HUMA network

Health for Undocumented Migrants and Asylum seekers

# ACCESS TO HEALTHCARE AND LIVING CONDITIONS OF ASYLUM SEEKERS AND UNDOCUMENTED MIGRANTS IN CYPRUS, MALTA, POLAND AND ROMANIA

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# CONTENTS

# INTRODUCTION

This report presents the results of multi-disciplinary research into access to healthcare for asylum seekers and undocumented migrants in four European Union countries: Cyprus, Malta, Poland and Romania. It reports on legal rights and entitlements and presents the findings of a quantitative survey conducted in 2010 by HUMA network members in these four countries: KISA in Cyprus, Skop in Malta, the Association for Legal Intervention (SIP) in Poland, and ARCA in Romania.

The main purpose of this report is to provide insight into the precarious situation and health problems of two of the most vulnerable groups living in Europe, asylum seekers and undocumented migrants, in Cyprus, Malta, Poland and Romania. In more concrete terms, it provides an overview of the legal systems regulating access to healthcare for undocumented migrants, asylum seekers and their children in these countries, as well as comprehensive data about their living conditions, perceived health status and difficulties in accessing healthcare.

The information and analysis contained in this report are aimed at policy makers, health professionals, NGOs and the general public in the hope of bringing about an improvement in the health situation of asylum seekers and undocumented migrants by guaranteeing full protection of their right to access healthcare.

This report adopts the same approach as that used by the Médecins du Monde European Observatory on access to healthcare and by the HUMA network in previous workings. The Médecins du Monde European Observatory has already published two reports of findings from field studies into the living conditions, access to healthcare and health status of undocumented migrants in first 7 and then 11 European countries, in 2007 and 2009 respectively.[1] In 2009, the HUMA network published a comparative analysis of legal entitlements to healthcare for undocumented migrants and asylum seekers in 10 EU countries.[2]

Undocumented migrants and asylum seekers are highly vulnerable population groups. In Romania, the tolerance holders are also particularly vulnerable as no rights are attached to their permission to stay; they will also be taken into account in this study.[3] The difficulties experienced by these migrants in their home countries and that determined their decision to migrate, compounded by an often extremely arduous journey into exile, can have very long-lasting effects on their health. Furthermore, once living in Europe, in a so-called "host" country, the majority endures very difficult living and working conditions due to or aggravated by their administrative situation. These factors are all potentially harmful to their health over the medium to long term, all the more because the status of asylum seeker and the lack of status of undocumented migrants provide respectively little or no entitlements to healthcare. This makes their situation extremely preoccupying, both in human rights terms and from a public health perspective.

According to international Human Rights instruments, healthcare is a fundamental right for every human being. The United Nation's International Covenant on Economic Social and Cultural Rights requires that states recognise *"the right to the enjoyment of the highest attainable standard of physical and mental health"*[4], and this by *"refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal migrants to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices*

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[1] Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009), *op. cit.*; See also Médecins du Monde European Observatory on access to healthcare, Chauvin, P., Parizot, I., Drouot, N., Simonnot, N., Tomasino, A. (2007). *First European survey on undocumented migrants' access to healthcare.* Paris, Médecins du Monde. Available at: www.mdm-international.org.

[2] HUMA network (2009). *Access to healthcare for undocumented migrants and asylum seekers in 10 EU countries. Law and practice*. Paris, Médecins du Monde. Available at: www.huma-network.org

[3] For a legal definition of asylum seekers and undocumented migrants, as well as of holders of a tolerance, please look at the table on the terminology at the end of the introduction.

[4] Article 12 (1) of the International Covenant on Economic Social and Cultural Rights, Resolution 2200A (XXI) of 16 December 1966.

*as a state policy"*[5]. In addition to this treaty, other international instruments protect the healthcare rights of specific populations, such as the Convention on the Rights of the Child[6], or the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, although this convention has not been not ratified by any of the countries targeted in this report or by the European Union.[7]

The European Union is supposed to promote health systems based on principles of universality, solidarity and equity. However, as EU member states remain individually competent to determine who should benefit from their public health system, legal entitlements to healthcare for undocumented migrants and asylum seekers depend on national legislation. At the EU level, regulations are in place on healthcare for asylum seekers[8], imposing access free of charge to emergency care and the necessary treatment of illnesses as a minimum provision.[9] However, as far as undocumented migrants are concerned, no aspect of European hard or soft law protects or addresses their fundamental right to healthcare. This is hardly surprising as debate on undocumented migrants continues to focus on the "fight against illegal migration", and no discussion has yet been launched into the need to protect undocumented migrants' rights at EU level.

As highlighted in the first HUMA legal report[10], most EU countries fall far short of offering the level of protection foreseen in international instruments with regard to healthcare coverage for undocumented migrants and, to a lesser extent, asylum seekers. Many current legal frameworks are highly discriminatory, and in addition, there are still enormous barriers to accessing health services in practice. The last survey by the Médecins du Monde European Observatory on access to healthcare[11] revealed that undocumented migrants encounter numerous problems, including no effective access to healthcare entitlements, administrative and language barriers, a lack of information, unaffordable medical treatment and the fear of being reported or refused healthcare. As a consequence, 72% of the pathologies of the undocumented migrants interviewed in the survey went without treatment or follow up.

The two reports cited above have also confirmed the current trend to restrict the healthcare entitlements of these population groups. All over Europe, countries are using healthcare as an immigration control instrument rather than treating it a human right to be protected or a public health concern to be addressed. Yet access to healthcare should not only be considered a priority in terms of human rights, it should also be seen as a key public health issue, as access to healthcare for all contributes to reduce health inequalities and is a means of ensuring a healthy society. Conversely, denying healthcare to people with little or no legal status only serves to increase their marginalisation and leads to increased health inequalities.

Cyprus, Malta, Poland and Romania - the four countries targeted in this report - are each in a quite similar situation and face similar challenges with regard to managing migration. They all joined the EU recently (in 2004 for Cyprus, Malta and Poland and in 2007 for Romania) and are all geographically situated on the external borders of the European Union.

For all of them, joining the EU meant adopting EU immigration policy and so they have all received instructions and incentives for preventing illegal entries by tightening border controls and for

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[5] See Committee on Economic Social and Cultural Rights (2000). *General Comment n°14. The right to the highest attainable standards of health*, E/C/2000/4, §34. For more details about International Human Rights and the right to health, see www.huma-network.org

[6] See in particular Article 24 of the United Nations Convention on the Rights of the Child. Available at: http://www2.ohchr.org/english/law/crc.htm

[7] See in particular articles 28, 43, 45, 70 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW). Available at: http://www2.ohchr.org/english/law/cmw.htm; to date, no EU Member State has signed or ratified this convention.

[8] [8] Note that the EU Charter of the Fundamental Rights of the European Union specifically states that health rights ("right of access to preventive healthcare and the right to benefit from medical treatment") are recognised "under the conditions established by national laws and practices" (Article 35).

[9] Council Directive 2003/9/EC of 27 January 2003, *op.cit*.

[10] HUMA network, *op. cit.*

[11] Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009). *Access to healthcare for undocumented migrants in 11 European countries.* Paris, Médecins du Monde. Available at: www.mdm-international.org

managing the reception of asylum seekers. These countries are also all new transit and immigration countries for asylum seekers and for migrants in general. Although essentially seen as gateways into the European Union by migrants looking to reach EU countries further west, they are gradually becoming immigration countries themselves. A growing number of migrants are staying and settling because of the difficulties involved in reaching or settling in other countries due, among other things, to EU legislation on asylum[12].

Some trends can be identified as a result of their geographical location. For instance, Cyprus and Malta are both Mediterranean islands that have seen a rapid inflow of immigrant arrivals over a short period of time, mainly migrants entering the country illegally (by sea or by air) and planning to continue to other EU countries. Both Poland and Romania, on the other hand have long been emigrant nations. Situated on the eastern border of the European Union, they are not yet considered to be attractive locations for immigrants because of their weak economic situation compared to that of other EU countries. In both countries, immigration is not yet a noticeable social phenomenon or a priority in terms of policy or legislation.

These four countries, for which immigration is a very recent issue, are ill-equipped to cope with this phenomenon, and their legislation on migrants' rights, including the right to healthcare, is generally weak.

The current economic crisis now constitutes another excuse for these countries to opt for restrictive regulations and practices rather than for a friendlier approach to migration and health issues. This situation is not helped by fact that most of the four countries targeted in this report are currently engaged in general reforms to modernise their health systems and address the numerous problems affecting users as a whole.

# METHODOLOGY

## ■ Organisation of the report

This report is divided into 4 main parts, one part for each country namely Cyprus, Malta, Poland and then Romania. In each part, a first section presents the legal entitlements to healthcare and a second section presents the findings of a field survey on access to healthcare for asylum seekers and undocumented migrants. A conclusion is drawn for each country and a general conclusion is given at the end of the report.

## ■ Methodology used in the legal section

The legal entitlements for each country are presented in the same way as in the 2009 HUMA legal report, by type of population: nationals, authorised residents, asylum seekers, undocumented migrants.

In order to clearly show the specific characteristics of access to care/treatment for each of the different groups residing in a country, as well as any discrimination with regards to legal entitlements and administrative conditions, a distinction has been made between: i) nationals, asylum seekers and undocumented migrants; ii) adults and children; and iii) types of care (primary and secondary, emergency, inpatient, ante-post natal) and treatments (medicines, treatment of HIV and treatment of other infectious diseases).

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[12] Acording to the Dublín II regulation, i.e. the *Council Regulation (EC) No 343/2003 of 18 February 2003 establishing the criteria and mechanisms for determining the Member State responsible for examining an asylum application lodged in one of the Member States by a third-country national*, "Member States have to assess which Member State is responsible for examining an asylum application lodged on their territory on the basis of objective and hierarchical criteria. (…) Where another Member State is designated responsible under the criteria in the Regulation, that State is approached to take charge of the asylum seeker and consequently to examine his/her application. If the Member State thus approached accepts its responsibility, the first Member State must transfer the asylum seeker to that Member State." See this summary of legislation on http://europa.eu/legislation_summaries/justice_freedom_security/free_movement_of_persons_asylum_immigration/l33153_en.htm

The research also describes healthcare entitlements for migrants held in detention centres, as well as the residence permits or other mechanisms provided for in national legislation to protect from expulsion any seriously-ill undocumented migrants and asylum seekers who cannot effectively access treatment in their home countries.

The entitlements are presented in tables to make it easier to compare particular populations or types of medical care between countries (including countries studied in the 2009 HUMA publication). For the purposes of the report, it has also been necessary to adopt a common terminology despite the wide differences in healthcare and legal terminology existing between Member States[13].

The main source of information for this study was the immigration, asylum and healthcare legislation in force in the different countries, analysed by HUMA's legal expert with the help of a legal specialist from each of the countries concerned. The four HUMA network's member organisations also contributed to this task.

## ■ Methodology used in the quantitative survey: « statistical testimony »

**• Aims and limits of the survey**

The field survey conducted to collect the data analysed in this report was coordinated by the HUMA coordination team and conducted by its members: KISA in Cyprus, Skop in Malta, the Association for Legal Intervention (SIP) in Poland, and ARCA in Romania.

The objective of this field survey was to provide "statistical testimony" of the situations witnessed by HUMA network's member organisations on their programs or within specific groups of asylum seekers or undocumented migrants. The findings do not attempt to offer a fully representative picture of access to healthcare as experienced by all asylum seekers and undocumented migrants in each of the four countries. Indeed, the general sample and the samples taken in all four countries for each category of population - asylum seekers, undocumented migrants (and, in the case of Romania, holders of a "tolerance") - were too small to allow a generalisation of the findings. Similarly, although the organisations conducting the survey made significant efforts to obtain a randomised selection of respondents, there were still a number of biases in the recruitment of respondents in each country due to difficulties in gaining access to migrants.

Furthermore, the fact that the asylum seekers and undocumented migrants were recruited via non governmental organisations (NGOs) may also have resulted in some bias for two main reasons:

- The people interviewed were already in contact with the NGO sector and so may well have been beneficiaries of the support provided by these NGOs, i.e. social counselling and, in some cases, support and translation to facilitate their access to healthcare. Undocumented migrants and asylum seekers not reached by such programs, and so possibly living in worse general and health conditions, may well have remained "invisible" in this survey.
- Undocumented migrants and asylum seekers living in slightly better conditions probably do not seek NGO support services and so were not reached by our survey.

However, as no randomised, representative surveys have yet been conducted amongst the general undocumented migrant or asylum-seeking population in the countries targeted, the quantitative findings by country presented in this report at least offer key trends that, although calling for prudent interpretation, go some way towards illustrating the problems faced by these populations in accessing healthcare.

It is also important to bear in mind that this survey gathers the asylum seekers' and undocumented migrants' own descriptions of their living conditions and access to healthcare. So, to a certain extent, the answers given will reflect their subjectivity.

[13] For the terminology used in the legal sections of the report, see HUMA network, *op. cit.*, pp. 10-11.

**• Survey design, sample per country and interview process**

The survey was conducted by 29 surveyors who interviewed respondents by means of a questionnaire. All received two to three days' training before beginning the field work[14]. These surveyors came mainly from the HUMA network's member organisations (staff, volunteers, or people otherwise identified for this work), and sometimes from their partner organisations. Fifteen surveyors had migrant backgrounds themselves, which enabled them to hold the interviews in their own language and overcome language barriers. In Malta, for example, the interviews were held in 14 different languages, including Amharic, Tigrinya, Arabic and Djula.

The field work was carried out between August and October 2010. In total, 434 people took part in the survey, and 100 to 122 questionnaires were completed in each country. The objective was to reach at least 50 asylum seekers and 50 undocumented migrants in order to produce a statistical analysis for each category. This proved possible in Poland and Cyprus[15].

The following criteria were used for selecting respondents:

- Only undocumented migrants and asylum seekers (and holders of a "toleration" in the case of Romania) were invited to participate.
- Only adults (over 18) were selected, except in three specific cases where 17-year olds were interviewed (a pregnant woman, and 2 young men).
- For asylum seekers, the survey primarily targeted people not living in reception centres, as in the countries concerned there was little or no existing data on their living circumstances.

The respondents were mostly recruited on the member organisation's programs or on the programs of other organisations. Some of the organisations concerned provide medical care, but most of them offer other kinds of support, including health-related support, such as translation, for example. In some countries, respondents were also recruited through the interviewers' social network. On the programs, everyone meeting the survey's criteria (adult asylum seeker or undocumented migrant) was invited to participate. In some countries, and where possible, the interviewers attempted to specifically target women in order to increase their representation, but this strategy was not always successful.
Each questionnaire took between 30 and 45 minutes to complete. The detailed data-collection protocols, as well as any specific biases, are presented by country in each country section and in the appendices.

**• The questionnaire**

The questionnaire[16] used in the survey is a shortened version of the questionnaire developed by the Médecins du Monde European Observatory. The main part of the questionnaire comprises 60 questions focusing on general demographic information,; on the social determinants of health i.e. social situation, living and working conditions; on the self-perceived state of health; and on the use of and barriers to accessing medical services. An additional part of the questionnaire specifically focuses on the experience of women who were or had been pregnant in the 'host country' regarding their access to antenatal and delivery care. The last part targets parents living with their children in the 'host country' and focuses on the difficulties and barriers faced when trying to access healthcare for their children.

The structure of the questionnaire was identical for all four countries, but some questions were adapted to their respective legislation and health systems. Participation in the survey was anonymous and no formal controls of the respondents' administrative status were carried out.

[14] Except in Poland, where the surveyors, who all had prior experience of interviewing, attended a half-day work session run by a Polish social researcher and SIP to ensure they all used the same methodology. Furthermore, the role of the surveyor was not the same in Poland as in the other countries, as SIP wished to use an alternative methodology: The surveyors assisted the respondent who filled in the questionnaire himself or herself, contrary to the other countries where the surveyors interviewed the respondents and filled in the questionnaire.
15 In Cyprus, 49 undocumented migrants were interviewed.
[16] See Appendix 1.

**• Additional qualitative testimony**

In order to back up and help illustrate the quantitative data collected, qualitative interviews were also held among undocumented migrants or asylum seekers willing to recount some of their concrete experiences in accessing healthcare. These interviews were conducted during the field work. Respondents identified for having experiences of special interest to the study were invited to describe in more detail the way they dealt with their health problems and with healthcare in the host country. To help them conduct these interviews, the surveyors were provided with an interview guide[17]. Between one and fifteen testimonies were collected per country.

**• Analysis of the report**

The analysis was carried out by the survey coordinator, Anne Soler (sociologist), with the support of a researcher from the department of Social Determinants of Health and Health Service Use at the National Institute of Health and Medical Research (INSERM), Annabelle Lapostolle. Two Polish sociologists also contributed to the section on Poland, Natalia Klorek for the analysis and Monica Szulecka for the field methodology and field work. The four HUMA network's members and their principal surveyors in each of the four countries provided additional input to the report, enabling more in-depth analysis by commenting on the statistical data and their experience. At the last stage, the report was reviewed by the four HUMA member organisations.

**• Presentation of findings**

Some data are provided for all respondents, but most data on the asylum seekers and undocumented migrants interviewed are presented separately.

The designation of « asylum seekers » or « undocumented migrants » in the survey analysis always refers to « asylum seekers interviewed » or « undocumented migrants interviewed ». There is no intention to imply that the survey's findings are representative of the situation of all asylum seekers or undocumented migrants in the country in question.

Some questions on access to healthcare refer to the last time the respondent encountered a health problem, but the question on barriers faced when trying to access healthcare concerns the last year. In other words, the question on barriers encountered in accessing healthcare does not necessarily refer to the last time the respondent had a health problem.

**• Interpretation of findings and figures**

The percentages, tables and graphs presented exclude non-responses, except when otherwise stated.

When two or more findings are subject to a simple comparison (percentages, proportions, averages), it is often indicated that the findings are, or are not, "significantly different." This is a shortened version of the term "statistically significantly different", meaning that it is very unlikely that the difference observed occurred purely by chance.

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

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

[17] The surveyors were also trained in the qualitative methodology to use in holding these interviews.

# TERMINOLOGY IN THE FRAMEWORK OF THIS REPORT

- **MIGRANTS:** Third country nationals residing (regularly or irregularly) in the EU. EU citizens are excluded from this category.

- **NATIONALS:** Persons who have the nationality of an EU member state, no matter their country of birth or origin.

- **AUTHORISED RESIDENTS:** Persons who are entitled to permanently or temporarily stay/reside in an EU country. Different from naturalized people: persons who get the nationality of an EU country. Once they are nationals of an EU member state, they are automatically considered as EU citizens as well. Refugees as well as beneficiaries of the subsidiary protection are authorized migrants.

- **TOLERANCE HOLDERS (IN ROMANIA):** The Romanian legislation has also established a "tolerance": it is a "permission to remain on Romanian territory" for objective reasons that prevent the persons' *expulsion from Romania*", creating a category of people who cannot be expelled from the country[18]. This permission only protects against expulsion, with no social or economic rights attached.

