



THE SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF UNDOCUMENTED MIGRANTS

NARROWING THE GAP BETWEEN
THEIR RIGHTS AND THE REALITY IN
THE EU

FEBRUARY 2016

 **PICUM**

PLATFORM FOR INTERNATIONAL COOPERATION ON
UNDOCUMENTED MIGRANTS

The Platform for International Cooperation on Undocumented Migrants (PICUM) is an international non-governmental organisation that represents a network of 140 organisations working with undocumented migrants in 33 countries, primarily in Europe as well as in other world regions. With nearly 15 years of evidence, experience and expertise on undocumented migrants, PICUM promotes recognition and realisation of their human rights, providing an essential link between local realities and the debates at policy level. PICUM provides regular recommendations and expertise to policy makers and institutions of the United Nations, the Council of Europe and European Union, and has been awarded participatory/consultative status with both the United Nations and Council of Europe.

By Alyna C. Smith, Advocacy Officer and Michele LeVoy, Director

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SIGRID RAUSING TRUST

PICUM
Platform for International Cooperation on Undocumented Migrants
Rue du Congres / Congresstraat 37-41, post box 5
1000 Brussels
Belgium
Tel: +32/2/210 17 80
Fax: +32/2/210 17 89
info@picum.org
www.picum.org

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EXECUTIVE SUMMARY

Sexual and reproductive health is an essential component of human development and wellbeing through all phases of life. The right to sexual and reproductive health, as part of the right to health as well as the rights to privacy and security of the person, is well established in international human rights instruments that bind all EU member states.

Within the EU, significant disparities exist in relation to undocumented migrants that are at odds with governments' stated commitments to sexual and reproductive health rights (SRHR). Undocumented migrants face a number of challenges undermining their SRHR, including disproportionately high maternal and infant mortality; limited access to contraception and pregnancy termination; and heightened levels of discrimination and gender-based violence (particularly among women and LGBTI migrants, and migrant sex workers), including at the border, in transit and in detention.

For undocumented migrants, access to basic health care, including sexual and reproductive health services, is the exception rather than the rule in the majority of EU member states. Limited entitlements exist for pregnant women who, in 21 member states, can access some form of maternity care, from delivery-only to a full complement of reproductive services; and for HIV, for which free screening is available in 15 (and treatment available in 10) EU member states. But in the majority of EU member states, entitlements carved out for these particular groups are disconnected from the primary care system: only 10 member states provide some access to primary care, which is a vital portal into the public health system that ensures continuity and coordination of care, and is instrumental in supporting prevention efforts through the provision of information, and in the case of pregnancy, of contraception and family planning counselling. Undocumented migrants in the EU face several significant obstacles to achieving sexual and reproductive health:

- › National laws that severely curtail their right to access health services, beyond emergency care.
- › Burdensome, inconsistently applied administrative procedures that make it difficult to access those services to which they are entitled.
- › Cost barriers that render existing entitlements meaningless.
- › Health care provision that is linked to the enforcement of immigration rules.
- › Cultural and linguistic barriers in national systems not adapted to the needs of a diverse population.

To address these barriers, PICUM recommends that **policymakers** reform legislation and policies that deny or limit access to sexual and reproductive health services on the basis of residence status, implement a firewall between the provision of basic services from immigration control, and take measures to ensure undocumented migrants' access to support and services when they have experienced sexual or gender-based violence.

For their part, **service providers** should implement training for health care professionals and administrators to foster culturally-sensitive approaches to care, be proactive in working with migrant communities to improve their uptake of services available through the public system, and partner with civil society to improve access to health care for undocumented migrants regionally and locally, by providing services directly and advocating for systematic, sustainable reform of restrictive law.

Finally, the **European Union** can promote evidence-based policy dialogue and exchange of good practices, ensure the coherence of sexual and reproductive health objectives across all EU policies relevant to undocumented migrants, and provide financial support to civil society organizations and member states for the provision of expanded services, as well as to researchers contributing data and analysis addressing the current lacunae regarding the specific legal entitlements to sexual and reproductive health services across member states, and the impact of restricted access on individuals, communities and health systems.

1. THE ISSUE

A woman well advanced in her pregnancy was told by her healthcare provider that her baby was poorly positioned in her uterus and that she would need to have a caesarean section to avoid complications. When she went to the hospital to make arrangements for the procedure, she was informed that no caesarean section could be scheduled because, as an undocumented woman, she was only entitled to emergency care. She would have to wait until she was in active labour, and a caesarean section became a necessary emergency treatment to avoid significant harm to her and her baby. When she became upset at being turned away, a security guard physically removed her from the hospital.¹

1.1 Sexual and Reproductive Health Rights (SRHR)

Sexual and reproductive health is an essential component of human development and wellbeing through all phases of life,² and is inextricably linked to notions of human dignity and autonomy.

Sexual and reproductive health refers not only to the absence of disease: it encompasses physical, mental and social wellbeing linked to sexuality and reproduction. Sexual and reproductive health presupposes reproductive freedom, including access to information and health services relating to family planning, pregnancy and fertility; sexual experiences free of coercion, discrimination, and violence; and the prevention and management of disease or infection.³ The right to sexual and reproductive health is a right that applies to children and adults alike, whatever their gender identity, gender expression or sexual orientation.⁴

But, despite widespread international consensus on the importance of sexual and reproductive health for individuals, couples, families, and communities, and the binding force of international human rights instruments guaranteeing the right to sexual and reproductive health, in Europe significant gaps in access remain.⁵ This is particularly true for migrants with irregular status who, in the majority of EU member states, have limited access to services of any kind beyond emergency care through the public health system, including those related to their sexual and reproductive health rights (SRHR).

This policy brief is intended to bring visibility to the disparity between EU member states' obligations and avowed commitments with respect to SRHR in the international arena, and the restrictive policies they pursue at the national level with respect to undocumented migrants. It also aims to show the impact of these policies on the lives of individuals excluded from services because of their residence status, and to set out concrete recommendations for improving access to SRHR for this population.

1.2 SRHR and Undocumented Migrants in the EU

Undocumented or irregular migrants⁶ are those who, for a variety of reasons, do not have a valid permit to remain in the country in which they live. The majority of undocumented migrants enter the EU through regular channels – that is, with a valid permit to study or work, to seek family reunification or asylum – and later lose that status, often because of job loss, administrative delays in processing their immigration application, expired documents, having been born “undocumented” to undocumented parents, or having left an exploitative employer or abusive partner on whose status they depended.⁷

The following illustrate some of the primary challenges experienced by undocumented migrants in the context of SRHR.

Maternal Health

Reducing maternal and infant mortality is high on the global agenda⁸ and a key priority for the EU from a development standpoint.⁹ In its report on the EU's contribution to the UN Millennium Development Goals, the European Commission notes: "The EU supports governments in more than 30 countries to develop and implement national health policies and strategies, and strengthen health systems to improve access and uptake of lifesaving maternal health services and reach universal access to quality and affordable reproductive and sexual health services and information."¹⁰

Meanwhile, significant inequities persist in maternal health in Europe. Research has shown that difficult pregnancies and poor pregnancy outcomes are disproportionately experienced by migrants throughout Europe, including low birth weight, and infant and maternal mortality,¹¹ and that migrants are more likely to deliver their babies without professional assistance.¹² Of 310 pregnant women in situations of vulnerability from whom data was collected by Doctors of the World/Médecins du Monde in Europe in 2014, 54.2% had no access to antenatal care.¹³ At the country level, a 2015 report found that the rate of maternal death was significantly higher for foreign-born mothers – for instance, nearly three times higher for Somali-born women, and more than ten times higher for migrants born in the Congo – compared to UK-born residents.¹⁴ According to a report on infant mortality in the UK, babies of certain ethnic minorities "are known to be at significantly increased risk of stillbirth and neonatal mortality."¹⁵ In Birmingham, where a sizable proportion of the population is foreign-born and the infant mortality is one of the highest in England,¹⁶ the Birmingham Primary Care Trust has worked with charitable organisations to provide temporary accommodation for women with no recourse to public funds, including undocumented women, as well as advice and access to health care.¹⁷

Pregnancy at the Border, in Transit and in Detention

Pregnant women and adolescents arriving at the EU's borders are acutely affected by inadequate access to medical care,¹⁸ as are children (including newborns and infants) who in December 2015 were estimated to account for one in five maritime arrivals to Europe that year.¹⁹ They are also at heightened risk of sexual violence, as recognised by a written declaration by members of the Parliamentary Assembly of the Council of Europe in October 2015. Noting that the "lack of access by women, especially pregnant women, to reproductive health services represents a major health disaster," the declaration calls on Council of Europe member states to allocate resources to this issue, and to provide better hygiene, medical assistance and protection for these populations.²⁰

In the context of detention, the United Nations High Commissioner for Refugees (UNHCR) has stated that "[a]s a general rule, pregnant women and nursing mothers, who both have special needs, should not be detained."²¹ Detention is both a cause of diminished physical and mental health,²² and a place where access to adequate health care is generally limited.²³ The result is a double blow to the health of pregnant women.

