

EU HEALTH POLICY PLATFORM
Thematic Network on “Migration and Health”

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FRAMING DOCUMENT

This document was created through a process of dialogue with two dozen health stakeholders over a period of months, as part of the EU Health Policy Platform thematic network on “migration and health”, co-led by the Platform for International Cooperation on Undocumented Migrants (PICUM) and the International Rehabilitation Council for Torture Victims (IRCT). An initial outline was created following a face-to-face meeting with health partners in Brussels on 30 May 2017. Feedback, input and proposed recommendations were accepted until August, after which the draft was shaped into the present Framing Document, and a separate Call to Action, whose recitals are drawn from this document, and which enumerates a common set of priority actions.

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Introduction

The European Commission has devoted attention and resources to migrant health for more than a decade. Under the first and second Health Programmes (2003-2013) managed by DG Health and Food Safety, work on “health inequalities” was a distinct theme that included 64 projects¹ under two main clusters: “the social gradient” and “vulnerable groups.” Migrants and ethnic minorities were addressed in the latter category, along with certain high-risk social groups, such as people who use drugs and sex workers. In the third Health Programme (2014-2020), “reducing health inequalities” is a general, rather than specific, objective;²³ eight projects have focused on migrants, with the bulk of these prompted by the sharp rise in arrivals via the Mediterranean in 2015.⁴⁵

Other directorates-general (DGs) within the Commission have supported work on issues related to migrants’ health.⁶ These efforts, however, lack coordination, and do not adequately address the ways that policies across a range of sectors outside of health are determinants of migrants’ health. Notably, DG Migration and Home Affairs, which is responsible for many policies that directly affect migrant health, does not systematically assess the health consequences of those policies. To adequately address migrants’ health, the EU needs to work across all relevant policy domains to “foster collective will and leadership in a way that health is regarded as a shared responsibility.”⁷

Migrants’ health status in Europe

Existing research shows that people with migrant backgrounds in Europe are generally worse off, as far as health outcomes, than native-born populations: migrant women on average have higher rates of pregnancy-related complications and caesarean sections;⁸ refugees and asylum-seekers show higher levels of post-traumatic stress and depression⁹¹⁰; and migrant workers tend to experience

¹ CHAFAEA (2014) *Action on health inequalities in the European Union. The EU Health Programme’s contribution to fostering solidarity in health and reducing health inequalities in the European Union 2003–13*. Luxembourg: Consumers, Health and Food Executive Agency. <http://bit.ly/1kW1VBo>

² https://ec.europa.eu/health/programme/policy_en

³ https://ec.europa.eu/health/programme/policy_en

⁴ https://webgate.ec.europa.eu/chafea_pdb/health

⁵ https://webgate.ec.europa.eu/chafea_pdb/health

⁶ For instance, DG Migration and Home Affairs has funded various projects, mainly with regards to asylum seekers and refugees health, including through the Asylum, Migration and Integration Fund and its predecessors; DG Employment, Social Affairs and Inclusion has supported projects on migrants’ access to health care, as well as their health and safety at work; DG Education and Culture has supported training programmes, joint masters projects and lifelong learning projects concerned with migrants and ethnic minorities’ health; and DG Research and Innovation (which has supported research on migrant and ethnic minority health. The Fundamental Rights Agency (FRA), the European Asylum Support Office (EASO) and the European Centre for Disease Prevention and Control (ECDC) have also regularly focus on migrant health.

⁷ R. Benedict, et al., IOM, *MIGRATION HEALTH: BETTER HEALTH FOR ALL IN EUROPE*, 2009.

⁸ I. Keynaert, et al., “[What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants? A review of existing evidence in the WHO European Region \(2016\)](#).”

⁹ M. Hollifield, et al., “[Measuring trauma and health status in refugees: A critical review](#)”, Journal of the American Medical Association, 2002.

¹⁰ S. Priebe, et al., “[Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region \(2016\)](#)”, 2016.

higher rates of musculoskeletal, respiratory and mental health problems, as well as fatal and non-fatal injuries among compared to native populations.¹¹

For some people who have migrated, health-related vulnerabilities come from experiences – torture, trauma, gender-based violence or other forms of abuse or hardship – in their country of origin, during transit, or upon arrival. For the rest, a variety of social, economic and political factors¹² drive an erosion of their relative health advantage after their arrival in Europe.

A “migrant” is any person who has crossed an international border, regardless of the length of their stay. Many people can be viewed both as ‘migrants’ and as ‘members of ethnic minorities’. Although the latter covers groups that are not included in the category ‘migrant’, it can still provide a valuable perspective and insights relevant for health and social policy. For instance, the offspring of migrants, especially the so-called ‘second generation’, are not migrants themselves but may nevertheless be affected by many of the same issues as the first generation, including cultural, linguistic or biological factors, as well as social factors like acceptance or rejection by the majority.¹³ An example is the descendants of ‘guest workers’ who migrated to North-Western Europe and Austria between the 1950s and early 1970s and are often severely disadvantaged.¹⁴

Other types of difference should also be systematically taken into account in considering the health of migrants, including age and gender, as well as socioeconomic status, using an intersectional approach that examines the interactions among these variables simultaneously.