- **ASYLUM SEEKERS:** Persons who are in the procedure of seeking asylum in an EU country (Geneva Convention protection or subsidiary protection). Persons under Dublin regulation are asylum seekers.

  *Beneficiaries of subsidiary protection can be asylum seekers if they appeal from the decision taken as regards their international protection – there might be such cases in the survey in Malta and in Cyprus.*

- **UNDOCUMENTED MIGRANTS:** Third country nationals who are not entitled to stay or reside in an EU country. They do not have a permit or authorisation to stay, live or work in any EU member state. National legislations differ in defining undocumented migrants.

  <u>These are the main common administrative situation in which undocumented migrants can be found in a EU country:</u>

  - Persons who are planning to seek asylum but have not formally submitted an application to asylum to the national competent authorities;
  - Rejected asylum seekers (those asylum seekers whose application for asylum failed);
  - Persons whose application for residence permit/authorization to stay/family reunification is still pending (no decision has been taken by the competent national authorities); in some countries however, they are considered in regular situation;
  - Persons whose application for residence permit/authorization to stay/family reunification or renewal of this authorisation has failed;
  - Over-stayers of visas (tourist, student, medical reasons, …);

[18] With regard to tolerance, see Article 104 of the General Emergency Ordinance 194/2002.

- Over-stayers of expired residence or work permits;
- Persons who did not apply for any visa or residence permit and entered illegally.

Are not considered undocumented migrants:

- Asylum seekers
- Holders of a valid residence permit in another EU country. As authorised residents, they have the right to travel for three months in EU countries other than the host EU state. After this period, they can be sent back to their host EU state since they remain in a regular situation there
- EU citizens (nationals of any EU member state)

It must be noted that undocumented migrants can be free or in detention

# MAP OF INVESTIGATED COUNTRIES:

# CYPRUS

## KISA (Action for Equality, Support, Antiracism)

KISA is member of the HUMA network, and implemented the research in Cyprus for this report.

KISA's overall long-term objective is the creation of a multicultural society, where there is equality of all persons, irrespective of nationality, race or ethnic origin, colour, creed, gender, sexual or any other orientation, background or characteristic.

KISA's activities focus on two general directions:
1. Sensitisation of the Cypriot society about social discrimination and racism, the benefits of a multicultural society and reform of the immigration and asylum framework in Cyprus, through campaigns, conferences, cultural events, provision of information, publications and lobbying the authorities.
2. Support centres providing free legal and social services, guidance and advice to migrants, refugees and asylum seekers, in order to enable them to claim their rights and facilitate their integration and full participation in society.

## INTRODUCTION – CONTEXT IN CYPRUS

Nowadays, Cyprus is de facto divided in two areas. The area controlled by the Government of the Republic of Cyprus, in the South, and the non Government controlled areas in the North[19]. The international community only recognizes the Government of the Republic of Cyprus in the south. Cyprus as a whole acceded to the European Union in 2004, however the application of EU law in the northern part is suspended as long as the island is not reunified[20].

The data presented in this report refer exclusively to the situation in the part of the island controlled by the government of Cyprus, i.e. the southern part of Cyprus.

**In Cyprus, the issue of asylum and immigration is relatively complex, partly because of the country's geographical situation as an island at the gateway to Europe, and partly because of its political situation**: the territory is divided into two parts which barely communicate, especially on sensitive matters such as asylum and immigration.

**Migration inflows to Cyprus began long before the country's accession to the European Union**. Cypriot immigration policy, among other things, provides for a status of "guest" worker for migrants since 1991, accompanied by a strict visa control policy[21]. **People are recruited in their home country by agencies that organise the whole migration process. These migrants are mainly women from the Philippines and Sri Lanka.** A serious element of concern is the fact that according to the above decision of the Ministerial Committee, *"[i]n case the business has serious problems in working conditions (safety, health, welfare) permit for the employment of foreigners will*

[19] The northern part of the island is under the control of Turkey since 1974 and has proclaimed itself as the « Turkish Republic of Northern Cyprus », an entity not recognised by the international community
[20] Under Protocol 10 to the Treaty of Accession of the Republic of Cyprus to the European Union, the application of EU law in the non government controlled areas is suspended.
[21] The Alien and Immigration law was established in 1972 and put in effect in 1991 when the present model was adopted by decision of the Ministerial Committee. http://www.mlsi.gov.cy/mlsi/dl/dl.nsf/dmlcriteria_en/dmlcriteria_en?OpenDocument

*be granted for a reasonable time period needed by the business to make the necessary changes for improvement on the basis of the recommendations of the Director of the Labour Inspection Department*".[22]

**Furthermore, as the status of these migrant workers is linked to their employment contracts – which are temporary** - and so is very much in the hands of their employers. Losing their job means losing their work permit and, consequently, their legal status. Some remain undocumented.

**Regarding asylum seekers, Lebanese and Palestinians were the first to seek asylum** in Cyprus during the war in the Lebanon (1975-1991)[23]. Further inflows later **followed from other Middle Eastern countries and, to a lesser extent, from Africa**[24]. In 2009, 2,665 claims for asylum were made in Cyprus[25], **and the asylum recognition rate is very low**, around 2%, as is the rate of subsidiary protection granted[26]. **The 2005 law on asylum is in force in Cyprus, imposing EU standards for the reception of asylum seekers**. However, according to the UNHCR, not all aspects of this law are applied by the Cypriot administration. Indeed, the Ministry of Welfare and Labour argues that this law is not valid as it contradicts other previous regulations, and is concerned that it is too liberal and would give access to welfare to a large number of asylum seekers.

**According to KISA, the number of undocumented migrants In Cyprus is estimated to be between 20 000 and 40 000**. They come mainly from Asia (Sri Lanka, India, Philippines and Bangladesh) and Eastern Europe, and are mostly concentrated in the countries major cities, Nicosia, Limassol, Larnaka and Paphos. The majority of undocumented migrants are either migrant workers who have over-stayed their visa or work permit or rejected asylum seekers. A large proportion of migrants (becoming in part asylum seekers or undocumented migrants) also arrive unauthorised in the North of the island and then cross the green line to reach the southern part of the island.

[22] Ministry of Labour and Social Insurance, Department of Labour, *Criteria and Procedure for the Granting of Work Permits to Foreigners/ Renumeration and Terms of Employment*. Nicosia: 2/12/91.
http://www.mlsi.gov.cy/mlsi/dl/dl.nsf/dmlcriteria_en/dmlcriteria_en?OpenDocument

[23] Davie Michael F., "Cyprus, Haven and Stepping Stone for Lebanese Migrants and Emighrants", in Hourani Albert & Shehadi Nadim, *The Lebanese in the world, A century of emigration*, London, Centre for Libanese Studies, pp. 627-650, 1992

[24] Clochard O. (2008). Jeux de frontières à Chypre: quels impacts sur les flux migratoires en Méditerranée orientale ? *Géoconfluences.* Available at: http://geoconfluences.ens-lsh.fr/doc/typespace/frontier/FrontScient8.htm

[25] See Eurostat for the annual statistics on asylum applicants in 2009 at http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-QA-10-032/EN/KS-QA-10-032-EN.PDF

[26] Ibidem

# PART 1: LEGAL ANALYSIS

## HEALTH SYSTEM

Although Cyprus is planning to introduce a "National Health Insurance System" in the coming years, for the moment health services provision is not the responsibility of one central authority. Instead there are four types of coverage depending on the category of person: public healthcare provision in public facilities, either free of charge; or co-paid; health coverage funded by employers and trade unions, mainly in private facilities; and private health insurance schemes. The current public healthcare system is non-contributory and non-compulsory. It is directly funded from state funds and through the fees charged to those obliged to pay for medical care. The system is not linked to social security contributions or to taxation.

The future "National Health Insurance Scheme" will be based on contributions from the government, employers and employees. It will provide universal coverage to all Cypriots and EU nationals residing in Cyprus, as well as to anyone obliged to contribute to the National Health Insurance Scheme, such as migrant workers. It will allow procurement of healthcare services from both the public and private sectors and the free choice of healthcare provider. It will also introduce the concept of a family doctor. Although the legal framework for the implementation of the National Health Insurance System has been more or less in place since 2001 and the National Health Insurance Organisation has already been set up, substantial amendments to the legal framework are currently before the House of Representatives, and the system is not expected to be implemented before the second half of 2011[27].

## LEGAL ENTITLEMENTS TO HEALTHCARE

In Cyprus, there is no universal health coverage for **nationals** at present; there are different schemes which apply to different categories of nationals.

Civil servants, retired civil servants and their families, persons holding public positions (e.g. the President, Ministers, Mayors etc.), persons with specific chronic life-threatening diseases, other specific categories of persons such as students in Cyprus and abroad, members of the army, convicts and families or elderly (over 65) under certain income thresholds[28], have access to the public health system either free of charge or co-paid, depending on income levels: holders of "medical card A" have access to healthcare free of charge, and holders of "medical card B" have co-paid access to health services.

The coverage attached to "medical card A" (free of charge) and to "medical card B" (co-paid) includes primary and secondary care (outpatient and inpatient), tests, diagnosis and prevention, all necessary medicines for treatment prescribed by a doctor, dental treatment with the exception of

[27] Information provided by the Chair of the National Health Insurance Organisation.

[28] Persons without dependants with annual income below €15.377,41, members of families with total annual income below €30.754,83 (plus €1.708,60 for every dependant child); members of families with four or more children; and enclaved Greek Cypriots and the members of their families are entitled to healthcare free of charge (holders of medical card A). Persons without dependants with annual income over €15.377,41 but not higher than €20.503,22, and members of families with total annual income over €30.754,83 but not higher than €37.589,23 plus €1.708,60 for every dependant child, are entitled to a reduced rate (holders of medical card B).

dentures[29], medical rehabilitation, including certain prosthetic and orthopaedic items, medical home-visits in exceptional cases such as life threatening situations, and medical transport[30]. Chronic psychiatric care is excluded, but compulsory psychiatric care by court order in a public psychiatric institution is included and is free of charge in all circumstances.

Holders of “medical card A” and other categories entitled to medical care free of charge in public medical institutions pay a nominal contribution to access healthcare services as outpatients, for both primary and secondary care, except for example for persons over the age of 65 under certain income thresholds, for whom access is free of charge[31]. As inpatients however, they don’t pay anything, except civil servants and other government officials[32]. Holders of "medical card B” (middle-income nationals and their families) have to pay a certain amount for primary and outpatient secondary care per visit, plus 50% of the fees provided for in the relevant regulations[33]. As inpatients they have to pay 50% of the fees provided for in the regulations or fees calculated on the basis of income, whichever is the lowest.

Depending on the relevant regulations, and with the exception of these categories, other nationals have to pay full fees for primary and secondary care (outpatient and inpatient), as well as for medical transportation. However, persons not entitled to medical card A or B on the basis of their income, excluding civil servants, are basically excluded from public health coverage and have to access healthcare through other schemes. These include trade union provision of medical services (mostly primary healthcare), private sector health facilities, or employer-sponsored arrangements. Bank employees and persons working for organisations providing services in the public interest, for example, are provided with full medical cover in health facilities in the private and sometimes in the public sector.

Irrespective of the above categorisation, certain health services are always offered free of charge to all nationals. These include emergency care; the prevention and treatment of tuberculosis, sexually transmitted diseases and HIV; tests and treatment of thalassemia; blood tests linked to blood donations; immunization for preventive purposes; tests or treatment approved by the Minister of Health for scientific purposes, for reasons of public interest or for public health reasons; mandatory psychiatric care; treatment or services offered to persons suffering from kidney failure, muscle failure or multiple sclerosis; Alzheimer; persons who have undergone any type of organ transplant; hemophilia; paraplegics and quadriplegics; persons with hearing impairments; autistic or diabetic children and children with genetic physical anomalies (up to the age of 18); the treatment of various chronic illnesses such as cancer, diabetes, rheumatics, epilepsy, Parkinson's disease and hepatitis B and C. [34]

These health services are also free of charge to **all residents,** as this care is provided to anyone, irrespective of income, nationality or legal status[35]. The Ministry of Health confirms that the legal provisions must be interpreted as applying to every person living in Cyprus, irrespective of nationality or legal status. However, in practice, authorised residents and migrants without residence permits are usually denied these entitlements.

Not all **authorised residents** access healthcare on the same basis as nationals. Entitlements to healthcare vary according to the legal status of authorised residents and to their professional sector, and can be minimal. Legally, persons under international protection have the right to the same treatment as nationals as far as free medical care is concerned[36]. As a result, persons under international protection are entitled to medical card A or B according to income criteria. The other categories of authorised residents, mainly students and migrant workers, are completely excluded

[29] Dentures are however covered free of charge for some categories of persons. See Regulation 7(7) of the *peri Kyvernitikon Iatrikon Idrimaton kai Ypiresion Genikoi Kanonismoi* (on public health system) of 2000 as amended.
[30] See Regulation 6 of the *Iatrikon Idrimaton* of 2000.
[31] See Regulation 7(5) of the *Iatrikon Idrimaton* of 2000.
[32] See Regulation 9(2) and (3) of the *Iatrikon Idrimaton* of 2000.
[33] See Regulation 7(3) of the *Iatrikon Idrimaton* of 2000.
[34] Regulations 9(3), 8 and Table 6 of the *Iatrikon Idrimaton* of 2000.
[35] See Regulation 6 *peri Kyvernitikon Iatrikon Idrimaton kai Ypiresion Genikoi Kanonismoi* (on public health system) *of 2000* as amended. See also Regulation 3(3).
[36] *O peri Prosfigon Nomos tou* 2000 (Refugee Law), section 21(1)(b).

from public healthcare[37] and depend either on trade union medical insurance schemes or private medical insurance. Migrant workers who are members of trade unions or work in sectors where there are collective employment agreements, such as the building industry or the hotel industry, are normally covered by trade union medical insurance schemes. Remaining migrant workers, together with students, depend entirely on private medical insurance schemes. Migrant workers not covered by any specific medical scheme have to contribute 50% of the costs of their medical insurance, with the other 50% covered by their employer. Such insurance covers only very basic medical care. For instance, women domestic workers - the majority of the migrant workers in Cyprus[38] - contribute 50% of the costs for their medical insurance and are not even covered for gynaecological and delivery care. Their access to healthcare is therefore severely restricted.

An additional element that needs to be taken into account is that all migrants who wish to enter Cyprus, either as workers or as students, have to take health tests in their country of origin to obtain an entry permit. HIV-infected persons and persons with Hepatitis B or C, for example, are not allowed to come to Cyprus in any circumstances, whether for residency, work or study. For workers, these tests are renewed when they apply for a work permit and are at the expense of the employer, who usually transfers the cost to the migrant. If these health tests reveal any health problems, the law foresees that these migrants are deported to their country of origin without access to healthcare in Cyprus[39].

According to the relevant regulations, **asylum seekers** are entitled to access *"free medical care in all public medical institutions, if they do not have sufficient resources"*[40]. The medical care provided *"includes, as a minimum, emergency care and necessary treatment"*[41]. Emergency care is always provided to asylum seekers, whatever the circumstances[42]. Asylum seekers in reception centres or receiving welfare benefits are automatically presumed not to have sufficient resources[43]. Asylum seekers who come within the vulnerable group category, such as minors, unaccompanied minors, persons with special needs, elderly persons, pregnant women, single-parent families, and victims of torture, rape or other forms of psychological, physical or sexual violence, are entitled to the medical card A in all circumstances[44].

To access the health system free of charge, the remaining and also majority of asylum seekers need to obtain the "medical card A" directly from the Ministry of Health. Before being issued with this card, those not automatically presumed to lack sufficient resources need to prove this fact on the basis of the same income criteria applied to nationals eligible for "medical card A"[45]. This medical card is valid for as long as the persons has asylum seeker status. It therefore depends on the asylum process of each individual and is issued at the discretion of the Ministry of Health in coordination with the Asylum Service. According to the regulations, however, and as a general rule, all medical cards are valid for two years[46]. Asylum seekers usually receive their medical card six months after submitting their first asylum application. During the first six months, all asylum seekers are entitled to welfare benefits because they are not entitled to work. After this, the validity period depends on factors such as the duration of the asylum procedure, employment status and whether the person has earned sufficient means in the meantime. It should be noted that in legal terms[47], asylum seeker status is only valid until a decision is taken by the Refugee Reviewing Authority, which is the administrative body that determines appeals for asylum at second instance. Thereafter, even if asylum seekers have the right to challenge a decision of the Refugee Reviewing Authority

[37] According to the Regulations anyone who is not a national or an EU citizen should pay the full fees provided in the regulations, irrespective of income.
[38] According to the statistics of the Civil Registry and Migration Department, among the 66,000 third country nationals, residing legally in Cyprus, 20,000 are domestic workers; in addition, a big number of domestic workers are undocumented.
[39] See *Oi peri Allodapon kai Metanastefseos Kanonismoi* of 1972 (Aliens and Immigration Regulation).
[40] See Regulation 15 of the *Oi peri Prosfigon (Sinthikes Ypodohis Aititon) Kanonismoi tou* 2005 (on asylum seekers' reception conditions).
[41] See Regulation 15 (1) of the *Prosfigon* of 2005.
[42] See Regulation 15(3) of the *Prosfigon* of 2005.
[43] *idem*
[44] See Regulation 15(2) of the *Prosfigon* of 2005.
[45] *idem*
[46] See Regulation 4(3) of the *Iatrikon Idrimaton* of 2000.
[47] Sections 2 and 8 of *Peri Prosfigon Nomos tou* of 2000 (Refugee Law)

before the Supreme Court and therefore are still seeking asylum, they do not have the right to remain in Cyprus. Court proceedings can take up to three years. During this period, asylum seekers are not protected from refoulement and from detention for the purpose of deportation, nor do they enjoy any of the reception conditions provided for in the regulations, including access to healthcare.

There are no specific legal provisions regarding access to healthcare for **undocumented migrants.** However, according to Ministry of Health circulars, regulations should be implemented to allow access to emergency care free of charge for any person inasmuch as he or she does not require hospitalisation. As mentioned above, in addition to emergency care, some medical services (including the diagnosis and treatment of HIV and other infectious diseases) are offered free of charge, at least in theory, to all persons. Finally, if a court orders the mandatory treatment of an undocumented migrant in a psychiatric hospital, this treatment is always free of charge.