In October 2015, the UK Home Office offered a formal apology and announced it would pay compensation to a pregnant asylum-seeker who was arrested when she was five months pregnant and detained at Yarl's Wood immigration removal centre.²⁴ The woman had been detained without notice, held for ten hours in police custody, and then transported eight hours to the detention facility, where she was only seen once by a midwife during her month-long detention.²⁵ The Home Office also announced it would be reviewing its policy on the detention of pregnant women, which currently permits their detention in "exceptional" circumstances. Despite these guidelines, an audit by Her Majesty's Inspectorate of Prisons reported that 99 pregnant women were detained in Yarl's Wood in 2014.²⁶

GERMANY AND UNITED KINGDOM

Dispersal of Pregnant Women Seeking Asylum

In March 2015, a twenty-year-old pregnant woman from Guinea had a miscarriage after she was sent by Hamburg authorities on a twelve-hour train and bus trip to a refugee centre in another part of **Germany**. The woman, who was seeking asylum, was reportedly sent with her husband and toddler on the trip during her fifth month of pregnancy, shortly after having spent two days in hospital due to vaginal bleeding, and being advised to avoid movement because her pregnancy was high risk. The trip, which required switching trains five times, meant the family was often running to catch the next train, with the woman carrying her 15 kg son, and her husband carrying their bags. According to her husband, when they arrived at the refugee centre on a Saturday, his wife began to cry: “She told me, ‘I am bleeding again.’” No medical care was available at the centre on weekends, and the family was advised to wait until Monday, unless the situation was “a dangerous emergency.” The woman, not daring to request an ambulance, was taken to hospital on Monday, where she miscarried.²⁷

In the **United Kingdom**, a 2013 report²⁸ documents how, under the Home Office’s dispersal policy, which allows dispersal up to four weeks before a woman’s due date, women seeking asylum and whose claims have been refused but who receive statutory support are often moved to cities outside London multiple times during their pregnancies. The authors interviewed 20 women who had been dispersed and/or relocated while pregnant, 14 of whom were moved during the final trimester of their pregnancies, and eight of whom were moved during the final month of their pregnancy. Women interviewed reported feeling unwell during their pregnancy, and many had underlying conditions including HIV, diabetes, FGM, high blood pressure, severe headaches, and repeated urinary tract infections. More than half of the interviewed women had mental health conditions, such as depression, anxiety, high stress, and flashbacks, and two had attempted suicide during their pregnancy. Dispersal often meant that these women were separated from family, friends, and from care providers who had been monitoring their pregnancy.²⁹ The report notes that more than half the women, prior to being moved, stayed in what is called “initial accommodation”, where they experienced “dirty bathrooms and toilets, bad or inedible food, being forced to sterilise bottles in the toilets, safety issues, rooms on upper floors without lifts, and being assigned top bunks.”³⁰

Access to Contraception and Abortion

For undocumented women, an unplanned pregnancy can result in significant emotional and economic hardship. Overrepresented in low-wage jobs, pregnancy and the responsibilities of childcare can mean reduced hours or job loss, at a time of increased expenses.³¹ At the same time, undocumented women and girls often have more limited access to contraception, and limited mobility so travelling outside their country of residence to access services is not an option.³² Restrictive access to contraception and to termination of pregnancy therefore has a disproportionately negative impact of undocumented women and girls.

In Ireland, for instance, abortion is illegal, except when a woman’s life is at risk.³³ It is not, however, illegal to provide women with information about abortion services in other countries, although the provision

of abortion information is very strictly regulated, and women cannot be prevented from travelling abroad to get an abortion.³⁴ Indeed, an estimated 5,000 women each year travel from Ireland to a neighbouring country to terminate their pregnancy.³⁵ For women who do not have travel documents or residency permits, or whose documents or permits have expired, or who are asylum seekers, this process is even more arduous, costly and time consuming. When unable to use these channels to access abortion services, undocumented women have to resort to unsafe options of last resort, or are forced to parent against their wishes. The United Nations Human Rights Committee and Committee Against Torture have expressed concern regarding the “discriminatory impact” of Ireland’s abortion law on women who are unable to travel abroad to seek abortions and the “serious consequences” of the law on migrant women.³⁶

DENMARK

Linking Immigration Status and Pregnancy Status

The au pair scheme is framed as one of cultural exchange to permit young people to live within a local family unit, to broaden their cultural, professional and linguistic horizons. Consequently, au pairs receive a temporary residence permit and not a work permit.³⁷ Under Danish law, only unmarried, childless individuals are eligible to be au pairs.³⁸ Once in **Denmark**, the Danish Agency for International Recruitment and Integration has the authority to revoke or refuse to extend an au pair's residence permit if the grounds on which it was granted no longer apply.³⁹ Until 2014, the Agency used its authority to revoke an au pair's visa if she became pregnant.⁴⁰ This either forced pregnant au pairs to return to their country of origin, or to remain in Denmark as undocumented migrants. As undocumented migrants, they are not entitled to health care in Denmark. Migrant community organisations such as Babaylan Denmark reported that the stigma and destitution Filipino au pairs face when they return home pregnant and unmarried leaves many with little choice but to seek abortions. Indeed, the Abortion Council in Copenhagen has underlined disproportionate rates of late abortions among migrant women.⁴¹ Advocates argued that Danish policy constituted an invasion of au pairs' privacy rights, in regulating their right to get pregnant, and that deportation prevented them from establishing paternity and holding the father of their child responsible for child care⁴² as well as from seeking redress in those cases where the pregnancy may have been due to criminal or unlawful conduct.

This policy became law in May 2015, when Danish lawmakers adopted legislation,⁴³ which entered into force in July 2015, specifying that establishing a family is incompatible with the au pair scheme, and that being married or in registered partnerships, or having children is a basis for revoking an au pair's visa. Under the new law, pregnancy itself is not *per se* a basis for revocation; rather, it is *having a child*. An au pair who gives birth to a child in Denmark will be deported two months after her delivery. Withdrawal of an au pair's permit is not compulsory, but is at the discretion of the authorities, who may opt not to do so if revoking an au pair's status would create undue hardship.

Discrimination and Gender-Based Violence

Gender-based violence and discrimination is a pervasive phenomenon in the EU,⁴⁴ and globally.⁴⁵ Women and lesbian, gay, transgender, bisexual and intersex (LGTBI) migrants in an irregular situation face heightened levels of discrimination and violence,⁴⁶ which are linked to adverse health outcomes.⁴⁷

The majority of undocumented women arrive in Europe with regular, but often highly dependent, migration status and become undocumented for a variety of reasons.⁴⁸ Lack of an independent residence status increases the likelihood that they will face violence or exploitation by intimate partners or employers.⁴⁹ LGTBI migrants and

migrant sex workers often face stigmatisation – including within the health system – for practices or characteristics perceived as unacceptable.⁵⁰ The risk and the impact of gender-based discrimination and violence are magnified by one's irregular status (or the precariousness of one's status); victims and witnesses are reluctant to go to the authorities to seek help or protection for fear that they are more likely to be detained than supported.⁵¹

Addressing this discrimination is part of ensuring SRHR, as is supporting the health sector in its role in preventing gender-based violence, by helping to identify abuse early, providing victims with necessary treatment, and referring them to appropriate care.⁵²

PROMISING PRACTICE**United States Official Guidance on Additional Measures to Protect Transgender Migrants in Detention**

On 19 June 2015, the US Immigration and Customs Enforcement (ICE) issued a memorandum announcing a new policy that prioritises the safety of transgender detainees in decisions about their placement, and allowing them to be held in detention facilities that correspond to their gender identity.⁵³ No official records of the number of transgender detainees currently exist, but this will change under the new system, which will record a detainee's gender identity.⁵⁴ The guidelines require that transgender detainees be provided access to mental health care and transgender-related health care based on medical need. Under the new policy, transgender detainees already receiving hormone therapy will continue to be able to access to it, and those not already receiving hormone therapy are entitled to a medical assessment to determine if they may receive it.⁵⁵

HIV

Together with the WHO Europe office, the European Centre for Disease Control (ECDC) has called on all EU member states to provide HIV testing, prevention and treatment services to refugees and migrants, regardless of their immigration status.⁵⁶ The EU has seen a dramatic reduction in the number of migrants diagnosed with HIV in Europe, but migrants and refugees – and particularly undocumented migrants – remain a priority for HIV prevention and treatment for the ECDC, which has identified social exclusion, inadequate access to HIV services, and fear of stigmatisation as factors increasing the likelihood of HIV infection after their arrival in Europe.⁵⁷

The European Commission's Action Plan on HIV/AIDS for 2014-2016 includes access to prevention, treatment and care for undocumented migrants as an indicator.⁵⁸ But evidence suggests that prevention and treatment of HIV among migrant populations remains a low priority for the majority of EU member states.⁵⁹ On the other hand, some member states (Austria, Hungary, Latvia, and Greece) have adopted mandatory HIV testing for migrant sex workers, a discriminatory practice that has been condemned for reinforcing stereotypes about migration and sex work, and the notion of migration as a security health threat.⁶⁰

Criminalisation of Sex Work

The criminalisation of sex work and related activities compounds the barriers to health services faced by undocumented migrants. Sex workers have been described as “one of the most marginalised groups in the world who in most instances face constant risk of discrimination, violence and abuse.”⁶¹ And according to the WHO, this marginalisation “take[s] a huge toll” on their health.⁶² In August 2015, Amnesty International voted in favour of adopting a policy to protect the human rights of sex workers,⁶³ joining several international and human rights organisations (including WHO, UNAIDS, ILO, Human Rights Watch, the Open Society Foundations) that have called for the decriminalisation of sex work and related activities,⁶⁴ because of the damaging impact on their rights and health.⁶⁵

