condition, by country.

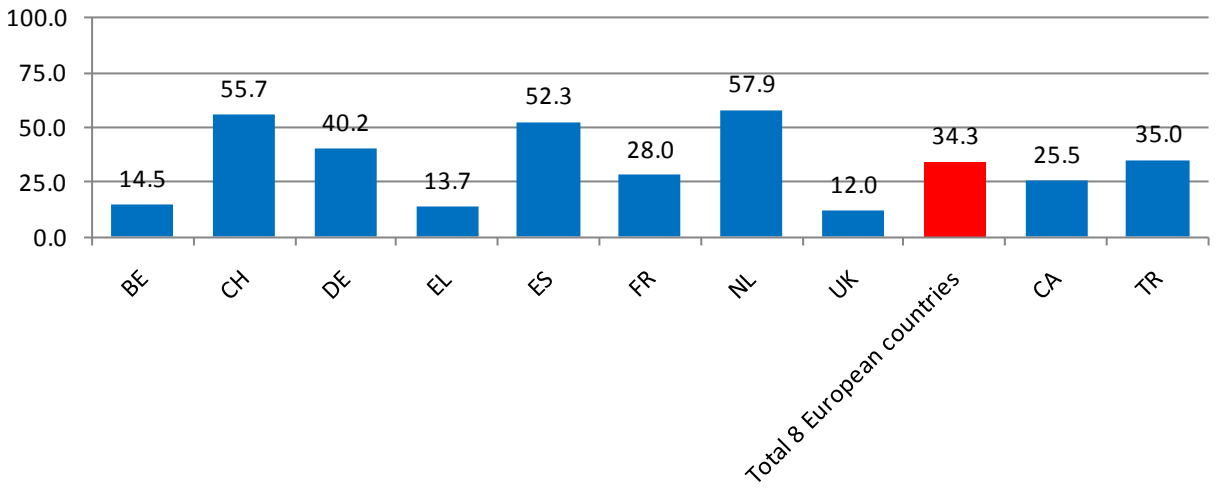


[100] In Switzerland, consultations are provided by nurses, who are responsible of filling in the medical notes (diagnoses and treatments). Everywhere else, doctors give medical consultations.

Over one third of patients (34.3%) who consulted a doctor in the European centres were diagnosed with at least one chronic health condition. This proportion is significantly higher in Switzerland, Spain and the Netherlands, where more than half of patients were in this situation.

In Montreal and Istanbul, 25.5% and 35.0% of patients seen respectively had at least one chronic health condition.

Figure 39. Proportion of patients with at least one chronic health condition, by country.



Asya, 38, a Chechen journalist, arrived in Nice with her seven-year old daughter in December 2012. She then applied for asylum. She came to see a doctor at the MdM clinic (CASO) at the end of the month. She told the doctor she had been treated for breast cancer in 2008 and for pulmonary and bone metastases in 2012. She complained of severe fatigue, weight loss and a heavy, persistent cough. The doctor referred her to a centre for tuberculosis prevention for a pulmonary X-ray, which showed anomalies urgently requiring the opinion of an oncologist.

At the same time, the MdM team contacted the government organisation responsible for finding accommodation for asylum seekers (DDCS) and asked them to find accommodation for Asya and her daughter; they were quickly allocated places in a reception centre for asylum seekers (CADA).

The cancer centre in Nice is a private institution which has a public service mission. A first appointment was quickly arranged where several metastases were diagnosed and the cancer was found to be at an advanced stage. The hospital doctor recommended a course of chemotherapy as a matter of urgency.

But Asya had no healthcare coverage. The MdM team completed the necessary documentation for her and asked the local healthcare coverage office (CPAM) to treat her application as urgent. A letter explaining Asya's situation was sent to the hospital admissions office.

An appointment was made for the first session of chemotherapy at the beginning of January. The hospital admissions office asked for a deposit cheque of €3,000, without which she would not receive treatment. When they were told this, the MdM team phoned the administrative department of the cancer centre, which responded by pointing out their private status (but omitting to mention their public service mission). The MdM team then intervened directly with the doctor who had prescribed the chemotherapy, and Asya was able to receive her treatment.

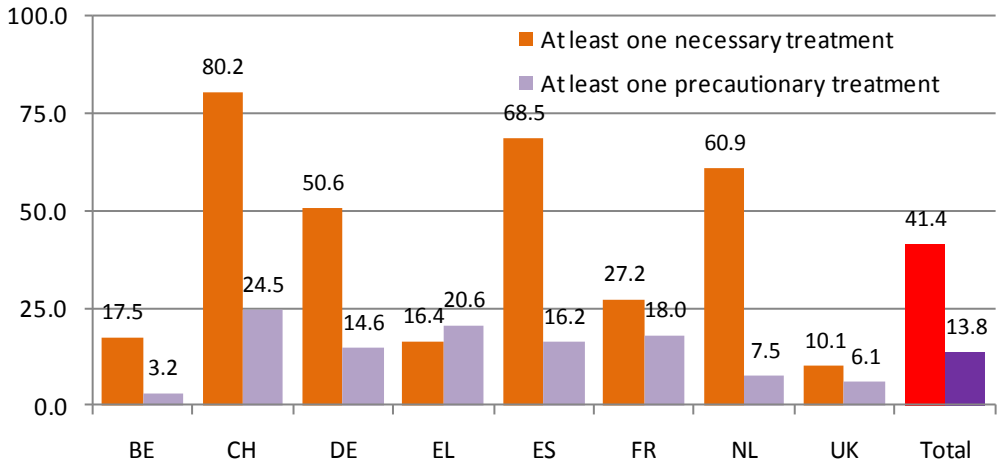
MdM France – Nice – January 2013

Treatments

In total, more than half (55.2%) of patients seen in the European centres needed treatment that was either essential or precautionary[101]. In three quarters of these cases, treatment was regarded as essential by the doctors, a considerable proportion.

This percentage was significantly higher in Switzerland (80.2% of patients needed at least one treatment), Spain (68.5%), the Netherlands (60.9%), as well as Germany (50.6%). In Montreal and Istanbul, 27.0% and 98.8% of patients respectively needed at least one treatment doctors considered necessary (and 15.6% and 16.2% of at least one treatment deemed precautionary).

Figure 40. Proportion of patients with at least one necessary treatment or at least one precautionary treatment, by country.



Patients who received little healthcare before coming to MdM

In the eight European countries surveyed, **29.1% of patients had at least one health problem that had never been monitored or treated** before coming to MdM.

This percentage was significantly higher in Switzerland (57.0%), in Spain (43.9%) and the Netherlands (39.9%), as well as in Germany (39.0%).

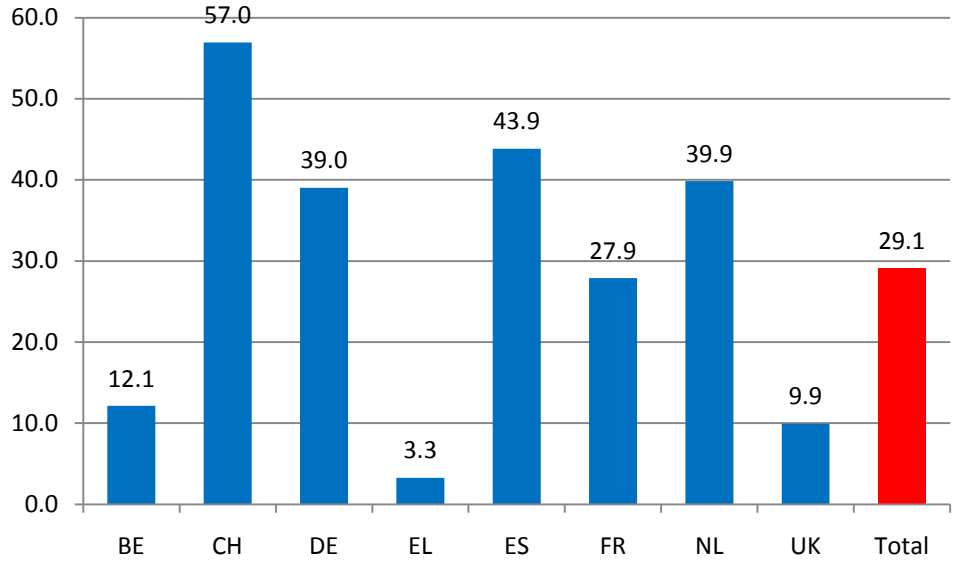
In Montreal and Istanbul, 24.5% and 95.8% of patients respectively had at least one health problem which had never been monitored or treated before coming to consult MdM.

In Greece the rate was particularly low (3.3%), indicating frequent breaks in the continuity of healthcare: health problems which had previously been diagnosed and treated were no longer being treated, which meant patients had to come to MdM. It must be remembered that the economic crisis and subsequent austerity measures have hit the Greek healthcare system extremely hard. Cuts in spending on

[101] Treatments were regarded as essential in cases where their lack would almost certainly mean a deterioration in the patient's health, or a significantly poorer prognosis: in other cases they were classed as precautionary. There is no question here of 'unnecessary' treatment, nor of simple 'comfort'.

hospitals and pharmaceuticals have even gone beyond the targets imposed by the Troika: the most underprivileged are obviously the worst affected[102].

Figure 41. Proportion of patients with a health problem that had never been monitored or treated before consulting MdM for the first time, by country.

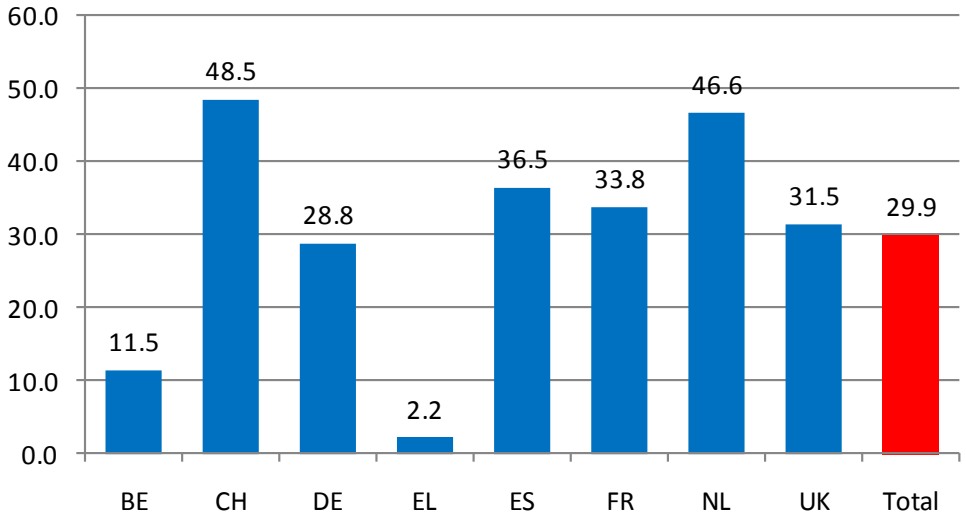


If we look at one other indicator, the percentage of patients requiring treatment (according to the doctor who saw them at MdM) and who had not been seen before coming to MdM, we find a very similar prevalence: **almost 30% of patients were in this group and for them MdM was therefore the primary healthcare provider for problems requiring treatment.**

The prevalence in this group was even higher in Switzerland and the Netherlands, where it exceeded 45%. In Greece, as noted above and for reasons already stated, the rate was remarkably low.

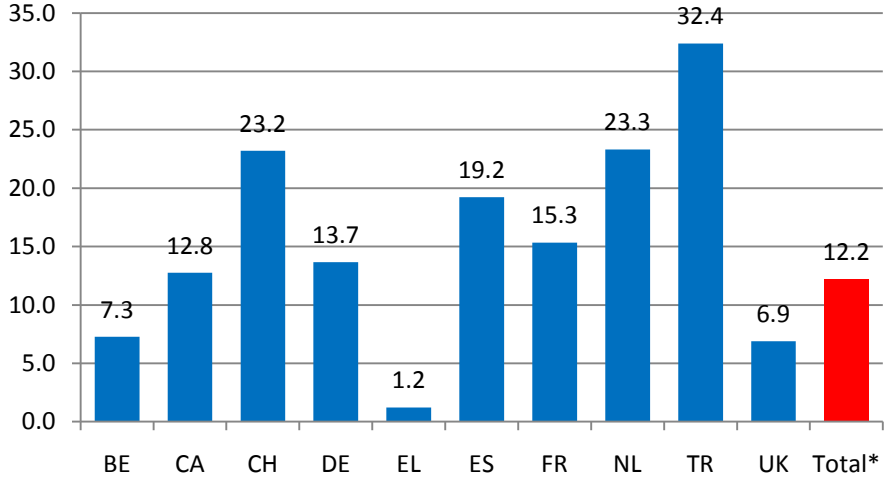
[102] Kentikelenis, A., Karanikolos, M., Reeves, A., McKee, M., Stuckler, D., 'Greece's health crisis: from austerity to denialism', *The Lancet*; Vol. 383, No 9918, 22.02.2014, pp. 748-53.

Figure 42. Proportion of patients requiring treatment who had no medical follow up before coming to MdM.



In all of the 10 countries, **12.2% of all patients seen in our centres had at least one chronic health condition for which they had received no medical follow up before they came to MdM (this percentage is 13.8% for the European countries).**

Figure 43. Proportion of patients with at least one chronic health condition that had no medical follow up before coming to MdM.



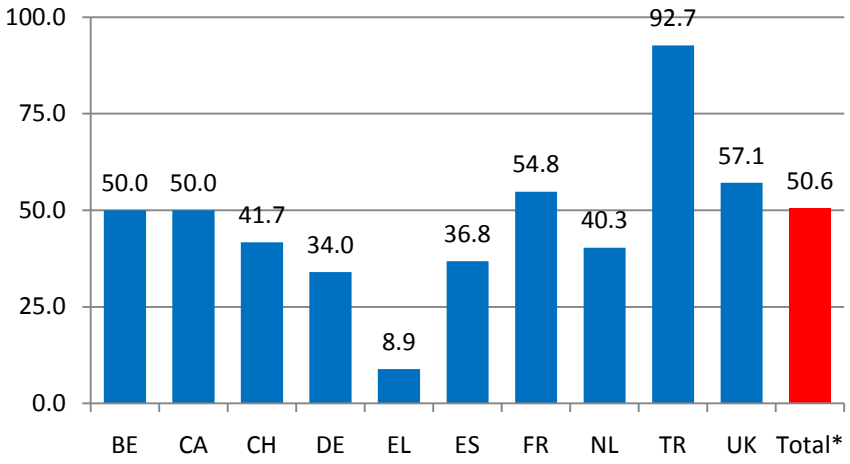
*CAP

This concerned around one third of the patients seen in Istanbul (32.4%), a quarter of patients seen in Switzerland and in the Netherlands, a fifth of the patients seen in Spain, 12.8% of patients seen in Montreal, and only 1.2% of patients seen in Greece.

In other words, **half of patients with one or more chronic health conditions hadn't received medical follow up before going to MdM** (for at least one of their chronic health conditions). This percentage rises to 40.5% if we only consider patients seen in the European centres.

Except in Greece where this situation was uncommon (8.9%), it affected at least one third of patients with a chronic health condition in Spain and Germany, slightly under half of the patients with a chronic health condition in Switzerland and the Netherlands, half or more in Belgium, Montreal, France and London. **This was also true for more than 90% of patients with chronic health conditions in Istanbul.**

Figure 44. Proportion of patients – among those suffering a chronic health condition – who had not received medical follow up before coming to MdM.



*CAP

Health problems mainly unknown of prior to arrival in Europe

Of the entire migrant population surveyed in the eight European countries, only **13.6% of patients**[103] **(non-nationals) had at least one health problem which they had known about before they came to Europe.**

In Istanbul, where there is no health insurance system and foreigners have to pay twice as much as Turkish people, 20.1% of the immigrant population had at least one health problem already known about before coming to Turkey. In Montreal, this percentage was 7.8%.

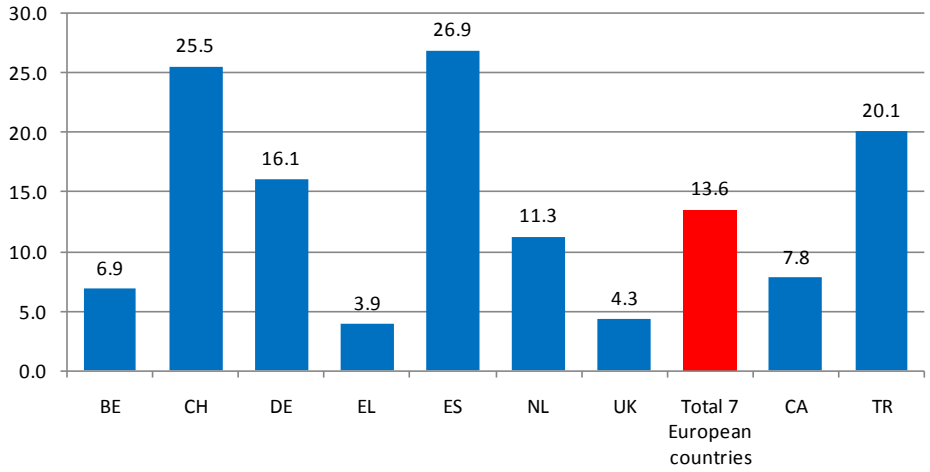
However, as has already been observed, healthcare reasons represented only 2.3% of all reasons for migration cited in Europe and this figure was even lower in Canada and Turkey. **This confirms the general finding cited above, that 'migration for healthcare' is rare, despite what is frequently claimed in the rhetoric of some populists and demagogues.**

There were only three countries where the rates were higher: Switzerland (where there were large numbers of asylum seekers), Spain and Turkey.