# ADULTS CARE

## EMERGENCY CARE

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| **Nationals** | **Entitlements:**<br>Access free of charge within the public system, excluding medical transport for non-holders of medical card A or B[48]. |
| | **Conditions:**<br>➢ Show and ID card or medical card A or B (if applicable).<br>➢ Pay the cost of the medical transport (except for holders of medical cards A or B). |
| **Authorised residents** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>➢ Show residence permit and ID card.<br>➢ Pay the cost of the medical transport (except for holders of medical cards A or B). |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge, medical transport included. |
| | **Conditions:**<br>➢ Show proof of their status as asylum seekers (“medical card A”, valid residence permit or confirmation of submission of an asylum application). |
| **Undocumented migrants** | **Entitlements:**<br>Access free of charge |
| | **Conditions:**<br>No particular conditions.<br>However in the health sector, there is a growing tendency to denounce undocumented migrants (mostly by the hospital administrations). |

[48] See Regulations 8(3) and 7(2) of the *Iatrikon Idrimaton* of 2000.

# PRIMARY AND SECONDARY (OUTPATIENT) HEALTHCARE

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| **Nationals** | **Entitlements:**<br>a) Holders of "medical card A", or other specific categories of persons holders of a special card[49]:<br>i) Low-income nationals and their families who are holders of "medical card A", as well as specific categories of persons who are holders of a special card (e.g. public officials, civil servants, students): access co-paid except for certain medical services and the treatment of serious chronic diseases to which they have access free of charge[50];<br>ii) The elderly (over 65) and certain other categories of persons and their families, regardless of income (e.g. army, persons with disabilities, welfare beneficiaries, and convicted persons): access free of charge[51].<br><br>b) Holders of "medical card B": access co-paid[52] except for certain medical services and the treatment of serious chronic diseases.<br><br>c) Nationals not entitled to a medical card or not coming within a specific category: Payment of full costs, except for certain medical services and the treatment of serious chronic diseases. |
| | **Conditions:**<br>a) Holders of "medical card A" and specific categories of persons, regardless of income:<br>i) Low-income nationals and their families who are holders of "medical card A", as well as specific categories of persons who are holders of a special card (e.g. public officials, civil servants, students)<br>➤ Show "medical card A" / special card.<br>➤ Pay the nominal contribution (€2), except for certain medical services and the treatment of serious chronic diseases.<br>ii) The elderly (over 65) and certain categories of persons and their families, regardless of income (e.g. army, persons with disabilities, welfare beneficiaries and convicted persons):<br>➤ Show "medical card A" / special card.<br><br>b) Holders of "medical card B":<br>➤ Show "medical card B".<br>➤ Pay the nominal contribution (a fixed amount: €6.50 for primary care and €8.50 for secondary care per visit).<br>➤ Pay 50% of the cost of specific medical services, except for certain medical services and the treatment of some serious chronic diseases.<br><br>c) Nationals not entitled to a medical card or not coming within a specific category:<br>➤ Show an ID card<br>➤ Payment of full costs, except for certain medical services and the treatment of serious chronic diseases[53]. |
| **Authorised residents** | **Entitlements:**<br>a) Persons under international protection: same as nationals.<br><br>b) Long-term residence status: same as nationals.<br><br>c) Other authorised residents:<br>i) If employed in a sector covered by trade union medical insurance schemes: access through the relevant schemes, mainly in the private sector. |

[49] See Regulation 7(5) of the *Iatrikon Idrimaton* of 2000.
[50] For the list of free medical services and serious chronic diseases see Regulation 8 and Table 6 of the *Iatrikon Idrimaton* of 2000.
[51] See Regulation 7(5) of the *Iatrikon Idrimaton* of 2000.
[52] Regulation 7(3) of the *Iatrikon Idrimaton* of 2000.
[53] For a complete list of these exceptions, see the introduction of the Cypriot country profile.

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| **Authorised residents** | ii) If employed in other sectors: Access co-paid by the patient and employer in ther public sector through a private insurance scheme covering limited medical services. If no private insurance scheme covers the medical services: full payment of care provided either in the public or private sector.<br>iii) Students and other categories of persons not in employment: Payment of full costs in the public sector if no private insurance coverage (which in any case is compulsory). |
| | **Conditions:**<br>a) Persons under international protection:<br>➢ Show medical card A or B (if applicable).<br>➢ Show valid residence permit.<br><br>b) Long-term residents:<br>➢ Show medical card A or B.<br>➢ Show valid residence permit.<br><br>c) Other authorised residents:<br>i) If employed in a sector covered by trade union medical insurance schemes:<br>➢ Show trade union membership.<br>➢ Show valid residence permit.<br>ii) If employed in other sectors:<br>➢ Take out private health insurance (compulsory).<br>➢ Pay 50% of private insurance contribution (the other 50% is paid by the employer).<br>➢ Pay total or part of the cost of the service (depending on insurance coverage).<br>iii) Students and other categories of persons not in employment:<br>➢ Take out private health insurance (compulsory).<br>➢ Pay the whole private insurance contribution.<br>➢ Pay all or part of the cost of the service (depending on insurance coverage). |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge to "necessary treatment" ONLY for holders of "medical card A", i.e. living in a reception centre, receiving welfare benefits, belonging to a vulnerable group, or with a proven lack of sufficient resources<br>Otherwise, they have to pay the full cost. |
| | **Conditions:**<br>a) Asylum seekers living in reception centres, receiving welfare benefits, or belonging to a vulnerable group:<br>➢ Show "medical card A".<br><br>b) Other asylum seekers:<br>i) If they can prove lack of sufficient resources:<br>➢ Show "medical card A".<br>ii) If they do not prove lack of sufficient resources:<br>➢ Payment of full cost.<br><br>Even if entitled to access free of charge, in practice, asylum seekers pay €2 as a nominal contribution, except for certain medical services and some serious chronic diseases, if treatment is necessary[54] . |
| **Undocumented migrants** | **Entitlements:**<br>Payment of full costs. |

[54] They are entitled to access medical care free of charge in accordance with the Refugee law and regulations. This means they should pay no fees at all. However, the authorities interpret this as the same care provided to nationals holding the medical card A and therefore require them to pay €2.

# HOSPITALISATION (INPATIENT CARE)

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| **Nationals** | **Entitlements:**<br>a) Holders of "medical card A" or other specific categories of persons[55]:<br>i) Low-income elderly (over 65) and nationals and their families, as well as specific categories of persons who are holders of a special card (e.g. public officials, civil servants, students): access free of charge.<br>ii) Certain categories of persons and their families, regardless of income (e.g. army, persons with disabilities, welfare beneficiaries, and convicted persons): access co-paid, except for certain medical services or chronic diseases.<br><br>b) Holders of "medical card B": access co-paid, except for certain medical services and serious chronic diseases.<br><br>c) Nationals not entitled to a medical card or not coming within a specific category: access co-paid, except for certain medical services and serious chronic diseases. |
| | **Conditions:**<br>a) Holders of "medical card A":<br>i) Low-income elderly (over 65) and nationals and their families, as well as specific categories of persons who are holders of a special card (e.g. public officials, civil servants, students):<br>➢ Show "medical card A" / special card<br>ii) Certain categories of persons and their families, regardless of income (e.g. army, persons with disabilities, welfare beneficiaries and convicted persons):<br>➢ Show their special medical card<br>➢ Pay a daily fixed amount for accommodation ranging from €6.83 to €20.50 per day according to accommodation class.<br><br>b) Holders of "medical card B":<br>➢ Show "medical card B".<br>➢ Depending on income criteria, pay 50% or a percentage ranging from 20% to 30% of the full cost of the medical service (some of the payment to be made in advance), except for certain medical services and serious chronic diseases.<br><br>c) Nationals not entitled to a medical card or not falling into a specific category:<br>➢ Show ID Card.<br>➢ Pay a percentage ranging from 20% to 30% of the full cost of the specific medical service depending on income, except for certain medical services or certain serious chronic diseases (some of the payment to be made in advance). |
| **Authorised residents** | **Entitlements:**<br>a) Persons under international protection: same as nationals.<br><br>b) Long-term residents: same as nationals.<br><br>c) Other authorised residents:<br>i) If employed in a sector covered by trade union medical insurance schemes, access through the relevant schemes, mainly in the private sector.<br>ii) If employed in other sectors, NO access free of charge to the public healthcare system. Access co-paid by the patient and employer through a private insurance scheme.<br>iii) Students and other categories of persons not in employment: NO access free of charge to the public healthcare system (payment of full cost if no private insurance coverage which in any case is compulsory). |

[55] See Regulation 9(2) of the *Iatrikon Idrimaton* of 2000

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| **Authorised residents** | **Conditions:**<br>a) Persons under international protection **&** b) Long-term residents:<br>➢ Show medical card A or B.<br>➢ Show valid residence permit.<br><br>c) Other authorised residents:<br>i) If employed in sector covered by trade union medical insurance schemes:<br>➢ Show trade union membership.<br>➢ Show valid residence permit.<br>ii) If employed in other sectors:<br>➢ Take out private health insurance (compulsory).<br>➢ Pay 50% of private insurance contribution.<br>➢ Pay all or part of the cost of the service (depending on insurance coverage).<br>iii) Students and other categories of persons not in employment:<br>➢ Take out private health insurance (compulsory).<br>➢ Pay the whole private insurance contribution.<br>➢ Pay all or part of the cost of the service (depending on insurance coverage). |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge to "necessary treatment" ONLY for holders of "medical card A", living in a reception centre, receiving welfare benefits, belonging to a vulnerable group, or with a proven lack of sufficient resources<br>Otherwise, they have to pay the full cost. |
| | **Conditions:**<br>a) Asylum seekers living in reception centre, receiving welfare benefits, or belonging to a vulnerable group:<br>➢ Show the "medical card A".<br><br>b) Other asylum seekers:<br>i) If they can prove lack of sufficient resources:<br>➢ Show "medical card A".<br>ii) If they do not prove lack of sufficient resources:<br>➢ Payment of full cost.<br><br>Even if entitled to access free of charge, in practice, asylum seekers pay €2 as a nominal contribution, except for certain medical services and some serious chronic diseases, if treatment is necessary. |
| **Undocumented migrants** | **Entitlements:**<br>Payment of full costs. |

# ANTE- AND POSTNATAL CARE

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| **Nationals** | **Entitlements:**<br>Access not provided for by particular legal or administrative provisions. In practice, the same entitlements apply as for any other healthcare service[56]. |
| | **Conditions:**<br>No particular legal or administrative provisions. In practice, the same conditions apply as for all other healthcare services, depending on whether they receive outpatient or inpatient services. |
| **Authorised residents** | **Entitlements:**<br>Same as nationals |
| | **Conditions:**<br>Same as nationals. |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>Same as nationals. |
| **Undocumented migrants** | **Entitlements:**<br>NO access free of charge, except in case of emergency. |
| | **Conditions:**<br>➤ Show passport or other documentation.<br><br>In practice, hospital authorities will as a rule inform the immigration police of the woman's irregular status and therefore she risks being arrested and deported once the health situation of the mother and the child allows[57]. |

[56] For instance, free of charge for holders of medical card A and the other categories entitled to free of charge services, and co-paid for medical card B holders. Nationals who are not holders of these medical cards have to pay the full fees.
[57] Information provided by the organisation KISA.

# ADULTS TREATMENT

## MEDICINES

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|---|---|
| **Nationals** | **Entitlements:**<br>a) Holders of "medical card A" and other specific categories of persons: access free of charge.<br><br>b) Holders of "medical card B": access copaid. Patients pay 50% of the cost of the medicines.<br><br>c) Nationals not entitled to a medical card or not coming within a specific category: NO access free of charge or co-paid (payment of full cost). |
| | **Conditions:**<br>a) For holders of "medical card A" and special categories of persons:<br>➢ Show "medical card A" / special card.<br><br>b) For holders of "medical card B":<br>➢ Show "medical card B". |
| **Authorised residents** | **Entitlements:**<br>a) Persons under international protection: same as nationals.<br><br>b) Long-term residents: same as nationals.<br><br>c) Other authorised residents:<br>i) If employed in a sector covered by trade union medical insurance schemes: covered by trade union medical insurance schemes.<br>ii) If employed in other sectors: NO access free of charge. Access co-paid by the patient and employer through a private insurance scheme, if medicines not excluded in the insurance coverage.<br>iii) Students and other categories of persons not in employment: NO access free of charge to the public healthcare system (payment of full costs if no private insurance coverage or if the private insurance does not cover medicines). |
| | **Conditions:**<br>a) Persons under international protection **&** b) Long term residents<br>➢ Show medical card A or B.<br>➢ Show valid residence permit.<br><br>c) Other authorised residents:<br>➢ Payment of full costs, unless covered by a trade union scheme or a private insurance also covering medicines. |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge ONLY for holders of "medical card A" living in a reception centre, receiving welfare benefits, belonging to a vulnerable group or with a proven lack of sufficient resources.<br>Otherwise, they have to pay the full cost. |
| | **Conditions:**<br>a) Asylum seekers living in reception centre, receiving welfare benefits or belonging to a vulnerable group:<br>➢ Show "medical card A".<br><br>b) Other asylum seekers:<br>i) If they can prove a lack of sufficient resources:<br>➢ Show "medical card A".<br>ii) If they do not prove a lack of sufficient resources:<br>➢ Payment of full cost. |
| **Undocumented migrants** | **Entitlements:**<br>NO access free of charge. |

# HIV SCREENING

| | |
|---|---|
| **Nationals** | **Entitlements:**<br>Access free of charge and anonymous. |
| | **Conditions:**<br>No particular conditions required. |
| **Authorised residents** | **Entitlements:**<br>a) Persons under international protection: access free of charge and anonymous.<br><br>b) Long-term residents: access free of charge and anonymous if on a voluntary basis.<br><br>c) Other authorised residents: access free of charge and anonymous if on a voluntary basis (law) BUT in practice payment of full costs in private facilities.<br><br>*All employed migrants are under the obligation to take HIV screening under the law. In such cases not only the screening is not done anonymously but the results of the test are always communicated to the immigration authorities so as to take the necessary actions (deportation/detention).* |
| | **Conditions:**<br>a) Persons under international protection & b) long-term residents<br>➤ Show valid residence permit.<br><br>c) Other authorised residents:<br>In practice, payment of full costs in private facilities. |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge ONLY for holders of "medical card A", i.e. living in a reception centre, receiving welfare benefits, belonging to a vulnerable group or with a proven lack of sufficient resources.<br>Otherwise, they have to pay the full costs.<br><br>*All asylum seekers are under the obligation to take HIV screening under the law. In such cases the screening is not done anonymously and the results of the test are always communicated to the asylum authorities so as to take the necessary actions (deportation/detention).* |
| | **Conditions:**<br>a) Asylum seekers living in reception centres, receiving welfare benefits, or belonging to a vulnerable group:<br>➤ Show "medical card A".<br><br>b) Other asylum seekers:<br>i) If they can prove a lack of sufficient resources:<br>➤ Show "medical card A".<br>ii) If they do not prove a lack of sufficient resources:<br>➤ Payment of full costs in private facilities. |
| **Undocumented migrants** | **Entitlements:**<br>Access free of charge and anonymous if done on a voluntary basis BUT in practice payment of full costs.<br>*The results of the test could be communicated to the immigration authorities so as to take the necessary actions (deportation/ detention).* |
| | **Conditions:**<br>No particular conditions required. |

# HIV TREATMENT

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|---|---|
| **Nationals** | **Entitlements:**<br>Access free of charge and anonymous. |
| | **Conditions:**<br>No particular conditions required. |
| **Authorised residents** | **Entitlements:**<br>a) Persons under international protection: access free of charge.<br><br>b) Long-term residents: access free of charge.<br><br>c) Other authorised residents: access free of charge (law) BUT in practice payment of full costs in private facilities. |
| | **Conditions:**<br>a) Persons under international protection: No particular conditions required.<br><br>b) Long-term residents: No particular conditions required.<br><br>c) Other authorised residents: in practice, payment of full costs in private facilities |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>No particular conditions required. |
| **Undocumented migrants** | **Entitlements:**<br>Access free of charge (law) BUT in practice payment of full costs. |

# TREATMENT OF OTHER INFECTIOUS DISEASES

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| **Nationals** | **Entitlements:**<br>Access free of charge to screening and treatment of infectious diseases including STD, TB and Hepatitis B and C. |
| | **Conditions:**<br>No particular conditions required. |
| **Authorised residents** | **Entitlements:**<br>a) Persons under international protection: same as nationals.<br><br>b) Long-term residents: same as nationals.<br><br>c) Other authorised residents:<br>i) If employed in a sector covered by trade union medical insurance schemes: if covered by the insurance, access through the relevant schemes, mainly in the private sector. Otherwise, access free of charge in public facilities.<br>ii) If employed in other sectors: access free of charge (law) BUT in practice NO access free of charge.<br>iii) Students and other categories of persons not in employment: access free of charge (law) BUT in practice NO access free of charge. |
| | **Conditions:**<br>For a), b) and c) Persons under international protection, long-term residents and authorised residents:<br>➤ Show valid residence permit. |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge as holders of "medical card A" ONLY if living in a reception centre, receiving welfare benefits, belonging to a vulnerable group or with a proven lack of sufficient resources. |

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| | **Conditions:**<br>a) Asylum seekers living in reception centres, receiving welfare benefit, or belonging to a vulnerable group:<br>➤ Show "medical card A".<br><br>b) Other asylum seekers:<br>i) If they can prove a lack of sufficient resources:<br>➤ Show "medical card A".<br>ii) If they do not prove lack of sufficient resources:<br>➤ Payment of full costs. |
| **Undocumented migrants** | **Entitlements:**<br>Access free of charge (law) BUT in practice NO access free of charge. |