In Finland, many aspects of prostitution are criminalised, but selling sexual services is not itself a crime. However, under the Aliens Act, a non-EU national can be deported if he or she is suspected of selling sexual services.⁶⁶ This form of regulation of sex work has effects that are akin to criminalisation, by fostering mistrust of public authorities, including the police, increasing isolation and vulnerability to violence, and creating reluctance to approach health authorities for assistance. Pro-tukipiste,⁶⁷ an

organisation that provides health care and social services free of charge to sex workers in Finland, also distributes condoms and lubricants. But according to its staff, those who use their services often throw away safe sex information and other signs that they visited the organisation. Fear that they will be found in possession of items that could be deemed evidence under this law means sex workers are reluctant to carry condoms, even if it puts their health at risk.⁶⁸

The tendency of policymakers to view the relationship between migration and sex work uniformly through the lens of trafficking can also have detrimental effects on undocumented migrants, and in practice often favours immigration enforcement measures over the welfare of sex workers. As one researcher has noted, “the criminal justice and immigration control focus of current anti-trafficking initiatives means that all migrants working in the global sex industry, who are undocumented and get caught in anti-trafficking police operations, are very likely to be deported unless they denounce their agents and/or partners as unambivalent exploiters and expose their families to dangerous retaliation at home.”⁶⁹ Of the small minority of sex workers who report having been coerced into selling sex, one of the greatest factors increasing their risk of exploitation appears to be their immigration status.⁷⁰

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) refers to procedures carried out on millions of young girls and women every year that involve the partial or complete removal of the female external genitalia, or other injury to the female genital organs for non-medical reasons.⁷¹ FGM is recognised as a violation of human rights, and has been the subject of UN and WHO resolutions calling for its abolition.⁷² Women and girls who have experienced FGM face a host of short- and long-term health-related effects, including severe pain, bleeding, infection, infertility, childbirth-related complications and newborn death.

There is little data on the number of undocumented migrants affected by FGM, but it can be assumed that undocumented migrant women and girls in Europe from communities where FGM is practiced are significantly disadvantaged by lack of awareness about the procedure and its impact on their SRHR among health professionals, and the lack of access to psycho-social and health-related services to identify and assist women and girls with, or at risk of, FGM.

2. THE INTERNATIONAL CONTEXT

2.1 The Right to Health under International Human Rights Law

Several international human rights treaties protect the right to health, including to sexual and reproductive health, and impose obligations on states parties to respect and guarantee this right without discrimination, including on grounds of race, colour, sex, language, religion, national or social origin, birth or other status.⁷³

These treaties have been ratified by, and therefore bind, all 28 EU member states. Among other things, they oblige EU member states to respect, protect and fulfil the rights of undocumented migrants to sexual and reproductive health.⁷⁴ Expert bodies that monitor states' compliance with the treaties have repeatedly expressed serious concerns about a range of both legal and practical barriers in access to sexual and reproductive health care, goods and services that impede and undermine undocumented migrants' enjoyment of the right to health. For example:

› The **International Covenant on Economic, Social and Cultural Rights (ICESCR)** enshrines the right to the highest attainable standard of health and requires states parties to guarantee enjoyment of this right free from discrimination. The Committee on Economic, Social and Cultural Rights has explicitly affirmed that states parties have an obligation to ensure that all persons, including undocumented migrants, have equal access to preventative, curative and palliative health care, regardless of their legal status and documentation.⁷⁵ It has also explained that the right to health includes sexual and reproductive health and the “right to control one’s health and body, including sexual and reproductive freedom.”⁷⁶ More specifically, the Committee has clarified that Article 12.2(a) of the treaty requires states to improve “child and maternal health, sexual and reproductive health services and access to

information, as well as resources necessary to act on that information.”⁷⁷ In light of these obligations the Committee has repeatedly called on states parties to ensure that undocumented migrants have access to all necessary health services.⁷⁸

- › Similarly, the Committee on the Elimination of Racial Discrimination, which monitors implementation of the **International Convention on the Elimination of Racial Discrimination** has affirmed that under Article 5(e)(iv) of that Convention states parties may not deny or limit access for non-citizens to preventative, curative and palliative health care.⁷⁹ The Committee has called on states parties to take all necessary measures at federal, regional and community levels to ensure that undocumented migrants have access to health care services.⁸⁰
- › The **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**, obliges states parties to eliminate discrimination against women in access to health care, goods and services, including family planning (Article 12), and requires states parties to ensure appropriate services related to pregnancy and maternity, including ante-natal and post-natal care. Article 16 of the Convention guarantees the equal right of women to decide freely on the number and spacing of their children. The Committee on the Elimination of Discrimination Against Women has recognized that migrant women often are unable to access health services, including reproductive health services, as a result of insurance or national health schemes that exclude them, and that they often do not have access to adequate and affordable reproductive health services.⁸¹ It has specifically called on states to provide culturally appropriate gender sensitive health services for migrant women.⁸²

› The **Convention on the Rights of the Child (CRC)** protects the rights of the child to the highest attainable standard of health without discrimination.⁸³ Under the Convention states parties must reduce infant and child mortality, provide access for children and adolescents to health care, ensure pre-natal and post-natal care for pregnant women and adolescents, and provide family planning education and services.⁸⁴ Furthermore states must take steps to abolish harmful traditional practices.⁸⁵ The Committee on the Rights of the Child has further stated that children are entitled to “access to a range of facilities, goods, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health.”⁸⁶ It has discussed the importance of states reforming legislation preventing children in an irregular situation and their families “from effectively accessing services and benefits such as health care,” and paying attention to the gender-specific effects of “reduced access to services, such as sexual and reproductive health rights and security from violence.”⁸⁷ The Committee has repeatedly called on states parties to ensure that undocumented children have access to health services in practice.⁸⁸

2.2 SRHR and the Global Development Agenda

Sexual and reproductive health is also a core element of the international development agenda based on recognition of the link between health and poverty. The Sustainable Development Goals, successors to the UN Millennium Development Goals, include several targets related to sexual and reproductive health, including, most explicitly, the aim of “ensuring universal access to sexual and reproductive health and reproductive rights, including family planning, information and education, and integration of reproductive health into national strategies and programs.” Targets also include reducing maternal and infant mortality, ending all forms of discrimination against women and girls, eliminating harmful practices such as FGM, and all forms of violence against women and girls. Unlike the Millennium Development Goals, which applied to developing countries, the Sustainable Development Goals reflect a truly global agenda that applies to all countries, including those in the EU.⁸⁹

2.3 European Law

Under EU treaty law, organising their health systems and the delivery of health care are the exclusive domain of national governments. The EU’s role is to support member states’ efforts, facilitate coordination and supplement their actions.⁹⁰ In areas of shared common concern, such as public health and consumer protection, the EU and member states have shared competence.⁹¹ EU law also makes health a cross-cutting concern, such that a “high level of human health shall be ensured in the definition and implementation of *all* Union policies and activities” (emphasis added).⁹²

The **EU Charter on Fundamental Rights** specifically recognises the right of everyone to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices (Article 35). This provision should be read together with Article 24, which reiterates that children shall have the right to such protection and care as are necessary, and Article 21, which prohibits discrimination.

The European Parliament has adopted several resolutions that explicitly call on member states to improve the provision of health care for undocumented migrants, and to protect and promote the health of undocumented pregnant women and undocumented children. For instance, **European Parliament resolution on undocumented women migrants in the European Union** of 4 February 2014⁹³ “points out that the right to health is a fundamental human right and therefore encourages the Member States to delink health policies from immigration control, and consequently to refrain from imposing on healthcare practitioners the duty to report undocumented migrants.” **European Parliament Resolution on “Reducing health inequalities in the EU”** of 8 March 2011⁹⁴ calls on member states “to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided equitable access to healthcare” and “to promote public policies aimed at ensuring healthy life conditions for all infants, children and adolescents.”

The **European Commission Communication on effective, accessible and resilient health systems** of 4 April 2014,⁹⁵ sets out actions that the EU can take to optimise the way that member states’ health systems work, such as by pooling knowledge and resources, fostering good practice exchange, and facilitating access to expert advice on health systems reform. It includes improving accessibility as one of the three areas for improvement through EU action, and notes the obligation for states to have an adequate healthcare system that does not exclude parts of the population from receiving healthcare services.

PROMISING PRACTICE

CoE Istanbul Convention and EU Victims' Directive

The Council of Europe *Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention)*,⁹⁶ which entered into force on 1 August 2014, is the first comprehensive and legally-binding instrument to address violence against women and gender-based violence. States parties⁹⁷ must bring their national laws into compliance with the provisions of the Convention, and ensure that its implementation is done without discrimination on any ground, including with regard to sexual orientation, gender identity or migrant status.⁹⁸

The Istanbul Convention addresses a number of issues related to SRHR. For instance, the Convention obliges states parties to introduce specific criminal offences for sexual violence, rape, sexual harassment, forced marriage, female genital mutilation (FGM), and forced abortion and forced sterilisation, all of which are recognised as forms of violence. The Convention has an entire chapter devoted to the prevention of violence, under which states must implement measures to eradicate stereotypes and sexist practices; and requires states to make available support services, including health care and social services, for all victims of violence, irrespective of the residence status. In May 2015, an international group of independent experts, the GREVIO Committee, was established to monitor the Convention's implementation at the national level.⁹⁹

At the EU level, the *Directive establishing minimum standards on the rights, support and protection of victims of crime (2012/29/EU)*¹⁰⁰ (**Victims' Directive**) was adopted in October 2012, and obliges all EU member states, with the exception of Denmark, to ensure basic rights to victims of crime, whatever their immigration status. The Directive underscores the particular needs of victims of gender-based violence, and notes that women who are victims of such violence and their children often need special support and protection. Under Article 9, specialist services that member states must provide include integrated support for victims of sexual violence, gender-based violence, or violence in close relationships, including trauma support and counselling. Victims' entitlement to support services attaches whether or not they have reported the crime to the police. This is important given the high level of under-reporting among undocumented migrants.¹⁰¹

At the Council of Europe level, the **European Social Charter** (which has been ratified by all EU member states) provides for the right to social and medical assistance (Article 13), and to the protection of health (Article 11). Despite language in the Charter limiting its application to lawfully resident foreigners, the European Committee for Social Rights has issued recommendations about providing health care to undocumented migrants (not limited to children) in its country conclusions, in the reporting cycle for states parties, and most notably in its country conclusions for Spain in January 2014.¹⁰² The Committee has also found, responding to Collective Complaint 14/2003 International Federation for Human Rights (FIDH)

v. France,¹⁰³ that the law at the time the complaint was submitted, which provided necessary medical assistance to undocumented children only after a certain period of residence, was a violation of their right to social, legal and economic protection without discrimination. Additionally, the **European Convention on Human Rights** contains several provisions that, depending on the circumstances, may require states parties to take measures to ensure undocumented migrants have access to sexual and reproductive health care, goods and services, including the right to life (Article 2), the right to be free from torture and cruel or inhuman treatment (Article 3) and the right to privacy (Article 8), among others.