Among the few people who reported having migrated for health reasons, 37.5% (or 18 of the 38 people), had in fact, according to doctors, a health problem that had been detected before they knew they were coming to Europe.

[103] This question was not asked in France.

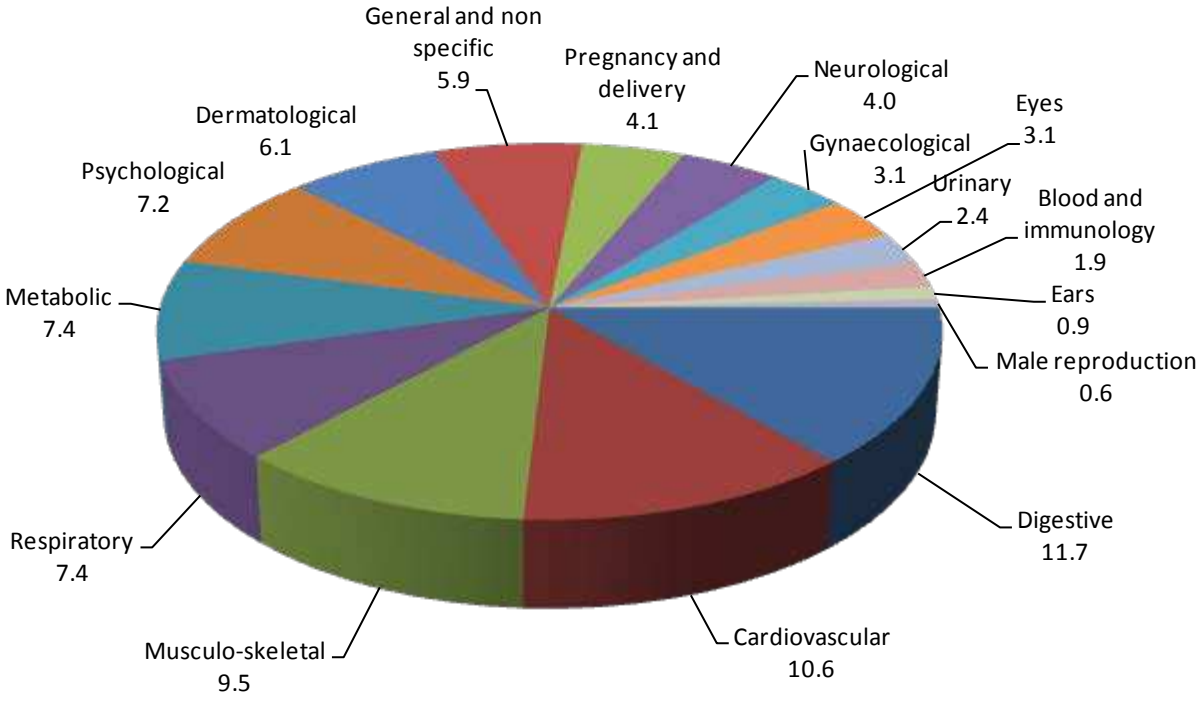
Figure 45. Proportion of immigrant patients with at least one health problem known about before migration.



Health problems by biological system

As every year (and as might be expected in primary healthcare), five of the body's systems group most of the health issues encountered. In descending order (and in the eight European countries) these were: 11.7% of the 17,393 medical consultations[104] were related to the digestive system; 10.6% the cardiovascular system; 9.5% the skeletal system; 7.4% the respiratory system and 7.4 % the metabolic and endocrinal system.

Figure 46. Division of medical consultations by biological system (in the 8 European countries).



The following detailed analysis of the diagnoses was done on all of the 23,697 diagnoses gathered in all 10 of the countries surveyed

Overall, around half of all medical consultations concerned nine health problems. These were: gastrointestinal symptoms (8.6%), hypertension (7.0%), non-specific musculoskeletal symptoms (6.7%), diabetes (insulin-dependent and non-insulin-dependent, 5.7%), anxiety, stress or psychosomatic problems (5.6%), upper respiratory tract infections (5.2%), other gastrointestinal diagnoses (4.6%), non-specific spinal problems (3.9%) and upper and lower back problems (3.6%). Added to these nine problems, the following eight affected 75% of those consulting and the next seven, 90% of patients .

[104] 15 799 of which were in the 8 European countries (the percentages do not alter by ± 0,1% if we consider these 8 countries or all the 10 countries together)

If these health problems are grouped under broader disease categories, **psychological problems were identified at 10.4% of medical consultations.** The most frequently reported mental health problems were anxiety, stress and psychosomatic problems (5.6% of consultations: 4.8% affecting women and 6.1% affecting men, $p<10^{-5}$) and depressive syndromes (2.8% of consultations, 3.6% affecting women and 2.3% affecting men, $p<10^{-8}$).

Psychotic disorders are much rarer (0.7%) as well as problems related to using psychoactive substances (0.4%, all substances combined, and significantly more common amongst men than women).

Table 14. Frequencies of psychological disorders by gender (as a % of the 17,393 medical consultations).

	Women		Men		p	Total	
	n	%	n	%		n	%
Anxiety/stress/psychosomatic problems	316	4.8	631	6.1	$<10^{-5}$	955	5.6
Other psychological problems	57	0.9	98	0.9	NS	155	0.9
Psychoses	47	0.7	65	0.6	NS	112	0.7
Depressive syndromes	237	3.6	238	2.3	$<10^{-8}$	477	2.8
Use of psychoactive substances	13	0.2	52	0.5	0,003	65	0.4
Total	670	10.2	1084	10.5		1764	10.4

A total of 10% of medical consultations for women patients dealt with gynaecological problems: normal pregnancy and postnatal issues (8.8%) were most frequently reported, followed by other unspecified gynaecological problems (2.3%), sexually transmitted infections (STIs) (2.0%) and finally, abnormal pregnancies and postnatal problems (0.8%).

Dermatological problems were reported at 6.1% of consultations.

Viral forms of hepatitis related to 1.5% of consultations (1.9 % for men), HIV infection 0.4% of consultations for women and 0.2% among men, and tuberculosis 0.1% of consultations.

Table 15. Diagnoses recorded in decreasing order (by % of the 17,022 medical consultations).

	Women			*Men*			*Total*		
	n	%	*Cumulative %*	n	%	*Cumulative%*	n	%	*Cumulative %*
N/S* Digestive system	546	8.3	8.3	917	8.8	8,8	1471	8.6	8.6
Hypertension	567	8.7	17.0	617	6.0	14.8	1191	7.0	15.6
Other N/S* musculoskeletal	376	5.7	22.7	753	7.3	22.0	1134	6.7	22.3
Diabetes (insulin and non-insulin depend.)	425	6.5	29.2	546	5.3	27.3	977	5.7	28.0
insulin-dependent	*145*	*2.2*	-	*184*	*1.8*	-	*331*	*1.9*	-
non-insulin dependent	*280*	*4.3*	-	*362*	*3.5*	-	*646*	*3.8*	-
Anxiety – Stress – psychosomatic disorders	316	4.8	34.0	631	6.1	33.4	955	5.6	33.6
Upper respiratory infections	313	4.8	38.8	576	5.6	38.9	893	5.2	38.9
Other digestive system diagnoses	278	4.2	43.1	497	4.8	43.7	777	4.6	43.4
N/S* spinal problems	218	3.3	46.4	439	4.2	48.0	662	3.9	47.3
Upper and lower back problems	208	3.2	49.6	405	3.9	51.9	617	3.6	**50.9**
Gum and teeth problems	174	2.7	52.2	427	4.1	56.0	604	3,5	54.5
Uncomplicated pregnancy and delivery	574	8.8	61.0	-	-	56.0	580	3.4	57.9
Other locomotor diagnoses	239	3.7	64.7	321	3.1	59.1	562	3.3	61.2
N/s* neurological problems	188	2.9	67.5	285	2.7	61.8	480	2.8	64.0
Other cardiovascular diagnoses	217	3.3	70.8	258	2.5	64.3	478	2.8	66.8
Depressive syndromes	237	3.6	74.5	238	2.3	66.6	477	2.8	69.6
Lower respiratory infections	160	2.4	76.9	303	2.9	69.5	465	2.7	72.4
General N/S*	157	2.4	79.3	283	2.7	72.3	443	2.6	**75.0**
Trauma	93	1.4	80.7	338	3.3	75.5	433	2.5	77.5
Cough	132	2.0	82.7	268	2.6	78.1	402	2.4	79.9
Other respiratory diagnoses	125	1.9	84.7	252	2.4	80.6	377	2.2	82.1
Other skin pathologies	82	1.3	85.9	269	2.6	83.2	351	2.1	84.1
N/S* skin	73	1.1	87.0	266	2.6	85.7	341	2.0	86.1
Rash / swelling	100	1.5	88.6	232	2.2	88.0	332	2.0	88.1
N/S* female reproductive system	318	4.9	93.4	-	-	88.0	318	1.9	**90.0**
Parasites / Candidiasis	60	0.9	94.3	253	2.4	90.4	317	1.9	91.8
Other eye diagnoses	113	1.7	96.1	194	1.9	92.3	309	1.8	93.6
Other N/S* respiratory	130	2.0	98.0	169	1.6	93.9	302	1.8	95.4
Heart disease, arrhythmia	90	1.4	99.4	190	1.8	95.7	281	1.7	97.1
N/S* eye	99	1.5	100.9	171	1.6	97.4	271	1.6	98.7
Other metabolic diagnoses	170	2.6	103.5	93	0.9	98.3	265	1.6	100.2
N/S* urinary	98	1.5	105.0	162	1.6	99.8	262	1.5	101.8
Viral hepatitis	63	1.0	106.0	193	1.9	101.7	257	1.5	103.3
Diagnoses NEC**	71	1.1	107.1	171	1.6	103.3	254	1.5	104.8
Skin infections	53	0.8	107.9	183	1.8	105.1	241	1.4	106.2
Menstruation problems	236	3.6	111.5	4	0.0	105.1	241	1.4	107.6
Vascular diseases	81	1.2	112.7	152	1.5	106.6	235	1.4	109.0
Other neurological diagnoses	102	1.6	114.3	129	1.2	107.8	233	1.4	110.3
Administrative	82	1.3	115.5	139	1.3	109.2	222	1.3	111.6
Asthma	71	1.1	116.6	146	1.4	110.6	217	1.3	112.9
N/S* nose-sinus	78	1.2	117.8	119	1.1	111.7	198	1.2	114.1
Atopic and contact dermatitis	54	0.8	118.6	142	1.4	113.1	196	1.2	115.2
Urinary / renal infections	127	1.9	120.6	66	0.6	113.7	195	1.1	116.4
N/S* male reproductive system	-	-	120.6	188	1.8	115.5	189	1.1	117.5
Eye infections	55	0.8	121.4	130	1.3	116.8	186	1.1	118.6
Drug treatments	71	1.1	122.5	106	1.0	117.8	178	1.0	119.6
Other gynaeco diagnoses	150	2.3	124.8	-	-	117.8	150	1.0	120.6
Ear infections	71	1.1	125.9	88	0.8	118.7	160	0.9	121.5
Other psychological problems	57	0.9	126.8	98	0.9	119.6	155	0.9	122.5

	Women			*Men*			*Total*		
	n	%	*Accrued %*	n	%	*Accrued %*	n	%	*Accrued %*
Overweight – Obesity	83	1.3	128.0	47	0.5	120.1	140	0.8	123.3
N/S* ear	41	0.6	128.7	97	0.9	121.0	139	0.8	124.1
N/S* Cardio-vascular	61	0.9	129.6	77	0.7	121.7	138	0.8	124.9
Other procedures	43	0.7	130.2	93	0.9	122.6	136	0.8	125.7
Fears / concerns	79	1.2	131.5	47	0.5	123.1	131	0.8	126.5
STI – women	129	2.0	133.4	-	-	123.1	131	0.8	127.2
Vaccination / other prevention	53	0.8	134.2	70	0.7	123.8	127	0.7	128.0
Epilepsy	44	0.7	134.9	74	0.7	124.5	123	0.7	128.7
Anaemia	95	1.5	136.4	17	0.2	124.7	113	0.7	129.4
Gastrointestinal infections	40	0.6	137.0	71	0.7	125.3	112	0.7	130.0
Psychoses	47	0.7	137.7	65	0.6	126.0	112	0.7	130.7
Follow up	27	0.4	138.1	80	0.8	126.7	107	0.6	131.3
Contraception	104	1.6	139.7			126.7	106	0.6	131.9
Cancers	57	0.9	140.6	35	0.3	127.1	92	0.5	132.5
Results	30	0.5	141.0	53	0.5	127.6	83	0.5	133.0
Other urinary nephrology diagnoses	24	0.4	141.4	52	0.5	128.1	78	0.5	133.4
Additional examinations	36	0.6	141.9	39	0.4	128.5	75	0.4	133.9
N/S* pregnancy, deliver and FP***	74	1.1	143.1	-	-	128.5	74	0.4	134.3
Other reproductive system diagnoses men	-	-	143.1	73	0.7	129.2	73	0.4	134.7
Care given	23	0.4	143.4	50	0.5	129.7	73	0.4	135.2
Glasses – lenses	36	0.6	144.0	34	0.3	130.0	71	0.4	135.6
Medical exam	31	0.5	144.4	36	0.3	130.3	68	0.4	136.0
STI – men	-	-	144.4	65	0.6	131.0	65	0.4	136.4
NEC** infectious diseases	27	0.4	144.9	30	0.3	131.2	60	0.4	136.7
Other ear diagnoses	26	0.4	145.2	32	0.3	131.6	59	0.3	137.1
Complicated pregnancy and delivery	55	0.8	146.1	-	-	131.6	55	0.3	137.4
Advice/ counselling, listening	28	0.4	146.5	25	0.2	131.8	53	0.3	137.7
N/S* metabolic diagnoses	21	0.3	146.8	26	0.3	132.0	47	0.3	138.0
HIV	23	0.4	147.2	21	0.2	132.2	45	0.3	138.2
Ulcerative pathologies	13	0.2	147.4	23	0.2	132.5	37	0.2	138.4
Other blood/immune syst. diagnoses	13	0.2	147.6	23	0.2	132.7	36	0.2	138.7
Use of psychoactive substances (alcohol)	4	0.1	147.6	25	0.2	132.9	29	0.2	138.8
N/S* blood/immune syst. diagnoses.	12	0.2	147.8	16	0.2	133.1	28	0.2	139.0
Use of psychoactive substances (tobacco/ medicines)	5	0.1	147.9	14	0.1	133.2	19	0.1	139.1
Use of psychoactive substances (drugs)	4	0.1	148.0	13	0.1	133.3	17	0.1	139.2
Tuberculosis	6	0.1	148.1	5	0.0	133.4	11	0.1	139.3
TOTAL	9692	148.1	-	13835	133.4	-	23697	139.3	-

[1]of the total number of medical consultations
*N/S: non-specific
**NEC: not elsewhere classified
*** FP: family planning

Screening

Questions on serology were inconsistently asked across the countries. All the following results only cover the 8 European countries. In Montreal, the missing data rate exceeds 95% for all these questions. In Istanbul, less than 8% of patients had already been tested for HCV or HBV and only 20% had already had an HIV test[105] (even though the vast majority of them are from sub-Saharan Africa).