The right to health and “health in all policies”

Improving migrant and ethnic minority health is a matter of states following through on existing obligations and commitments, repeatedly declared and endorsed in different international for a and firmly established international, regional and most often also national law.

The EU has a broad obligation to safeguard and promote the right to health under the EU primary law¹⁵. Every member state additionally has ratified and is bound by international human rights treaties guaranteeing the right to health. And while states have broad discretion to decide how they will work towards realising the right to health, the measures they adopt cannot discriminate based on national origin, migration or residence status.¹⁶ Furthermore, certain groups such as victims of torture, sexual

¹¹ J. Simon, et al., [“Public health aspects of migrant health: a review of the evidence on health status for labour migrants in the European Region \(2015\)”](#), 2015.

¹² S. Stringhini et al., [“Socioeconomic status and the 25x25 risk factors as determinants of premature mortality: a multicohort study and meta-analysis of 1.5 million men and women”](#), The Lancet 398 (10075), 25 March 2017; M. Tobias, [“Social rank: a risk factor whose time has come?”](#) The Lancet 389 (10075), 25 March 2017.

¹³ For example, unemployment among second-generation youth tends to be much higher than among majority youth.

¹⁴ The OECD has devoted much attention to this group, especially their education and employment, but very little attention is paid in research and policy to their health.

¹⁵ According to Article 168 of the Treaty on the Functioning of the European Union (TFEU): “A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health”. [...] (emphasis added).

¹⁶ Committee on Economic, Social and Cultural Rights (CESCR), [CESCR GENERAL COMMENT NO.14: THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH \(ART.12\)](#), 11 August 2000; Committee on Economic, Social

and gender-based violence and other forms of ill treatment, and persons with disabilities have rights to certain types of health support that are absolute in nature and this is not subject to progressive realisation.

The right to health is not limited to the right to health care: it also “embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a health environment.”^{17 18}

The EU has also made explicit commitments under the UN Sustainable Development Goals, which include “achieving universal health coverage (including risk protecting, access to quality essential health care services and access to safe effective, quality and affordable essential medicines and vaccines *for all*” (emphasis added), as well as reducing inequalities, such as by achieving social, economic and political inclusion, regardless of status, by 2030.

Under the auspices of the Portuguese¹⁹ and Spanish²⁰ EU Presidencies, migrant health was a high priority on the European agenda, with resulting detailed recommendations and pledges by governments and other stakeholders, and also respective Council Conclusions.²¹ Member states have also promoted positive action on migrant health through their engagement in intergovernmental bodies like WHO and IOM.²² In 2010, WHO and IOMI organised the first high-level global consultation on migrant health, following the 2008 World Health Assembly resolution on the health of migrants. That consultation generated a detailed report, reflecting the shared priorities of governments, academics and civil society, on improving migrants’ health – including promoting cooperation across sectors to achieve more migrant-sensitive health systems, and equal access to health services, as well as social protection in health and social security for all migrants.²³

and Cultural Rights, [DUTIES OF STATES TOWARDS REFUGEES AND MIGRANTS UNDER THE INTERNATIONAL CONVENTION ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS](#), 13 March 2017.

¹⁷ Committee on Economic, Social and Cultural Rights (CESCR), [CESCR GENERAL COMMENT NO.14: THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH \(ART.12\)](#), 11 August 2000.

¹⁸ International Organization for Migration (IOM), World Health Organization (WHO), UN Human Rights Office of the High Commissioner, [INTERNATIONAL MIGRATION, HEALTH AND HUMAN RIGHTS](#), 2013.

¹⁹ Under the auspices of the Portuguese EU Presidency, an EU-level consultation on health inequalities and migrants, led by IOM and supported by the Commission, produced a report recommending a “multi-sectoral approach to managing migration”. The report also called for policymakers across all relevant areas of the EU’s action to “foster collective will and leadership in a way that health is regarded as a shared responsibility.” See Consultation report, [Migration Health: Better Health for All in Europe](#).

²⁰ During the framework of the Spanish EU Presidency, a health equity Conference was organised, subsequent to IOM/WHO’s first high-level Global Consultation on migrant health in 2010, and following the 2008 World Health Assembly resolution on the health of migrants.

²¹ [Council Conclusions](#) on Health and Migration in the EU (6 December 2007); and [Council Conclusions](#) on Equity and Health in All Policies: Solidarity in Health (8 June 2010), which invites the European Commission and member states to “promote the exchange of information and the development of new methodologies for the various governance areas, which can measure the health impact of different policies that also explicitly include equity”.

²² For a select list of international initiatives on migrant health, see D. Ingleby (2012), “Acquiring health literacy as a moral task,” *International Journal of Migration, Health and Social Care*, vol. 8 Iss. 1, at 25.

²³ Health of Migrants – The Way Forward: Report of a global consultation, Madrid, Spain, 3-5 March 2010.

In 2016, WHO's regional office for Europe adopted, with the accord of its member states, a strategy and action plan for refugee and migrant health in Europe.²⁴ The document recalls that states have recognised the right to health and committed themselves to universality, solidarity and equal access as the guiding values for organising and financing their health systems. It adopts an explicitly human rights-based approach, and clarifies that the implication is a duty to respect, protect and fulfil the right to health of all people within a state's territory.