3. THE NATIONAL CONTEXT

Section II of this brief describes the international and EU norms that define the right to health, in general, and to sexual and reproductive health specifically. Section III sets out to illustrate what access to sexual and reproductive health services looks like in practice, for undocumented migrants. The analysis begins with an overview of undocumented migrants' legal entitlements to health services across the EU, and to sexual and reproductive health services in particular, and then moves on to consider other factors that affect their ability to access these services.

The picture that emerges is one of complexity: legal entitlements vary considerably among EU member states in terms of the specific services provided for, and are generally very limited. Where entitlements do exist, they do not themselves guarantee access to care: confusion about the scope of entitlements, the cost of care, administrative hurdles, information and cultural gaps present formidable barriers to accessing services. In some cases, the absence of legal entitlements is not the end of the story; administrative policies go beyond what the law formally provides for. Across the EU, volunteer health professionals and civil society actors play an important role in addressing the needs of the most vulnerable – the undocumented, the uninsured – who fall through the cracks. Amid the complexity, two things are clear: that the reality of undocumented migrants' access to sexual and reproductive health services sharply diverges from their rights under international human rights law, and that the negative effects of their exclusion are borne by individuals, communities and by the entire health system.

3.1 Undocumented Migrants' Legal Entitlements to SRHR in the EU

For undocumented migrants, legal entitlements to sexual and reproductive health services are a patchwork across the EU that follows a general pattern of exclusion. An entitlement refers to a right under national law to avail oneself of services provided as part of the public health system. Entitlements can vary within countries, depending on whether national or regional authorities are responsible for health care delivery.¹⁰⁴ This is the case, for instance, in Spain, where the central government, which has power to establish the basic conditions and general coordination of health-related matters, issued a royal decree in 2012 scaling back undocumented migrants' entitlement to health care to emergency care, care for pregnant women and care for children only; but where several autonomous regions, which also have some jurisdiction over health care, have gone beyond the standards mandated by national law and implemented systems granting more extensive access to health care to undocumented migrants.¹⁰⁵

The Numbers in the EU 28

EMERGENCY CARE:

> **5 EU member states** limit undocumented migrants' legal entitlement to *emergency care only*¹⁰⁶ and in 2 of these full payment is required¹⁰⁷

HIV SCREENING AND TREATMENT:

> **16 EU member states** provide an entitlement to screening for HIV¹⁰⁸ but only 11 allow access to treatment¹⁰⁹



- Undocumented migrants legally entitled to some degree of primary care under national law, including maternity care (but in some cases, only at full cost)
- Undocumented migrants not legally entitled to maternity care under national law
- Undocumented migrants legally entitled to some degree of maternity under national, but without any legal entitlement to primary care

Adapted from: Sarah Spencer, Vanessa Hughes, *Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe*, COMPAS, July 2015.

PRIMARY OR SECONDARY CARE:

> 10 EU member states provide an entitlement to some degree of primary or secondary care¹¹⁰ but 4 of these require payment of the full cost of care¹¹¹

MATERNITY CARE:

- > 7 EU member states make no specific provision for maternity care for undocumented migrants in their laws¹¹²
- > 21 EU member states make some provision for maternity care in their law, but the scope of specific services covered varies greatly, and in 3 of them entitlement to maternity care is limited to delivery¹¹³

In all 28 member states, irregular migrants are entitled to emergency care, though what qualifies as an “emergency” varies and, in some instances, payment may still be required for urgent care.¹¹⁴ In five member states, undocumented migrants are entitled to emergency care *only*.¹¹⁵ In thirteen member states, undocumented migrants are excluded from primary and secondary care, but have entitlements to certain specialist care, which typically includes HIV screening.¹¹⁶

In ten member states, undocumented migrants are permitted by law to *some degree* of primary or secondary care services, including (to a varying extent) sexual and reproductive health services.¹¹⁷ That entitlement is, however, significantly undercut in those member states (Czech Republic, Germany, Ireland and the UK) where there is also a requirement to pay the full cost of the care provided.¹¹⁸ In eight member states undocumented children have the same legal entitlement to health care as children who are nationals of that country.¹¹⁹

In the majority of EU member states, undocumented migrants’ access to sexual and reproductive health care is severely curtailed. One notable exception is with respect to pregnant women, who are entitled to some form of pregnancy-related care in twenty-one member states. But which specific services are covered under the rubric of “maternity care” varies tremendously, from delivery only in some states¹²⁰ to the full panoply of reproductive health services. Seven states have no specific provision relating to maternity care.¹²¹ Exceptions also exist with respect to the screening of certain communicable diseases, including HIV. Sixteen member states allow access to screening for HIV, eleven of which also allow access to treatment.¹²²

The above figures give an overall sense of the situation across the EU, but there remains considerable uncertainty when it comes to understanding the details of undocumented migrants’ legal entitlements to sexual and reproductive health care at the national level. This is in part due to ambiguities in national laws about the scope of rights covered (for instance, whether delivery comes within “emergency” services). More generally, there is a dearth of information about the specific sexual and reproductive health services available, under national laws, to undocumented migrants in the EU. Available information and evidence – perhaps in keeping with member states’ practice – tend to consider access within a traditional framework that focuses on access to maternity-

related care (namely, pre- and post-natal care, and abortion), on the one hand, and the management of infectious diseases (including HIV), on the other. A fulsome assessment of the full range of sexual *and* reproductive health services is needed that would permit a genuine comparison of entitlements across EU member states.

Health Care Categories

Emergency care includes life-saving measures as well as medical treatment necessary to prevent serious damage to a person’s health.¹²³

Primary care is the first level of contact between the individual and the national health system, addressing most health problems in the community through health promotion as well as provision of preventive, curative and rehabilitative services at first-contact and through ongoing care; and coordinating care, including with specialists when needed.¹²⁴

Secondary care comprises medical treatment provided by specialists and, in part, inpatient care.¹²⁵

Existing information about entitlements to sexual and reproductive services does permit some general conclusions about access. First, undocumented migrants have *no* entitlement to primary and secondary care in the large majority of member states. One can assume, then, that in most of the 21 member states that provide some degree maternal care, that care is extremely limited and likely confined to prenatal and postnatal care. This is significant because primary care practitioners are the first point of contact for individuals within the health care system, and play a critical role in coordinating access to any additional services that may be necessary, in identifying risks and facilitating prevention, and providing continuity of care and ongoing monitoring, which is particularly important in the case of chronic conditions like HIV. One exception is Spain, where undocumented pregnant women have equal access to all health services available to nationals, and *not only to pregnancy-related services*.¹²⁶ So, while one might welcome exceptions that carve out specific forms of care beyond emergency care, providing

“As of 1st of February 2016, private tenancy leases beginning on this date or later require that landlords check one’s residence status in the UK. There are penalties for renting property to someone that has no *right of abode* or *indefinite leave* to remain in the UK. This ‘right to rent’ home office guideline also requires that the landlord make a report to the home office when one’s right of abode expires. The guidance uses the terminology ‘illegal migrant’. For many on HIV treatment, housing, and the right kind, is an important component of their treatment and well-being regime. The ability to adhere to treatment, make sexual health decisions and have children requires a stable home environment. Poor housing or none will further exacerbate the issue of mental health and the right to a family life for undocumented migrants caught up in this – not to mention their susceptibility to co-infections.”

– *Nyambe Makelabai, European AIDS Treatment Group (EATG) (UK)*

access to a limited number of services, such as for HIV or for pregnancy-related care, while otherwise precluding access to meaningful primary care, arguably makes it very unlikely those few services will be effective in addressing the intended need.

Additionally, entitlements to care that are paired with the requirement to pay the full cost of that care are not true entitlements, in practice. Of the ten member states that provide some degree of primary or secondary care, in only eight are those entitlements meaningful, in so far as they include access free of charge. The issue of cost will be discussed in greater detail below, along with other practical obstacles to accessing care.