Hepatitis C

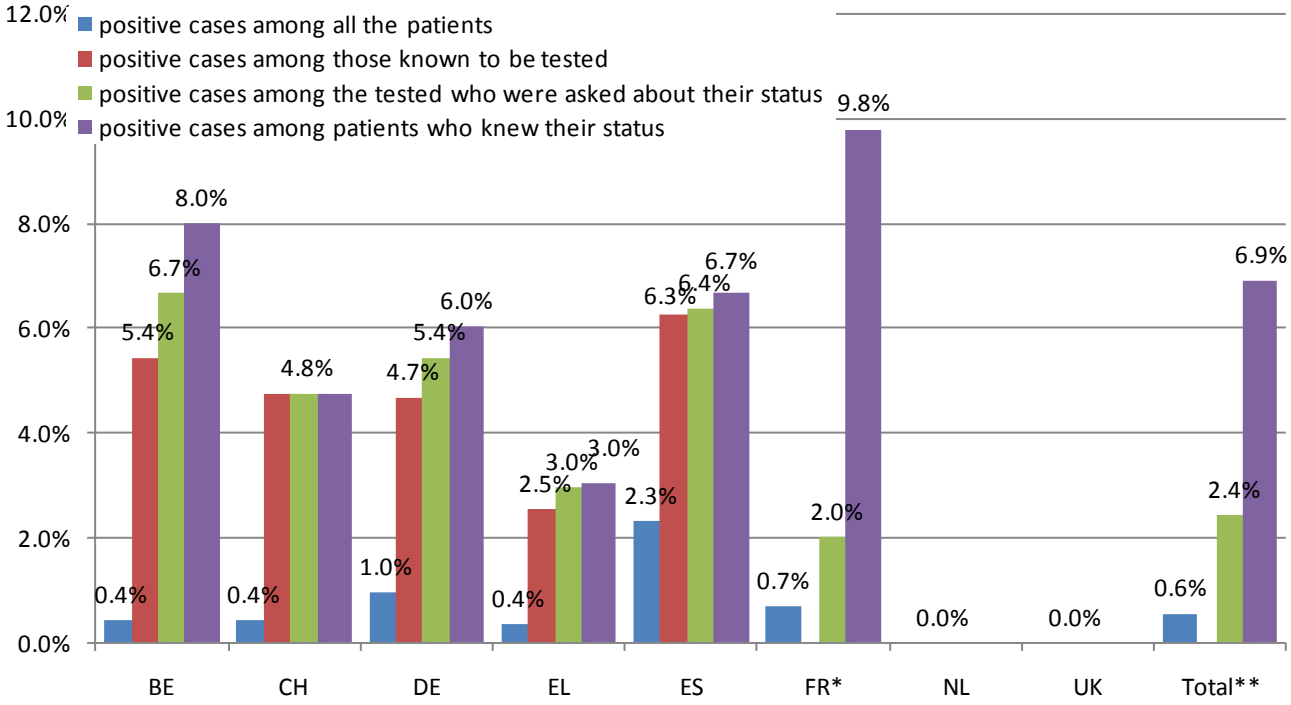
In the figures below, the results for Belgium and the United Kingdom are given for illustrative purposes since only 21.5% and 12.4% of patients respectively were asked if they knew their serological status[106]. The question was asked to 87.3% of patients in Switzerland, 100% in Germany and 90.1% in Greece. In France, patients were not asked if they knew their status, but were directly asked what their status was (and the results cover a third of patients). The second question (on the serological results) was not always asked.
Overall, **0.6% of all patients were identified as HCV positive.** If we record the number of those detected as positive only from amongst those to whom the two questions were asked (so excluding the missing data from those not questioned), we get a higher rate: **2.4% of those questioned were identified as positive.** If we reduce the denominator only to those people who were asked about the result of their past test, the rate therefore increases: **6.9% of patients questioned who knew their serological status were positive.**
In the Netherlands and London, no HCV positive cases were detected (and so whichever denominator or selection bias we use, all the rates will of course be zero)[107]. France was the country where the positive prevalence rate amongst patients who knew their status was the highest (9.8%), followed by Belgium (8.0%) and Spain (6.7%). **We can only encourage doctors to ask the question more systematically (it was not asked to 65% of the patients in France and 80% of the patients in Belgium) and perform or refer more patients for this test (in Spain, 40% of patients were not screened).**

Remarks on methodology

These prevalence differences, estimated according to which denominator used, demonstrate the importance of asking these questions systematically, since estimates can vary by as much as twofold according to whether everyone is asked or not. It is impossible to guess the HIV status of a patient and it is also impossible to assume that the HCV prevalence rate is the same amongst those who were asked and those who were not.
The second difference (between 2.4% and 6.9%) cannot be checked ; it depends on a patient's knowledge and memory, and constitutes a common skew of memory or statement (but we also see how this bias is rather in favour of routine screening for those who do not know their status, from a medical, personal and collective point of view as well as a public health standpoint).
For both these reasons, the figures given here can in no way be interpreted as an estimate of the HCV prevalence rate in the whole patient population seen by MdM. The most that can be concluded is that this prevalence rate is between… 0.6% and 6.9%, which is a significant percentage compared to the general population!
In Europe, the average HCV prevalence rate is around 1% with major variations from one country to the next: between 0.1% in the Netherlands and 4.5% in Romania; it stands at about 1% to 2% in Spain; 1% in Belgium and Greece; between 0.5% and 1% in Switzerland; 0.8% in France; between 0.4% and 0.7% in Germany and the United Kingdom[108]. Among drug users, this rate rose to 50% in Belgium in 2005; 60% in France in 2004; 40% in the United Kingdom in 2008[109]. The predominant mean of transmission for HCV still remains intravenous drug use (78.1% of new HCV infections in the European Union in 2011)[110].

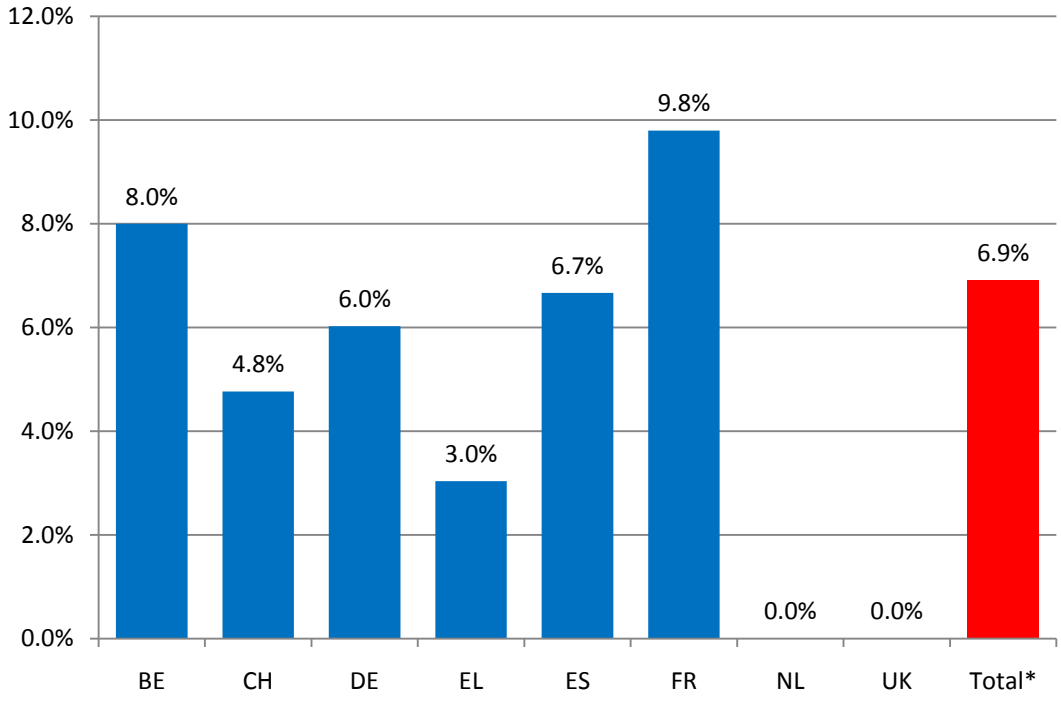
[105] 2.6% of patients who had had a test are HIV positive in Istanbul.
[106] This can be explained for London by the cessation of medical consultation for five months (from 14/05 to 21/10/2013).
[107] The questions were not asked to 44% of the patients seen in NL and to 88% of the patients seen in London (see below).
[108] Mühlberger N, Schwarzer R, Lettmeier B, Sroczynski G, Zeuzem S, Siebert U. HCV-related burden of disease in Europe: a systematic assessment of incidence, prevalence, morbidity, and mortality. *BMC Public Health* 2009; 9: 34.
[109] Hendrickx G, Vorsters A, Van Damne P. *Surveillance and prevention of hepatitis B and C in Europe*. Stockholm: ECDC, 2010.
[110] Fraser G, Gomes Dias J, Hruba F, Albu C, eds. *Annual epidemiological report. Reporting on 2011 surveillance data and 2012 epidemic intelligence data*. Stockholm: ECDC (Surveillance Report), 2013.

Figure 47. HCV prevalence rate in the different analysable populations by country.



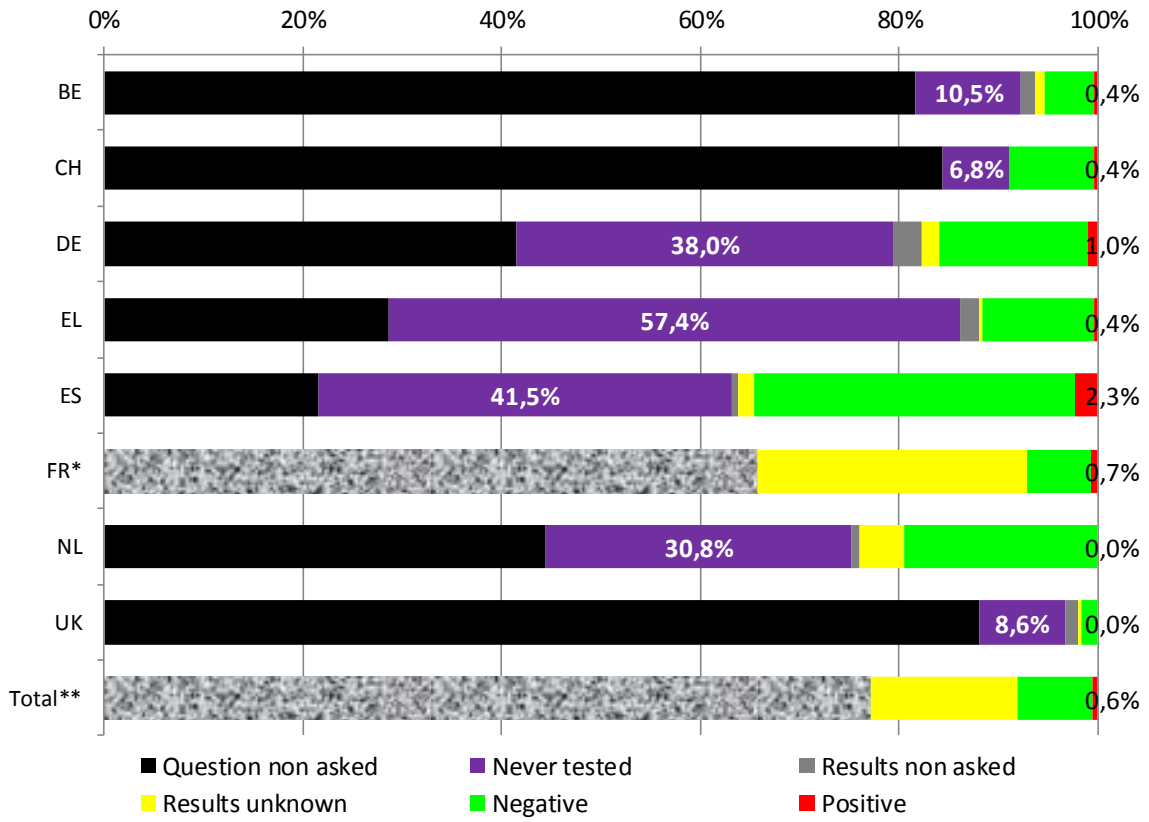
* For France (and the total) only the last two estimates can be calculated ** CAP

Figure 48. Proportion of HCV positive cases amongst those who knew their status by country.



*CAP

Figure 49. HCV serological status by country (as a proportion of all patients seen by country).



*For France (and for the total), the first 3 terms cannot be distinguished from each other
** total crude percentages

Hepatitis B

In total, **0.7% of all the patients were identified as HBV positive** (i.e. the two questions were asked, the patients knew their status and it was positive). This was the case for **2.9% of the people asked** the two questions and **8.2% of the patients who knew their status**.

In the European Union, around 17,000 cases of HBV infections are reported each year, of which 70% are chronic carriers of HBV. In countries with low or moderate prevalence rates (such as Western Europe), acute "indigenous" infections are transmitted mainly heterosexually (25%), hospital acquired (25%), intravenous drugs use (10 to 15%), male homosexuality (10%)[111].

The prevalence of hepatitis B is highest in sub-Saharan Africa and East Asia. Most of those living in these regions are infected by the hepatitis B virus during their childhood (the hepatitis B virus is generally transmitted at birth, from mother to child, or during early childhood, from one child to another) and 5 to 10% of the adult population is chronically infected. We also find high levels of chronic infection in the Amazonia and in southern parts of Central and Eastern Europe. In the Middle East and the Indian sub-continent, it is estimated that the chronic carriers represent 2-5% of the general population.

[111] Fraser G, Gomes Dias J, Hruba F, Albu C, eds. *Annual epidemiological report. Reporting on 2011 surveillance data and 2012 epidemic intelligence data*. Stockholm: ECDC (Surveillance Report), 2013.

Migrants from high prevalence areas represent a particularly at-risk population group: for themselves (liver complications, including oncologic, chronic HBsAG carrier) and for others (virus transmission, including mother to child). **In most European countries, HBV screening (and vaccination for those who test negative) is recommended for migrants from those areas of high endemicity.**

Figure 50. Proportion of HBV positive cases amongst those who knew their status by country.

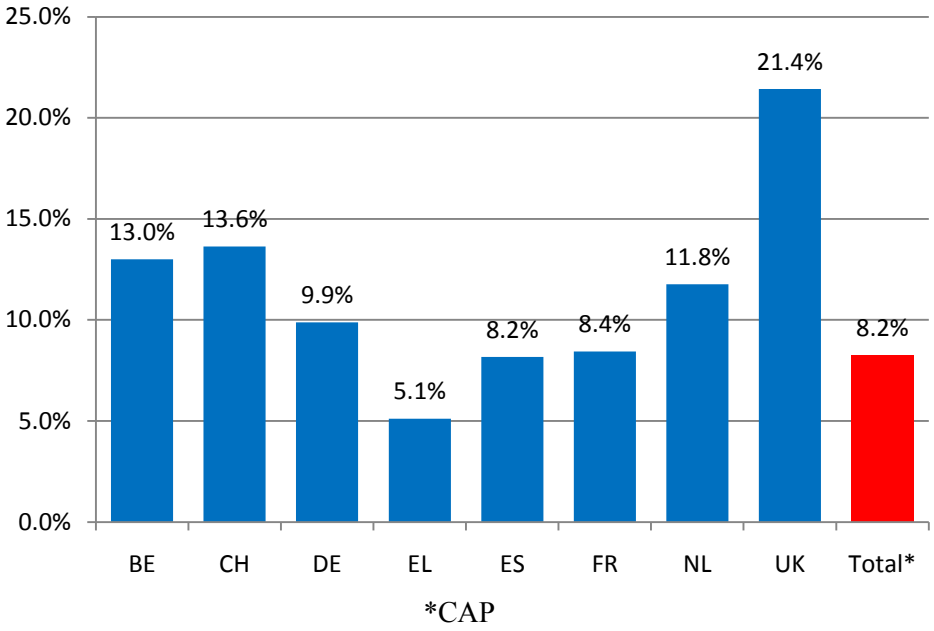
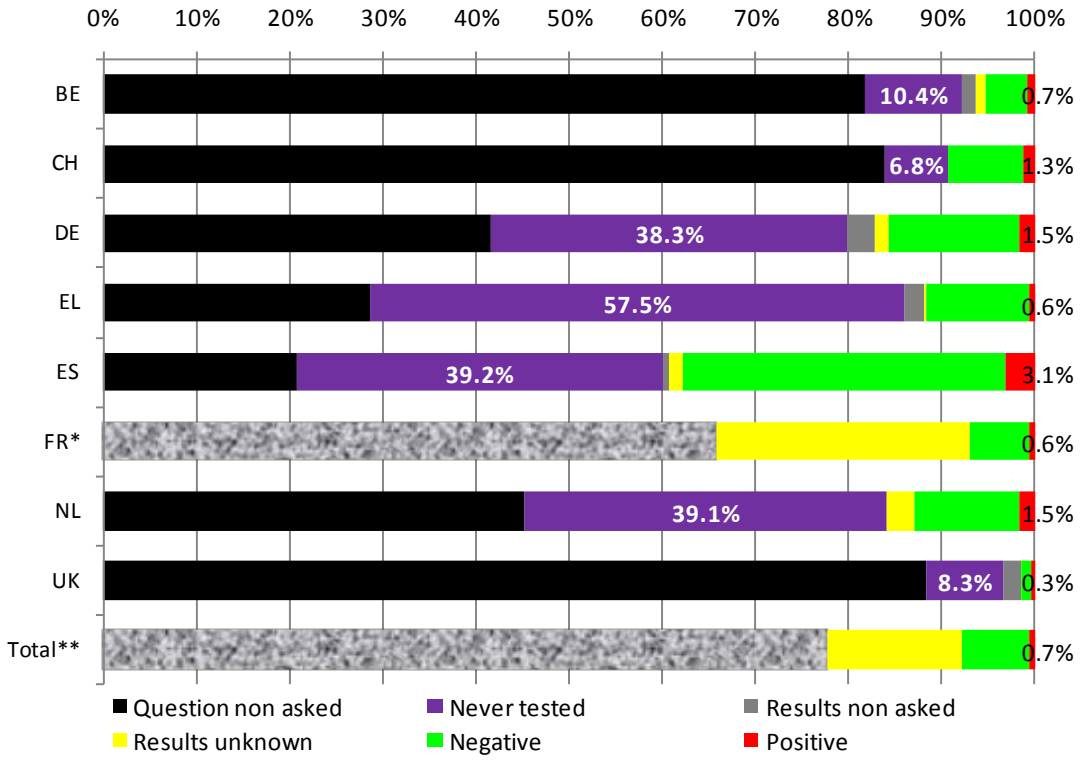