The New York Declaration for Refugees and Migrants²⁵ agreed by world leaders (including all EU member states) on 19 September 2016 contains several references to health. It launched a two-year state-led process to negotiate a Global Compact on Migration (in parallel with a Global Compact on Refugees), which is to be guided by the UN Sustainable Development Goals. IOM²⁶ and WHO²⁷ have been working with key partners to ensure that the Compact adequately integrates health-related considerations, and recently published specific recommendations that include adopting migrant-sensitive, non-discriminatory and inclusive health policies, laws and interventions; addressing the social determinants of migrant health through the implementation of a "Health in All Policies"; and providing universal health coverage to all, irrespective of residence status.²⁸

Migration and health: the European Commission's role

Health is primarily under the responsibility of DG SANTE, but because health affects (and is affected by) multiple factors, it should not be siloed within the Commission and instead be addressed in a coordinated manner that reflects its cross-cutting nature.

In the area of health, the Commission is constrained by the principle of subsidiarity: competence on health services is reserved to the member states, except in relation to certain issues designated matters of 'public health', or when principles such as non-discrimination are at stake. The Commission has used 'hard' measures to mandate standards of health care entitlement for regular EU migrants (Directive on Cross-border Healthcare), refugees (Qualification Directive) and asylum seekers (Reception Conditions Directive), but entitlements for third country nationals, documented or undocumented, are not regulated (except for those in detention) and the Commission is generally

²⁴ WHO/EURO12-15 September 2016, Strategy and action plan for refugee and migrant health in the WHO European Region.

²⁵ New York Declaration, available at <http://refugeesmigrants.un.org/declaration>.

²⁶ In February 2017, IOM and WHO Secretariat co-organised the 2nd Global Consultation on Migrant health (following the first, organised by Spain in 2010; see FN no. 2, above), which gave rise to the "Colombo Statement" expressing governments' support for promoting the health of migrants at a multi-sector level, and recommendations to advance migration health as a key global health agenda. "Colombo Statement", issued 23 February 2017 following the High-level meeting of the Global Consultation on Migrant Health, Colombo, Sri Lanka.

²⁷ In December 2016, the WHO Secretariat (Geneva) published a report on promoting the health of migrants, outlining current global health context and challenges confronted by migrants in accessing health. In January, WHO's executive board directed WHO to prepare, in consultation and cooperation with member states, IOM, UNHCR and other relevant stakeholders, a draft framework of priorities and guiding principles to promote the health of refugees and migrants; and to make every possible effort, based on the guiding principles, to ensure that health is duly addressed in the development of the global compacts. The framework was produced ahead of the World Health Assembly in May 2017, and now work is underway to create a global plan of action for 2019.

²⁸ WHO (September 2017), "Proposed Health Component: Global Compact for Safe, Orderly and Regular Migration."

limited in its ability to use coercive methods to influence member states. However, EU anti-discrimination legislation, in particular that which concerns ‘indirect’ discrimination, may offer more possibilities than have so far been exploited.²⁹ The UK’s Equality Act mirrors the EC’s ‘Race Equality Directive’ and mandates attention to many kinds of inequities in health care.

The added value of the Commission’s ‘soft measures’ is that they can overcome fragmentation, both at the global level where there is a growing knowledge base about health systems, and among member states by supporting them to join forces to solve problems, synthesise knowledge, share expertise and create synergies. The Commission’s initiatives in the field of Roma Health provide a model that can be followed in relation to migrants and other ethnic minorities.

The Commission does however have competence in relation to certain public health issues. In this context, the “health in all policies” principle is gaining ground, such that the health consequences of policies on (e.g.) air pollution or production and advertising of food, drink and tobacco are increasingly a focus of policy-making by the European Commission. Like the anti-discrimination principle, applying the “health in all policies” approach to the social determinants of migrant health is arguably a part of the EU acquis.

The EU’s approach to health care should not therefore be limited to compensating for the deficiencies of national health systems. It is important that the Commission put more emphasis on influencing the policies of member states, through dialogue and other ‘soft’ measures. The EU also has an obligation to ensure that its own policies are compatible with its obligations under Article 168.

In 2009, a Commission-funded analysis by IOM on the social determinants of health and health inequalities of migrants was published, which recommending a “multi-sectoral approach to managing migration” that addresses priorities including public sector reform; and that policymakers “of all related fields and levels throughout the EU... foster collective will and leadership in a way that health is regarded as a shared responsibility.”³⁰ In the subsequent eight years, the EU has done little to follow up on these recommendations. Strikingly, the EU’s adoption of a Pillar of Social Rights – the landmark and ambitious effort to set forth key principles and rights to promote fair and well-functioning labour markets and welfare systems – fails to address the ways in which human migration and mobility affect people’s access to social rights in Europe, and explicitly excludes migrants in an irregular situation.