The diversity and complexity of rules regulating undocumented migrants’ right to access health care in the EU, as well as the vagueness of some of the language defining their entitlements (for instance, to “care that cannot be deferred” in Sweden; to “essential or urgent care” in Belgium, and “medically necessary care” in the Netherlands; and to “emergency” care only in many countries) has naturally led to confusion not only among migrants themselves, but also among health care professionals, and contributes to the inconsistent application of those rules and mistaken denial of care.¹²⁷

Member States Whose Laws Entitle Undocumented Migrants to Access Sexual and Reproductive Health Services

Among the twenty-one member states that provide some form of maternity care, Belgium and France are part of a handful that have relatively expansive entitlements to sexual and reproductive health care for undocumented migrants not, in fact, limited to pregnant women.

In **Belgium**, undocumented migrants are ineligible for health insurance, but can access health care free of charge through Urgent Medical Assistance (*Aide Médicale Urgente (AMU) / Dringende Medische Hulpverlening (DMH)*),¹²⁸ which is administered through local public welfare centres (*Centre Public d’Action Sociale (CPAS) / Openbaar Centrum voor Maatschappelijk Welzijn (OCMW)*). Despite its name, the AMU/DMH covers a broad range of preventive, primary and secondary care, including all medical treatments covered by the basic national health insurance system. AMU/DMH also includes access to pre- and post-natal care, gynaecological services, and abortions up to 12 weeks gestation. Community-financed postnatal clinics are available to all women free of charge. As of 2015, with the AMU/DMH, health care expenses are directly reimbursed by the federal authorities. The period for which the AMU/DMH is granted can range from one consultation to three months of continuous care.¹²⁹

Few types of contraception are covered by the government as part of AMU/DMH – the intrauterine device (IUD) is not covered, for instance – but the morning after pill and condoms are often available free of charge through family planning centres in Brussels and the French-speaking community.

To access AMU/DMH, undocumented migrants must get a medical certificate showing their need for services, and demonstrate that they meet the financial requirements of the law. The latter is determined by way of a mandatory social inquiry conducted by CPAS/OCMW. These requirements impose a number of bureaucratic obstacles to access that will be addressed below.

In **France**, healthcare is managed almost entirely by the state. Health insurance is mandatory and affiliation depends on socio professional or residency criteria. Ninety percent of the population benefits from public health insurance. Undocumented migrants cannot benefit from health insurance, but those who have resided more than three months in France and whose monthly income is less than 720 € are entitled to State Medical Aid (*Aide Médicale d'Etat - AME*), which provides free access to nearly all healthcare services available to French nationals.¹³⁰ AME covers care related to sexual and reproductive health such as pregnancy, delivery, family planning, contraception and abortion. AME is valid for one year from the day a request is made. To obtain AME, one has to provide proof of one's economic situation, proof of identify (translated into French), and proof of having resided in France at least three months. Children can access AME immediately, regardless of their or their parents' status.¹³¹

Those who cannot access health care or AME are entitled to hospital services for urgent matters (including labour and delivery, and pregnancy termination) and, outside the hospital setting, to sexual and reproductive health services through *Protection Maternelle Infantile* (PMI) centres, which provide preventive medical, social and psychological care to pregnant women and children under 6 years, including pregnancy monitoring, information, accompaniment during the post-natal period, screenings and treatment of sexually transmitted infections (STIs). Consultations are free and available to undocumented migrants and the uninsured. PMI centres are present in all cities, and the list can be found through city halls. The *Centre gratuit d'information de dépistage et de diagnostic* (CeGIDD) is a public health centre present in each Department that provides free screening and prevention services, including family planning and contraception, information on abortion, treatment of STIs, vaccination centres, and medico-psychological centres to everyone, regardless of their administrative situation. Family planning centres are present in France to provide sexuality-related information, contraception, abortion and treatment of STIs. Consultations are free and open to anyone.

In December 2015, the French national assembly passed a law bringing about significant changes to

the common health insurance scheme that could have devastating effects for undocumented migrants. The law creates a system of Universal Health Protection (*Protection Universelle Maladie/PUM*), effective as of January 2016, which ties one's right to coverage to one's residence status. In the past, those who had made a request for status (including asylum-seekers) could apply and obtain coverage, and retain that coverage even if they no longer meet the necessary conditions, including residence, during the period of validity. Under the new scheme, applicants may not be able to rely on merely have applied for status to obtain protection, and those with protection could lose it immediately should they no longer meet the residency requirements. As of the time of writing (January 2016), the specific residence requirements had not been elaborated, and those ineligible for PUM could still apply for AME.

Member States With Restrictive Laws Regarding Undocumented Migrants' Access to Sexual and Reproductive Health Services

Luxembourg, Cyprus and Malta are among seven member states whose laws make no specific provision for maternity care for undocumented migrants.

In **Luxembourg**, undocumented migrants have no specific entitlement in law to healthcare, beyond emergency care.¹³² This exclusion includes undocumented children, unless they are unaccompanied.¹³³ Undocumented migrants are expected to pay for emergency services but may apply for post-treatment cost reimbursement of 80% from a fund dedicated to covering treatment costs for uninsured patients, which explicitly includes migrants in an irregular situation.¹³⁴

In 2013, the European Committee of Social Rights (Council of Europe) issued conclusions finding that Luxembourg's health system failed, in several respects, to conform to the European Social Charter. The Committee noted¹³⁵ specifically that Luxembourg's legislation and practice do not guarantee that all foreign nationals in an irregular situation can adequately benefit from emergency care, which is limited to two or three days, and that there is no specific legislation concerning undocumented migrants' access to health.

CYPRUS

Migrants' Access to Health Care While in Detention in Cyprus

KISA, an organization that defends migrants' rights in Cyprus, reports having received reports from migrants who have been subjected to involuntary medical examinations upon their detention. Some examinations are carried out without informing them of their right to provide, or deny, consent. In KISA's experience, this is particularly the case with persons who are considered "at high risk of infectious diseases," namely sex workers and transgender persons. Moreover, as a general rule, once test results are known, especially for STIs, the police reveal a detainee's health data indiscriminately to the Social Welfare Services, Civil Registry and Migration Department and other authorities, as well as to individuals (especially members of the detainee's family) and, in some cases, even to the media, without ever obtaining the consent of the person concerned. Those who test positive for STIs are detained in isolation and often without any right to visits or phone calls and without being allowed to spend any time outdoors. KISA has also dealt with cases of detainees with STIs being denied treatment while detained, and of detainees with serious health conditions, such as tuberculosis, being deported without having received treatment.

In **Cyprus**, only Cypriot nationals, registered EU nationals and victims of trafficking are entitled to health care, with very limited exceptions. In principle, the law grants everyone access to emergency health care for a flat fee of 10 €, which is waived for welfare beneficiaries, although patients are charged for any treatment they receive while hospitalised, including for labour and delivery. In addition to the cost barriers discussed further below, in practice, undocumented migrants are hindered from accessing emergency care in public hospitals because of the risk they face of being denounced to immigration authorities, arrested, detained and deported.

Under Cypriot law, access to treatment for infectious diseases should be available to everyone free of charge in principle, but in practice, this access is limited for undocumented migrants to certain health conditions, such as HIV, and on an exceptional and individual basis. Access to HIV *testing* is free for everyone.

The Aliens and Immigration Law provides that undocumented migrants subject to a return decision or deportation order have the right to emergency

medical care and also to necessary treatment for their health conditions. In reality, however, public health care facilities, including hospitals, do not recognise any entitlement beyond emergency care. For migrants in detention, police officers determine which health problems are considered to be minor and when and if a detainee can be taken to hospital for consultation with a health expert.

In **Malta**, undocumented migrants have no specific legal entitlement to health care. However, according to the Health Department, undocumented migrants and asylum seekers whose claims have been denied are entitled to "core health benefits" that include sexual and reproductive health services, on an administrative basis.¹³⁶ In 2008, the Migrant Health Unit (now called the Migrant Health Liaison Office) was established to assist migrants in accessing health care in Malta.¹³⁷ A central component of the unit's work has been the training of cultural mediators and health care professionals, to facilitate migrants' integration into the health system. Information about immigration status is never requested as a condition of access on the assumption that, in the absence of an explicit policy, everybody is entitled to care.

PROMISING PRACTICE

Medical Professionals and Medical Associations as Key Actors in Bringing About Change

Health care professionals represent an important political constituency that can drive change at the national level. This was demonstrated in an example of progressive legal reform in 2013, when **Sweden** amended its laws – which previously required undocumented migrants to pay full fees for all forms of health care, including in emergencies – to grant undocumented migrants access to care “that cannot be postponed”, which includes maternity care, pregnancy termination, contraceptive counselling and reduced cost medicines. The new law also gives power to county councils to offer undocumented migrants wider health coverage, up to the level received by Swedish nationals, and grants undocumented children the same entitlement to care as Swedish children.¹³⁸ An important driver behind these reforms was health professionals, who added their voices to those of migrant and human rights advocates, and later wider civil society and local authorities, in making the case to policymakers for more inclusive care.

Health professionals have taken a stand in favour of inclusive care in a number of other countries as well. For instance, in 2009, the Chamber of Deputies in **Italy** passed a bill that created a duty for all doctors to denounce undocumented migrants seeking treatment. Italian physicians, recognising the conflict between the proposed requirement and their ethical duties, protested the bill, which was later defeated in the senate.¹³⁹ The Royal College of Midwives in the **UK** has been outspoken in calling for more equitable access to care, and for an end to the detention of pregnant migrant women.¹⁴⁰ In the **United States**, the American Nurses Association has adopted the official position that everyone living in the US, including undocumented immigrants, has a right to health care, and is committed to “educat[ing] nurses about the wide-ranging social, economic and political ramifications of undocumented migrants’ lack of access to healthcare services.”¹⁴¹ Regionally, the **European** Board and College of Obstetrics and Gynaecology has produced standards of care for women’s health services in Europe¹⁴² for obstetric and neonatal services and for gynaecology services, addressing variations and inequities in access to care and instructing that migrants in an irregular situation seeking medical assistance should not be apprehended at or next to medical facilities.¹⁴³

3.2 Other Major Barriers to Access

Undocumented migrants confront numerous barriers to sexual and reproductive health care that are the result of poverty and social marginalisation. But they also face other barriers specifically linked to their immigration status, as well as their status as foreigners, who often have limited familiarity with the national health system, different customs and experiences related to sexuality and reproductive health, and languages that may be unfamiliar to health care practitioners.