# CHILDREN

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| **Nationals** | **Entitlements:**<br>Access free of charge, co-paid or on a full payment basis, depending on parents' status.<br>Vaccinations: There are no compulsory vaccinations. All are recommended. Some of them are offered free of charge to all children, otherwise depending on the parents' status. |
| | **Conditions:**<br>➤ Show parents' medical card A, B or other<br>➤ Pay nominal contributions and/or part/full amount of services, depending on parents' status. |
| **Authorised residents** | **Entitlements:**<br>a) Children under international protection: same as nationals.<br><br>b) Children of long-term residents: same as nationals.<br><br>c) Children of other authorised residents: NO access free of charge in public healthcare facilities. Access only in private facilities and on full payment basis, unless parents are covered by trade union schemes. |
| | **Conditions:**<br>a) Children under international protection:<br>➤ Show valid residence permit.<br>➤ Show parents' medical card A or B (if applicable).<br>➤ Pay nominal contributions and/or part/full amount of services, depending on parents' status.<br><br>b) Children of long-term residents:<br>➤ Show valid residence permit.<br>➤ Show the parents' medical card A or B.<br>➤ Pay nominal contributions and/or part/full amount of services, depending on parents' status. |
| **Asylum seekers' children** | **Entitlements:**<br>a) If children file an independent asylum claim: access free of charge to all kinds of healthcare, as they are considered "vulnerable".<br><br>b) If children do not file an independent claim: access free of charge to "emergency care and necessary treatment" ONLY if living in a reception centre, if their parents receive welfare benefits or have proven lack of sufficient resources. |
| | **Conditions:**<br>a) Children filing an independent asylum claim:<br>➤ Show the parents' medical card A.<br>➤ Payment of nominal contribution for primary and secondary care.<br><br>b) Children not filing an independent asylum claim: |

| | |
|---|---|
| | i) Children of asylum seekers living in reception centres, receiving welfare benefits, or belonging to a vulnerable group:<br>➢ Show parents' medical card A.<br>➢ Payment of nominal contribution for primary and secondary care.<br><br>ii) Children of other asylum seekers:<br>a. If parents can prove a lack of sufficient resources:<br>➢ Show parents' medical card A.<br>➢ Payment of nominal contribution for primary and secondary care.<br><br>b. If parents do not prove lack of sufficient resources:<br>➢ Payment of full cost.<br><br>Even if entitled to access free of charge, in practice, children of asylum seekers pay €2 as a nominal contribution, except for certain medical services and some serious chronic diseases, if treatment necessary. |
| **Unaccompanied (asylum seeking) children** | **Entitlements:**<br>Access free of charge to all kinds of healthcare, as they are considered "vulnerable". |
| | **Conditions:**<br>➢ Show medical card A.<br>➢ Payment of nominal contribution for primary and secondary care. |
| **Children of undocumented migrants/ Unaccompanied (migrant) children** | **Entitlements:**<br>Access free of charge ONLY to emergency care and some specific medical services, including treatment of infectious diseases[58].<br>No access to vaccinations unless they attend school and the Ministry of Health organizes the immunization of school children. |
| | **Conditions:**<br>➢ Show identity cards of parents / identity documents (for unaccompanied migrant children.. |

# DETENTION CENTRES

| | |
|---|---|
| **Adults** | All persons in detention are entitled to access healthcare free of charge and to communicate with a doctor of their choice in the presence of a police or prison officer, depending on where he/she is held (in a police station or in a prison). In the event that they do not exercise their right to choose their own doctor, they are entitled to access healthcare in public hospitals or from government doctors visiting the detention centre or prison. In the latter case, the person in charge of the detention centre or prison makes the necessary arrangements to provide the detainees with access to public healthcare free of charge. If persons in detention choose their own doctor, they pay the costs.<br><br>However, in practice this access is not granted. Although the law regarding the rights of detainees provides that all detainees should access to health care free of charge, the (public) hospitals deny this access. The excuse of the Ministry of Health about this is that they are responsible to apply the law on Medical and Public Health Services and not any other law. According to the law on Medical and Public Health Services, only persons in custody (that is persons, who are in custody with directions of the court waiting for their trial) and convicts (persons, who are convicted to imprisonment by court decision) have access to free healthcare. Therefore, in the case of detainees (migrants, who are detained with arrest and deportation orders, for example), hospitals ask for their medical card (which they do not have) or for full payment of hospital charges in order to provide them healthcare. As a result, in practice detainees have access only to |

[58] See introduction on Cyprus.

| | |
|---|---|
| | emergency treatment.<br><br>Persons in detention should be informed in writing of the right to access healthcare in a language they understand and should sign a document stating that they have been informed of their rights. In all cases, any communication regarding the right to healthcare should be in a language understood by the detainee.<br><br>All medical examinations conducted in a detention centre or in a prison should be held in a private place unless it is considered dangerous for the doctor to be left alone with the detainee, in which case a member of the prison or detention centre of the same sex as the patient should be present. The results of the examination should always be written: the doctor is under an obligation to produce a written report on the health situation of the patient.<br><br>Pregnant women in detention are entitled to all necessary accommodations, namely access to the personal hygiene items required by their pregnancy. Women in detention who are breastfeeding are entitled to the accommodations necessary to be able to continue breastfeeding in detention in a private place and they have the right to choose to keep their baby in detention with them[59]. |
| **Children** | There is no general prohibition on the detention of children. The Refugee Law only prohibits detention of the children of asylum seekers[60]. However, children of asylum seekers may be detained under the Aliens and Immigration Law[61].<br><br>If children undergo a health examination or health treatment, the parents may be present. Children are entitled to the same healthcare as adults under detention, as there are no special provisions regulating children's access to healthcare. |

# TRANSFER OF OR ACCESS TO INFORMATION BY THE AUTHORITIES

**Transfer of or access to information on administrative status**: There is no legal provision requiring one authority to report or to provide information on the legal status of migrants to other authorities or to the immigration police.

However, as a matter of administrative practice, all authorities report to each other on the legal status of undocumented migrants and, as a rule, they inform the immigration police when they encounter undocumented migrants. Furthermore, according to KISA, there is a growing tendency in the health sector for undocumented migrants to be reported, usually by hospital administration services and, although more rarely, by doctors in public healthcare facilities.

[59] There are also provisions on the abuse of rights to access healthcare, such as asking for medical examinations or a transfer to the hospital so as to take advantage of more comfortable accommodation or other benefits, without this being necessary. Such abuse is punished by imprisonment not exceeding three years or a financial penalty not exceeding three thousand euros or both of these sanctions. See Section 30 of the *O peri to dikiomaton ton prosopon pou teloun ipo kratisi nomos tou* of 2005 (law on the rights of persons under detention).
[60] Section 7 of the *Peri Prosfigon* of 2000.
[61] Section 14 of the *Peri Allodapon kai Metanastefseos Nomos* (Aliens and Immigration Law)

# NON EXPULSION ON MEDICAL GROUNDS

## SUSPENSION OF EXPULSION PROCEDURES OR OF REFUSAL-OF-ENTRY ON HEALTH GROUNDS

The law[62] does not include any provisions relative to the suspension of deportation procedures or the suspension of refusal of entry on health grounds. However, whereas the Chief Immigration Officer has the power to deport any undocumented migrant, in practice, deportation may be suspended on health grounds, especially where children are concerned. This does not mean that the migrants concerned will necessarily be granted legal status.

## RESIDENCE PERMIT FOR MEDICAL REASONS: "RESIDENCE PERMIT ON HUMANITARIAN GROUNDS"

There are no specific residence permits granted for medical reasons. However, a special permit may be granted for humanitarian reasons on health grounds.

⇒ **WHO?**
Undocumented migrants who are seriously ill

⇒ **CONDITIONS:**
Permits on humanitarian grounds may be granted either as part of the asylum procedure or outside of the asylum procedure, directly by and at the discretion of the Minister of the Interior.

a) Residence granted under asylum procedures:
   - Under the asylum procedures, an applicant who has been denied refugee status or subsidiary protection may be granted a temporary residence permit on humanitarian grounds for as long as the humanitarian reasons continue to exist.
   - The status may be granted for any humanitarian reason, or when deportation is impossible in fact or in law, or if the applicant has the possibility of securing an entry visa for a third country willing to accept him/her. The decision to grant a permit on humanitarian grounds may also take account of the migrant's medical situation

b) Residence granted by the Minister of the Interior in accordance with the general framework on aliens and immigration:
   - No rights are attached to this status by law. In practice, if the Minister provides such a permit, the holder will be provided with the right to work and eventually enter the category of authorized resident migrant worker without access to free healthcare.

⇒ **DURATION:**
As long as the humanitarian reasons continue to exist[63]

⇒ **ACCESS TO HEALTHCARE:**
a) If a temporary residence permit is granted on humanitarian grounds through the asylum procedure: access to healthcare under the same terms as asylum seekers.
b) If a temporary residence permit is granted on humanitarian grounds by the Minister of the Interior within the general framework on aliens and immigration: NO access free of charge.

[62] O peri allodapon kai metanastevseos nomos (CAP. 105) as amended.
[63] There are not legal provisions establishing a time limit, although the authorities can re-examine the case at any time.

# PART 2: FIELD SURVEY IN CYPRUS

## METHODOLOGY AND SAMPLING

The survey was conducted between 15th August 2010 and 21st October 2010 in two cities in the southern part of Cyprus: Nicosia and, to a lesser extent, Limassol. Nine surveyors took part in the field work: eight volunteers (including one anthropologist) and one social worker, all from KISA.

Two complementary methods were used to identify the survey's target population:

- Asylum seekers and undocumented migrants who came to KISA were invited to participate
- The interviewers also held a number of interviews with respondents already known to them and then with others persons recommended by these respondents (the so-called snowball sampling method).

All in all, 103 people were interviewed, including 54 asylum seekers and 49 undocumented migrants.

1. Distribution by administrative status


Were considered as asylum seekers:

- Respondents who were in the administrative procedure of seeking asylum, e.g. it was their first claim for asylum in Cyprus and the decision was still pending in front of the administration (Asylum Service or Refugee Reviewing Authority); 47 people were interviewed.
- Respondents appealing to the Supreme Court against the denial of their asylum request. In such cases, although the person is still technically an asylum seeker, he or she no longer benefits from any protection or rights: the person is at risk of deportation and has no access to social benefits[64]. Seven asylum decision appellants were interviewed.

Among the 49 undocumented migrants interviewed, five respondents had an application for residency or citizenship pending at the time of the interview or were involved in a labour dispute, and one had been released from a detention centre because he could not be deported. Although these six people are undocumented, while these specific circumstances apply (application pending, labour dispute), they can not be deported.

A further six 'testimonial interviews' were held with KISA beneficiaries who had had recognised health problems since being in Cyprus. They were selected purposively and had not necessarily completed the questionnaire. Three were asylum seekers and three were undocumented migrants. These interviews were held by the interviewer who works as a social worker.

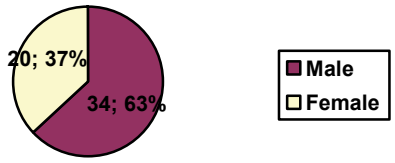
[64] In this regard, their situation is similar to that of undocumented migrants.

# I. DEMOGRAPHIC CHARACTERISTICS

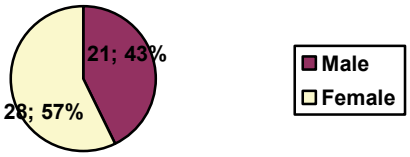
## 1. SEX AND AGE

2. Distribution by sex, by administrative status (nb; %)

Asylum seekers




Undocumented migrants



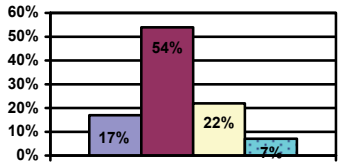

**63% of the asylum seekers interviewed were men and 37% were women**. This distribution is quite an **accurate reflection of the actual distribution by sex among asylum seekers in Cyprus** as, according to Eurostats, in the first quarter of 2010, 65% of asylum seekers were men.

Contrary to distribution per sex among asylum seekers, **undocumented women were more numerous (57%)** than undocumented men in our sample.

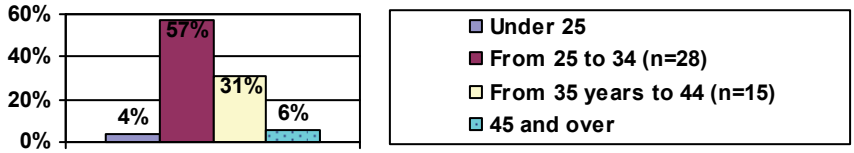
**The population interviewed was quite young:** asylum seekers were on average 32 years old (with no significant age difference between the men and the women), and undocumented migrants were on average 34 years old (35 on average for men and 32 for women).

3. Distribution by age groups, by administrative status (%)

Asylum seekers




Undocumented migrants




**In our sample, the majority of the asylum seekers interviewed (54%) were between 25 and 34 years old at the time of the interview**; few were under 25 (17%). The proportion of asylum seekers aged between 17 and 35 (71%) is again close to the actual proportion among asylum seekers in Cyprus in the first quarter of 2010[65]. Only 29% of the respondents were aged 35 or over, and a small minority was over 45 (7%). The eldest respondent was 60 years of age.

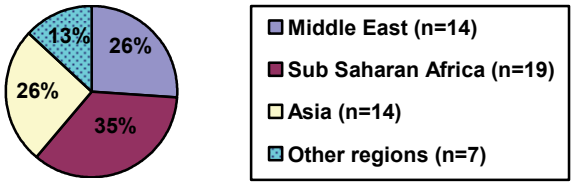
The distribution of **undocumented migrants** by age group does not differ significantly from that of asylum seekers. Altogether, **almost 90% of the respondents were aged between 25 and 44**. Only two respondents were under 25 and three were over 45 years of age (range: 24 to 53 years).

65 According to Eurostat, in the first quarter of 2010, 76% of asylum seekers over 17 years old were aged between 18 and 34 . Albertinelli A. (2010). Asylum applicants and first instance decisions on asylum applications in Q1 2010, *Eurostat,* 32/2010. Available at: http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-QA-10-032/EN/KS-QA-10-032-EN.PDF

## 2. REGIONS OF ORIGIN AND NATIONALITIES

### ASYLUM SEEKERS

4. Regions of origin of the asylum seekers interviewed (%)




**Twenty-seven nationalities were represented among the 54 asylum seekers interviewed, from three main regions of the world: 35% from Sub Saharan African countries, 26% from Asian countries and another 26% from Middle Eastern countries. A further 13% came from other regions or were stateless**.[66]

**Sub-Saharan Africa (n=19)**: **Among the 19 asylum seekers interviewed from Sub-Saharan African countries, seven different nationalities were represented**: five people were from **Cameroon**, four from the **Democratic Republic of Congo**, three from **Ghana**, three from **Somalia** and four from other countries (**Congo Brazzaville, Nigeria and Chad**). As reflected in our sample, asylum seekers from Cameroon are actually among the most numerous in Cyprus. Men were overrepresented (68%).

**Middle East (n=14): Respondents from the Middle East were of eight different nationalities including Palestine, Afghanistan, Lebanon, Iran, Jordan, Pakistan, Egypt and Syria** (one Kurd). Iraqis were not represented in our sample[67] although they are in fact the most numerous Middle Eastern asylum seekers in Cyprus[68].

**Asia (n=14)**: **Respondents from Asia came mainly from Nepal (5 respondents), Sri Lanka (4 respondents) and Bangladesh (2 respondents), but also from China, India and the Philippines**[69]. In our sample, half of the Asian asylum seekers were women.

**Other regions (n=7):** Three asylum seekers came from European countries outside of the European Union (Armenia, Georgia and Turkey), one came from Morocco, and three asylum seekers were stateless.

### UNDOCUMENTED MIGRANTS

5. Regions of origin of the undocumented migrants interviewed (%)


**The 49 undocumented migrants interviewed came from 17 different countries**. Most of their countries of origin were also represented among the asylum seekers interviewed, but there are significant differences in the distribution by regions of origin. **Nearly 60% of the respondents among the undocumented migrants interviewed came from Asian countries, 24% from**

[66] For a more precise repartition by nationality, see appendix 2, table 1 (section about Cyprus)
[67] This is partly because Iraqi asylum seekers are granted protection (at least, subsidiary protection) in Cyprus and therefore, they generally do not stay long under the status of asylum seeker. Moreover, the majority of Iraqis asylum seekers are Palestinians from Iraq. Two Palestinians from Iraq participated in the survey, but they are listed in the sample as Palestinians due to the fact that they do not possess the Iraqi citizenship
[68] According to Eurostat, however, in the first quarter of 2010, most Asian asylum seekers in Cyprus actually came from India. See Albertinelli A. (2010). Asylum applicants and first instance decisions on asylum applications in Q1 2010, *Eurostat,* 32/2010. Available at: http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-QA-10-032/EN/KS-QA-10-032-EN.PDF
[69] http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-QA-10-032/EN/KS-QA-10-032-EN.PDF

**European countries and only 10% and 6% from Middle Eastern countries or other regions respectively**.[70]

**Asia (n=29)**: **Among the undocumented migrants from Asian countries, 9 were from Sri Lanka, 7 from the Philippines, 5 from Bangladesh, 4 from Nepal, 3 from India and 1 from China**. **Most of the respondents were women** (62%).

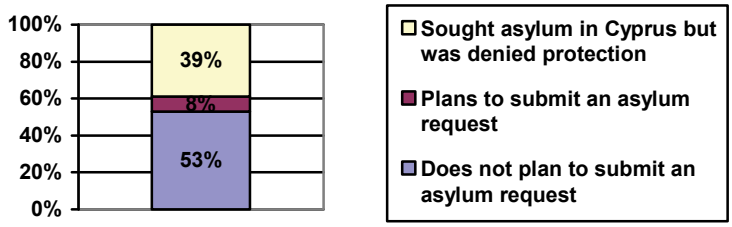
**Europe (n=12)**: The undocumented migrants with European citizenship came from **Georgia** (6 people), **Serbia** (3 people), **Russia**, and **Turkey** (one Kurd). **The majority were female**.

**Middle East and other regions (n=5)**: The respondents from Middle Eastern countries came mainly from **Syria** (3 respondents, including 2 Kurds). The two others came from **Jordan and Iran**. Three out of the five were women. **A further two respondents came from Sub Saharan African countries and one was stateless**.

# II. MIGRATION EXPERIENCE

## 1. ASYLUM PROCEDURES ATTEMPTED BY UNDOCUMENTED MIGRANTS

6. Asylum procedures attempted by the undocumented migrants interviewed, by region of origin (%)



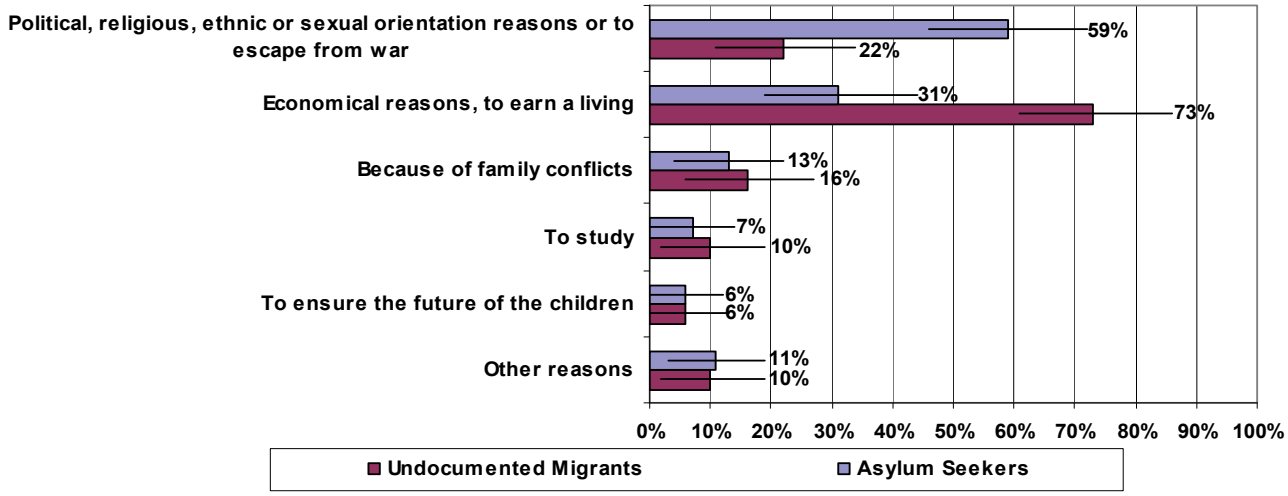

**Almost 40% of the undocumented migrants interviewed were former asylum seekers whose request for protection had been denied**. **These migrants came mainly from countries affected by conflicts or political instability**. 38% of the undocumented respondents from Asian countries who had sought asylum in Cyprus were from Bangladesh, India, Nepal and Sri Lanka. Those from Middle Eastern countries who had sought asylum were from Iran, and one was a Serbian Kurd. The two Sub Saharan Africans and the stateless respondent were also rejected asylum seekers. The European undocumented respondents who had sought asylum (25%) were from Georgia (two respondents) and one was a Kurd from Turkey.