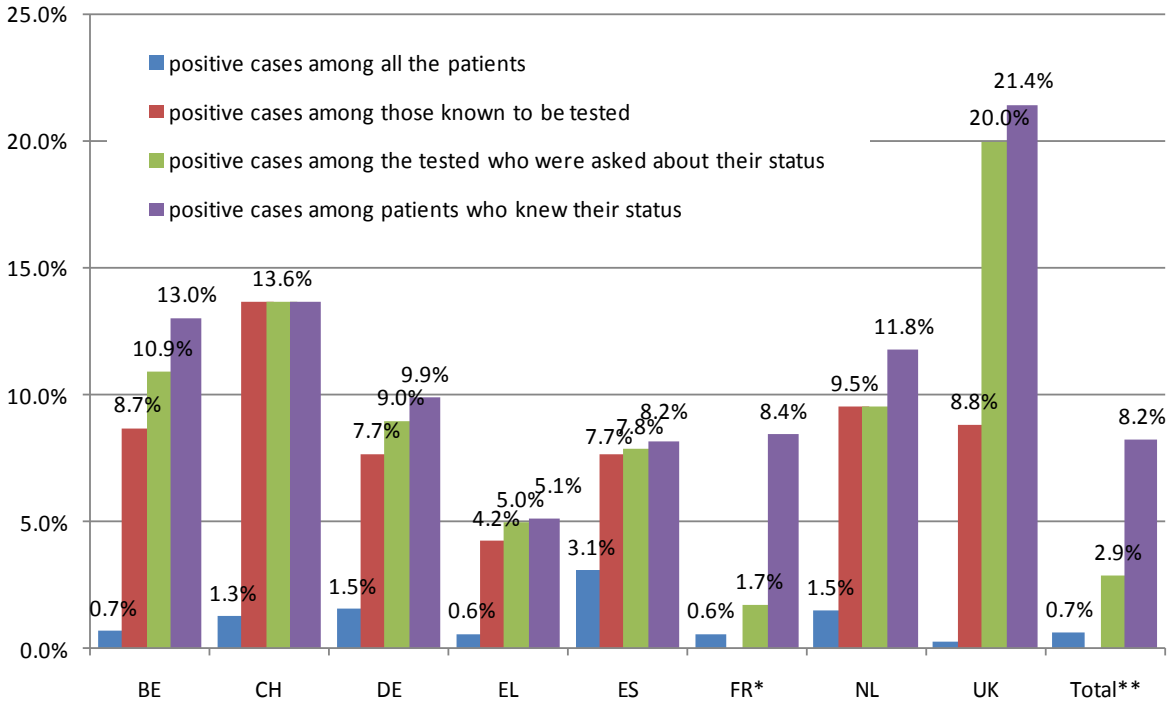
Figure 51. HBV serological status by country (as a proportion of all patients seen by country.



*For France (and for the total), the first 3 terms cannot be distinguished from each other

** total crude percentages

Figure 522. HBV prevalence rate in the different populations by country.



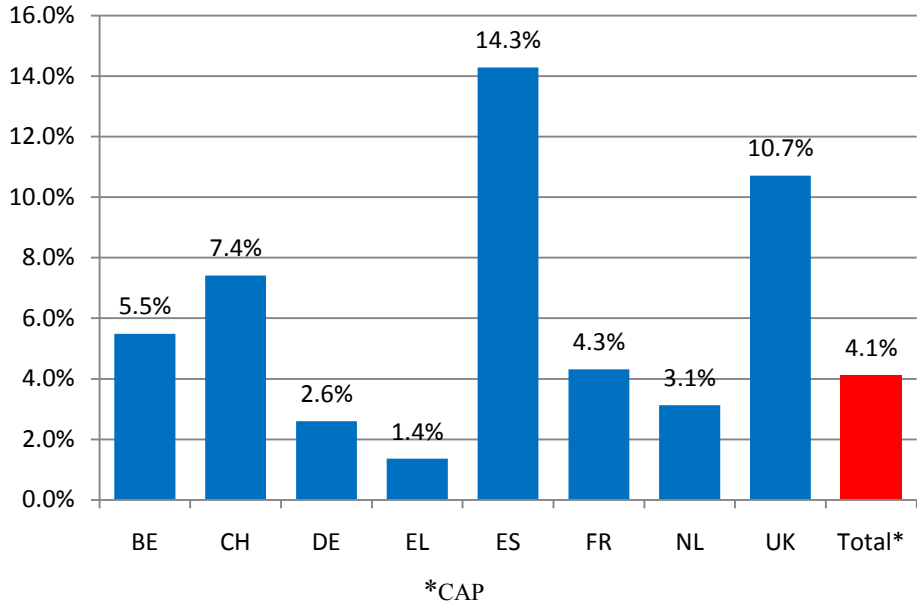
* For France (and the total) only the last two estimates can be calculated ** CAP

HIV/AIDS

In total, **0.4% of all patients were identified as HIV positive** (i.e. the two questions were asked, the patients knew their status and it was positive).This was the case for **1.6% of the people asked** the two questions and for **4.1% of the patients who knew their status.** This proportion was significantly higher in Spain (probably related to the fact that those supported by some of MdM's programmes often have a history of drugs use, more than in other countries) and in the United Kingdom where 10.7% of people knew their HIV status to be positive[112].

[112] Let's remember that in England, HIV treatment has only been reintroduced as free to all and not dependent on residency status, since October 2012 (after 8 long years).

Figure 53. Proportion of HIV positive cases amongst those who knew their status by country.



*CAP

It is worth noting the high prevalence rate in many countries of people who have never been tested for HIV. Despite the high proportion of missing data (i.e. people to whom the question was never asked), at least 30.1% of the patients seen in the Netherlands had never been tested, as well as 38.5% of patients seen in Munich and the Spanish programmes and 58.5% of patients seen in Greece. Overall, in the 7 countries[113], **at least 27.1% of patients had never been tested**.

This percentage is especially worrying, in light of the particular vulnerability of migrants (and their partners) to HIV, as highlighted in particular by the European Centre for Disease Control (ECDC)[114].

Also of note is that for the past ten years we have seen increasing numbers of women infected by HIV amongst migrants. Women are more vulnerable to the virus, both biologically and socially.

The Council of Europe Committee on migration, refugees and displaced persons report[115] highlights that "Due to a lack of data and hard evidence on HIV prevalence among migrants in Europe, [the information] should be treated with caution. Crosscountry comparisons are further complicated due to the fact that there is no common definition of the term "migrant" in epidemiological data collection. Nevertheless, evidence suggests that migrants from countries with a high HIV/AIDS prevalence, particularly in sub-Saharan Africa, are disproportionately affected by HIV. [...] [On the other hand] the levels of HIV amongst migrants to Europe are in general significantly below HIV levels in their countries of origin. This can be explained by what migration specialists call the "healthy migrant effect" – a process of self-selection where only the healthiest in a society migrate."

[113] In France, this percentage cannot be estimated because only the second question was asked (test result) but not the first (recourse to the test).

[114] ECDC. *Migrant health: HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA/EFTA member States*. Stockholm: ECDC, 2011.

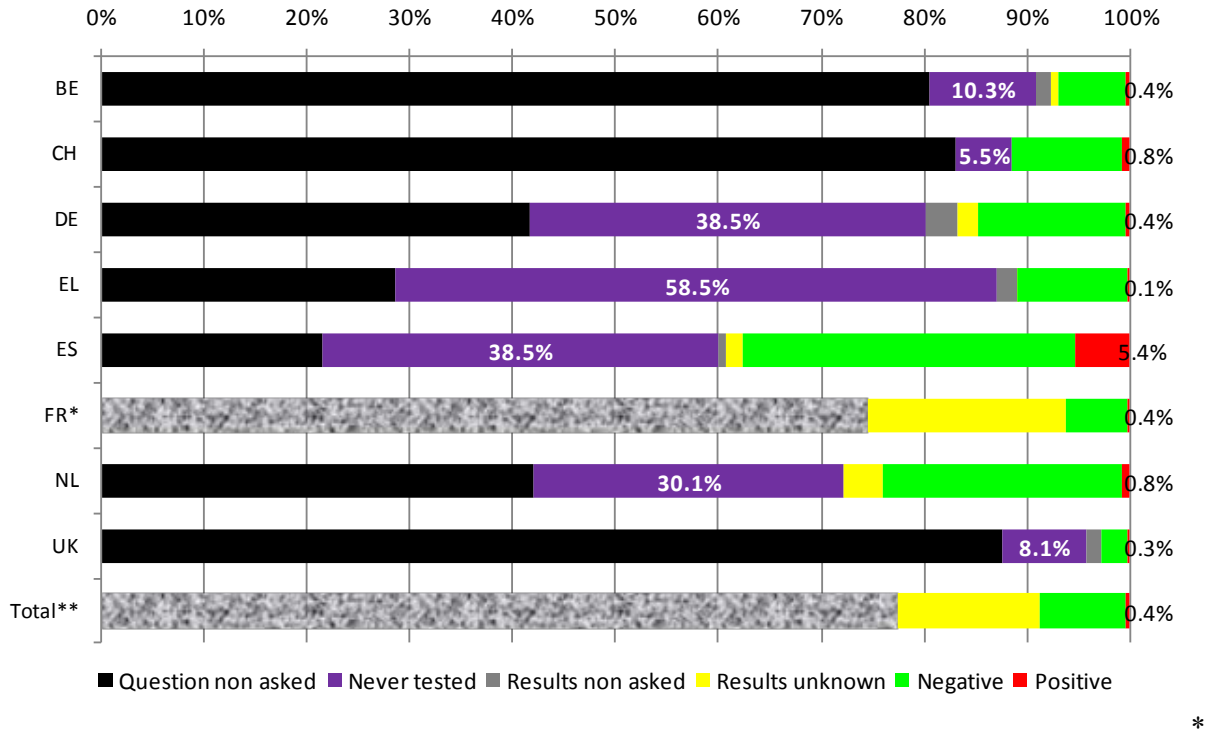
[115] Committee on migration, refugees and displaced persons. *Migrants and refugees and the fight against AIDS*. Strasbourg : Council of Europe, January 2014.

In 2011, the proportion of HIV infected migrants amongst the population was less than 10% of all infections in the countries of Eastern Europe and some countries of Central Europe. **In most Northern European countries, it was greater than 40%. In most West European countries, the percentage of migrants among those infected with HIV ranged from between 20% to 40%**[116].

Current studies and data do not reveal precisely if migrants mainly contract HIV in their country of origin or afterwards, in the country they have migrated to.

A study by the ECDC in 2013 showed major differences between destination countries for the proportion of post-migratory infections[117]. This percentage ranged from 2% for sub-Saharan Africans in Switzerland, while it had reached 62% among black Caribbean men who were having sex with men in the United Kingdom. The report cited earlier states that "migrant workers who live alone, far from their spouse or usual sexual partners, can be more exposed to the virus. This is due to the fact that they seek out other casual partners, increasing their own risk of exposure to HIV and that of their sexual partners."

Figure 54. HIV serological status by country (as a proportion of all the patients seen by country).



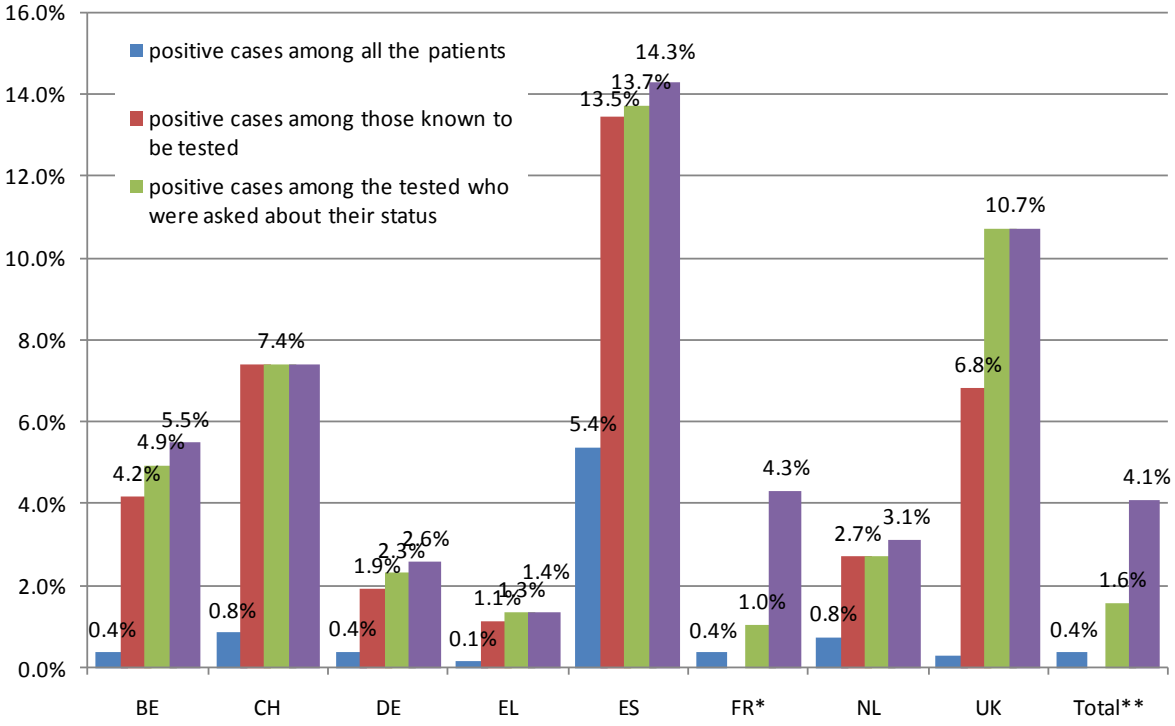
*

*For France (and for the total), the first 3 terms cannot be distinguished from each other
** total crude percentages

[116] ECDC technical report, Migrant health: Epidemiology of HIV and AIDS in migrant communities and ethnic minorities in EU/EEA countries, Stockholm, 2010.

[117] ECDC technical report, Migrant health: Sexual transmission of HIV within migrant groups in the EU/EEA and implications for effective interventions, Stockholm, 2013.

Figure 555. HIV prevalence rate in the different analysable populations by country.

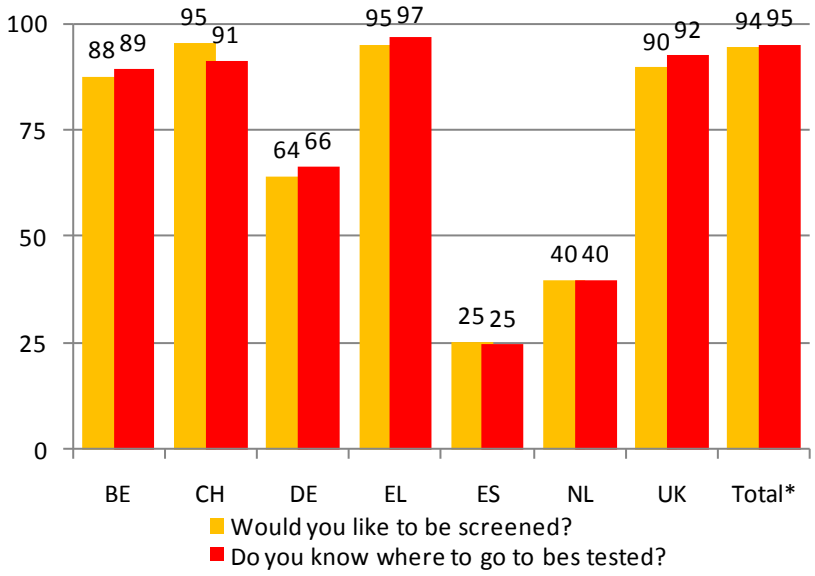


*For France (and the total) only the last two estimates can be calculated
** CAP

HIV, HBV or HCV virus screening: desire and knowledge

Two questions were asked at the end of the questionnaire in all countries except France; this related to previous testing, and covered on the one hand a possible desire to be tested for one of the three viruses and on the other hand knowledge about where to go to in order to be tested. Unfortunately, these questions were, in practice, rarely asked. With the notable exception of Spain[118] and the Netherlands[119], in all other countries, only between 3% and 12% of people were asked about this issue.

Figure 56. Missing data rates for wishes and/or knowledge about HIV, HBV and HCV testing.

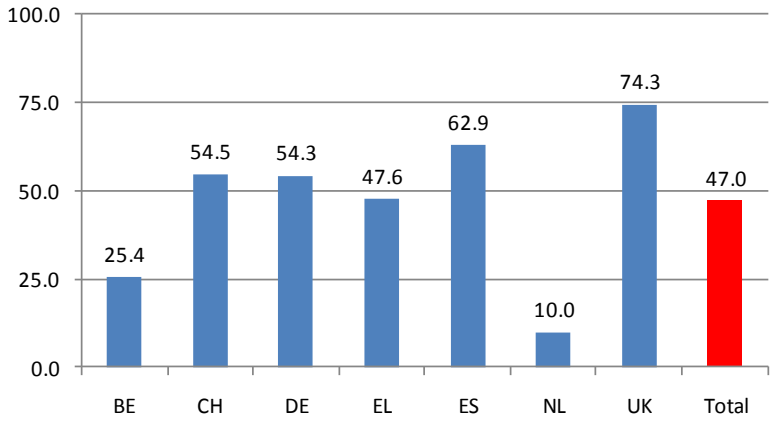


*CAP

For this reason, the following results are given only for information purposes. In total, close to half the people asked expressed a wish to be tested for one or more of these viruses: 63% in Spain where the response rate was the only one that was usable.