Absence of a Firewall between the Provision of Health Services and the Enforcement of Immigration Law

In some member states, national law includes an entitlement for undocumented migrants to access sexual and reproductive health services, but those provisions are undercut by an intermingling of health system care provision and immigration enforcement.

This is the case in **Germany** where, despite a formal legal entitlement under the Asylum Seekers Assistance Law to access cost-free medications and non-emergency care, undocumented migrants must obtain a health insurance voucher (*Krankenschein*) from the social welfare office,¹⁴⁴ which has a duty to report them to the immigration authorities under the Residence Act.¹⁴⁵ So while undocumented migrants are, in principle, afforded the same right to care as asylum seekers under German law, in practice they only access emergency care, which is available free of charge. A temporary tolerated stay, or *duldung*, is available to undocumented women for a limited period when they are considered “unfit to travel” (typically, six weeks before and twelve weeks after delivery), during which time they do not have to pay the costs of antenatal and postnatal care. Volunteer health professionals,¹⁴⁶ municipalities,¹⁴⁷ and civil society organisations¹⁴⁸ have mobilized at the local level in many parts of Germany to address this lacuna in service provision for undocumented migrants.

UNITED STATES

Undocumented Women Detained By Authorities During Gynaecological Appointment

In September 2015, an undocumented woman, Blanca Borrego, was detained by county deputies while at the Northeast Women's Healthcare clinic in Atascocita, Texas, for her annual gynaecological exam. Staff at the clinic had called the authorities and stalled the woman for several hours before she was shown to an examination room where she was arrested and removed from the clinic in handcuffs in front of other patients and her two daughters. When asked for identification by clinic staff, Ms Borrego had provided a false driver's licence. Ms Borrego was charged with one felony count of tampering with a government record because authorities claim she also had a fake Social Security card in her possession, and was held in Harris County jail on a 35,000 USD bond for several days until her family raised the money to secure her release. Ms Borrego is eligible for permanent residence status through her daughter, who was born in the US and is a citizen, but if convicted of a felony, would be disqualified from obtaining this status and likely be deported to Mexico.¹⁴⁹

In the **United Kingdom**, health care provision and immigration applications are also interlinked in a way that creates barriers to access. All secondary health care, including maternity care, is free of charge to people who are ordinarily resident in the UK, or to those with visas over six months who have paid a health surcharge. Treatment provided in accident and emergency departments is free for everyone, as is treatment for serious infectious diseases, including HIV. Irregular migrants can also register with a general practitioner (GP) or local health centre and receive primary health services free of charge.¹⁵⁰ Maternity care (which includes antenatal, birth and postnatal care)¹⁵¹ is considered to be "immediately necessary" care, which means that undocumented migrants and others not entitled to free care and who are unable to pay cannot be refused care, but may be charged later and incur significant debts (antenatal care costs about £1,590-5,233, birth £2,244-3,282 and postnatal care £355.50-1,207.50).¹⁵² Family planning is available free

to everyone, but pregnancy termination must be paid out of pocket.

These debts can create obstacles to obtaining or retaining regular status in the UK. NHS (National Health Service) hospital administrators have to inform the immigration authorities if a patient incurs a debt of £1,000 or more, which means that when that person later seeks permission to re-enter or to remain in the UK, her petition is likely to be denied. The 2014 Immigration Act also imposes upfront surcharges for access to NHS services that apply to non-European nationals who apply to obtain a visa to enter the country, or who apply from within the UK to extend or regularise their stay. Low-income applicants seeking to regularise their status will likely have their application rejected if they cannot pay the surcharge, and those with leave to be in the country will have their application to renew their status rejected if they cannot pay the surcharge, leaving them undocumented.¹⁵³

"Throughout the course of my pregnancy in Denmark, I did not visit a doctor. I was afraid, because I was in the country without permission, and I believed that I would be sent back to the Philippines. So I continued my work as a cleaner. I went to the hospital only when the pain was unbearable. I did not even make the decision, it was my friends and boyfriend who took me. The labour was already advanced. There was so much blood I had a caesarean section, but the baby did not survive. She died in an incubator. But I did see my daughter, I have a photograph of her. The priest came to the hospital to bless and baptise the children. I named her Claire. She is buried in Copenhagen on the north side. I stayed in the hospital for two weeks. During that time, nurses and doctors told me that I because I am in the country 'illegally', they should report me to the police. A short time later the police came to see me and said that I must leave the country. They would pay for my flight. I pleaded with the police, but they said they had no choice."

– 26 year-old woman.

UK organisations working with migrants report that the linkage between immigration status and cost of care has had a chilling effect on help-seeking behaviour among migrants who fear the consequences of incurring insurmountable debts. In one case that drew media attention, a heavily pregnant woman carrying

a foetus that had died in utero did not seek medical assistance to have the foetus removed, which would have cost thousands of pounds, because she feared her inability to pay would mean she could not get a visa to remain with her spouse in the UK.¹⁵⁴

PROMISING PRACTICE

Support for Destitute Pregnant Women

Bethel Doula Project is an organisation based in Birmingham, **UK** that provides support to isolated pregnant women, including undocumented women. Their work involves training volunteers to become doulas who give support to pregnant woman that is complementary to the work of midwives. A significant number of their volunteers are themselves migrant women, reflecting a great diversity of languages and experiences. Women – often destitute, alone and unsupported – are referred to the organisation through the NHS, community midwives, outreach workers or agencies that work with asylum-seekers. The organisation works to ensure that a volunteer doula is available to be at the hospital throughout a woman’s labour and birth, and to accompany the woman through the discharge process, as well as the transition to housing. Women also receive about two weeks of postnatal support. Project staff have noticed that the women they work with tend to be automatically perceived as “high risk” because of their socio-economic situation, and rarely are given a choice about where to give birth, or how to give birth. They are also typically provided with very limited information about antenatal care and available services. Bethel Doula assists more than 60 women each year, a number of whom are undocumented.

Cost of Care

As noted above, cost factors are extremely relevant in assessing entitlements. In practical terms, where the cost of obtaining care is out of reach, either because one must pay for private insurance or out-of-pocket, then any legal entitlement to care is an entitlement in name only. Such is the case, for instance, in the Czech Republic, Germany, Ireland and the UK (as noted above), as well as in Cyprus and Poland, where the cost of care is cited as the main barrier to access.¹⁵⁵

In **Poland**, undocumented migrants are ineligible for statutory health insurance, and can only access care – including sexual and reproductive health care – free of charge through emergency teams stationed outside hospitals,¹⁵⁸ or for the treatment of infectious diseases that require mandatory treatment.¹⁵⁹ Undocumented migrants can be required to bear the full costs of treatment for emergency services provided in hospitals, although it is unclear how and whether this applies in practice.¹⁶⁰ As the FRA has noted: “public officials [interviewed in Poland] were not able to identify any government approach or programmes dealing with healthcare access of

migrants in an irregular situation, and further, did not assign specific relevance to this issue.”¹⁶¹ The FRA also reports instances where healthcare staff and civil society actors were aware of migrants who sought care in hospitals and were reported to the authorities.¹⁶²

In **Cyprus**, as noted above, under regulations that came into force in 2013,¹⁶³ emergency health care and specific services (such as for infectious diseases) are free for all patients, including undocumented migrants, aside from a registration fee (10 €, foreseen for all apart from welfare beneficiaries). Access is, otherwise, on a full payment basis. Under a decision of the Council of Ministers,¹⁶⁴ undocumented children and pregnant women (during prenatal and postnatal care) should be given any necessary treatment. While they are still expected to pay for care, they cannot be turned away because of inability to pay, and in the event they cannot cover the expenses on their own, the hospital can issue an invoice for expenses and the patient can, in principle, request that the Minister of Health write off the debt. However, in practice, the Council of Ministers’ decision has not been officially published, and awareness and implementation levels

The Costs of Health Systems of Excluding Undocumented Migrants

In September 2015, the **EU Fundamental Rights Agency (FRA)** published a report on the financial impact on health systems of excluding undocumented migrants from accessing non-emergency care, looking at the examples of hypertension and prenatal care in Germany, Greece and Sweden. Conditions were selected according to several factors, including *inter alia* their prevalence among undocumented migrants, the cost impact of the condition if left untreated, and the availability of data. The outcome looked at in the case of prenatal care was low birth weight babies. According to the study's findings, which are based on economic modelling, Germany and Greece would, after two years, see savings of up to 48 percent of health system costs, and Sweden up to 69 percent, if regular care were made equally available to undocumented women. The study does not consider other costs to the health system, or to individuals, their families or to society, of the long-term effect of low birth weight.¹⁵⁶ A peer-reviewed research article, published in July 2015, similarly concludes that the cost of providing restricted access to health care for asylum-seekers and refugees in Germany is higher than granting them regular access.¹⁵⁷

remain low.¹⁶⁵ In practice, hospital staff continue to deny access to health care to pregnant women and children, unless they have been granted individual permission by the Ministry of Health. In the case of pregnant women, the Ministry of Health requires a medical report confirming pregnancy (even when the pregnancy is obvious) to grant free access to health care; and for children, grants free access to health care only in the event they have a chronic or serious health condition.