53% of the undocumented migrants interviewed said they did not plan to submit an asylum request.

[70] For a more precise repartition per nationality, see appendix 2, table 2 (section about Cyprus)

## 2. REASONS FOR MIGRATION

7. Reasons given for migrating by the respondents, by administrative status (%)*




* The cumulated percentages exceed 100% because this was a multiple choice question.
* "Other reasons" include a contract to work in Cyprus, fleeing imprisonment and death of a husband. For undocumented migrants, half coming to join someone, one came for personal health reasons, and one was a victim of blackmail.

### ASYLUM SEEKERS

When asked about their reasons for migrating, **a large majority of the asylum seekers interviewed (**almost 60%) **said that they had fled political or religious persecution or persecution due to their ethnic origin or sexual orientation, or that they were escaping from war**. For 3/4 of these, this was the sole reason given for their emigration, and it was given most often by respondents from countries that are and/or have been affected by political instability and/or war. It was cited by 70% of the respondents from Middle Eastern countries (mostly respondents from Palestine and Iran and Kurds from Syria), and by all of the stateless respondents.

**On the other hand, 31% of respondents stated that they had emigrated for economic reasons**, to earn a living. This reason was most frequent among respondents from Asia (46%) and Europe (33%)[71], which is true of the actual situation in Cyprus and is a result of Cyprus's working immigration policy. **Some migrants from these regions came to Cyprus with work contracts signed in their countries of origin, and some may have been victims of people trafficking.** In Cyprus, trafficked persons are mainly women. Victims of human trafficking for sexual exploitation in their vast majority come from Eastern Europe (mainly Russia, Ukraine, Moldavia and Belarus) and Asia (mainly China and Vietnam). Victims of trafficking for labour exploitation usually are from China, Philippines and Sri Lanka[72]. **In more than half the cases where economic reasons were cited, additional reasons were given, usually linked to fear of political or religious persecution or persecution as a result of their ethnic origin or sexual orientation, or to the desire to escape from war.**

**The third most common reason given for migrating (13% of respondents) was family conflict**. **One-quarter of the women interviewed gave this reason**, which is quite an alarming figure (in five of the seven cases observed, the respondents were women). These women came from different regions of the world (Somalia, Philippines, Cameroon, or Bangladesh).

[71] This reason was only cited by 5% of the respondents from Sub-Saharan Africa, 13% of the respondents from Middle Eastern countries and none of the stateless asylum seekers interviewed.
[72] There also have been cases of trafficking for labour exploitation involving victims – both men and women – from new EU member states (i.e. Romania).

### UNDOCUMENTED MIGRANTS

**73% of the undocumented respondents gave economic motives as their reason for emigrating. A further 22% explained that they had emigrated to escape persecution on political, religious, ethnic origin or sexual orientation grounds, or to escape from war - reasons that in theory should ensure them refugee status. Among those, most had requested asylum, but were denied protection.**

A further 16% explained that they had emigrated to provide their children with a better future,10% came as students and 6% had fled family conflicts.

The reasons given by undocumented migrants for migrating differed considerably between respondents according to their countries of origin corresponding to the profile of immigration in Cyprus. Thus, for example the fact that the respondents from Sri Lanka and from the Philippines were more likely to explain they came to Cyprus for economical reason, can be linked to Cyprus immigration policies which encourage working immigration from these countries, by providing migrants with temporary working visa. On the other hand, the respondents from Middle East who were more likely to explain they fled persecution, corresponding to the inflows of people seeking protection in Cyprus. Overall, half of the rejected asylum seekers and undocumented migrants planning to submit an asylum request claimed to have left their countries for political, religious, ethnic or sexual orientation reasons or to escape from war.

### ALL RESPONDENTS

**Only one person out of the 103 respondents to the survey said that he had left his country for health reasons, among other reasons (less than1%). This finding tends to show that, contrary to some beliefs, seeking healthcare is a very uncommon reason for migration.**

## 3. TIME PERIOD SINCE MIGRATION

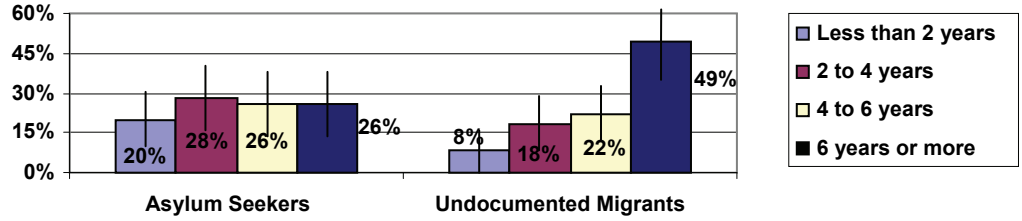
**Most of the migrants interviewed had been in Cyprus for a quite long period, more than 5 years on average.**

8. Average amount of time spent in Cyprus by region of origin of the respondents and by administrative status (%).

| Administrative status / Region of origin | Asylum seekers | Undocumented migrants | All respondents |
|---|---|---|---|
| **Asia (n=43)** | 4.5 | 7.5 | **6.5** |
| **Middle East (n=19)** | 4.7 | 5.3 | **4.8** |
| **Europe (n=15)** | 3.0 | 4.0 | **3.8** |
| **Sub Saharan Africa (n=21)** | 3.2 | 2.5 | **3.2** |
| **Total** | **3.9** | **6.1** | **4.9** |

**An analysis by region of origin of the average amount of time spent in Cyprus since migration reflects the different migration inflows into the country. Asian nationals had lived in Cyprus the longest** with an average of 6.5 years spent in the country, **followed by Middle Eastern nationals** with an average of almost 5 years, then European nationals with 3.8 years on average, and lastly, migrants from Sub Saharan African countries with 3.2 years on average.

9. Time period since migration, by administrative status (%)



### ASYLUM SEEKERS

**The asylum seekers interviewed had been living in Cyprus for an average of four years.** This average reached five years for people who had appealed against an asylum decision before the Supreme Court. **These findings demonstrate the extremely lengthy nature of the asylum process in Cyprus and how long asylum seekers have to live with uncertainty** about their future. This particular problem has been raised by institutions, NGOs and asylum seekers themselves[73].

More than half of the asylum seekers interviewed had been living in Cyprus for at least four years, and 26% for 6 years or more.

### UNDOCUMENTED MIGRANTS

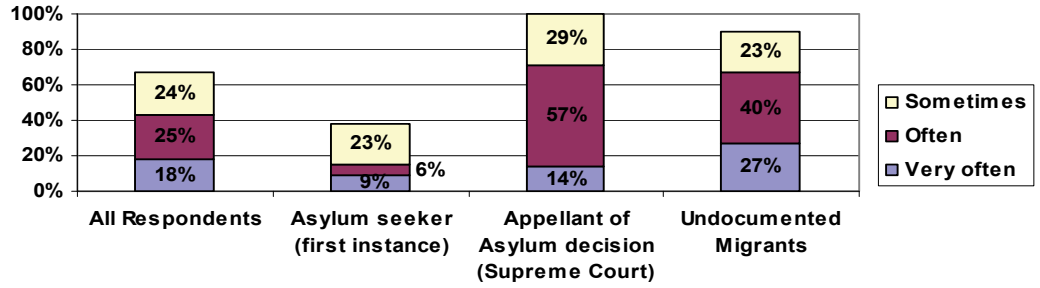
**The undocumented migrants interviewed had been living in Cyprus for longer than the asylum seekers, with an average of over six years**. In fact, half of the respondents had been living in Cyprus for six years or more**. It is probable that some** of the undocumented migrants interviewed had outstayed their visas and had thus **spent some months, or even some years, living legally in Cyprus before becoming undocumented**.

One respondent explained that he had first arrived in Cyprus more than twenty years ago and had therefore spent most of his life in the country. However, at the time of the interview, he did not officially exist in Cyprus and, as an undocumented migrant, had no rights.

The undocumented migrants who had applied for citizenship or a residence permit were generally those who had been living in Cyprus the longest (an average of ten years).

## 4. LIVING IN FEAR

10. Percentage of respondents who limit their activities for fear of arrest, by administrative status (%)




### ASYLUM SEEKERS

**Among the asylum seekers interviewed, 46% claimed to regularly limit their activities for fear of being arrested by the authorities**.

This finding calls for a closer analysis. The asylum seekers who felt the most vulnerable were those appealing to the Supreme Court against an asylum decision, as they are not anymore protected against deportation. All seven appellants interviewed claimed to limit their activities for fear of being arrested. However, even among asylum seekers whose request was at first instance (non appellants), almost 40% said they limited their activities for fear of being arrested. **This clearly illustrates that the asylum seekers interviewed felt their status gave them little protection**. **Even more disturbing is the fact that this tendency to limit activities for fear of arrest does not appear to decrease the longer a person spends in the country. Asylum seekers fled their countries to find protection, yet In Cyprus they live in constant fear and feel forced to live in hiding**.

**It should also be emphasized that 11% of the asylum seekers interviewed had been held in detention**[74].

[73] Olivier Clochard (2008), *op. cit*.
[74] Under the Refugee Law, detention can be ordered under Court decision if the person has destructed his travel documents for the purpose of identification examination, for a maximum time of 32 days (article 7). Asylum seekers can indefinitely remain in

**UNDOCUMENTED MIGRANTS**

The situation of the undocumented migrants interviewed was also very disturbing. **Overall, 90% claimed to limit their activities for fear of being arrested, generally often to very often. This behavior alerts us to the environment of fear in which undocumented migrants live their daily lives** and, as with asylum seekers, the situation does not appear to improve the longer they remain in Cyprus. **Testimony reveals that undocumented migrants are often the victims of suspicion, open racism in the street and threats of denunciation by Cypriots from all spheres of society**.

Furthermore, four respondents (i.e. 9% of the undocumented migrants interviewed) had been held in detention in Cyprus because of their administrative status. It should be noted that Cyprus has not set a legal maximum period for detention, although the authorities claim that, in practice, people are not held more than 6 months. There are cases, however, of detention lasting more than 2 years, especially for asylum seekers whose claim has been rejected but who cannot be deported[75].

**ALL RESPONDENTS**

**In Cyprus, most respondents lived in constant fear. As a result, 67% of them limited their activities to try to remain invisible.**

**Staying hidden was even more important when children were involved**. Some ¾ of the respondents who live with their children in Cyprus limit their activities. According to KISA, some may not send their children to school for fear of being discovered, especially undocumented migrants.

**Living in fear is potentially harmful to health as it not only leads to delays in seeking healthcare, but can also have serious consequences on psychological and physical health.**

# III. LIVING CONDITIONS IN CYPRUS

## 1. FAMILY AND SOCIAL NETWORK

### ■ Family situation

24% of the asylum seekers (n=12) and 39% of the undocumented migrants interviewed (n=19) had children. However, **some of the respondents lived apart from all or some of their children. This situation concerned two asylum seekers and eight undocumented migrants**.

**Some families may have been torn apart by migration[76] and it is known that separation from the family, especially from children, can seriously affect a person's psychological health**.

Depending on how long the migrants interviewed had lived in Cyprus, some respondents may also have (re)built a family in the host country, i.e. some of the respondents living with their children had had these children since migrating to Cyprus or may have reunified with their children in Cyprus. **Building a stable (new) personal relationship seemed however to have been quite rare**: only 24% of the asylum seekers and 22% of the undocumented migrants were living with a partner in Cyprus.

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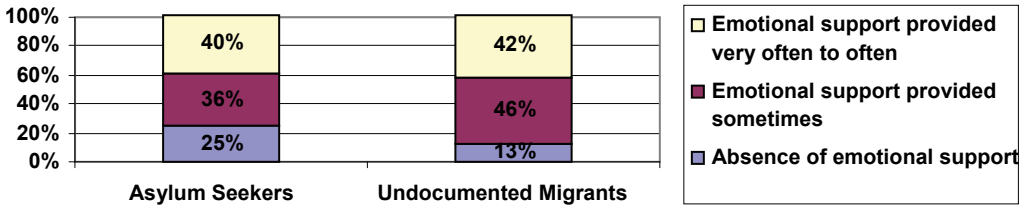
detention in case prior or after filing their asylum application a deportation and detention order is issued by the migration officer due to the fact that the asylum seeker was an irregular immigrant before he or she applied for asylum.

[75] As reported by Jeanine HENNIS-PLASSCHAERT in the report by the LIBE commission's delegation on its visit to Cyprus ( 25th to 27 th May 2008), Brussels, July 22nd 2008

[76] However, living apart from their children did not necessarily imply a separation due to the migration process, but may also refer to people whose children live in Cyprus but with the other parent. Nonetheless, it seems unlikely that this is the case for all the respondents who said they lived apart from their children. Testimony shows that, in particular for work migrants, the children did not accompany the migrant parent to Cyprus.

## ■ Access to emotional support

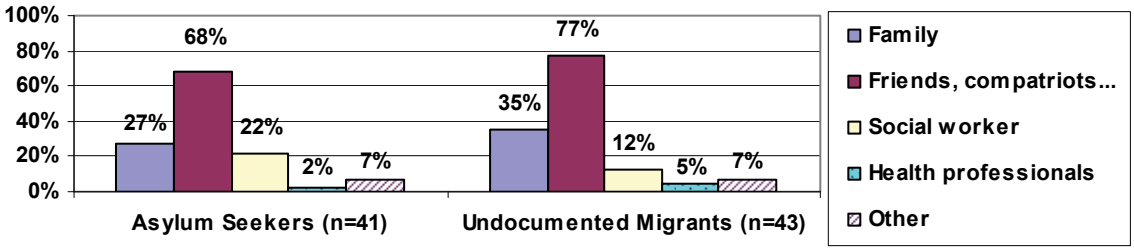
11. Availability of emotional support when needed, by administrative status (%)




**25% of the asylum seekers and 13% of the undocumented migrants said that they could never or almost never count on anyone for emotional support when they needed it.** This finding is significant as we know there is **a correlation between social isolation and a higher risk of disease** (not only mental health conditions). It has also been reported that **social isolation, a weak network and poor social support are factors in estrangement from the health system and more limited access to health services.**[77]

Only 40% of the asylum seekers and 42% of the undocumented migrants could count on emotional support often to very often. Among asylum seekers, there was no difference in the frequency of emotional support for men or for women. Among the undocumented migrants, however, the men interviewed were more likely to lack emotional support than women: almost 20% of them said they could never or almost never obtain emotional support when they needed it.

12. Source of emotional support for respondents who said they could count on such support when needed, by administrative status (%)*




*The cumulated percentages exceed 100% because this was a multiple choice question.

**For both undocumented migrants and asylum seekers, emotional support was mostly provided by friends or compatriots** (for 68% of asylum seekers and 77% of undocumented migrants benefitting from such support). Family members were cited by only 27% and 35% of asylum seekers and undocumented migrants respectively, due to the fact that many migrants had been separated from their family in migrating.

**Social workers played a role in providing emotional support for 22% of the asylum seekers and 12% of the undocumented migrants interviewed**. These findings should be treated with caution, however, as the interviewers were from KISA (the organisation KISA provides social counselling), and may have interviewed asylum seekers and undocumented migrants frequenting this organisation and benefitting from these services. It is possible that more isolated migrants not benefitting from such support were not reached by the survey.

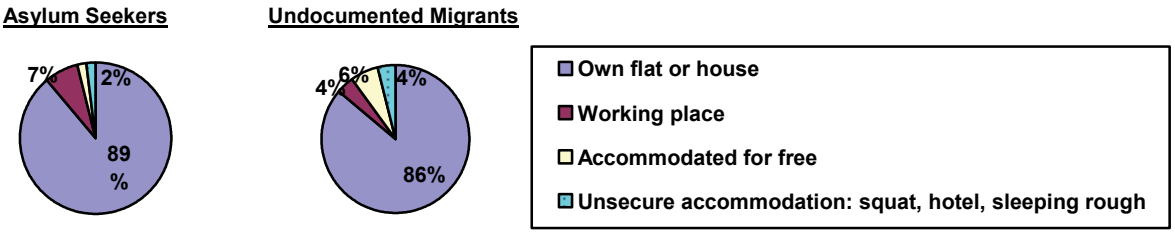
**Recourse to a health professional, and in particular a mental health professional, for emotional support was marginal**: only one asylum seeker and one undocumented migrant said they had recourse to a health professional when they needed support.

[77] On this subject see study specifically carried out among undocumented migrants in Milan; Devillanova C. (2008). Social networks, information and healthcare utilisation: evidence from undocumented immigrants in Milan. *Journal of Health Economics*, 27: 265-86.

## 2. HOUSING CONDITIONS

### ASYLUM SEEKERS

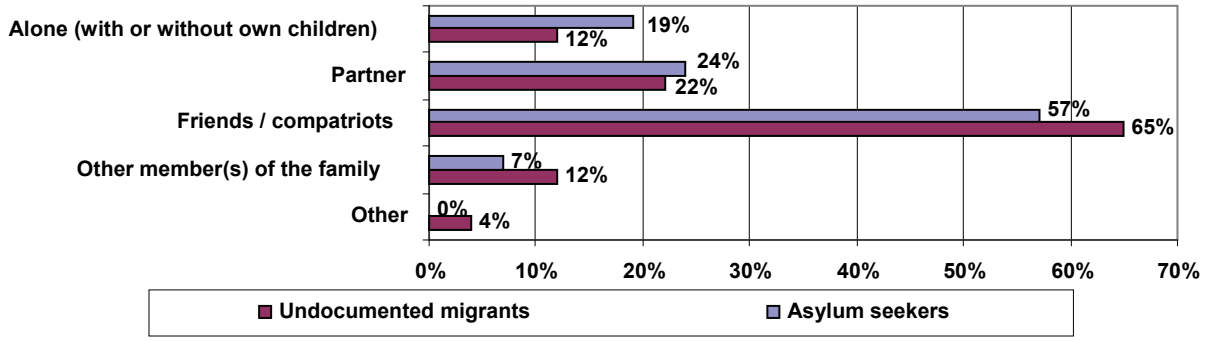
13. Distribution by type of accommodation, by administrative status (%)




**The type of accommodation occupied by our respondents did not differ significantly between undocumented migrants and asylum seekers**. **Almost 90% of the asylum seekers and 86% of the undocumented migrants interviewed were living in their own rented flat or house at the time of the interview.** Only four respondents were accommodated for free by their family or friends (7%), one worker was accommodated by his employer, and one was living in a hotel room at the time of the interview. The situation of two respondents was extremely precarious: one was squatting in abandoned premises and the other was sleeping rough.