The EU Agency for Fundamental Rights (FRA) has conducted numerous analyses of the situation of migrants in an irregular situation, including a 2015 study³¹ showing the damaging financial impact on health systems of excluding people from accessing non-emergency care, based on residence status. Their results, which looked at the examples of hypertension and prenatal care in Germany, Greece and Sweden, are consistent with peer-reviewed research published the same year concluding that the cost

²⁹ McHale, J (2010) Fundamental rights and health care. In E. Mossialos, G. Permanand, R. Baeten, T.K. Hervey (eds.) *Health Systems Governance in Europe: The Role of European Union Law and Policy*. pp. 282-314. Cambridge: Cambridge University Press. <http://dx.doi.org/10.1017/CBO9780511750496.007>

³⁰ Roumyana report: <http://www.migrant-health-europe.org/files/AMAC%20Public%20Report.pdf> (webpage: <http://www.migrant-health-europe.org/index.php/home.html>)

³¹ FRA (2015), Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation.

of restricting access to healthcare for asylum seekers and refugees in Germany is higher than granting them regular access to services.³²

Current Challenges

a) Social rights, including right to health, often defined by (type of) residence status

At the national level, social rights are largely dependent on the right to reside, and the individual conditions attached to one's permit. Migration or residence status is consistently cited as one of the most significant factors determining access to affordable and adequate health services for migrants in a country³³ in a clear example of how migration and health intersect to influence the underlying conditions of health.³⁴ The linking of social rights to residence status means that people with precarious status tend to live in precarious living conditions, which has significant consequences for the health of individuals, and the wellbeing of their families and communities. There is growing evidence that precarious residence status is itself a risk factor for poor mental health, and that more secure status can have a positive impact on mental health and wellbeing.³⁵

Refugees have the right to access health services equivalent to nationals.³⁶ EU law guarantees asylum seekers the right to adequate living conditions, with member states required to ensure they receive at least emergency care and essential treatment of illnesses and serious mental disorders.³⁷ Both asylum seekers and beneficiaries of international protection who have special needs, such as victims of torture, sexual and gender-based violence and other forms of ill treatment, benefit from additional rights and safeguards under international and EU law guaranteeing access to secondary and tertiary healthcare. However, member states do not offer the specialised services required to effectively address their health needs and many of those that do, only grant access once refugee status has been awarded. Asylum seekers also have limited social rights and are excluded from most benefits and services available to nationals and often having to reside in designated places, such as temporary shelters.

People living in the EU irregularly have extremely limited rights to social protection and health care in most EU countries. Member states have tried to deter certain forms of migration by limiting access to basic services.³⁸ In five EU member states, someone who is undocumented is only entitled to

³² Kayvan Bozorgmehr, Oliver Razum, "Effect of Restricting Access to Health Care on Health Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994-2013.," 22 July 2015.

³³ A. Hannigan et al., "[How do variations in the definitions of 'migrant' and their application influence the access of migrants to health care services? \(2016\)](#)", 2016.

³⁴ M. Tobias, "[Social rank: a risk factor whose time has come?](#)", The Lancet, 31 January 2017.

³⁵ R. G. Gonzales, et al., "[Analysis: DACA boosts Young immigrants' well-being, mental Health](#)", NBC, 15 June 2017.

³⁶ 1951 Refugee Convention.

³⁷ Article 19 of the Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection ("Reception Conditions Directive"); Article 30 of Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted ("Qualification Directive").

³⁸ IOM (2016), [Recommendations on Access to Health Services for Migrants in an Irregular Situation: An Expert Consensus](#).

emergency care, and of the ten member states that provide some degree of primary or secondary care to people without proper status, in only eight does this include access free of charge.³⁹ Just eight member states guarantee children the right to full care, regardless of status.⁴⁰ Even in those countries where there is some entitlement to health care, the real or perceived absence of a firewall between the provision of health services and the enforcement of immigration law significantly undermines patients' trust in the health systems, deters and significantly delays health-seeking behaviour.⁴¹ The absence of firewalls is also significant for LGBTI migrants, who fear being outed, and for others facing discrimination or criminalisation, such as people who use drugs or sex workers.

EU nationals residing in another member state can face similar hardships. Under Union law,⁴² EU citizens must be treated equally with nationals after three months of residence. But their right to reside in another EU country is tied to their level of economic self-sufficiency, so that economically inactive or destitute EU citizens may lose their right to reside after three months, and thus their right to social benefits, including health care coverage. Their eligibility for benefits must be demonstrated based on a high degree of social integration, determined on a case-by-case basis, and benefits may be limited in scope or duration (e.g., jobseeker's allowance received in another EU member state is limited to three-month maximum).^{43 44}

The inability of migrants to access mental health services, which are often viewed as a luxury, presents a particular worry, as does the tendency to medicalise the mental health problems of refugees and migrants instead of addressing their causes, which are often due to environmental or social factors such as trauma, lack of a support network, poverty and exclusion.⁴⁵

b) *The right to work and to safe working conditions, and to housing limited for many migrants*

Migration status also influences access to labour markets, because of, among others, limitations attached to different types of permits (e.g., asylum seekers are not allowed to work during the first six months of their asylum procedure), the absence of a proper permit, and lack of recognition of one's qualifications. Migrants are overrepresented in informal sectors of the economy, increasing their risk of working under hazardous or unsafe conditions, often with no ability to report violations without risking deportation.⁴⁶ Migrant domestic workers, for instance, often experience high levels of social

³⁹ See, e.g., PICUM (2016), [The Sexual and Reproductive Health Rights of Undocumented Migrants: Narrowing the Gap Between their Rights and the Reality in the EU](#), at pp.21-22.