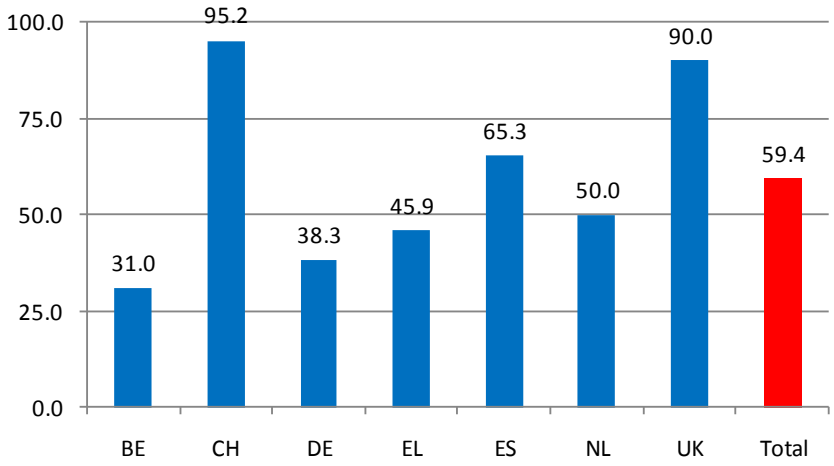
[118] Response rate = 75%.
[119] Response rate = 60%.

Figure 57. Proportion of patients wishing to have one or the other tests for HIV, HBV or HCV.



Overall, close to 4 in 10 patients did not know where to go for testing. This was true for 1/3 of patients seen in Spain (the only usable figure due to the non-response rate in other countries).

Figure 58. Proportion of patients who know where to go for testing for one or other of the 3 viruses.



Tuberculosis

For the record, two questions were also asked about tuberculosis: "Have you ever been tested for tuberculosis?" and "Has a doctor ever told you that you have tuberculosis?"

In the seven European countries where the second question was asked (not France), only 8.7% of patients were asked[120] ; therefore, the response data is hard to use. Overall (but again, the population interviewed is severely selected), **a significant proportion of people declared that they had had tuberculosis (4.9%)**. Significantly, this percentage was even higher in Spain: 18.2% of the people questioned about this issue said that they remembered a doctor telling them that (at some time) they had tuberculosis.

This level of lifetime prevalence appears significantly high enough to recommend more specific questions being introduced into future surveys (provided that the sub-groups of people being questioned are more specifically targeted and they are then asked more systematically); however, this may be beyond the objectives of routine data collection.

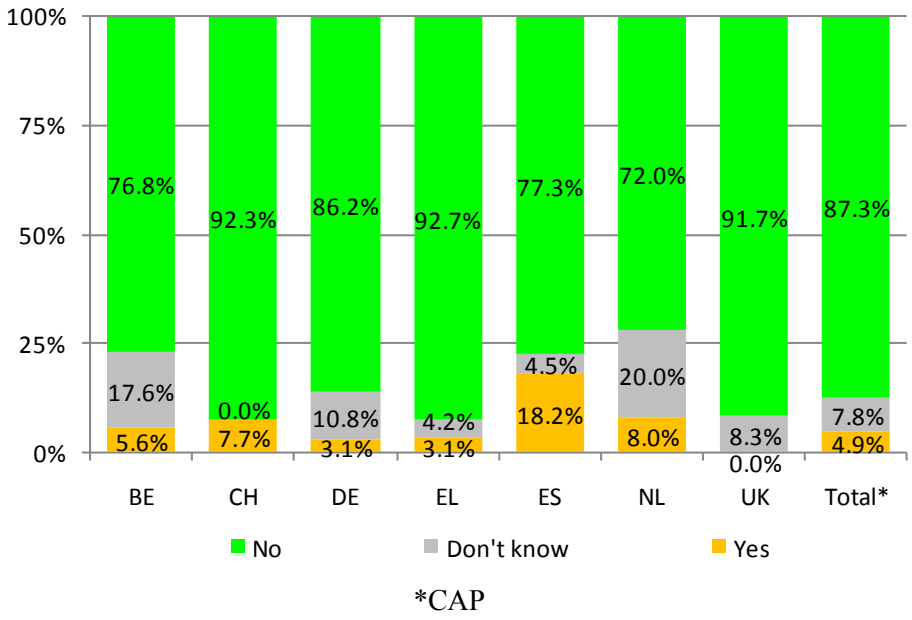
Remarks on methodology

These two questions should be reformulated or simply deleted.

The first question should be deleted as it does not make much sense: tuberculosis testing is not done in the same way as it is for the three previous viruses, based on a voluntary routine test. It is performed in different contexts with different modalities (the practice of screening by means of a routine chest x-ray is generally considered a poor idea, except for specific populations with high prevalence). It is interesting to ask about these contexts and the results if there has been a previous test but it is probably too lengthy a question to ask and to find out about routinely as part of this survey.

The second question could possibly be maintained by itself but it is not, strictly speaking, a question about testing but rather a specific question about a person's medical history. For all that though, the questions is not very interesting: what counts is to try to know when, under what circumstances, and if the patient was correctly treated or not.

Figure 599. "Has a doctor ever told you that you have tuberculosis?"



[120] Respective response rates: BE=5.3%, CH=11.0%, DE=12.5%, EL=11.2%, ES=33.8%, NL=18.8%, UK=1.1%.

Spain: turmoil in the healthcare system and social resistance

Dismantling of a previously universal healthcare system

On 20 April 2012 the Spanish government and the parliament approved Royal Decree-Law 16/2012 'On urgent measures to ensure the sustainability of the national health system and to improve the quality and safety of its services'. This law excludes undocumented migrants from access to healthcare and ties healthcare coverage to employment status, instead of the previously universal health system; out-of-pocket charges for medication were also increased. In addition to undocumented migrants, anyone (including Spanish nationals and migrants with regular administrative status) who lives outside Spain for periods longer than three months without paying social security contributions automatically loses their healthcare entitlement card. They must then go through the entire reapplication process for social security registration.

The law creates serious ethical problems for health professionals (medical staff, nurses, pharmacists, administrative staff, social workers, etc.) and **violates codes of professional ethics**. It also imposes changes to the Spanish healthcare model which are **unjust** in regard to human rights, economically **inefficient** and **dangerous** for public health.

With the introduction of the new law, 750,000[121] foreign nationals with no permit to reside[122] were abruptly deprived of their health coverage. Although the law explicitly retains healthcare protection for pregnant women and children, their access to healthcare is nevertheless made impossible in practice by administrative barriers in some autonomous communities, as well as by the failure to issue individual health cards, and by the increasingly widespread impression created by political discourse that all undocumented foreign nationals are excluded from the healthcare system.

Moreover, the non-access to the health system can result in health risks both for the individual and for the population in general: communicable diseases are no longer identified and treated within general medical practice, nor are injuries resulting from violence. The only remaining point of entry for many people is through hospital accident and emergency services, which means that, increasingly, diseases and victims of violence are not identified and given the necessary care and treatment.

A system of personal health insurance, which costs €60 per month for those below 65 years of age and €157 per month for those aged 65 and above, is only open to people who have been resident in Spain for longer than one year and who can afford to pay these amounts. However, this option is available in only two of the autonomous regions.

It is also essential to stress the effects of the increase in out-of-pocket charges for medication, already somewhat high in Spain at 40%, with no upper limit, for people with an annual income of less than €18,000 (in effect, a potential maximum of €1,500 per month), and at 50% for those with an annual income between €18,000 and €100,000. People with chronic health conditions are not exempt from charges and must pay 10% of the cost of their medication (irrespective of their income), limited to a maximum of €4.13 for each medication (but with no upper limit on the total monthly amount). The patients who were seen by the MdM teams were all living on incomes below the poverty line, which in Spain is currently €645. For these people, buying medication is a particularly substantial expense[123].

[121] This figure was given to the United Nations High Commissioner for Human Rights by the Spanish government in February 2014.

[122] The Clandestino Project report estimated that in 2008 the number of people residing in Spain without permission was 354,000. (Triandafyllidou A, ed., *Clandestino Project. Final report*. Brussels: European Commission, 2009).

[123] The only exemptions are for retired people who receive the basic minimum pension and unemployed people who are not in receipt of benefits or receive benefits of less than €400 per month. In addition, there is an out-of-pocket payment limit of €8.14 per month (in March 2014) for retired people whose annual income is less than €18,000.

The response by Médicos del Mundo

In 2012 MdM, in collaboration with the Spanish Society for Family and Community Medicine (*Sociedad Española de Medicina de Familia y Comunitaria – semFYC*), one of the principal medical associations specialising in primary healthcare, launched the Derecho a Curar (Right to Care) campaign. The first and most important action of this campaign was to mobilise medical personnel, calling on them to object on grounds of conscience to the new measures[124].

The campaign also had the support of other important organisations involved in primary and specialist health services, as well as a range of social sector organisations and European networks engaged in defending migrants' rights.

Various promotional materials are available online from the www.derechoacurar.org website, including posters, videos, car stickers and widgets for social media, created to provide publicity for the campaign and disseminate information. These tools are among the measures which health professionals, users of the healthcare system and the general public can use to support the campaign.

There is no doubt that the campaign video, featuring health professionals who refuse to implement the new law, gained the most positive response, and it rapidly went viral, not only among other health professionals but also among the general public. Confronted with this law excluding migrants of irregular status from the healthcare system, MdM urges health workers to exercise their individual and collective right to resist and to object to the law on grounds of conscience, and to continue to treat all people in need of healthcare, regardless of their administrative status. When the protest campaign against the law was re-launched in the social media in summer 2013 with the video series #leyesquematan (laws that kill), it became a trending topic on Twitter, which is a clear indication of the significant amount of attention it attracted. In the course of just a few months, over 253,000 people had viewed the Médicos del Mundo videos[125].

During the first phase of the campaign, more than 2,000 health professionals took the risk of formally declaring their refusal to implement the exclusions required under law. This also gives an indication of the total number of health professionals who quietly and privately continue to treat people with no healthcare coverage. In addition, we collected 19,000 signatures in support of a letter submitted to the Minister of Health at the beginning of January 2014 as part of the "Derecho a Curar" campaign.

Médicos del Mundo is an organisation with a long experience (24 years) of projects within Spain: this is why Médicos del Mundo groups in several of the autonomous communities are key drivers for networking among organisations opposed to the reforms in the healthcare system. We currently operate 45 programmes providing access to healthcare in 12 autonomous regions.

The context created by Royal Decree-Law 16/2012 is of such serious concern to organisations and groups engaged in the defence of human rights and the fight against discrimination and xenophobia, that it has led them to reinforce and intensify their network activities. While this effect could already be seen in 2012, it would be confirmed in September 2013, when the first anniversary of the law coming into force gave

[124] From the Hippocratic oath to the Declaration of Geneva adopted by the World Medical Association (WMA) in 1948 and revised in 2006, the medical profession has expressed in its code of ethics its strong commitment to protect the health of the population, without discrimination: "I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient."
The WMA Declaration of Lisbon on the rights of patients: "Whenever legislation, government action or any other administration or institution deny patients these rights, physicians should pursue appropriate means to assure or to restore them." http://www.wma.net/en/30publications/10policies/l4/

[125] In fact many more people have watched them since we cannot include the number of views via El Pais, El Mundo and public television channels.

renewed impetus to the social mobilisation. The negative consequences of the new regulations and other austerity measures have also been documented in articles published in The Lancet and the British Medical Journal. Some experts[126] have already predicted that, as a result of denial of access to healthcare and medications for about 2% of the population, there will be an increase of communicable diseases such as HIV and tuberculosis in the population as a whole[127]. Other experts[128] have warned of the probability of an increase in mental health problems, including cases of suicide.

With the aim of documenting as accurately as possible cases encountered and barriers to accessing healthcare, Médicos del Mundo has promoted the establishment of 'observatories' similar to those already operating successfully in the Valencian community (ODUSALUD), with 63 member organisations and entities (April 2014), the Observatory on the Right to Health (ODAS), recently launched on the Balearic Islands, and the Platform for Universal Healthcare in Catalonia.

Towards the end of 2013, Médicos del Mundo expanded its communication and mobilisation strategy beyond the health sector to reach out to Spanish society as whole through its "Nadie Desechado" campaign (turn nobody away). This campaign revealed how the healthcare reform, announced as affecting 'only' migrants, also excludes all of society's most vulnerable groups from the healthcare system, in particular people with chronic health conditions. 40,000 signatures have already been collected in support of the new campaign, targeting the Ministry of Health. Médicos del Mundo has so far recorded more than 1,000 cases of violation of the right to healthcare, and has prepared reports which have been submitted to the Health Commission of the Congress of Deputies and to the Ombudsman.

Médicos del Mundo calls on the government to repeal this law and to restore the system of universal healthcare in Spain.

The health authorities must in the meantime ensure that all children and pregnant women have unrestricted access to healthcare, and at the very least that undocumented migrants who need emergency healthcare services receive them free of charge.

Finally, we urge all medical and social workers to object on grounds of conscience and to exercise their right to refuse to collude in the violation of fundamental human rights.

[126] Helena Legido-Quigley of the London School of Hygiene and Tropical Medicine or Santiago Moreno, head of the infectious diseases department of Ramón y Cajal hospital

[127] See the story of Alpha Pam, the 28 years old Senegalese man who died of tuberculosis on the Balearic Islands, page 67.

[128] Including Manuel Desviat, WHO consultant.

Data on Greece

The data for Greece are broken down here by centre. This additional analysis of the data for 2013 is due to the scale of the economic and social crisis in Greece. Access to healthcare can thus be monitored from one year to the next. The figures, however, should be interpreted with caution as in some centres, only few questionnaires have been captured in the database, even though the actual number of patients received was sometimes much higher[129]. These figures should only be consulted in addition to the global Greek figures given above.

In the following tables, integers (with no decimal point) refer to the number of patients and numbers with a decimal point are percentages. Indeed, in the majority of these tables, for each category the number of respondents who answered is shown as well as the percentage (%) that it represents amongst all the population who answered in the centre (city) in question (percentages are therefore calculated without taking into account missing data, the number of which is, however, always given separately).

Number of people

Overall, 3,430 questionnaires were collected and recorded in Greece. Just under half of them came from Mytilene and 30% from Patras. Patients for the most part were seen only once in the Greek MdM programmes, except in Thessaloniki where they were seen twice more often.

Table 16. Number of people in Greece.

	N	%
Mytilene	1571	45.8
Patras	1026	29.9
Perama	508	14.8
Athens	255	7.4
Thessaloniki	70	2.0
	3430	100.0

Table 17. Number of visits by centre.

N° visits	Mytilene	Patras	Perama	Athens	Thessaloniki	Total
1	1553	1021	424	249	13	3260
	98.9	99.5	83.5	97.7	18.6	
2	18	5	67	6	56	152
	1.2	0.5	13.2	2.4	80.0	
3	0	0	10	0	1	11
	0.0	0.0	2.0	0.0	1.4	
4	0	0	6	0	0	6
	0.0	0.0	1.2	0.0	0.0	
5	0	0	1	0	0	1
	0.0	0.0	0.2	0.0	0.0	
Total	1571	1026	508	255	70	3430

[129] In Mytilene around 91% of patients were actually recorded in the database; 57% in Perama; 50% in Patras; 13% in Thessaloniki and 2% to 3% in Athens.

Most consultations were for medical reasons, but in Patras close to 30% of visits were for administrative, legal or social issues (8% to 10% in Perama and Thessaloniki).

Table 18. Reasons for coming by centre (as a % of visits).

	Mytilene	Patras	Perama	Athens	Thessaloniki	Total
For medical care	1582	881	608	258	125	3454
	100.0	85.6	99.2	99.2	97.7	
For administrative, legal or social issues	2	296	50	5	13	366
	0.1	28.8	8.2	1.9	10.2	
For psychological or psychiatric issues	0	1	8	0	10	19
	0.0	0.1	1.3	0.0	7.8	
Other	0	2	5	4	12	23
	0.0	0.2	0.8	1.5	9.4	
Total	1584	1180	671	267	160	3862

Missing values = 14

Demographic characteristics and living conditions

The M/F gender ratio varies from one centre to the next. In **Thessaloniki, Perama and Athens, women formed the majority of the patients seen;** they were far less numerous in Mytilene (20%) and Patras (29%).

Table 19. Distribution by gender and by centre.

	Mytilene	Patras	Perama	Athens	Thessaloniki	Total
Women	307	299	276	128	42	1052
	19.8	29.3	55.2	51.2	60.0	31.0
Men	1245	721	224	122	28	2340
	80.2	70.7	44.8	48.8	40.0	69.0
Total	1552	1020	500	250	70	3392

Missing values = 38

On average, patients were younger in Mytilene and Patras, the two centres where data on patients was most often recorded compared to other cities. A quarter of patients were under 18 in these two centres. The median age of those consulting was higher in Perama (51) and Thessaloniki (49).

Figure 600. Proportion of patients who were minors (<18 years) by centre.