In **Ireland**, the Health (Amendment) Act¹⁶⁶ introduced "ordinary residence" as a prerequisite for accessing health care,¹⁶⁷ but emergency care is provided free of charge for all, regardless of residence status, aside from a 100 € administration fee that is foreseen for all patients if they do not have a referral from a GP (except in specific circumstances). Children up to 6 weeks of age who receive emergency care are always exempt from this fee.¹⁶⁸

All people in Ireland are expected to pay for primary health services, including for children unless their parent's income is below a certain level. Irregular migrants are not able to apply for the medical card that entitles the holder to these services free of charge, which means that primary care services must always be paid at full cost.¹⁶⁹ In practice, the level of care is decided by hospitals on a case-by-case basis for payment.¹⁷⁰ In some instances, irregular migrants may be able to access secondary care at reduced cost or for free if the care is deemed urgent and necessary

and if charging the full economic cost would cause undue hardship.¹⁷¹ All secondary services are free for children.¹⁷²

Administrative Barriers

Even in countries with fairly inclusive legal entitlements to sexual and reproductive health care, bureaucratic complexity and inconsistency can create significant obstacles to access.

In **Belgium**, for instance, undocumented migrants must prove habitual residence to access Urgent Medical Assistance (AMU/DMH),¹⁷³ which can be difficult for those who are staying with friends or family or in a shelter, or who are homeless. They must also obtain certification from a doctor of their need of care, which means they are responsible for the costs of the initial consultation. Burdensome procedures also lead to treatment delays, which are particularly problematic for urgent cases, and for women seeking a termination of pregnancy: by the time medical certification has been obtained, and AMU/DMH issued, the 12 week window within which a legal abortion can take place has passed. Another challenge is that the local social welfare centre (CPAS/OCMW)'s social investigation can take up to a month, as defined by law. Each CPAS/OCMW has discretion to determine what constitutes sufficient evidence of place of residence,¹⁷⁴ and there is a lack of visibility about criteria used to assess an applicant's situation.¹⁷⁵

PROMISING PRACTICES

Initiatives to Provide Sexual and Reproductive Health Services to Undocumented Migrants

Aquarelle asbl¹⁷⁶ is a **Brussels**-based non-governmental organisation linked to the Saint-Pierre Hospital. It was created in 1999 to provide pre- and post-natal monitoring and consultations to destitute pregnant women, as a way of supporting women and reducing infant and maternal mortality. Aquarelle offers medical prenatal consultations, birth preparation and the follow-up of the mother and baby for one year. Aquarelle also provides additional support for women and families living in extreme poverty, on a case-by-case basis. In 2014, Aquarelle social workers met 329 women representing 57 nationalities, 82% of whom were non-EU nationals and undocumented. Aquarelle is not financially supported by any public authority and depends on private donations.

Doctors of the World/Médecins du Monde (MdM) in 2014 received more than 10,861 women and 700 pregnant women into their program in **France**. The social precariousness of these women has negative consequences on the monitoring of their pregnancy: nearly 45% of pregnant women seen at MdM clinics had delays in pregnancy follow up, and only 42 % had access to prenatal care. Volunteers in these programs (gynaecologists, midwives, mediators, etc.) inform patients of where they can access pregnancy monitoring, abortion and other types of care they may need. They connect them with non-governmental or institutional health partners, do social accompaniment, provide support in navigating the administrative requirements of AME, visit squats to inform residents about contraception, and accompany women to their appointments in hospitals.

In **France** each administrative area (*département*) varies in how it applies the regulations around eligibility for AME¹⁷⁷ and can decide which documents it will accept to prove the residence and financial eligibility requirements. Eighty percent of patients who consult Médecins du Monde's clinics in France can theoretically benefit from health coverage, but only 15 percent of them have any form of coverage when they are seen for the first time.¹⁷⁸ Very little information is provided to promote access to health care and access to rights. The obstacles mentioned by patients in MdM programs are first related to administrative difficulties and complexity of the procedure (33%) and ignorance of rights to which they are entitled (28% of patients).¹⁷⁹ Seventeen percent

of patients cite their inability to meet documentary requirements, such as the need to provide evidence of having been in France at least three months. The lengthy procedures have an impact on the monitoring of a pregnancy and on emergencies, such as abortion, which have to be performed before 14 weeks gestation. Unlike Belgium's AMU/DMH, accessing AME is not contingent on obtaining a medical certificate or an invasive and time-consuming social investigation. And while Belgium's AMU/DMH is valid for a maximum of three months, in France AME is valid for one year from the day it is requested, although in practice the period of coverage is shorter because it can take several months for a request to be processed.¹⁸⁰

PROMISING PRACTICE**UK Guidelines Clarify Undocumented Migrants' Access to General Practitioners**

In November 2015, the **UK** addressed an important barrier for undocumented migrants seeking to register with a general practitioner: the risk of being turned away because of failure to prove their address or identity.¹⁸¹ Under new guidelines, the NHS clarified that there is no regulatory requirement for patients to prove identity, address, immigration status or their NHS number to register with a GP, and that patients unable to furnish these documents must not be declined registration on this basis.¹⁸² Whereas one must be “ordinarily resident” to access secondary (hospital care), “anybody in England may register and consult with a GP without charge.”

Cultural and Linguistic Barriers

Improving uptake of existing health services – particularly prevention-related interventions – among undocumented migrants requires addressing proactively the impact that divergent cultures, customs and languages, as well as gaps in information and mutual understanding, can have on access.

PROMISING PRACTICE**Working with Migrant Communities To Improve Access to Prevention Services**

In the north-eastern part of Gothenburg, **Sweden's** second largest city, 50 percent of its 100,000 residents are foreign-born, and 40 languages are spoken, the most common being Arabic, Bosnian, Croatian, Serbian, Persian, Kurdish, Somali and Finnish.¹⁸³ Healthcare providers in Gothenburg realised that ensuring equitable access to care meant taking into account this diversity, as well as the relative poverty and poor health of their immigrant population. To improve the participation rates of foreign-born women in mammography and cervical cancer screening, for instance, a project was undertaken to train doulas who were representative of their communities, and who had pre-existing bonds with women in those communities, to inform women of available services, provide information and answer women's questions about their health, and assist in the provision of care – such as through the use of a mobile unit offering Pap smears free of charge in public spaces. The result was a significant uptick in the number of women from these communities accessing screening services.¹⁸⁴

In **Malta**, the Migrant Health Liaison Office was established in 2008 to assist migrants in accessing health care in Malta.¹⁸⁵ A cornerstone of its work has been the training of cultural mediators and health care professionals, to facilitate migrants' integration into the health system. In 2014 and 2015 training sessions were held with health and social care professionals on migration and associated challenges. FGM sessions were also delivered to nurses and midwives working in antenatal, postnatal and delivery wards. In 2015-2016, the Migrant Health Liaison Office plans to deliver training on the issue of human trafficking,

and the identification of victims, to health and social care professionals likely to encounter them in their daily work. Sessions to public services officers (i.e., teachers, health professionals, employment officers, housing department employees and NGOs) were also delivered in 2015 as part of a project that focused on cultural competence, communication and the provision of culturally sensitive services. A health education program is currently being run with migrants in the community as well as at the Islamic School on the island.

CONCLUSION AND RECOMMENDATIONS

Sexual and reproductive health rights enjoy protection in international human rights law, and considerable political consensus regarding their importance to human health and wellbeing, economic development and social justice. And yet the situation in EU member states with regard to undocumented residents is marked by exclusion: most strikingly, exclusion grounded in law, but also, where legal entitlements to care do exist, exclusion based on significant barriers in practice.

Twenty-one member states have laws providing undocumented women with some degree of access to maternity care, and in a minority of states, this care includes access to a range of sexual and reproductive health services. The overwhelming trend, however, is towards shutting this population out of the public health system. Undocumented migrants, whatever their age, sexual orientation, gender identity or gender expression, in the majority of member states

rely on volunteers and civil society organisations to fill the gap in access. Laws and policies that limit access to cases requiring urgent attention not only violate individuals' basic rights to health care, they are also economically unsound and contrary to national and international medical standards of care. The corollary, of course, is that achieving more inclusive access advances the human rights of people with an irregular status, improves individual and public health outcomes, and saves health systems unnecessary costs.

The following are PICUM's recommendations to policymakers and to service providers to remedy the disparity between member states' legal commitments regarding SRHR and their restrictive laws and policies concerning undocumented migrants' entitlements to sexual and reproductive health care in the national context.

1. For policymakers at the national, regional and local levels

Reform legislation and policy that deny or limit access to sexual and reproductive health services on the basis of residence status, to ensure that services are provided based on need.

- › Amend or remove provisions in law barring or limiting access to health services, including sexual and reproductive health services, on the basis of residence status. The right to access health services – including financial subsidies – on equal terms with nationals, regardless of residence status, should be made explicit in law and policy.
- › Address administrative barriers to access by simplifying and publicising rules on the process for accessing care, and removing or introducing alternatives to onerous and unnecessary requirements that cannot be met by undocumented applicants or unduly restrict their rights in practice.
- › Take measures to ensure that sexual and reproductive health services and other essential services are not made inaccessible because of cost barriers.