⁴⁰ PICUM Children's report.

⁴¹ See Maternity Action, March 2017, [The Impact on Health Inequalities of Charging Migrant Women for NHS Maternity Care: A Scoping Study](#).

⁴² Directive 2004/38/CE.

⁴³ Eva-Maria Poptcheva, 10 June 2014, "[Freedom of movement and residence of EU citizens: Access to social benefits.](#)"

⁴⁴ Health care schemes set up for undocumented migrants in some member states are not applicable to EU citizens without authorisation to reside, with the exception of Belgium and France. Médecins du Monde, [Legal Report on Access to Healthcare in 17 Countries](#) (November 2016).

⁴⁵ Mental Health Europe, 16 October 2016, "The need for mental health and psychosocial support for migrants and refugees in Europe."

⁴⁶ FRA (2011), Situation of migrants in irregular situation. The ILO's governing body has identified eight ILO Conventions as fundamental to the rights of people at work and hence applicable to all workers.¹⁸⁸ Similarly, the social policy measures to combat exclusion and to protect the rights of workers envisaged in Article 151 and 152 TFEU are not expressly restricted to nationals or lawfully staying third-country nationals.

exclusion, confinement and isolation, as well as low pay, long working hours, physically strenuous and hazardous work, and the risk of sexual abuse and violence – combined with lack of health care and social protection, due to the informal and atypical nature of their employment.^{47 48}

At the same time, “occupational deprivation” - defined as restrictions on education, work, leisure and self-care - which may be associated with insecure residence status, is known to have harmful effects on mental and physical health. Conversely, having a meaningful occupation facilitates integration and social inclusion.

Migration status can also constrain options for obtaining accommodation and material assistance, because of discrimination, legal or practical barriers. The EU’s efforts to penalise facilitation of irregular stay through the Facilitation Directive has restricted migrants’ ability to rent housing on the private market, which can “force them into accepting precarious and insecure accommodation, sometimes at exploitative conditions.”⁴⁹ A patient who is discharged from hospital has a high probability of returning if they do not have adequate housing. On the other hand, there is evidence that a “housing first” approach provides savings of 50% in hospitalisations and emergency care.⁵⁰

c) Multiple practical barriers and poorly adapted health services

There is limited evidence in Europe on the health status of migrants.⁵¹ What evidence exists indicates disproportionately poor health outcomes, which are in part a product of their limited social rights, including a limited entitlement to health in most member states.

It is estimated that up to 40% of refugees and asylum seekers are survivors of torture, sexual and gender-based violence or other forms of ill-treatment⁵², occurring in the country of origin, in transit or at the borders or even in the country of destination in the EU. Torture and ill-treatment have devastating consequences for victims, their families and the broader community. Their severe physical and psychological effects include chronic physical pain years after their abuse as well as psychological symptoms such as anxiety, depression, withdrawal and self-isolation. They disrupt the lives of victims and often prevent them from continuing their life plan in the country of destination, hindering inclusion. In addition to the immediate consequences on their quality of life, survivors’ mental health situation often causes negative consequences for the enjoyment of other rights including the right to an effective remedy in asylum proceedings and access to adequate social support.

Even among migrants with more than minimum entitlements to health, such as asylum seekers, there is evidence of significant unmet need, with most studies focusing on maternity and mental health

The 1989 Directive on Safety and Health at Work defines ‘worker’ as ‘any person employed by an employer’ without restricting it to regular workers.¹⁸⁹ An employment relationship where core labour law rights are disregarded becomes exploitative.

⁴⁷ http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/briefingnote/wcms_467720.pdf

⁴⁸ J. Simon, et al., “[Public health aspects of migrant health: a review of the evidence on health status for labour migrants in the European Region \(2015\)](#).”

⁴⁹ FRA (2011), Migration in irregular situation, p.69.

⁵⁰ ME Larimer et al, JAMA (2009) <http://jamanetwork.com/journals/jama/fullarticle/183666>

⁵¹ Reference HEN reports.

⁵² https://www.cvt.org/sites/default/files/SurvivorNumberMetaAnalysis_Sept2015_0.pdf and http://www.rkh.se/PageFiles/5889/ENG_Summary_Newly%20resettled-refugees-and-asylum-seekers-in-Sweden.pdf

outcomes. Practices like the dispersal of pregnant asylum seeking women have reportedly contributed to health-related vulnerabilities.⁵³ The practice in some member states of imposing charging on non-nationals significantly affects health-seeking behaviour: people avoid approaching the health system until their situation reaches a point of crisis, increasing the likelihood of poor outcomes.⁵⁴ In some cases, debts by non-nationals incurred to the health system are communicated to migration authorities, with implications for immigration status and enforcement.

A host of practical barriers also limit the ability of migrants from obtaining appropriate and timely care. The services they need may not be available in the city, region or country where they reside voluntarily, or are forced to stay (such as in a hotspot or detention centre or city to which an asylum seeker has been designated to live for the duration of the application process); services may also be overwhelmed, especially in the case of safety net services or may be practically inaccessible because they are too distant and transportation costs are too high, or because they are only provided during working hours.