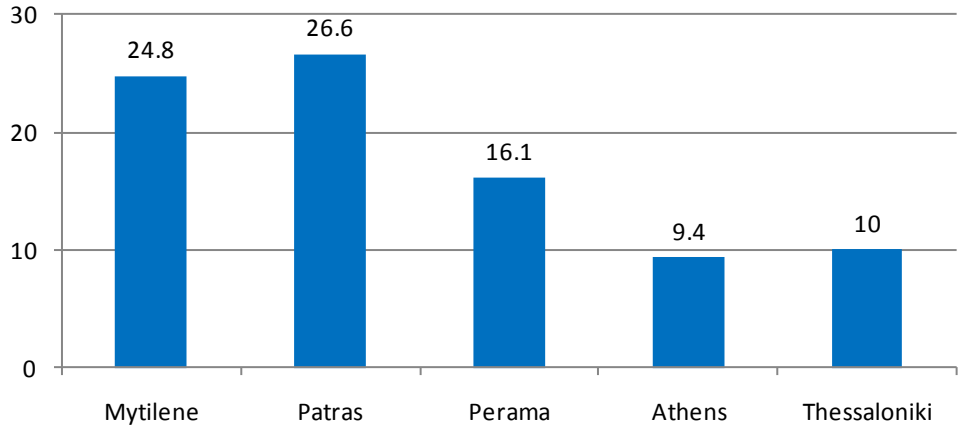


Table 20. Distribution of ages by centre.

	N°	Average	Minimum	1st quartile	Median	3rd quartile	Maximum
Mytilene	1557	22.81	0.00	18.00	21.00	27.00	86.00
Patras	1003	29.53	0.00	18.00	27.00	39.00	87.00
Perama	489	46.07	0.00	36.00	51.00	60.00	85.00
Athens	249	33.55	0.00	26.00	32.00	41.00	74.00
Thessaloniki	70	43.86	0.00	35.00	49.00	57.00	66.00
Total	3430	29.4	0.00	18.50	26.00	38.00	87.00

In Greece, the proportion of nationals (24.8%) remained the highest among all the countries surveyed in Europe. In **Thessaloniki**[130] **and Perama, most of the patients seen in consultations were Greek citizens (50% and 79.6% respectively).**
Moreover, these two centres had little need for interpreters: 92% and 84% of patients respectively had no need for interpreters, while in Patras close to half of patients (46%) needed an interpreter[131].

In Thessaloniki, 80% of patients declared that their housing was harmful for their health or that of their children[132].

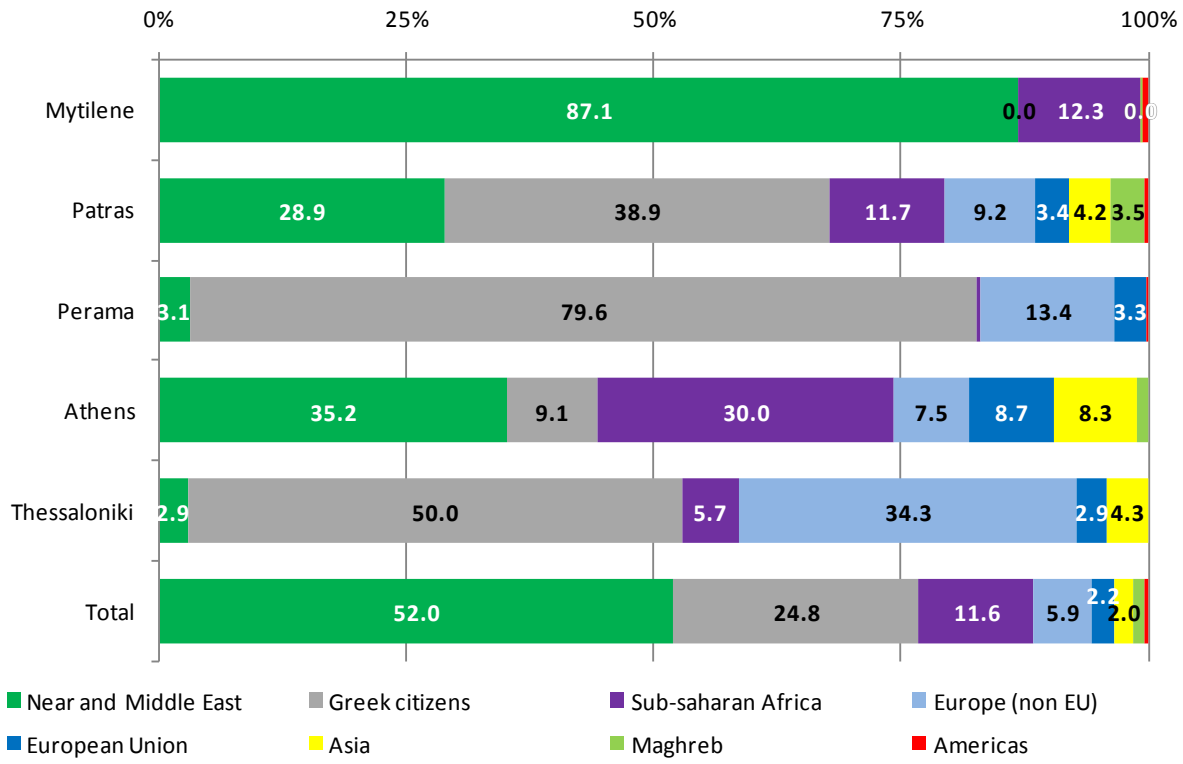
[130] Only 13% of patients seen in Thessaloniki were recorded in the database and 57% in Perama, which largely explains the low proportion of Greeks in the population seen.
[131] The question was little asked in Mytilene (86% of data missing) or in Athens (50%).
[132] The question was not asked in Mytilene and the response rate was too low in the other centres to be useable (29% in Patras, 18% in Athens, 11% in Patras, 16% in Perama).

Table 21. Geographic origins by centre.

	Mytilene (n=1571)	Patras (n=1026)	Perama (n=508)	Athens (n=255)	Thessaloniki (n=70)	Total
Middle East	1364	289	15	89	2	1759
	87.1	28.9	3.1	35.2	2.9	52.0
Greek	0	389	391	23	35	838
	0.0	38.9	79.6	9.1	50.0	24.8
Sub-Saharan Africa	192	117	2	76	4	391
	12.3	11.7	0.4	30.0	5.7	11.6
Europe (non EU)	0	92	66	19	24	201
	0.0	9.2	13.4	7.5	34.3	5.9
European Union	0	34	16	22	2	74
	0.0	3.4	3.3	8.7	2.9	2.2
Asia	1	42	0	21	3	67
	0.1	4.2	0.0	8.3	4.3	2.0
Maghreb	3	35	0	3	0	41
	0.2	3.5	0.0	1.2	0.0	1.3
Americas	7	3	1	0	0	11
	0.5	0.3	0.2	0.0	0.0	0.3
Total	1567	1001	491	253	70	3382

Missing values = 48

Figure 611. Nationalities by centre.



Details of the nationalities by centre are indicated in the tables below. As we have already seen in Greece, Syrians were the third largest group by nationality in 2013 (15.5%), after Afghans (33.6%) and Greeks (24.4%).

Table 22. Details of nationalities by centre.

Mytilene		
Country	*Incidence*	*Percentage*
AFGHANISTAN	845	53.92
SYRIA	511	32.61
SOMALIA	161	10.27
ERITHREA	28	1.79
HAITI	6	0.38
PALESTINE	6	0.38
CONGO BRAZZA	2	0.13
MOROCCO	2	0.13
ALGERIA	1	0.06
BANGLADESH	1	0.06
CAMEROON	1	0.06
DOMINICAN REPUBLIC	1	0.06
IRAN	1	0.06
PAKISTAN	1	0.06

Perama		
Country	*Incidence*	*Percentage*
GREECE	391	79.63
ALBANIA	61	12.42
AFGHANISTAN	10	2.04
BULGARIA	10	2.04
PAKISTAN	3	0.61
POLAND	3	0.61
ARMENIA	2	0.41
UKRAINE	2	0.41
DOMINICAN REPUBLIC	1	0.20
FINLAND	1	0.20
IRAQ	1	0.20
LITHUANIA	1	0.20
RUMANIA	1	0.20
SERBIA	1	0.20
SOMALIA	1	0.20
SYRIA	1	0.20
TANZANIA	1	0.20

Patras		
Country	*Incidence*	*Percentage*
GREECE	389	38.86
AFGHANISTAN	231	23.08
ALBANIA	87	8.69
SUDAN	63	6.29
PAKISTAN	41	4.10
BANGLADESH	40	4.00
BULGARIA	25	2.50
ALGERIA	21	2.10
ERITHREA	20	2.00
SENEGAL	20	2.00
SYRIA	11	1.10
TUNISIA	8	0.80
NIGERIA	6	0.60
RUMANIA	6	0.60
MOROCCO	5	0.50
SOMALIA	5	0.50
IRAN	3	0.30
GAMBIA	2	0.20
IRAQ	2	0.20
MOLDAVIA	2	0.20
BOLIVIA	1	0.10
BRAZIL	1	0.10
CHINA	1	0.10
DOMINICAN REPUBLIC	1	0.10
ETHIOPIA	1	0.10
GEORGIA	1	0.10
GERMANY	1	0.10
LIBYA	1	0.10
PALESTINE	1	0.10
PHILIPPINE	1	0.10
POLAND	1	0.10
SERBIA	1	0.10
UKRAINE	1	0.10
UNITED KINGDOM	1	0.10

Thessaloniki		
Country	*Incidence*	*Percentage*
GREECE	35	50.00
ALBANIA	11	15.71
ARMENIA	5	7.14
GEORGIA	5	7.14
BANGLADESH	3	4.29
BULGARIA	2	2.86
RUSSIA	2	2.86
SENEGAL	2	2.86
AFGHANISTAN	1	1.43
NIGERIA	1	1.43
PAKISTAN	1	1.43
SERBIA	1	1.43
SOMALIA	1	1.43

Athens		
Country	*Incidence*	*Percentage*
AFGHANISTAN	64	25.30
GREECE	23	9.09
NIGERIA	20	7.91
BANGLADESH	15	5.93
BULGARIA	15	5.93
ALBANIA	14	5.53
CONGO BRAZZA	11	4.35
ERITHREA	9	3.56
ETHIOPIA	8	3.16
SYRIA	7	2.77
KENYA	6	2.37
PAKISTAN	5	1.98
SRI LANKA	5	1.98
IRAN	4	1.58
IRAQ	4	1.58
POLAND	4	1.58
CAMEROON	3	1.19
COTE D'IVOIRE	3	1.19
EGYPT	3	1.19
GEORGIA	3	1.19
RUMANIA	3	1.19
ALGERIA	2	0.79
GHANA	2	0.79
PALESTINE	2	0.79
SIERRA LEONE	2	0.79
SOMALIA	2	0.79
TANZANIA	2	0.79
BURKINA FASO	1	0.40
GAMBIA	1	0.40
GUINEA	1	0.40
LIBERIA	1	0.40
MALI	1	0.40
MOROCCO	1	0.40
NIGER	1	0.40
ORIENTAL TIMOR	1	0.40
SENEGAL	1	0.40
SUDAN	1	0.40
TURKEY	1	0.40
UKRAINE	1	0.40

Immunisation status

The immunisation data for Greece are recorded in the following table and figure. The answers for the different antigens were very similar. Overall, half of patients were vaccinated, one quarter were probably vaccinated and 20% should be (re)vaccinated (they did not know their immunisation status or knew they were not vaccinated)[133].

Table 23. Vaccination characteristics by centre.

Tetanus	**Mytilene** (1571)	**Patras** (1026)	**Perama** (508)	**Athens** (255)	**Thessaloniki** (70)	Total
Yes	957	350	226	127	21	1681
	61.7	39.8	68.9	62.3	36.2	55.6
Probably	460	249	33	31	13	786
	29.7	28.3	10.1	15.2	22.4	26.0
No	71	130	19	35	11	266
	4.6	14.8	5.8	17.2	19.0	8.8
Don't know	62	150	50	11	13	286
	4.0	17.1	15.2	5.4	22.4	9.5
Total	*1550*	*879*	*328*	*204*	*58*	*3019*
HBV						
Yes	961	348	207	125	20	1661
	62.0	39.5	63.3	61.3	34.5	55.0
Probably	461	249	34	30	12	786
	29.7	28.3	10.4	14.7	20.7	26.0
No	68	133	19	38	11	269
	4.4	15.1	5.8	18.6	19.0	8.9
Don't know	61	151	67	11	15	305
	3.9	17.1	20.5	5.4	25.9	10.1
Total	*1551*	*881*	*327*	*204*	*58*	*3021*
MMR						
Yes	960	352	224	125	22	1683
	62.0	39.9	68.5	61.9	38.6	55.8
Probably	459	247	35	30	11	782
	29.6	28.0	10.7	14.9	19.3	25.9
No	68	132	19	36	9	264
	4.4	15.0	5.8	17.8	15.8	8.8
Don't know	62	151	49	11	15	288
	4.0	17.1	15.0	5.5	26.3	9.5
Total	*1549*	*882*	*327*	*202*	*57*	*3017*

People were best vaccinated in Mytilene (less than 10% were not immunized or did not know). In Thessaloniki, on the other hand, over 40% of patients had not been properly vaccinated and over 30% in Patras. Questions about knowledge of where to get vaccinated were not usable by centre[134]. In Thessaloniki, amongst the 53/70 (75.7%) of patients who replied, 32/53 (60.4%) knew where to go to get vaccinated.

[133] Greek report on vaccinations in the general population: http://www.nsph.gr/files/011_Ygeias_Paidiou/Ereunes/ekthesi_emvolia_2012.pdf

[134] Missing data rate: 94% in Mytilene, 57% in Athens, 93% in Patras, 81% in Perama

Figure 62. Immunisation data by centre.

Serological status

Figure 62. HIV status by centre.

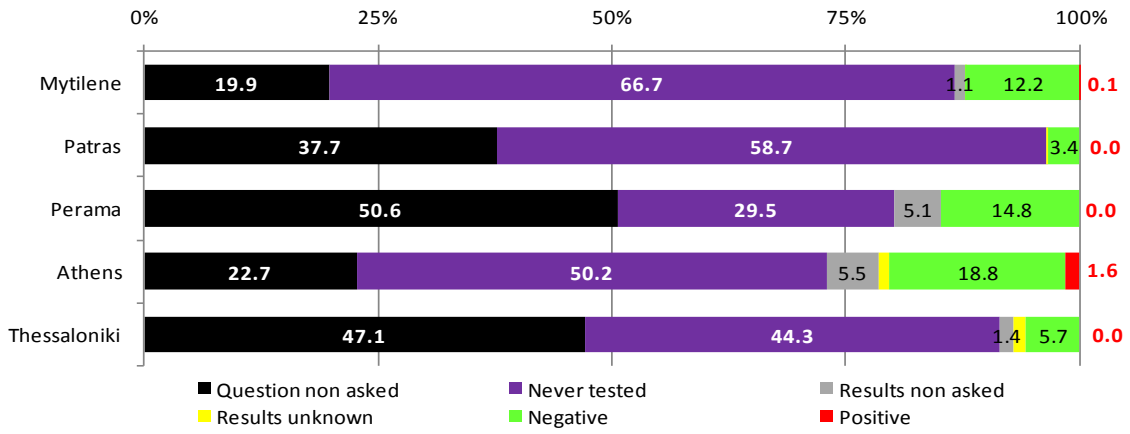


Figure 63. HCV status by centre.