**It appears that, like undocumented migrants, asylum seekers have very poor access to decent accommodation. The reception centre has a very low capacity, and single men are not accepted**.[78] Consequently, both asylum seekers and undocumented migrants need to find their own accommodation.

14. Persons with whom the respondents share accommodation, by administrative status (%)*




*The cumulated percentages exceed 100% because this was a multiple choice question.

**Respondents were usually sharing accommodation with friends or compatriots** (57% of the asylum seekers and 65% of the undocumented migrants).

**Overall, only 37% of the asylum seekers and 25% of the undocumented migrants were living alone or with their nuclear family** - children and/or partner- at the time of the interview. This concerns in particular those who had been living in Cyprus the longest (men and women alike).

**35% of the asylum seekers felt they had insecure occupancy**, including when they rented their own flat or house. **Furthermore, even the most vulnerable asylum seekers did not appear to receive the necessary protection and access to basic assistance**. Thus, this testimony by a woman diagnosed as HIV positive and appealing against the asylum decision to the Supreme Court is edifying:

> At the time of the interview she had no source of income and no rights to state support, as she was without legal status pending the Supreme Court decision. She would sleep at friends' or be lodged by various people until they asked for money. She explained that usually she could not spend more than a month in any one place: *"I have nothing...I*

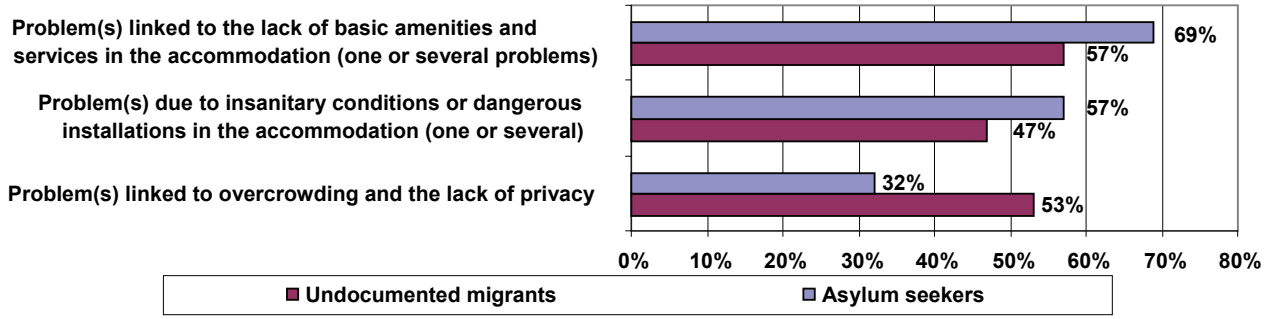
[78] Jeanine HENNIS-PLASSCHAERT in the Report of the delegation of the LIBE commission on the visit to Cyprus ( 25th to 27 th May 2008), Brussels, July 22nd 2008, p.5

*didn't eat for 2 days and so when I took my pills [antiretroviral treatment] I felt dizzy.""*
Asylum seeking woman from Cameroon, 32 years old

**The accommodation status of undocumented migrants was even more preoccupying. Almost half of them felt their current occupancy status was insecure and didn't offer a long term solution**, even though, on average, they had been living in Cyprus for many years. It is clear that **undocumented migrants encounter many barriers when trying to obtain decent accommodation**, including being unable to provide official documents proving residency or income, discrimination and abusive practices by landlords, no rights to social housing, a weak social network and the fear of being reported[79].

**Only 35% of the respondents rated their living conditions positively,** with no significant difference between asylum seekers and undocumented migrants. However, when asked to describe the **problems encountered with their accommodation that could potentially affect health, 87% of the respondents interviewed mentioned at least one problem**, and 65% mentioned several.

15. Types of problems encountered in the accommodation, by administrative status (%) *




*The cumulated percentages exceed 100% because this was a multiple choice question.

The numerous problems cited have been arranged into 3 categories to make their analysis easier: overcrowding and lack of privacy; lack of access to basic amenities; and insanitary and dangerous conditions. If the respondents cited several problems in the same category, only one was counted. This was actually the most common situation.

**Problems linked to the lack of access to basic amenities were cited by almost 70% of the asylum seekers and 57% of the undocumented interviewed**: overall, 50% lacked **ventilation**, 38% had no **temperature control**, 11% had no access to **fully functioning toilets or washrooms**, others had no access to **running water** (two respondents), or **electricity** (one respondent) and one other respondent did not have any windows in the accommodation.

In addition, **57% of the asylum seekers and 47% of the undocumented migrants said they were living in insanitary or dangerous accommodation**: 40% of the asylum seekers testified to the **presence of pests and vermin**, 19% described **dangerous and faulty electrical fittings**, and 17% complained **of damp and degradation**.

**Overcrowding was a problem for almost one-third of the asylum seekers and more than one half of the undocumented migrants interviewed**.

The description by one undocumented respondent of his housing conditions confirms the above data:

> His rented flat was due to be demolished. When he moved in, he discovered a filthy apartment filled with rubbish left by the previous occupiers, a dead cat, a broken washing machine, damp walls and overgrown vegetation outside. He alerted the municipality, to no avail. The rent was €500 euro and 9 people were living there: *"There are too many people, but we have no money."* Undocumented man from India, living in Cyprus for seven years

[79]Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009), *op. cit.,* p.59

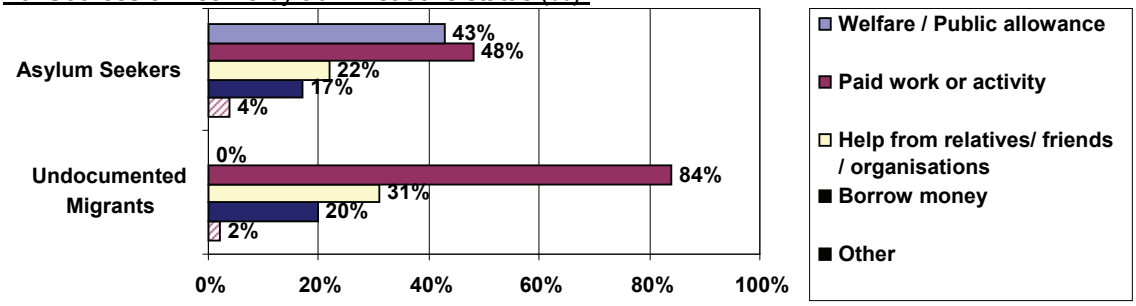
**These indecent, unsanitary and dangerous living conditions can have a serious impact on health, especially for the most vulnerable**. A testimony of a female asylum seeker infected by the Hepatitis B virus is enlightening: at the time of the interview, she had been in Cyprus for 4 years and was sharing a flat with another migrant woman in difficult and unsanitary conditions. They could hardly afford to the pay for electricity, so they didn't heat the water and there was no air conditioning.

## 3. SOURCES OF INCOME AND WORKING CONDITIONS

### ■ Sources of income

**Asylum seekers are allowed to work in Cyprus 6 months after filing a claim for asylum.**

16. Sources of income by administrative status (%)*




*The cumulated percentages exceed 100% because this was a multiple choice question.

#### ASYLUM SEEKERS

**In our sample, almost half of the asylum seekers interviewed (48%) were working for a living**. However, almost a quarter of these working asylum seekers also relied on a complementary source of income, usually help from a third party, which indicates that they earn very low salaries or do not regularly. **84% of the working asylum seekers said their work was not stable**. More men considered their work not to be stable (93%) than women (73%).

**43% of the asylum seekers depended on welfare as a source of income. 75% of them were entirely dependent on welfare payments which do not exceed €650 for a single person**. Slightly more men depended on welfare (47%) than women (35**%). KISA and other NGOs have denounced the fact that effective access to welfare entitlements is complicated and not ensured for all asylum seekers.**

Among the asylum seekers interviewed, **work and welfare were never combined**. However, in most cases, help from a third-party or borrowing money was cited as an additional source of income to work or welfare.

#### UNDOCUMENTED MIGRANTS

**The majority of undocumented migrants interviewed were working for a living** (84%). One third of them still depended on another source of income - help from a third-party or borrowing money - to obtain a minimum and stable level of income. **83% of the working undocumented migrants claimed their work was not stable**. Again the men in our sample were slightly more affected than the women. **Many studies highlight the precariousness and unstable working conditions of immigrants in Europe**: they are the first to lose their jobs in times of economic crisis.

Those who did not work received help from a third-party and/or borrowed money.

### ■ Sector of activity

**In Cyprus, asylum seekers have restricted access to labour market**. The initial governmental policy, which restricted asylum seekers' access to employment only to the farming and agricultural sector has been denounced as discriminatory and unlawful by the Ombudswoman[80] and by several NGOs. This led to a decision on 2/10/2008 which broadened the employment **sectors asylum seekers have access to. All of these sectors concern low-paid and unskilled jobs**[81]. Despite this decision, it is reported by NGOs that the employment offices **continue to offer jobs to asylum seekers only in the agricultural industry.** They base on the fact that the decision to broaden the areas of work gives **the employment offices a discretion power in its implementation**. Even in the case asylum seekers manage to find on their own a job in a sector that they theoretically have access to outside the agricultural and farming industry, employment offices use their discretion power to refuse to approve these employment contracts. **This reality consequently reduces the possibilities offered to asylum seekers to find work.**

**Among the working asylum seekers interviewed, no more than 4% actually worked in farming and agriculture**. This very small percentage may be a result of the **restrictive employment policy followed by the employment offices even in the agricultural sector**. Another reason could be the fact that most of the interviews were held among asylum seekers living in Nicosia and Limassol, i.e. in cities, but it may also be linked to a **certain disconnect between what the law provides for and the reality of the labour market for asylum seekers**. In any case, **the asylum seekers interviewed were forced to work outside of the legal framework and therefore did not benefit from social insurance or protection from exploitation**[82].

**Furthermore, the legal provision limiting the sectors in which asylum seekers are authorised to work does not take specific cases into account**. Some people may be unable to work in the farming sector because of physical health problems or because they have a dependent to take care of (disabled or sick child, for example), as in the following example:

> A Lebanese woman who has been seeking asylum in Cyprus for 7 years explained in an interview that her daughter had lost both her arms in an Israeli air strike in 2000. She was trying to find a job but, as asylum seekers are only employed in the farming sector, all the opportunities were at a considerable distance from her home. Nobody allowed for the fact that her disabled daughter was completely dependent on her and could not be left alone for any length of time.

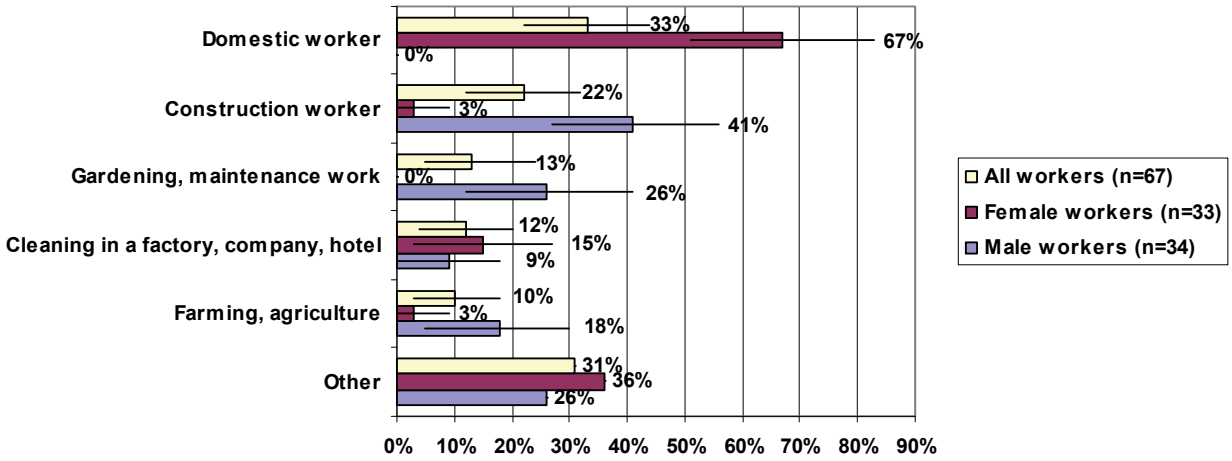
There is no significant difference between the sectors of activity in which the asylum seekers and the undocumented migrants interviewed worked. Thus all workers are included in the following graph, irrespective of their administrative status. However, **there is a significant difference in the sectors of activity in which men and women worked**.

[80] Equality Body, Ombudsman, *Report regarding the Limitations to the Right to Work of Asylum Seekers* (original in Greek: *Έκθεση της Αρχής Ισότητας αναφορικά με τους Περιορισμούς στο Δικαίωμα Απασχόλησης των Αιτούντων Άσυλο*). Nicosia. 21 Dec. 2007.

[81] After the 6-months period, asylum seekers have access in the following employment sectors: agriculture (laborers), animal husbandry (laborers), fishery (laborers), manufacture (forage production laborers), waste management (laborers), wholesale trade-repairs (gas station and car wash laborers and freight handlers of whole sale trade), building and outdoors cleaners, distributors of advertising and informative material and food delivery (http://www.mlsi.gov.cy/mlsi/dl/dl.nsf/dmlemploymentasylum_en/dmlemploymentasylum_en?OpenDocument)

[82] Although, as we will see further on, even when migrants have a legal employment contract they still appear to be vulnerable to exploitation and abusive working conditions.

17. Sectors of activity in which the respondents worked, by sex (%)*



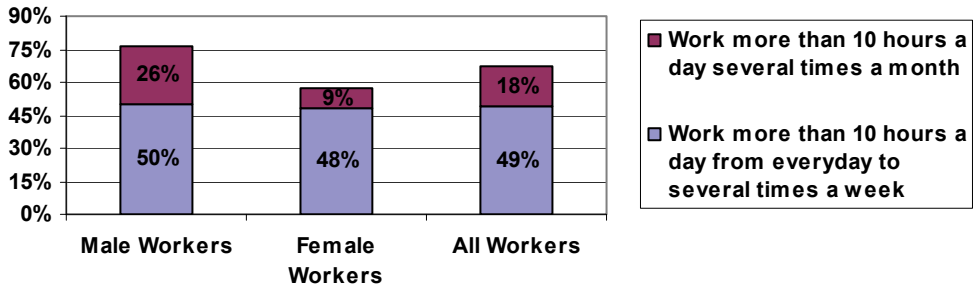

*The cumulated percentages exceed 100% because this was a multiple choice question – some of the workers were active in several sectors of activities at the time of the interview. The percentages refer to the number of respondents.
* "Other" includes: working in restaurants (6%); selling objects in the street (4%), on transport, etc.

**The women respondents were mainly domestic workers** (67%), especially the Sri-Lankan and Filipino women. It is known that **the salaries offered to migrant domestic workers are very low. The average salary of a domestic worker is only about €450 per month**[83]. Consequently, these women are in an insecure situation. **A quarter of the women interviewed had several jobs**. Some women were working as cleaners in companies (15%), or in various other sectors, including skilled sectors: one woman worked as a secretary and another was a teacher.

**41% of the men worked as construction** workers and 26% in gardening or maintenance work, sometimes for private households. **21% of the men had several jobs**.

## ■ Working conditions

18. Proportion of the workers regularly working more than 10 hours a day, by sex (%)




**Almost 70% of the working respondents claimed to regularly work more than ten hours a day, and almost half worked more than ten hours a day, everyday to several times a week, which is an indicator of hard and working conditions that can potentially affect health**. This concerned both men and women, regardless of their status and without significant differences.

Respondents working as cleaners and in farming were the most exposed to long working hours: respectively 75% and 71% of them worked more than 10 hours every day or several times a week.

The following testimony by an undocumented respondent on working conditions is quite enlightening.

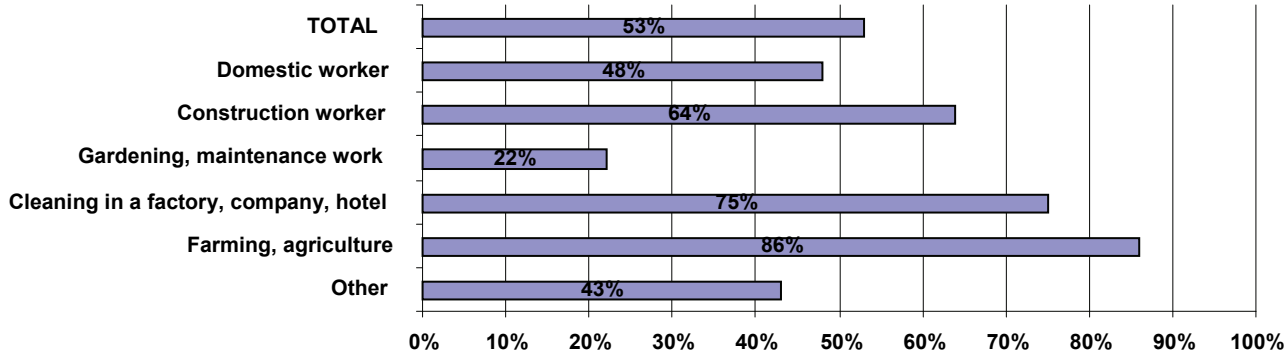
> Mr. M. came to Cyprus with a working visa. He used to work 18 hours a day, 7 days a week. If he felt sick, his employer didn't allow him to take time off. *"No time for doctors, we had to keep on working",* he explained. The only treatment given to him was painkillers. *"Some employers don't want to spend money on it; you work without rest."* He suffered from a partial disability. As he made an official complaint, he was released form his job and entitled to find another employer. Unfortunately he failed to find an

[83] As an element of comparison, a shop worker is paid on average €880, which is the lowest.

employer willing to renew his work permit and so became undocumented. He could not go back to India, so he asked for asylum. Because of his health problems, he could not continue working in farming*: "I stayed there for 4 months; they* [the workers] *live like dogs, work 15 hours, no matter what is written in their contract."*

It is evident that the difficult working conditions described in this testimony were not specifically related to being undocumented, but may concern all migrant workers, irrespective of their legal status. In this testimony, the person was clearly a **victim of work exploitation**. This is a common phenomenon in Cyprus.