A significant constraint for many migrants and ethnic minorities is the lack of interpretation and cultural mediation services, difficulty navigating often complex national health systems, and insufficient cultural competency on the part of health professionals. Where interpretation is available, it may not be effective or appropriate. For instance, anti-LGBTI interpreters may refuse to properly interpret all or part of LGBTI migrants' statements; and interpreters favourable to FGM as a traditional practice may deliberately not translate the claims of an FGM survivor seeking help. An interpreter holding stigmatising views about mental ill-health may inadequately comment on the credibility of the person.

Migrants may experience difficulties in communicating their health concerns or may be wrongly understood by health professionals, who in turn are unable to provide care in these circumstances. This is especially important for mental health, as culture affects conceptions of mental health, expressions of emotions and the manifestation of symptoms.

Even when they are available and accessible, services may not be adapted to the needs of migrants. For instance, most EU member states do not have a procedure for the early, systematic identification of the special needs of asylum seekers and beneficiaries of international protection, as required by EU law. Most screening procedures focus on communicable diseases, but fail to take into consideration broader health needs. This results in delays in accessing adapted, specialised services, such as rehabilitation for victims of torture and ill treatment, support services for survivors of gender-based violence, access to hormone replacement therapy for trans migrants, or appropriate care and counselling for women and girls with female genital mutilation.

The Health Program has funded several projects for the training of health professionals to improve their familiarity with the health needs migrants, and their degree of cultural competence. This training must become standardised, as should training about medical ethics and health professionals' obligations to provide non-discriminatory care for all patients, regardless of status or ethnic background, and to ensure that a patient's privacy and confidentiality (and doctor-patient trust) are not compromised by the sharing of personal data with third parties, including immigration authorities.

⁵³http://picum.org/picum.org/uploads/publication/Sexual%20and%20Reproductive%20Health%20Rights_EN_FINAL.pdf – see p. 7.

⁵⁴ Maternity Action, March 2017, [The Impact on Health Inequalities of Charging Migrant Women for NHS Maternity Care: A Scoping Study](#).

d) Stigmatisation and Discrimination

Migrants and ethnic minorities experience stigmatisation and discrimination on multiple levels, with consequences for their physical and mental health.⁵⁵ Most insidious is the discrimination embedded in the dehumanising language used to describe migrants, as “illegals”, as “swarms” or “carriers of parasites and protozoa” – language that falsely represents them as threats to health, the social welfare system, and the social fabric, and that perpetuate stereotypes and myths.

Migrants also experience discrimination as the targets of violence based on ethnic and racial bias. Racist attacks against migrants and their accommodation have been reported across the EU, with 3,729 such attacks against refugees and asylum seekers in Germany in 2016 – more than 10 hate crimes every 24 hours – and 75 racist attacks on migrants in Greece in 2015, up 60 percent over the year before.⁵⁶ Despite their rights under the EU Victims’ Directive, people with precarious status have difficulty safely reporting these acts, or other forms of abuse, violence and exploitation, perpetuating a climate of impunity.⁵⁷ NGOs have also reported immigration detection and enforcement practices – such as identity checks, workplace inspections, large-scale raids, searches of accommodation, and the policing of sites where migrants are likely to be present, including schools, medical facilities, counselling centres and churches – that target migrants based on racial or ethnic profiling. These practices, which have been described as “frightening, humiliating or even traumatic,” undermine trust in the authorities, and inform migrants’ reluctance to go to the police when they are victimised.⁵⁸ Individuals with spouse-dependent visas or irregular status are also more exposed to sexual violence and other forms of victimisation because of their inability to safely report crimes.⁵⁹

Barriers are compounded for migrants who belong to groups that are criminalised or highly stigmatised. For instance, the criminalisation of sex work and related activities, of sexual orientation and identity, and of the use of drugs, undermines access to health care, fosters distrust of public authorities, including the police, and increases the risk of isolation and vulnerability to violence.⁶⁰

Stigmatisation related to HIV status also compromises efforts to diagnose and adequately treat and support migrants at risk of infection. The European Centre for Disease Control (ECDC) gathers data on the HIV infection among migrants, and has reported that HIV disproportionately affects migrants, but that there is “growing evidence that sub-groups are at risk of acquiring HIV after arrival in the EU/EEA.”⁶¹ This presents a critical opportunity for prevention; however, nearly half of EU/EEA countries report major gaps in testing services for undocumented migrants, with several reporting

⁵⁵ Y. Paradies et al, “Racism as a determinant of health: a systematic review and meta-analysis” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4580597/>

⁵⁶ ENAR 2017 Shadow Report: <http://www.enar-eu.org/Racism-plays-a-key-role-in-migrants-exclusion-and-violations-of-rights-in-the>

⁵⁷ PICUM (2015), [Guide to the EU Victims’ Directive: Advancing access to Protection, Services and Justice for Undocumented Migrants.](#)

⁵⁸ Victims Report http://picum.org/picum.org/uploads/publication/VictimsDirective_EN.pdf at p. 21

⁵⁹ I. Keynaert, et al., “[What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants? A review of existing evidence in the WHO European Region \(2016\).](#)”

⁶⁰ TAMPEP (2009), [Sex Work Migration Health: A Report on the Intersections of Legislations and Policies regarding Sex Work, Migration and Health in Europe.](#)

⁶¹ ECDC (2016), Country level implementation of the Dublin Declaration on HIV/AIDS in the EU and EECA, <http://ecdc.europa.eu/en/healthtopics/aids/Documents/hiv%20dublin%20declaration%20special%20report%20Europe%202016.pdf>

“major gaps in testing services for migrants from high-prevalence countries, [men who have sex with men] and sex workers.”