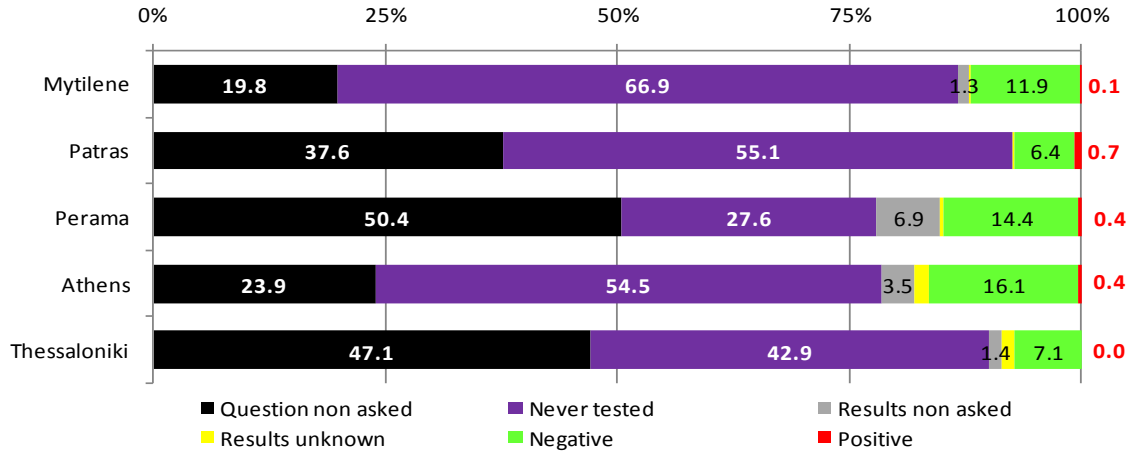
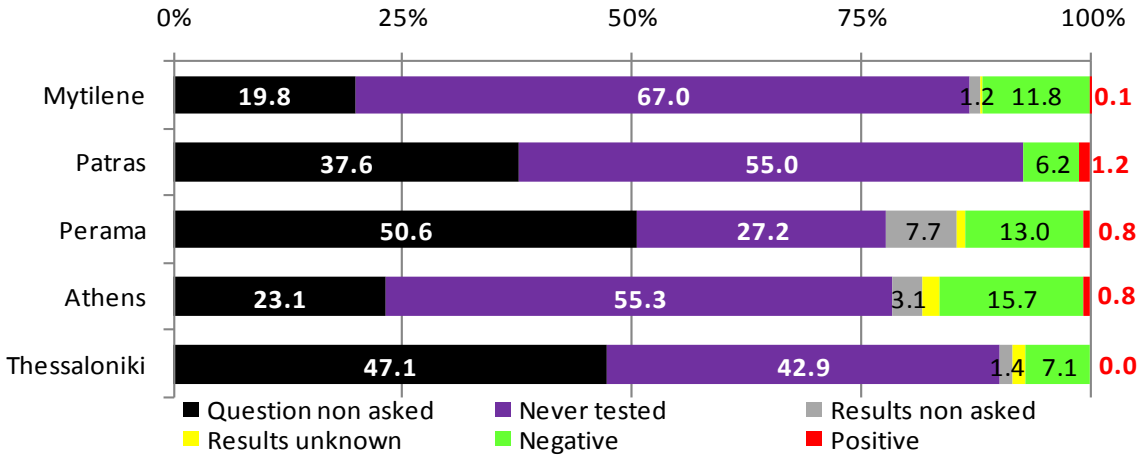


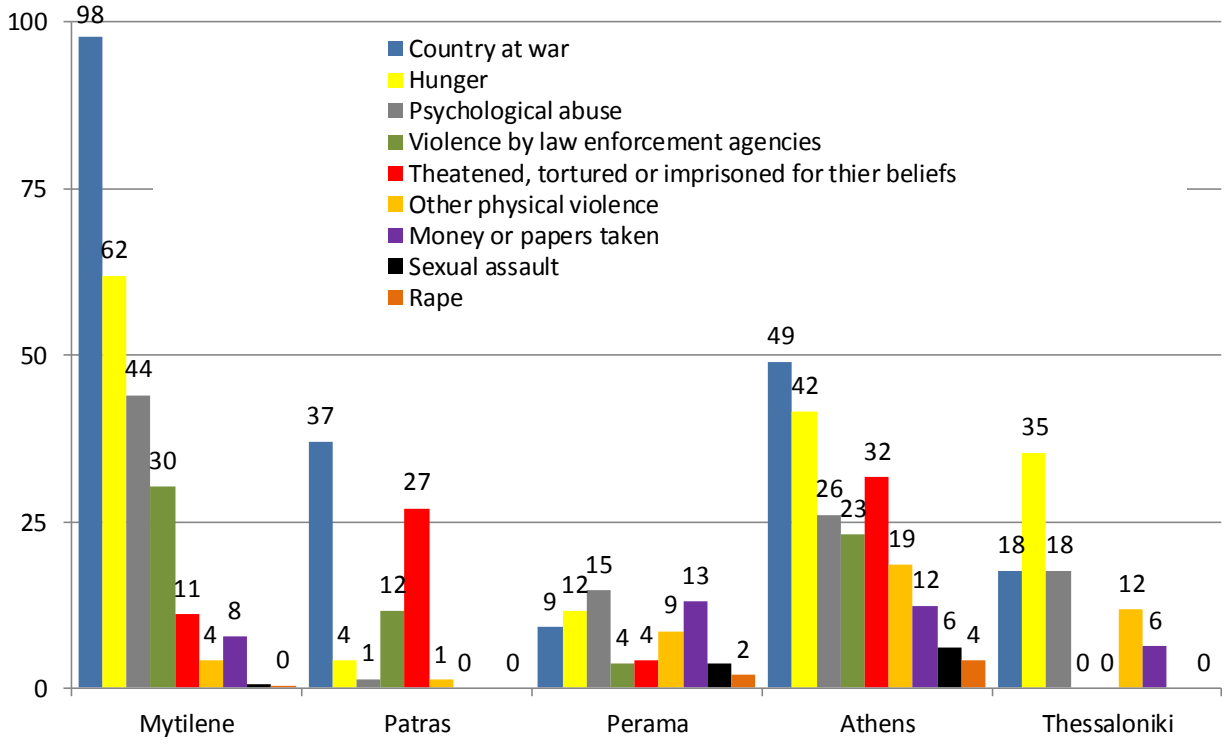
Figure 64. HBV status by centre.



Violence

Mytilene had overwhelmingly the highest number of reported incidences of violence among the patients (in absolute numbers and relative frequency), i.e. in the programme that receives the most immigrants from Afghanistan and the Middle East (and no Greeks). To a lesser extent, but still with significant percentages, the Athens centre also saw very diverse types of victims of violence. Logically, Perama (which sees a vast majority of Greek citizens) had the lowest levels of reported violence.

Figure 65. Frequency of incidences of violence reported by centre.



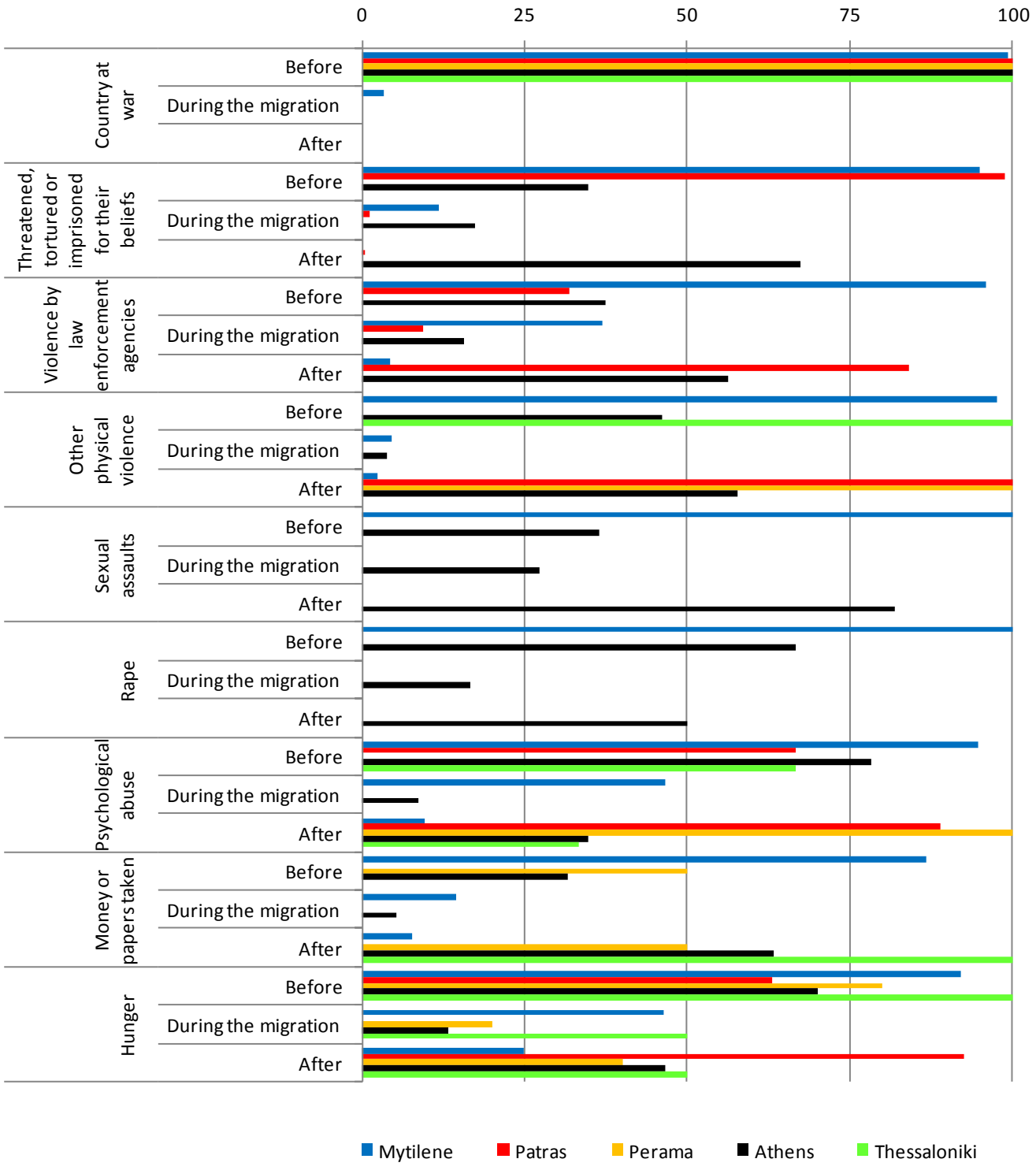
'Other physical violence' also includes domestic violence.
The percentages are shown here without a decimal point so they are easier to read.

However, although violence was reported particularly often in Mytilene, few victims declared that they had suffered any since their arrival in Greece (except for hunger: 25% of those interviewed in Mytilene who had suffered hunger had done so since their arrival in Greece).

Conversely, in Patras, although violence was rarer, it was reported proportionally more often since arriving in Greece. In this city, since their arrival in Greece, 84% of people reported that they had been victims of law enforcement agents, 89% of people had been victims of psychological violence and 100% of people reported being victims of other types of physical violence. Also in Patras, 93% of the victims of hunger had suffered from this since their arrival.

Equally, in Athens (but for a smaller number of people surveyed) victims reported high instances of cases since their arrival in Greece and this is particularly true for victims of sexual violence: 82% of those who had been victims of sexual assault had been victims of it since their arrival in Greece and 50% of the victims of rape. We also recorded that for 56% of the victims of violence by law enforcement agencies and for 67% of the people threatened or tortured for their beliefs, it had happened since their arrival in Greece.

Figure 66. Period of time when the violent incidents occurred during the migration, by centre (for the cases reported of each type of violence).



* including domestic violence (the totals are greater than 100% because people could suffer from a type of violence at different points in their migration journey)

E.g.:

In Athens, for 50% of those who reported having been raped, it had happened since their arrival in Greece

In Patras, 93% of people who had reported suffering from hunger had done so since arriving in Greece.

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Members of MdM Belgium, Canada, France, Germany, Greece, Japan, the Netherlands, Portugal, Spain, Sweden, Switzerland, the United Kingdom and the United States show their solidarity for those without healthcare coverage in Greece: pregnant women, children and doctors try to come together but are blocked by a financial barrier. MdM Flashmob, Monastiraki Square, Athens, 21 February 2014.

Greece, can public health be saved?

In Greece, the crisis and austerity measures have led to a much deeper recession than expected, as acknowledged by the International Monetary Fund[135]. In December 2013, unemployment had risen to 28%[136]. The massive cuts in health expenditure have led to: a reduction in the benefit packages from EOPYY (the National Organisation for Healthcare Provision); reduced public healthcare services; cuts in prevention programmes; and to an increase in user charges for consultations and medication, including for chronic conditions such as diabetes, coronary heart disease, cancer.

According to official figures the number of uninsured citizens in Greece is close to 3 million, out of a total population of 10,815,197, whilst the figures from the national agency for healthcare services show that the number of people without insurance could reach 4 million. However, *"the failure of public recognition of the issue by successive Greek governments and international agencies is remarkable"* stated Alexander Kentikelenis[137] and his co-authors in the Lancet.

The last Memorandum of Understanding between the Greek authorities and the Troika[138] contained a Health Voucher programme that was supposed to provide free access to primary healthcare services (including up to seven antenatal visits) for the uninsured. In reality, the programme is estimated to theoretically cover only 230,000 uninsured citizens for 2013-2014, less than 10% of the actual number of uninsured people. Moreover, between the announcement of the programme in July and October 2013, only 21,000 health vouchers were actually issued[139] (less than 1% of uninsured persons). At the time the current report was drafted (March 2014), a shutdown had been ordered by the Minister of Health for at least a month of most public primary healthcare facilities to reorganise the new Primary National Healthcare Network (PEDY). A wide protest movement is taking place among medical professionals against the entrance fee of 5€ in health facilities which is a real barrier to care for the most destitute living in Greece.

Vaccination, antenatal care and delivery

Although the national immunisation schedule in Greece has not been changed, more and more children remain unvaccinated, because public health services, where children used to have free access, are slowly disappearing. According to a study conducted by the National School of Public Health, published in May 2013, 65-70% of children are vaccinated by private paediatricians, increasing still further the financial burden on unemployed and uninsured parents. It costs around 1,200€ to fully vaccinate a child when uninsured. This is why the teams of Doctors of the World vaccinated around 9,000 children in 2013, in the open polyclinics and in the mobile units going to remote villages and islands, where we also saw children and people with no access to healthcare because previously existing health facilities have been closed.

Access to Public Maternity Clinics has become extremely difficult or even impossible for uninsured pregnant women. They must pay for antenatal care during their pregnancy and must bear the cost of delivery. Although asylum seekers can theoretically access antenatal and delivery care, they are now faced

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135 Gordon J, Karpowicz I, Lanau S, Manning J, McGrew W, Nozaki M, Shamloo M. Greece: Ex Post Evaluation of Exceptional Access under the 2010 Stand-By Arrangement. Washington DC: International Monetary Fund, Country Report No. 13/156, 2013.

136 Eurostat. *Harmonised unemployment rate by sex*. http://epp.eurostat.ec.europa.eu, last access on 3 March 2014.

137 Kentikelenis A, Karanikolos M, Reeves A, McKee M, Stuckler D. Greece's health crisis: from austerity to denialism. *Lancet* 2014; 383: 748–53.

138 Samaras A, Stournaras Y, Provopoulos G. Greece: Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding, 17 July 2013. Available on the International Monetary Fund website: https://www.imf.org/external/np/loi/2013/grc/071713.pdf

139 Zafiropoulou M, Kaitelidou D, Siskou O, Oikonomou B. *Impact of the crisis on access to healthcare services: country report on Greece*. Brussels: Eurofound, 2013.

with many administrative barriers. More specifically, they need to prove their inability to pay before they are allowed to have free access to healthcare in Public Hospitals.

The cost of antenatal care for uninsured women during a normal pregnancy is around €650. Then, they have to pay a further €650 for an uncomplicated delivery and about €1,200 for a caesarean section. Termination of pregnancy is a legal procedure in Greece, but it costs about €350 when uninsured. Not being able to pay for antenatal care makes new born children more vulnerable, and puts the health of mother and child at serious risk. It also causes a lot of anxiety among the women who arrive at hospital on the day of their delivery without any previous care, prevention or counselling. It is also a source of additional stress for the medical teams.

Some public maternity wards have refused to deliver birth certificates to children whose mothers could not pay the cost of the delivery. Sometimes the employees of public maternity wards have threatened the parents with refusing to hand over the child to them if they fail to bring the requested amount of money to pay for the delivery…

Stigmatised groups who were already victims before the crisis

In April 2013, in massive sweep operations called 'Thetis', the Greek police picked up drug users in the centre of Athens, lead them handcuffed either to the migrant detention centre of Amygdaleza (an outer suburb of Athens), or just dropped them off in the countryside, hours away from Athens. In Amygdaleza, the drug users had mandatory HIV testing[140]. These operations were repeated many times, increasing the victims' vulnerability.

However, there is also some good news. At the end of 2013, a major step forward was taken in Athens through the opening of a small safe consumption room for drug users, near Omonia Square. It can serve only 2 drug users at a time and cannot stay open in the evenings or during weekends. We hope that the OKANA organisation that runs the room will get more funding in order to extend the opening hours and number of persons who can safely use drugs as the open air drug scene in Athens is the biggest in Europe.

Sex workers lived through terrible times in April 2012 just before the new set of elections, when a law was issued that allowed for forced testing for infectious diseases. Some of them were dragged by their hair to State medical teams (!) who tested them for HIV and other diseases, against their will.

The photos of the HIV positive women were then published in the newspapers. They were even accused of contaminating their clients and faced heavy fines. These kinds of severe breaches of human rights go against the recommendations of all international bodies, whether they are public institutions or NGOs, for instance those of UNAIDS, the Global Commission on HIV and the Law, WHO, the EU Fundamental Rights Agency, the ECDC, or Human Rights Watch. Non voluntary testing without the guarantee of anonymity leads to distrust towards testing facilities. All NGOs and infectious diseases specialists are waiting for this decree[141] to disappear once and for all.

Unfortunately, migrants are still suffering from hate speech and harsh violent acts. They are still designated as responsible for the economic crisis that hit the country. As social safety nets fall apart, destitute people face growing despair, and fear for the future is widespread. The social crisis has been widely exploited by extreme right parties.

[140] Kokkini E. Greece… the country of harm induction. Amsterdam: Amsterdam: Correlation Network (Policy paper), newsletter 03/2013. Who is paying the price for austerity?

[141] This decree 39A was reactivated in July 2013 by the Ministry of Health who said at a meeting at the EU commission on 18 March 2014 that it would be changed at the latest in April 2014.