19. Workers who feel that their work may put them at risk of accidents or affect their health, by sectors of activity (%)



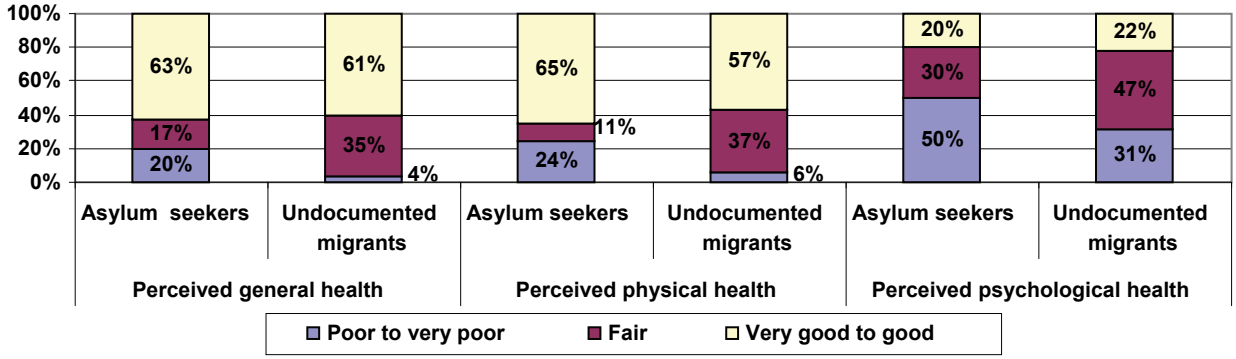

Those people working in the sectors of activity with the most difficult working conditions (long working hours) were also those who felt they were at risk of an occupational accident or that their work could adversely affect their health. This was the case for 86% of the people working in farming or agriculture and 75% of those working as cleaners in companies. However, workers in all other sectors of activity also felt this way. In total, more than half of the workers interviewed felt their health could be harmed by the conditions in which they worked or that they were at a risk of an accident at work.

# IV. PERCEIVED HEALTH AND ACCESS TO HEALTHCARE

## 1. PERCEIVED HEALTH STATUS

The self-perceived health of a population is a subjective indicator, but most studies show there to be a clear correlation with medical indicators of health, although not necessarily at individual level.[84]

20. Self rated general, physical and psychological health statuses, by administrative status (%)




Self-perceived general and physical health

There is a clear link between how respondents perceived their physical health and how they perceived their general health (i.e. respondents who perceived their general health to be poor or very poor mostly gave the same answer about their physical health, and vice-versa).

**Findings on the self-perceived state of health of the migrants interviewed are worrying, especially given the young age of the population**. No more than 63% of the asylum seekers and 61% of the undocumented migrants considered themselves to be in a good or very good state of general health. Available statistics on the self-perceived health status of Cypriot nationals are significantly different: among Cypriots aged between 25 and 44, about 90% considered they were in a good or very good state of general health in 2009[85].

**There is a correlation between the poor living conditions, i.e. housing and working conditions, of the migrants interviewed and their poor self-perceived general and physical state of health**. Thus 44% of those who rated their housing conditions as poor to very poor considered themselves to be in a poor to very poor state of physical health (against only 8% of those who rated their housing conditions as good to very good)[86]. Similarly, workers who felt their work affected or could affect their health were less likely to consider themselves in a good to very good state of health than workers who felt they were working in safe conditions.

Perceived psychological health

**The self-perceived state of psychological health among the respondents is extremely worrying: half of the asylum seekers and almost one-third of the undocumented migrants interviewed declared themselves to be in a poor to very poor state of psychological health**. At the other end of the spectrum, only around 20% of both undocumented migrants and asylum seekers felt in a good to very good state of psychological health.

[84] Kaplan G.A, Goldberg D.E., Everson S.A et al. (1996). The perceived health status and morbidity and mortality: evidence from the Kuopio Ischaemic heart disease risk factor study. *International Journal of Epidemiology,* 25: 259-65; and DeSalvo K.B, Bloser N., Reynolds K., He J., Muntner P. (2005). Mortality prediction with a single general self-rated health question a meta-analysis. *Journal of General Internal Medecine*. 21: 267-75

[85] Eurostats' findings show that 95.8% of Cypriots aged between 24 and 34 years consider themselves to be in good or very good general health; the rate is 87.4% for 35 to 44 years old.

[86] See appendix 2, table 3 (section dedicated to Cyprus).

**Their experience of traumatic events and exposure to violence in their home country can partly explain this particular vulnerability. However, the living conditions in the host country, such as insecure economic, poor housing and working conditions and social isolation, may be an additional factor contributing to low self-perceived psychological health. Other factors are linked to the migration itself and the poor status of migrants**. These include being far from their family and from their children in particular, uncertainty about the future, a lack of security and protection due to their lack of access to basics rights, and fear of arrest. As one undocumented women explained:

> *"I tried to make a family in Cyprus...You can survive better even if it's hard here...I believe somebody will help us...(…) I cry at nights...I'm not lucky but I need to be strong for my sons".* Undocumented woman from the Philippines, 39 years old, 10 years in Cyprus

The lack of emotional support and access to mental health professionals are factors here: 28% of the respondents who felt in a poor to very poor state of psychological health could never rely on anyone for emotional support.

**Furthermore, many studies have shown a correlation between self-perceived physical and psychological health**. Such link is seen in the following testimony of a seriously ill asylum seeker woman: her state of health and difficulties in accessing healthcare are a source of constant anxiety:

> *"I think they don't treat my illness properly...I'm just waiting... I feel a lot of stress (…) I think I have no future anymore..."* Asylum seeking woman from Somalia, 24 years old, 4 years in Cyprus

## 2. ENTITLEMENTS TO HEALTH COVERAGE

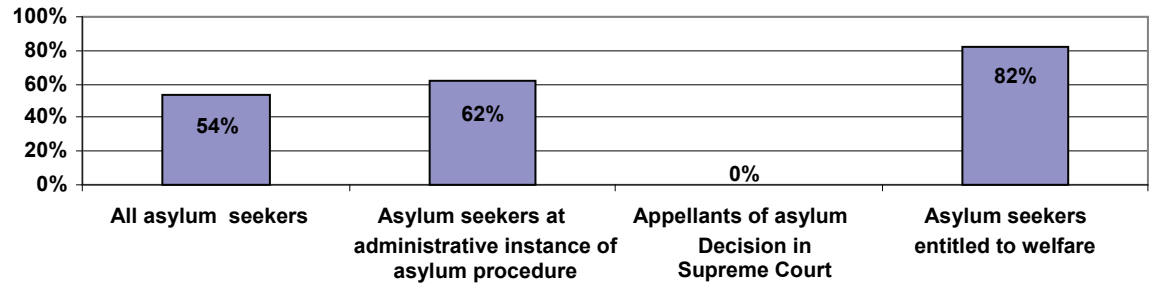
### ■ Entitlements to health coverage

**Undocumented migrants are entitled to emergency care only**. As soon as their health situation stabilises, they are discharged or have to pay full costs for their care, irrespective of their income. In the survey, as they have no rights to health coverage, no questions were asked to them about their knowledge of entitlements.

**ASYLUM SEEKERS**

**To benefit from the health coverage, asylum seekers need the medical card A, which they can get only if** their income in below the designated threshold**, if theiy receive welfare support or if they come within the vulnerable group category (or if they live in a reception centre)**[87]. On the other hand, appellants are not entitled to any health coverage.

21. Proportion of asylum seekers holding medical card A, according to the stage of the asylum procedure and the source of income (%)




[87] The length of validity of the medical card varies from one asylum seeker to another. Generally speaking, after their first asylum claim, they receive the card for six months, which can be then renewed. (see above legal analysis, Part 1 on Cyprus). All asylum seekers, irrespective of their place of residence, have to go often to the Ministry of Health in Nicosia to renew their cards. Theoretically, they can apply for a renewal in the cities they dwell, but in practice, they have to apply at the Ministry of Health in Nicosia so as to receive their new medical card on time (otherwise, they have to wait for it many weeks)

**All in all, only 54% of the asylum seekers interviewed had been issued with medical card A**. This represents 62% of the first instance asylum seekers and none of the appellants. **Among the respondents receiving welfare support, 18% (n=4) did not hold a Medical card A**, and among these four respondents, three did not know they were entitled to it.

22. Reasons given to explain the lack of medical card A (%)

| Reasons given to explain the lack of medical card A | Nb. cit. |
|---|---|
| Did not know of this entitlement | 10 |
| Did not know how to get the card or whom to ask for help | 10 |
| Lack of papers/unable to prove a lack of sufficient resources | 1 |
| Other reasons** | 5 |
| Total of respondents who did not have the Medical card A | 24 |

* The cumulated percentages exceed 100% as this question had multiple choice answers.
** In "other reasons": three said they did not need it since they had no medical problems, one was afraid of approaching the authorities, and the third was about to apply for it.

Twenty-four asylum seekers did not have the medical card A: 10 of them claimed they did not know what the card was and that they were entitled to it; another 10 did not know how to obtain the card or whom to ask for help. **These two reasons are clear evidence of a shortfall in the information provided to asylum seekers, a situation which can apparently last for years** (the respondents who did not have the Medical card A had been living in Cyprus for an average of 3.6 years).

### ■ Knowledge of entitlements to health coverage

Only holders of medical card A were asked if they knew that this card allowed them access to healthcare free of charge. **All but one of the 29 respondents holding medical card A were aware of their entitlement.**

## 3. ACCESS AND RECOURSE TO HEALTHCARE: CASE STUDY

### ■ Health problems meriting a consultation

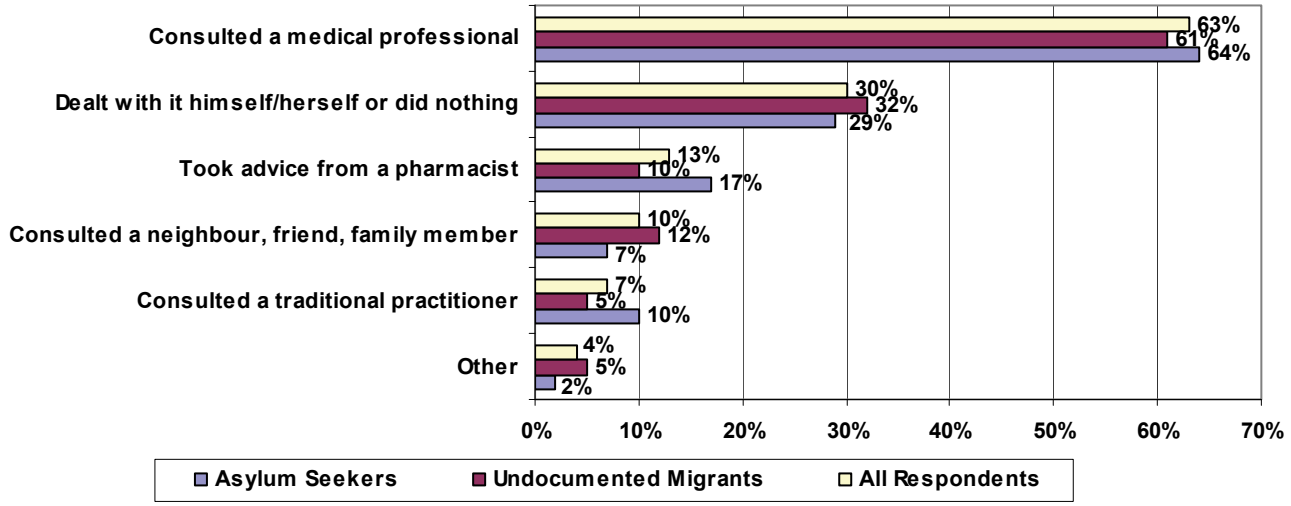
Among the sample, 20 respondents said they had never had a health problem meriting a consultation since arriving in Cyprus: 12 were asylum seekers and 8 were undocumented migrants. The fact that these respondents had been living in Cyprus for an average of more than 3 ½ years (and up to 10 years) raises questions about their self-assessment of their health: was it that the respondents really had not had any health problems that merited a consultation since their arrival, or was it that some respondents were reluctant to seek healthcare if they could manage without?

It is interesting to note that three-quarters of respondents who said they had never had a health problem worth consulting on also stated that they limited their activities for fear of being arrested. On the other hand, almost half of those who said they had had recourse to a medical professional were also among those less likely to limit their activities. Thus, **fear of arrest may well affect decisions to consult at a healthcare facility in the event of a health problem**.

### ■ Action taken in response to the most recent health problem

The following graph only includes respondents who had had a health problem that they considered merited a consultation since their arrival (n=83; 42 asylum seekers and 41 undocumented migrants).

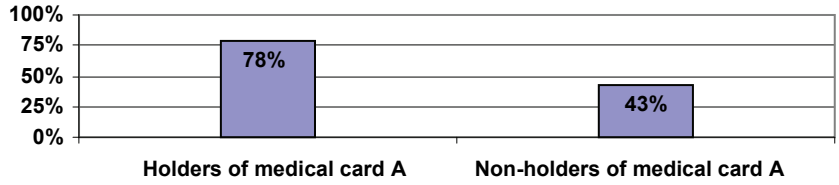
23. Actions taken during the most recent health problem by respondents who considered their health problem merited a consultation, by administrative status (%)*




* The cumulated percentages exceed 100% as this question had multiple choice answers.
* The percentages refer to the 83 respondents who considered they had a health problem meriting a consultation in the past year in Cyprus: 42 asylum seekers and 41 undocumented migrants

Actions taken during the most recent health problem did not differ significantly by administrative status. **Only 63% of the respondents who considered their health problem merited a consultation had consulted a medical professional (nurse, doctor or specialist) on their most recent health problem. This rate falls to one-half if we include those who considered they had not had any health problems since their arrival in Cyprus**. Conversely, more than one person in three (37%) did not consult a medical professional on their most recent health problem. These respondents dealt with the problem themselves or did nothing (30%), took advice from a pharmacist (13%), from a neighbour, friend or family member (10%) or consulted a traditional practitioner (7%)[88].

24. Proportion of asylum seekers who consulted a medical professional among those who considered they had a health problem that merited a consultation, by health coverage status (holders or non-holders of the Medical card A) (%)




* The percentage refers to asylum seekers who considered they had a health problem meriting a consultation in the past year (n=42)

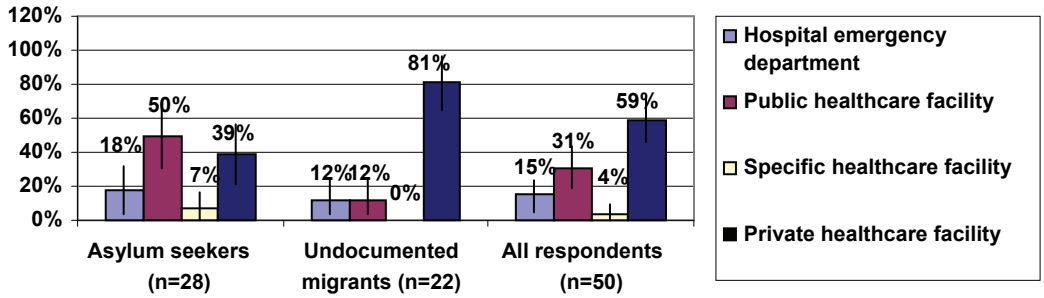
**For asylum seekers, possession of medical card A and thus entitlement to healthcare free of charge clearly influenced the actions taken during their most recent health problem**. Indeed, those who held a medical card A were significantly more likely to have consulted a medical professional (78%) than those who did not have the card (43%). Furthermore, it has been proven in other studies that effective access to health coverage positively increases the likelihood of consulting a health professional when sick[89].

## ■ Medical facility attended

In the section of the questionnaire dedicated to attending a medical facility in response to their most recent health problem, only respondents who consulted a health professional on their most recent health problem are taken into account (n=50, 28 asylum seekers and 22 undocumented migrants).

[88] Most of the respondents who did not consult a medical professional gave multiple answers (e.g. consulted a friend and a traditional practitioner; or dealt with it themselves after consulting a pharmacist (self medication).
[89] Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009), *op. cit,* p.87.

25. Services consulted during the most recent health problem, by administrative status (%)*




* The cumulated percentages exceed 100% as this question had multiple choice answers.
* The percentages refer to the 50 respondents who consulted a health professional in the past year in Cyprus: 28 asylum seekers and 22 undocumented migrants

Medical facilities attended during the most recent health problem differed according to administrative status: **most of the asylum seekers consulted at a public healthcare facility (50%) whereas a large majority of the undocumented migrants consulted at a private healthcare facility (81%).**

A more in-depth analysis allows us to link the type of medical facilities attended to health coverage status[90]. **Respondents without health coverage were more likely to attend a private healthcare facility than a public facility when consulting a health professional; they have to pay for the consultation in any case**. This is the case for 60% of asylum seekers without a medical card A and 81% of undocumented migrants.

Choosing a private healthcare facility may be due to a desire to avoid public facilities, and tends to show migrants' distrust of public healthcare facilities, as shown in the following table.

26. Reasons given by the respondents who attended a private healthcare facility, explaining why they consulted at a private facility (%)

| Reasons given to explain why they consulted at a private facility | Nb. cit. |
|---|---|
| More secure: do not fear being reported | **18** |
| Better medical attention | **13** |
| Takes less time than in the public system | **8** |
| The treatment wasn't available in the public facility | **5** |
| Were advised to go to this medical facility | **5** |
| Other reasons | **4** |
| **Total Respondents to have chosen a private facility** | **32** |

* The cumulated percentages exceed 100% as this question had multiple choice answers.

**More than half of those who had consulted at a private healthcare facility explained that they felt more secure in private facilities as they did not fear being reported to the authorities to the same extent as in public facilities**. The respondents also reported that in private facilities they received better medical attention, had faster access to a consultation or that the treatment they needed was not available in public facilities.

## ■ Effective access to health coverage

27. Effective access to medical consultations free of charge by health coverage status (%)

| Paid Consultation / Health coverage status | No answer | Paid consultation | Consultation free of charge | TOTAL |
|---|---|---|---|---|
| **Holders of a medical card A** | 0% ( 0) | 28% ( 5) | 72% (13) | **100% (18)** |
| **Non- holders of a medical card A** | 3% ( 1) | 78% (28) | 19% ( 7) | **100% (36)** |
| **TOTAL** | **2% ( 1)** | **61% (33)** | **37% (20)** | **100% (54)** |

[90] See appendix 2, Table 4 on section dedicated to Cyprus

Among asylum seekers holding a medical card A (n=18), 72% did not pay for their medical consultation. Most asylum seekers who had been asked to pay had consulted at a private facility, which explains why their treatment was not free of charge. However, one asylum seeker holding a medical card A claimed that he was asked to pay for his medical consultation at a public facility[91].