The stigma associated with mental health conditions and treatments in certain cultural contexts, and more broadly in Europe, can prevent migrants from accessing specialised services. This results in low levels of utilisation of healthcare services and poorer health outcomes.

The EU Fundamental Rights Agency has noted that multiple forms of discrimination, including migration status, religion, social and economic standing, sexual orientation, disability and having a chronic condition, can intersect in ways that make people more likely to receive unequal treatment, and has recognised the critical role of health professional in guaranteeing access to services on a non-discriminatory basis.⁶²

Health Impact of Asylum and Migration Policies

Detention is one of the pillars of the EU’s new migration policy, announced in March 2015. The European Commission has explicitly encouraged member states to scale up use of detention as a strategy for achieving more “effective returns”. The EU has also urged member states to curb procedural safeguards for asylum seekers by limiting their ability to appeal, and to more vigorously track and round up people present in the EU irregularly. Human- and health-related concerns are confined to the EU’s efforts to “save lives”, which is mostly oriented towards rescues at sea, targeting smuggling operations, and other forms of “border management”.

a) Immigration detention

The EU does not collect data on the number of people in immigration detention, but a 2014 study estimated that over 90,000 people were detained in 22 EU countries and Norway at that time.⁶³ Detention is both a well-known cause of diminished physical and mental health,⁶⁴ and a place where access to adequate health care is generally limited.⁶⁵ The result is a double blow to the health of people in detention, particularly those with special needs, such as pregnant women, children,⁶⁶ victims of torture and ill-treatment, with potential lifelong consequences. A 2011 study of people with HIV in immigration detention found repeated interruptions and disruptions of antiretroviral (ARV) therapy,

⁶² FRA multiple discriminations in health care (2012) <http://fra.europa.eu/en/publication/2012/inequalities-and-multiple-discrimination-healthcare>

⁶³ EMN (2014), [The use of detention and alternatives to detention in the context of immigration policies: Synthesis report for the EMN focussed study 2014.](#)

⁶⁴ T. Filges et al., “The Impact of Detention on the Health of Asylum Seekers: A Systematic Review,” September 2015, Campbell Collaboration, <http://www.campbellcollaboration.org/lib/project/253/>.

⁶⁵ S. E. Zimmerman, D. Chatty and M. L. Norredam, “Health Needs and Access to Care in Immigration Detention: Perceptions of Former Detainees,” *International Journal of Migration Health and Social Care*, 8(4) 2012 180-185. See also PICUM Bulletin (September 2015), “Migrant Women File Complaint over Lack of Medical Care in Family Detention Centres,” http://picum.org/en/news/bulletins/48295/#cat_25446.

⁶⁶ S. Mares, J. Jureidini, “[Psychiatric assessment of children and families in immigration detention – clinical, administrative and ethical issues](#),” *Australian and New Zealand Journal of Public Health*, Dec 2004; K. Brabeck, Q. Xu, “[The impact of detention and deportation on Latino immigration children and families: A quantitative exploration](#),” *Hispanic Journal of Behavioral Sciences*, July 2010.

the occurrence of demeaning and degrading practices that worsened individuals' condition, and the deportation of people with HIV with less than a three-month supply of ARVs.⁶⁷

Detention also has harmful effects for LGBTI people: they are often overlooked and wary of identifying themselves as such, particularly if they come from a country where being LGBTI is taboo or illegal. Detaining LGBTI migrants alongside people who discriminate against them increases the likelihood of detrimental effects on their mental and physical health.

Research has shown that putting children in immigration detention has severe and lifelong effects on their mental and physical health, and development.⁶⁸ In 2009, the UK's Royal College of Paediatrics and Child Health, Royal College of General Practitioners, Royal College of Psychiatrists and Faculty of Public Health published a brief on the significant harm caused by detention on the health of children, young people and their families, taking the position that "such detention is unacceptable and should cease without delay."⁶⁹ The report cites evidence that children's physical and mental health rarely informs decision to maintain them in detention,⁷⁰ and that many children experience the actual process of being detained as a newly traumatising experience.

Health professionals are often called upon to assist in immigration procedures, for instance to determine whether a person is "fit to fly," or to conduct age assessments. These non-therapeutic interventions may create ethical conflicts, particularly where people do not have confidence in the independence of health professionals' assessments, which can also serve to more broadly undermine trust in health providers, to the detriment of the quality and adequacy of care.