Create a firewall by uncoupling the provision of basic services, including sexual and reproductive health services, from immigration control.

- › Ensure respect for the privacy and confidentiality of all patients, including those who are undocumented, by prohibiting – in law and in practice – the sharing of personal information, including immigration status, between health care providers and institutions, and immigration enforcement authorities. Any existing requirements on health care providers to provide personal information to immigration authorities should be removed and information and training provided to ensure both providers and patients are aware of their rights and responsibilities. Apprehensions near health care providers should also be prohibited.

Implement measures to ensure undocumented migrants' access to support and services, when they have experienced sexual or gender-based violence.

- › Consistent with the Istanbul Convention and with the EU Victims' Directive, take steps to ensure that all victims of violence (including female genital mutilation (FGM) and gender-based violence) have access to appropriate support and services, irrespective of residence status, sexual orientation or sexual expression.

2. For service providers at the regional and local levels

Implement training for health care professionals and administrators to increase their awareness of undocumented migrants and relevant issues related to sexual and reproductive health.

- › In partnership with civil society, develop training modules for health professionals – e.g., physicians, nurses and midwives – and health administrators to facilitate access to and use of services as well as appropriate and culturally-sensitive service provision, and foster greater awareness of sexual and reproductive health of undocumented migrants and the specific health-related risks and vulnerabilities they face because of their irregular status and social exclusion.

Be proactive in working with migrant communities to improve their uptake of services through the public system.

- › Take steps to empower migrant communities to utilise available health services through information, advice and referrals, and proactively adapt services to respond to the needs of local migrant communities, through consultation, to understand their characteristics, customs and practical needs, including through the provision of interpreters and cultural mediators as needed.

In partnership with civil society, take steps to improve access to health care for undocumented migrants, regionally or locally.

- › Work with local and regional authorities and / or with civil society organisations to provide access to services that are otherwise unavailable to undocumented migrants through the public system.
- › Advocate for systematic, sustainable reform of laws restricting access to care for undocumented migrants.

3. To the European Union

Promote evidence-based policy dialogue and exchange of good practices, and ensure coherence of sexual and reproductive health objectives in all EU policies relevant to undocumented migrants.

- The **European Council** should provide a forum for exchange of promising practices and evidence-based policy dialogue on the development of universal health coverage in diverse health systems, and measures to ensure the inclusion of undocumented migrants and other uninsured or low-income populations.
- The **European Commission** should:
 - Ensure that undocumented migrants are explicitly addressed in the work of DG Health and Food Safety; systematically address the effects on sexual and reproductive health objectives in other policy areas across the work of the Commission affecting the health of migrants, and undocumented migrants in particular (such as employment, justice, and research); and use available financial instruments to support non-governmental organisations and member states to advance implementation of universal health coverage.
 - Fund studies gathering data and undertaking analyses of the specific legal entitlements to sexual and reproductive health services of undocumented migrants, on the impact of the absence of legal entitlements on individuals, communities and health systems; and the health-related impact of limited entitlements disconnected from access to primary health care.
- The **European Parliament** should ensure protection and promotion of health for all residents, regardless of immigration status, through ongoing legislative and non-legislative actions, and Members of the European Parliament (MEPs) who voted for previous resolutions of the European Parliament should follow up on their recommendations to improve access to health services through action at the European, national and local levels.

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- 4 World Health Organisation (WHO) (2015), [Sexual Health, Human Rights and the Law](#).
- 5 See, e.g., IPPF (2015) *op. cit.* note 3, which shows a continuing gap in research and data collection in Europe on SRHR, including access to contraception, as well as evidence that there are domains in which European countries fall short in supporting women's SRHR.
- 6 PICUM does not use the term "illegal" to refer to an individual migrant or to any form of migration, because the term "illegal": (i) implies criminality, and a person can never be "illegal" and migration is not a crime; is discriminatory, because "illegality" as a status is only applied to migrants and is used to deny them their rights; has a real impact on policy and public perception, because inaccurate language leads society to accept that people labelled in this way should be prosecuted and punished. Following the United Nations, the EU institutions and agencies (including the European Fundamental Rights Agency, Parliament, and the Commission) have taken promising steps espousing the use of the term "irregular migrants" in all official communications. See PICUM, "[Why 'Undocumented' or 'Irregular'?](#)" at www.picum.org.
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- 81 CEDAW, General Recommendation No. 26, U.N. Doc. CEDAW/C/2009/WP.1/R (2008), para. 17-18. See also CEDAW Concluding Observations: Greece, U.N. Doc. CEDAW/C/GRC/CO/7 (2013), para. 31: "31. The Committee urges the State party to: ... (c) Improve the quality and accessibility of sexual and reproductive health services and guarantee their access to disadvantaged groups of women."
- 82 CEDAW, General Recommendation No. 26, U.N. Doc. CEDAW/C/2009/WP.1/R (2008), para. 26 (i).
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- 96 Council of Europe Convention on preventing and combating violence against women and domestic violence, November 2014, ISBN 978-92-871-7990-6.
- 97 As of January 2016, 20 states had ratified the Istanbul Convention, including 12 EU member states (Austria, Denmark, Finland, France, Italy, Malta, Netherlands, Poland, Portugal, Slovenia, Spain and Sweden). See Chart of signatures and ratifications, available at <http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/210/signatures>.
- 98 An entire chapter of the Convention is devoted to women migrant and asylum-seekers, and the Convention's explanatory note acknowledges the particular vulnerability of undocumented migrant women to gender-based violence. See CoE "The Convention in Brief," <http://www.coe.int/en/web/istanbul-convention/the-convention-in-brief>.
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- 102 "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... 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 Committee of Social Rights, Conclusion XX-2 (2013) (SPAIN), Articles 3, 11, 12, 13 and 14 of the 1961 Charter and Article 4 of the 1988 Additional Protocol, January 2014, p.13, http://www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/SpainXX2_en.pdf).
- 103 European Committee of Social Rights, International Federation of Human Right (FIDH) v. France, Decision on the Merits, Complaint No. 14/2003.
- 104 Sarah Spencer, Vanessa Hughes, Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe, COMPAS, July 2015, at 10.
- 105 PICUM (October 2014), Access to Health Care for Undocumented Migrants in Europe: The Key Role of Local and Regional Authorities.

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- 107 Bulgaria and Finland. PICUM (2015) *op. cit.* note 106.
- 108 Belgium, Croatia, Cyprus, France, Germany, Greece, Hungary, Ireland, Italy, Malta, Netherlands, Poland, Portugal, Spain, Sweden and the UK. Spencer (2015) *op. cit.* note 104, but see note 106 about the inclusion of Cyprus.
- 109 Belgium, Cyprus, France, Greece, Italy, Malta, Netherlands, Portugal, Spain, Sweden and the UK. See Spencer (2015) *op. cit.* note 104, but see note 106 above regarding Cyprus.
- 110 Belgium, Cyprus, Czech Republic, France, Germany, Ireland, Italy, Netherlands, Portugal, Sweden and the UK. See Spencer *op. cit.* note 104, but see note 106 above regarding Cyprus.
- 111 Czech Republic, Germany, Ireland and the UK. See Spencer (2015) *op. cit.* note 104.
- 112 Bulgaria, Cyprus, Finland, Lithuania, Luxembourg, Poland and Slovakia. Spencer *op. cit.* note 104, at 24.
- 113 Austria, Greece, Slovenia. Spencer (2015) *op. cit.* note 104.
- 114 See Spencer (2015) *op. cit.* note 104, at 11.
- 115 Bulgaria, Cyprus, Finland, Lithuania, Luxembourg and Slovakia. Spencer *op. cit.* 104, at 11-12.
- 116 Austria, Croatia, Cyprus, Denmark, Estonia, Greece, Hungary, Latvia, Malta, Poland, Romania, Slovenia and Spain. Spencer *op. cit.* note 104, at 11.
- 117 See note 101 above.
- 118 See Spencer (2015) *op. cit.* note 104, at 2.
- 119 Estonia, France, Greece, Italy, Portugal, Romania, Spain and Sweden. See Spencer (2015) *op. cit.* note 104 at 29. Note that Cyprus is not included in this list, consistent with the narrow definition of what constitutes a legal entitlement under national law adopted by the researchers cited here. Cyprus is, by contrast, listed in an earlier PICUM publication among those member states providing an entitlement for undocumented children to health services, on the basis of a Circular [Y.Y. 11.11.09(4)] by the Minister of Health dated 2 December 2011 that regulates the access of undocumented children and pregnant women (during prenatal and postnatal care) to care, which, although not binding, has a legal basis in the national law ratifying the CRC and is official policy. PICUM (2015) *op. cit.* note 106.
- 120 Austria, Greece and Slovenia. Spencer *op. cit.* note 104, at 24.
- 121 See note 112 above.
- 122 See notes 108 and 109, above. It should be noted that the ECDC has published figures indicating that 15 EU member states provide antiretroviral therapy for undocumented migrant, based on states' reports, rather than an assessment of undocumented migrants' legal entitlements under national laws. ECDC (September 2015), [Thematic Report: Monitoring Implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 Progress Report.](#)
- 123 FRA (2011), [Migrants in an Irregular Situation: Access to Healthcare in 10 European Union Member States.](#)
- 124 See [Declaration of Alma-Ata 1978](#), which provides an extensive definition of primary health care that is adapted here; also WHO/EURO "Primary Health Care," <http://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/main-terminology>.
- 125 FRA (2011) *op. cit.* note 123.
- 126 *Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones.*
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