Violence against migrants in Greece does not spare children.

> Ismail[142], a 14 year old Afghan boy, was assaulted by three people when he told them he was Afghan. He required 30 stitches after his assailants disfigured him with broken bottles. They left him on the pavement covered in his own blood. He was brought to the hospital by a passer-by and received emergency care. Unfortunately, he was discharged a few hours later, alone, as he had no residence permit or health coverage. MdM treated him, found him safe accommodation and provided him with social support so he could find his family.

Extremists indiscriminately attack women (including pregnant women), children, and lone men, mainly at night; they organise racist sweeps against Albanians, foreign market stall holders and openly threaten humanitarian NGO workers, calling for hate crimes…

Response of MdM Greece to the crisis

In response to the crisis and the massive needs it generates, Doctors of the World Greece has multiplied its areas of action. Every day hundreds of volunteers and 30 paid staff members run 22 domestic projects of which 13 began after 2010. For example, the organisation runs 5 polyclinics, a shelter for refugees and asylum seekers in Athens, and four mobile units offering medical services to people living in isolated and remote places across Greece[143]. Social assistance and legal support are offered to migrants who may be in need of international protection on the islands of Lesbos and Chios.

Other projects target the homeless of Athens (including a night shelter), intravenous drug users (a harm reduction project called "Streets of Athens"), the Roma children living in camps around Athens and the elderly (the "Message for Life" programme).

The "Enough!" programme, in collaboration with the Greek Council for Refugees, aims to promote tolerance, fight racist violence in Greece and provide medical, psychological, social and legal assistance to victims of racist violence. The project also aims to contribute to a better understanding of the extent of the phenomenon.

In 2013, MdM Greece treated 75 victims of xenophobic violence. In many cases, the use of clubs, chains, knives, broken bottles, and dogs was reported. All but one attack included multiple perpetrators who in the majority of cases, were dressed in black and bearing neo-Nazi insignia. Four attacks took place inside police headquarters. As half of the victims were undocumented, they could not file any complaint. The EU Victim's Directive (2012/29/EU) established minimum standards on the rights, support and protection of *all* victims of crime, specifically including undocumented migrants[144]; it will have to be transposed and implemented also in Greece. Some perpetrators were minors themselves: this is the reason why the MdM Greece "Enough!" project also goes into schools to meet children aged 12 to 16: 19 discussions have been organised with 770 adolescents.

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[142] See the video at www.mdmeuroblog.wordpress.com

[143] A paediatric mobile unit, a dental mobile unit, an ophthalmological mobile unit and a general medicine unit focussing on women and children.

[144] Unfortunately, Greece has not yet implemented the Directive.
DG Justice Guidance Document related to the transposition and implementation of Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA. Brussels: European Commission, DG Justice, December 2013.

The presentation in schools starts with a photo showing children's hands of different ethnicities holding the globe. This inaugural slide emphasises the aim of the presentation which is social cohesion and solidarity without discrimination. In order to show that we have to overcome the negative connotation of the word "foreigner (xenos)" examples of some well-known personalities from the academic and athletic world are given and we demonstrate that even though they are migrants (either Greeks living abroad or foreigners living in Greece) they play an important role in society for young people as positive role models. In addition, we show photographs of the mass migration of Greeks in the 50s and explain that Greeks are also migrants in other countries and that "everyone is a foreigner somewhere". After explaining that Greece today is a gateway to other European countries, there is a brief reference to the work done by MdM, presenting some services and medical care provided to vulnerable groups aiming to induce solidarity. During the presentation, the students are asked to share their personal opinions and experience of the issue of "acceptance and difference". The presentation closes with encouraging them to adopt good practices which include accepting diversity, preventing racist behaviour and strengthening social solidarity. Students are also asked to write a short essay on the issue of racism. These texts are collected and used as material in the anti-racist campaign.

International and EU bodies commit to health protection

During the last two years, a growing body of international and European institutions has asked governments to protect the most vulnerable populations from the consequences of the economic crisis and austerity measures.

UN Committee on Economic, Social and Cultural Rights

Article 12 of the International Covenant on Economic, Social and Cultural Rights specifies the right of everyone to *"the enjoyment of the highest attainable standard of physical and mental health*". Already in May 2012, the Committee expressed its concern over reductions in the levels of protection afforded to the rights to housing, health, education, and work, among others, as a consequence of austerity measures taken by the Spanish government. With regards to the exclusion of undocumented adult migrants from healthcare, the Committee called on Spain to ensure that all persons residing in its territory, regardless of their administrative status, have access to healthcare services in compliance with the principle of universality of health services[145].

Council of Europe

In February 2013, Human Rights Commissioner Nils Muižnieks firmly condemned the xenophobic violence and impunity in Greece[146]. Concerning Spain, the Commissioner criticised the fact that migrant children with undocumented parents have, on various occasions, been denied access to a health card or healthcare (misinformation concerning RDL 16/2012 that only excludes adult undocumented migrants). He also denounced the disproportionate impact of the austerity measures on children's access to healthcare[147].

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[145] Committee on Economic, Social and Cultural Rights of the United Nations Office at Geneva. Concluding Observations on Spain May 2012, available at http://www.unog.ch/80256EDD006B9C2E/%28httpNewsByYear_en%29/C2126B1B80ACCE10C1257A020032D5C3?OpenDocument, last access on March 31 2014.

[146] "Greece must curb hate crime and combat impunity" (Muiznieks N. *Report following his visit to Greece from 28 January to 1 February 2013*. Strasbourg:

[147] Muiznieks N. *Report following his visit to Spain from 3 to 7 June 2013*. Strasbourg

In June 2013, following a report on equal access to healthcare, the Parliamentary Assembly of the Council of Europe issued resolution 1946 (2013), drawing attention to the negative impact of austerity measures on social rights and their effects on the most vulnerable.

The Assembly "*believes that the crisis should be viewed as an opportunity to rethink health systems and be used to increase their efficiency and not as an excuse for taking retrograde measures*". **The Assembly particularly calls on Member States to ensure access to vaccination for all and universal access to healthcare for pregnant women and children, irrespective of their status.**

Finally, the Assembly also calls for a "***dissociation of security and immigration policies from health policy***", e.g. by abolishing the obligation on health professionals to report migrants in an irregular situation.

In November 2013, the Parliamentary Committee on Migration, Refugees and Displaced Persons asked Member States to guarantee universal access to HIV prevention and treatment, strongly denouncing the myth of health tourism[148]. The Committee expressed their concern about obligatory HIV testing. Furthermore, **the Committee considered that a migrant living with HIV** "***should never be expelled when it is clear that he or she will not receive adequate healthcare[149] and assistance in the country to which he or she is being sent back. To do otherwise would amount to a death sentence for the person.***"

In January 2014, the European Committee of Social Rights of the Council of Europe published its country conclusions. The Committee warned that the exclusion of adult undocumented migrants from healthcare (RDL 16/2012 in Spain) is contrary to Article 11 of the Charter, which states that "*everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable*".

"The Committee has held here that the States Parties to the European Social Charter have positive obligations in terms of access to health care for migrants, whatever their residence status. […] The economic crisis should not have as a consequence the reduction of the protection of the rights recognised by the Charter. Hence, the governments are bound to take all necessary steps to ensure that the rights of the Charter are effectively guaranteed at a period of time when beneficiaries need the protection most."

European Union institutions

In 2011, **the EU Fundamental Rights Agency (FRA)** published "Migrants in an irregular situation: access to healthcare in 10 European Union Member States". The FRA formulated the opinion that undocumented migrants should, as a minimum, be entitled by law to access to necessary healthcare. Such provisions should not be limited to emergency care only, but should also include other forms of essential healthcare such as antenatal, natal and postnatal care, child healthcare, mental care and care for chronic conditions[150].

In July 2013, a large majority of the European Parliament (EP) voted in favour of a resolution on the "Impact of the crisis on access to care for vulnerable groups" (2013/2044(INI)), reminding people that the fundamental values of the EU should be respected even in a crisis situation. And yet "*the most vulnerable*

[148] Draft resolution adopted by the Committee on 20 November 2013: Migrants and refugees and the fight against AIDS (see http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=20322&lang=en, last access on March 31 2014)

[149] Adequate healthcare in the country of origin "should be evaluated based on geographical and financial availability of treatment for the concerned individual in that particular State. Special attention should be given to the accessibility of continuous treatment and of specialised follow-up care (e.g. sufficient qualitative and quantitative availability of physicians and care structures that specialize in HIV as well as necessary blood tests and other equipment, etc.). The absence or presence of treatment also needs to be evaluated in light of the specific state of health of the individual applicant (progression of the illness, complications)."

[150] European Union Agency for fundamental rights. *Migrants in an irregular situation: access to healthcare in 10 European Union Member States*. Vienna: FRA, 2011.

groups are being hit disproportionately in the current crisis". The EP acknowledges that "*groups presenting several vulnerability factors, such as Roma, persons without a valid residence permit or homeless people, are at an even higher risk of being left out of risk prevention campaigns, screening and treatment*." The EP called on the Commission and on Member States to not only focus on the financial sustainability of social security systems but to also take into account the social impact of austerity measures. The Parliament considered that "***leaving vulnerable individuals without access to healthcare or care services is a false economy as this may have a long-term negative impact on both healthcare costs and individual and public health***."

Concerning the Troika, in March 2014, the EP criticised the fact that "*among the conditions for financial assistance, the programmes included recommendations for specific cuts in real social spending in fundamental areas, such as pensions, basic services, healthcare and, in some cases, pharmaceutical products for the basic protection of the most vulnerable […]*[151]." The Parliament called on the Commission and the Member States to "*consider public health and education spending not as a spending exposed to cuts but as a public investment in the future of the country, to be respected and increased so as to improve its economic and social recovery*."

During a Doctors of the World round table in the European Parliament ("Impact of the crisis on women's and children's access to healthcare") in November 2013, the Secretary General of the European Popular Party Antonio LÓPEZ-ISTÚRIZ declared "***there are cases when people come and really need healthcare services and are rejected, and these people who do not have the means, nor health coverage, whether they are in a regular or irregular situation, should have access to free universal healthcare and this is what we need to maintain in the whole of the EU.[…]Pregnant women and children must obviously have immediate access to healthcare…***

As part of monitoring the implementation of the 2004 Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia, the **European Centre for Disease Prevention and Control** (ECDC) explicitly recommended that member States guarantee universal access to preventive and curative care for HIV, including for prisoners, intravenous drug users, men who have sex with men, sex workers and undocumented migrants[152].

In March 2014, on the occasion of the International Day for the Elimination of Racial Discrimination, the heads of three human rights institutions[153] made a joint declaration: "When leaders speak out against hate crimes, it sends a strong reassuring message to communities that are affected. Political leaders also play a key role in developing policies to combat hate crimes. First they must put in place a system for reporting racist incidents, thereby providing policy makers with the information they need to introduce strong and effective responses".

[151] Committee on Employment and Social Affairs. Report on employment and social aspects of the role and operations of the Troika (ECB, Commission and IMF) with regard to euro area programme countries (2014/2007(INI). Strasbourg: European Parliament (plenary sitting), 20/02/2014

[152] See the collection of ECDC reports at: http://ecdc.europa.eu/en/activities/diseaseprogrammes/hash/Pages/monitoring-dublin-declaration.aspx (last consulted on 16 April 2014).

[153] Ambassador Janez Lenarčič, Director of the OSCE department for the Office for Democratic Institutions and Human Rights, Christian Ahlund, President of the Europe Commissions against Racism and Intolerance (ECRI) and Morten Kjaerum, Director of the EU Fundamental Rights Agency (FRA)

Conclusion

This fifth report from the Doctors of the World international network Observatory highlights once again the serious difficulties these populations, often invisible in health statistics, face in accessing healthcare. These people are facing daily multiple vulnerability factors, including: unfit housing, lack of financial resources, isolation, dealing with multiple forms of violence, administrative uncertainty....These people, who should receive even more care than the rest of the population, are in fact excluded from public healthcare systems and have to turn to our facilities.

Our findings reveal that three quarters of the pregnant women who came to our programmes had no access to antenatal care: in Europe 84% had no health coverage, 95% in Canada and 100% in Turkey and none of them had the financial means to pay for prenatal care...

Children are treated no better; between half and three quarters of them had no access to immunisation.

In Belgium, Greece and Turkey, babies of parents who did not have the means to pay for the delivery were refused birth certificates, leaving them without legal status.

The fundamental rights of these women and children are not respected, even though they are the most destitute, most vulnerable and most at-risk.

The people who attended our health and social centres often consulted too late (30%), had been denied care (17%) and were unfamiliar with the health system in their host country and/or unaware of their rights. In Europe, only 2.3% of them cited health as a reason for migration (and virtually none in Canada or Turkey). Once again we prove to what extent the discourse on so-called “health tourism” is totally unfounded for the most vulnerable populations.

There is urgent need for States to respect the commitments they have made on protecting the health of mothers and children; health professionals need to get mobilised, and together with international institutions need to advocate for access to care for pregnant women and children to become an immediate reality.

Health policies should not be used as tools to regulate migratory flows. This goes against the recommendations made by European and international health bodies. Doctors must oppose this manipulation that tramples over their ideology and professional ethics.

The slow on-going dismantling of health systems based on solidarity in Spain, Greece or the United Kingdom is increasingly obvious year on year. Restrictions on accessing healthcare on the pretext of the economic crisis or the burden of migration are short term calculations. They impact negatively on the health of everyone, and first and foremost those who should be protected most of all. These restrictions and stigmatisation at the expense of the most vulnerable can only prove costly in the medium term in human, financial and political terms.

On the contrary, we advocate for universal and fair health systems that are accessible to all, without distinction or discrimination.

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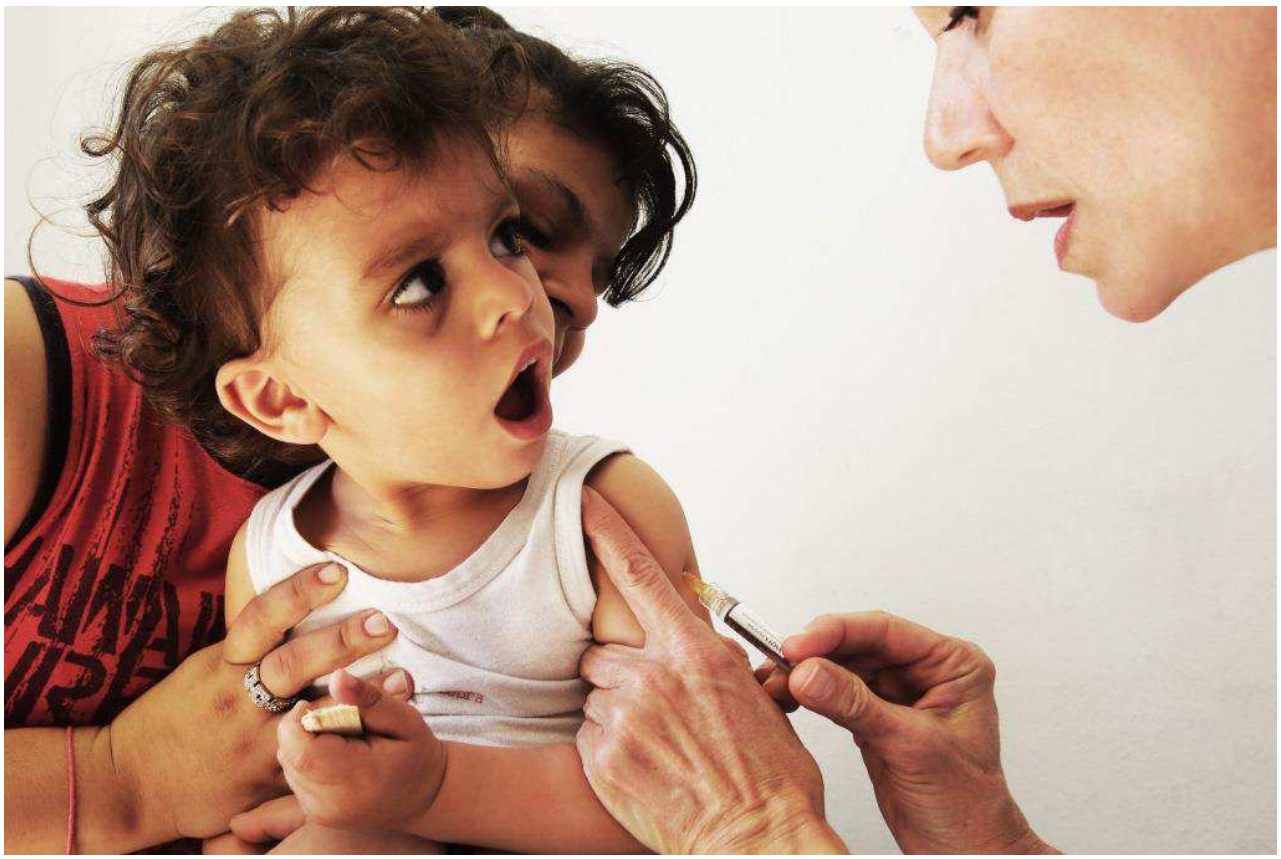

© Giorgos Moutafis – Dr Liana Mailli vaccinates a child at the clinic in Perama, MdM Greece, 2013

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