The Committee on the Rights of Persons with Disabilities has noted the EU's failure to take a human rights-based approach in its migration policies, recommending that the EU "mainstream disability in its migration and refugee policies" and to "issue[] guidelines to its agencies and member States that restrictive detention of persons with disabilities in the context of migration and asylum seeking is not in line with the Convention," to which the EU is a party.

b) Poor living conditions and prolonged uncertainty exacerbated due to migration management policies

The EU has also deepened the external dimensions of its migration agenda, entering into numerous informal agreements with third countries to facilitate return and readmission, in some cases explicitly using foreign aid as leverage. Civil society organisations have repeatedly condemned this strategy, which excludes the European Parliament, making it harder to hold the EU accountable for the agreements' content and the consequences,⁷¹ and has included deals with countries with poor human rights records.

NGOs have also reported extensively on the human impact of one such deal, concluded with Turkey on 18 March 2016. Since the implementation of the so-called EU-Turkey statement and the closing of

⁶⁷ Medical Justice (2011), *Detained and denied: The clinic care of immigration detainees living with HIV*.

⁶⁸ Lorek et al, "The mental and physical health difficulties of children held within a British immigration detention centre: a pilot study," *Child Abuse and Neglect*, 33: 573-585 (2009).

⁶⁹ Intercollege briefing paper, [Significant harm – the effects of administrative detention on the health of children, young people and their families](#), 2009.

⁷⁰ [The arrest and detention of children subject to immigration control: a report following the Children's Commissioner to England's visit to Yar's Wood Immigration Removal Centre](#) (2009).

⁷¹ [ECJ ruling]

the Balkan routes, NGOs confirm that the “movement of people has never stopped, but their routes are fragmented and their journeys have become increasingly dangerous.” The number of migrants stranded in Greece increased significantly,⁷² as a result of a policy adopted by the Greek government of containing migrants on islands in hot spots and other reception facilities, to facilitate rapid processing and return to Turkey, which has been designated a “safe first country” by the EU. Expediting processing is not, however, always compatible with adequate individual assessments, particularly for migrants who do not understand the process, who frequently are not assisted or accompanied by a lawyer, and who may have difficulty speaking about extremely difficult events. For LGBTI people, for instance, an expedited procedure, with reduced resources for asylum seekers, any reluctance they have to come out and to seek support and protection will be amplified, increasing the likelihood of violence – as well as deportation to places like Turkey, which is not a safe country for LGBTI people.

The reception capacity on the islands has not been increased accordingly, leading to poorer living conditions impacting the physical and mental health of migrants. Civil society organisations have described extremely poor living conditions and overcrowding in the Greek islands. In December 2016, the EU recommended that Greece end exemptions for the vulnerable groups (including pregnant women, unaccompanied children, single parents with children, victims of torture and people with disabilities) that allow them to be transferred to the mainland; the expansion of detention on the islands; and the curbing appeal rights for asylum seekers. The poor conditions on the islands, and prolonged uncertainty about the length and reasons for their detention, as well as the possibility of deportation to Turkey or another country, have caused feelings of despair and depression, with reported incidents of self-harm, and suicide attempts, particularly since January 2017.⁷³ Mental health experts have coined the term *Ulysses Syndrome*⁷⁴ to describe the cluster of psychological and somatic symptoms experienced by migrants under chronic and severe stress – depression, sadness, crying spells, difficulty concentrating, anxiety, headaches, body aches, fatigue, irritability – without access to treatment, support systems, or coping strategies.⁷⁵

Registration and examination of asylum claims on the Greek islands are prioritised based on nationality, with people of certain nationalities considered presumptively “economic migrants” and treated as having manifestly unfounded claims. A representative from MSF has noted: “Such discriminatory procedure is not comprehensible. The person rightly believes that their case should be assessed on the basis of their individual claim, not their nationality, but that is not happening on the islands. The system completely destroys the dignity of people.”

c) Hostile environment for migrants

Harder to document is the impact that the EU’s strategic approach to migration has had in fostering a hostile environment for all migrants, and the consequences for migrants’ health and safety.

The EU’s heavily deterrence-oriented agenda has arguably bolstered efforts by member states to actively discourage migrants from seeking asylum or family reunification within their borders, and

⁷² IOM Monthly flows compilation June 2017, http://migration.iom.int/docs/Monthly_Flows_Compilation_Report_June_2017.pdf.

⁷³ MSF 2017 report on mental health.

⁷⁴ The term was coined by Prof. Dr. Joseba Achotegui, University of Barcelona.

⁷⁵ Luz M. Garcini, Mental health of undocumented Mexican immigrants living in high-risk neighborhoods near the California-Mexico border <http://escholarship.org/uc/item/4rx729wt#page-1>

emboldened some member states to enact laws and institute practices favouring detention as a first option, including for people awaiting asylum decisions, despite this being in violation of safeguards under EU law. Countries such as Sweden have seen social services being asked to turn over the names of people they serve who are in the country irregularly to immigration authorities.

This aim of creating a hostile environment for migrants finds an echo in strategies adopted by some member states as a mechanism for internal migration control, where the goal is to make people's lives so intolerable – by constricting their ability to find work, obtain decent housing, get health care, go to school – that they either do not wish to come in the first place, or are motivated to leave. As NGOs have observed, this approach has the effect of promoting intolerance, racial and ethnic profiling, and pushing people into deeper social isolation and precarity.