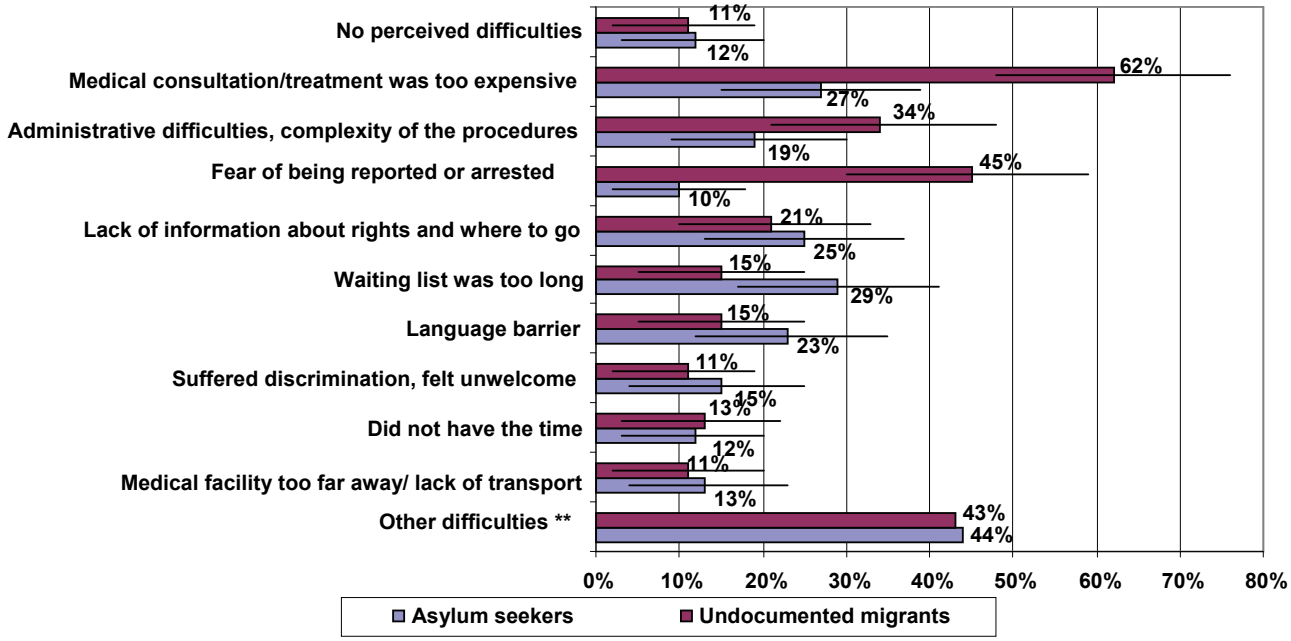
As regards respondents without a medical card A (this includes part of the asylum seekers and all undocumented migrants), almost 80% had to pay for their medical consultation. Among those who claimed they did not pay for their consultation (n=7, 19%), three attended a hospital emergency department (they are entitled to emergency care free of charge), and two others attended a public healthcare facility. One went to a specific healthcare facility providing healthcare to migrants.

## 4. DIFFICULTIES AND BARRIERS IN ACCESSING HEALTHCARE

**The percentages presented in this section refer to the whole sample (n=103).** The difficulties cited referred to the ones faced on any occasion the respondents had tried to access healthcare in the past year in Cyprus or since they arrived in the country (if in Cyprus for less than a year). Thus, the barriers encountered by the respondents do not refer exclusively to the last time they fell ill but may have been encountered on one or several occasions.

As a consequence, the findings in this section are not to be cross-referenced with those obtained in the previous section (case study about the last time they fell ill).

28. Difficulties encountered by the respondent in accessing healthcare in the past year, by administrative status (%) *




*The cumulated percentages exceed 100% because this was a multiple choice question.
** "other difficulties" refer to: lack of trust in doctors or treatment (9%), afraid of the consequences on their job (3%); no female or male doctors (3%), inappropriate opening hours of the medical facility (3%), medical professionals not aware of the patient's entitlement to healthcare free of charge (2%), etc.

**Among the respondents, 89% testified to having encountered one or several difficulties and barriers when attempting to access healthcare in the past year** (or since arriving in Cyprus). This wide-spread phenomenon affected asylum seekers as much as undocumented migrants.

### ASYLUM SEEKERS

**The main barriers encountered by the asylum seekers interviewed were linked to difficulties in effectively obtaining health coverage**: 27% said that the consultations and/or treatment were too expensive, and 19% cited the complexity of procedures for obtaining health coverage; in

[91] NB: the interviewee may be referring to a time before he had been issued with medical card A.

addition, 23% encountered a language barrier, which can contribute to a lack of understanding of the procedures. The **language barrier** may also mean that they had problems being understood by the health professionals and/or understanding what was said to them. **There is therefore a clear need for translation and mediation for asylum seekers in the health system**. Another 25% claimed they **lacked sufficient information about their entitlements to healthcare and on where to go**. Almost 30% had to cope with a long waiting list[92].

**Also 15% of respondents felt they had been discriminated against when attempting to seek healthcare** in the past year in Cyprus. There was much testimony by migrants who felt they had been victims of discrimination. The example of a seriously ill asylum seeker is enlightening:

> When she visited her doctor for an examination, the doctor asked her many unpleasant questions on her migratory route and migration experiences, and wanted to know her reasons for coming to Cyprus. She felt uncomfortable with these questions, which she perceived as being more like those of an immigration officer than a doctor. So, she asked the doctor to stop asking such questions and focus on her health problems.

**It is also alarming to note that 10% of the respondents claimed they were afraid of being arrested when they consulted a medical facility.** This particular barrier affected both people appealing to the Supreme Court against an asylum decision who have no protection against deportation, and asylum seekers in the first instance of the procedure (n=4). **This shows asylum seekers tended to feel poorly protected by their administrative status.**

#### UNDOCUMENTED MIGRANTS

**The undocumented migrants interviewed faced even more barriers and difficulties than the asylum seekers. Three-quarters of those who had encountered at least one difficulty in fact cited several difficulties and barriers** (up to 7).

**Meeting the costs of the medical consultations and/or the treatment was the main difficulty**, shared by 62% of the undocumented migrants interviewed. **This particular problem was probably a barrier that precluded some of them from even attempting to access healthcare** (rather than a difficulty when actually accessing healthcare). Indeed, the testimony of an undocumented woman from the Philippines clearly shows that the cost of healthcare led her to give up on seeking healthcare and self medicate:

> At the time of the interview she could not afford a medical examination or treatment. She said that when it was really necessary, she went to a pharmacy, and sometimes she had to wait a few days before going because she lacked money: *"If I don't have any money, I just don't go*." Filipino undocumented woman, 39 years old, 10 years in Cyprus

**The second most frequently-cited problem was linked to the fear of being arrested when trying to access healthcare: 45% of the undocumented migrants gave this response**. Again, this fear probably led some people to give up on or delay seeking healthcare. **It should be emphasized that at least three of the undocumented migrants interviewed claimed that they had been reported to the authorities when they had sought healthcare in the past year**, either by the administration of the medical facilities or by health professionals**. KISA and the Ombudsman also report cases of denunciation of undocumented migrants at the emergency unit of the General Hospital of Nicosia, mainly by the Hospital administration, leading to their deportation.**

Complex administrative procedures were cited by 34% of the undocumented migrants interviewed, which again can be linked to the language barrier for 23% of the respondents. 25% lacked information about their rights and about where to go and who to consult (25%).

**Discriminatory practices were cited by 15% of the undocumented migrants**. This rate is similar to that for asylum seekers and is a high percentage that should be underlined. The interviewers

[92] The problem of long waiting list is a sad and generalised reality concerning the public hospitals of Cyprus. More specifically, patients, who need a general practitionner can do it immediately in any public health centre (these are apart from public hospitals (one in every city), in Larnaca there are also health centres in every district, also run by the Ministry of Health), but if they need to visit a specialist (e.g. a otolaryngologist, an orthopaedist, a gynaecologist, etc), they have to schedule appointments and have to wait long waiting lists for such appointments, reaching up to eight months of waiting.

reported that migrants often feel discriminated against in their everyday life, including at the pharmacy and the hospital.

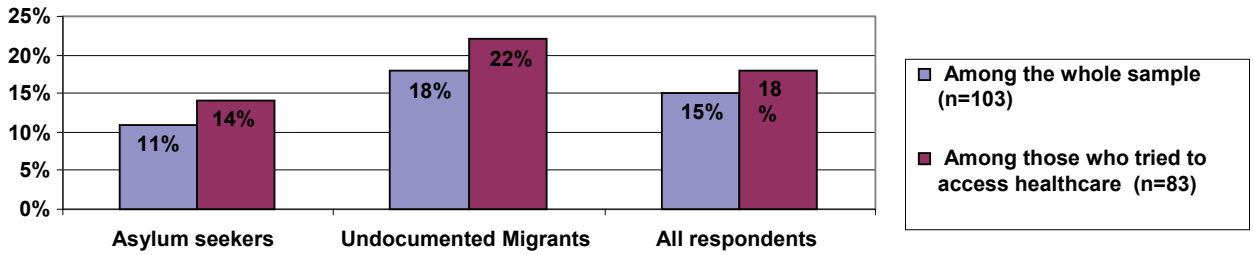
**ALL RESPONDENTS**

**Migrants encounter numerous difficulties and barriers in attempting to access healthcare. The level of protection theoretically attached to the status of asylum seeker, as well as their access to the most basic rights – i.e. accessing healthcare without discrimination and in dignity - were not sufficiently guaranteed for the asylum seekers interviewed. Our findings also show that the health system and health facilities are not friendly to migrant users who suffer from the complexity of the system, a lack of information, and from practices perceived as discriminatory. For undocumented migrants, the difficulties cited, in particular the fear of being reported, probably prevented them from attempting to access healthcare. This comes in breach of the most basic human rights, and is inefficient in public health terms.**

## 5. HEALTHCARE REFUSALS

**Out of the 103 respondents, 15 people, both men and women, were refused access to healthcare in Cyprus, whether by health administrations or by health professionals.** This represents **18% of the respondents who attempted to access healthcare in Cyprus**. This proportion is particularly alarming as it is higher than the average refusal rate found by Médecins du Monde's survey on access to healthcare of undocumented migrants[93], which was already high at 14%.

29. Frequency of denied access to healthcare, by administrative status (%)




**Healthcare refusals concerned both asylum seekers and undocumented migrants, but undocumented migrants were more likely to be affected:** 14% of the asylum seekers interviewed who had tried to access healthcare since arriving in Cyprus had been refused access against 22% of undocumented migrants.

It is important to note that, in our sample, respondents from Sub Saharan Africa and Asia were more likely to be denied access to healthcare than respondents from other regions, and significantly more than respondents from European countries, and this irrespective of their administrative status. **This assessment seems to imply that such refusals may result, at least in part, from discriminatory and racist practices.**

[93] This is even more worrying since in the European Observatory on access to healthcare, only undocumented migrants are taken into account, not asylum seekers, yet undocumented migrants are more frequent victims of refusals.
In Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009), *op. cit.,* p.97

## 6. ABANDONING HEALTHCARE

**In Cyprus, 22% of the asylum seekers interviewed had given up on accessing healthcare at least once in Cyprus, and the proportion reaches 39% among the undocumented migrants interviewed. Overall, 30% of respondents had given up on seeking access to healthcare on at least one occasion.**

Generally speaking, giving up on obtaining healthcare is seen to be a consequence of the difficulties and barriers faced by the people interviewed when trying to access healthcare. More specifically, **a clear link exists between having been refused access and having given up on accessing healthcare at least once**. The testimony of an undocumented migrant, a former asylum seeker, who has lived in Cyprus for more than 7 years, illustrates this link:

> Mr M. came to Cyprus with a work permit and worked in extremely difficult conditions. When he lost his job he became undocumented, although he quickly found another job. Since then he has been undocumented and has no access to state support. He went to see a doctor in a public hospital, but the doctor refused to examine him, telling him that his file had been closed and that he should go back to his home country. Since then, he goes to a pharmacy when he has a health problem and buys treatment without a prescription.

30. Type of healthcare and/or treatment given up on (%)*

| Kind of treatment | Nb. cit. |
|---|---|
| Medical check up or medical treatment | 13 |
| Dental care | 12 |
| Laboratory analyses, blood test, MRI or radiology | 8 |
| Pharmacy, drugs | 7 |
| Physiotherapy | 2 |
| Mental health or psychological treatment | 2 |
| Other treatments or unknown** | 7 |
| TOTAL OBS. | 31 |

*The cumulated percentages exceed 100% because this was a multiple choice question.
** In « other treatment or unknown »: optical care (n=1; 3%); vaccination (n=1; 3%); undefined (n=5; 16%);

The type of healthcare given up on by the respondents did not differ according to the administrative status, age and sex of the respondents. **Almost half of those who gave up on healthcare actually gave up on various types of medical care and/or treatment.** Very commonly, the respondents gave up on obtaining medical check ups (42%), dental care (39%), laboratory analyses, blood tests, MRI or radiology (26%), and/or on pharmacy and drugs (23%).

**A further two respondents reported giving up on obtaining mental healthcare, but as mental health issues are often hard for respondents to mention, this proportion is likely to be much higher in reality**.

# V. ACCESS TO HEALTHCARE FOR PREGNANT WOMEN AND CHILDREN

**CONTEXT**

**According to the law (art.13-2), welfare services should pay special attention to people with special needs, such as unaccompanied minors, pregnant women, victims of torture and people with disabilities in order to ensure they receive the special treatment they need**. However, some testimonies and studies show that many people with special needs do not benefit from this protection.[94]

**Access to healthcare for all pregnant women is not guaranteed in Cyprus**. Asylum seeking women should receive perinatal care free of charge if they have a medical card A, but undocumented women have to pay the full costs of antenatal and postnatal care. Furthermore, **there have been cases of hospital authorities informing the immigration police about the women's irregular status**, leading to arrest and, when the health situation of the mother or the child allows, deportation. One case was reported in the press on May 22nd 2010[95]. A migrant woman was fired from her job because she was pregnant. Thus, after 7 years of legal residence in Cyprus, she became undocumented because her employers fired her when they discovered about her pregnancy. The child was born preterm and both mother and child were in serious need of healthcare. However, the child was taken away from the woman who was put in detention, and both she and her child were threatened with deportation. Only action by the child's father, supported by local NGOs – including KISA –, who demanded respect for his rights as a father, prevented this dramatic outcome.

## 1. PREGNANT WOMEN: ACCESS TO ANTENATAL AND POSTNATAL CARE

Among the women interviewed, 15 had been pregnant while in Cyprus or were pregnant at the time of the interview. All in all, **11 undocumented women and 3 asylum seeking women answered questions regarding their experience in accessing perinatal care**. One of the women interviewed did not carry her pregnancy to full term, so she was not asked about her experience of perinatal care.

### ■ Socio-economic and health situation of the pregnant women interviewed

The interviews held with the three women who were pregnant at the time of the interview provided us with insight into their living and health conditions at a crucial moment in the life of the mother and her future child. No questions were asked to women who were not pregnant at the time of the interview about their accommodation during their pregnancy, so they are not included here.

The three pregnant women interviewed, two asylum seekers and one undocumented migrant, were between 30 and 39 weeks pregnant.

**Two of them described difficult living conditions**. They reported having very little income (one received welfare benefits and the other had to borrow money) and poor accommodation. One explained that her accommodation had no ventilation or central heating and was infested with pests and vermin, a potential source of disease or infection. She was sharing it with friends and compatriots and suffered from the overcrowded conditions and a lack of the most basic privacy. Her accommodation was an insecure, short-term solution.

[94] UNHCR are referring since 2007 tens of such cases per year.
[95] Article from the *Cyprus Mail*, 22nd of May 2010.

**These two women's perception of their psychological health was also worrying: one considered it to be poor, the other as only fair**.

The third woman considered her living conditions to be good also felt in a good state of psychological health.

Happily, the three women rated their physical health as good.

### ■ Access to antenatal care

**All but one of the women who were or had been pregnant in Cyprus had benefited from antenatal care** (n=13). The woman who did not receive antenatal care was undocumented. **It is important to bear in mind that access to antenatal care can be crucial and have long term consequences on the state of health of the child.**

**Among the 13 women who obtained access to antenatal care, only three received this care free of charge**, excluding one asylum seeking woman who was in theory entitled to health coverage. She claimed that **the administration and doctors were not aware of her rights to receive antenatal care free of charge**. **All 10 of the women who had to pay for their antenatal care said that this had been a problem for them and that the consultations were very expensive**. **The woman who did not access antenatal care said she could not afford it.**

**It is worrying to note that all but one of the 13 women interviewed had encountered at least one difficulty when accessing antenatal care**. The **fear of being reported** and arrested was mentioned by half of the women interviewed, mainly those who were undocumented. Also one woman asylum seeker, who should have felt sufficiently protected, said she shared this fear. **A lack of information about their rights** was cited by four women (31%) and this was also one of the barriers mentioned by the woman who didn't access antenatal care. **The language barrier** (4 women; 31%), **administrative difficulties** (3 women; 23%) and the fact that the health facilities were too far and hard to reach due to a lack of transport (3 women; 23%) were also among the most frequent difficulties faced by these women in accessing antenatal care.

### ■ Access to delivery care

Eleven of the women interviewed gave birth in Cyprus (one asylum seeker and ten undocumented migrant women). **Nine women had to pay for their delivery care, all were undocumented.**

**It is interesting that almost half of the undocumented women chose to deliver in a private facility (n=4)**. Among the remaining six women, three delivered in a public facility and three in the emergency department of a hospital. The woman who received no antenatal care delivered in the emergency unit of a hospital. Although she was undocumented, she did not have to pay for her delivery care, which might be due to the fact that it was an emergency delivery.

Although none of the migrants interviewed reported giving birth in non-medical facilities (at home or with the help of a non-health professional), cases have been reported by KISA. Recourse to a non medical professional for delivery care can result in a life-threatening situation for the mother and child.

**Five of the eleven women claimed to have experienced difficulties with regard to their delivery care** (whether they delivered in a private or public facility or the emergency department of a hospital). **All of the five said that the cost of the delivery care was too high for them**.

Also the **undocumented women who delivered in a public facility said they were afraid of being reported**. **One woman said that she had at first been refused access to delivery care, had felt discriminated against and complained of the lack of attention given to her by the health professionals.** The testimony of an undocumented woman from the Philippines who gave birth in a public facility gives a clear picture of the type of situation faced:

> *"I was in hospital for 6 days. They didn't want to help me, I cried...I couldn't put on my underwear...they didn't allow my friends to help me take a shower. They just said: Only at 8 o'clock* [when her friends couldn't be there]*, go now! Finally, I was asked for €1,800*

*for the caesarean birth. I couldn't afford it. I paid €600 and the rest was covered by KISA."*

Two women also said they had had difficulties with the administrative procedures and the language barrier.

### ■ Vaccination of the new born

**Three new-borns were not vaccinated** (27%). This finding is particularly alarming as access to such preventive care is crucial. A child who is not vaccinated can be exposed to serious and avoidable pathologies. **It is a known and proven fact that preventive care and frequent follow-up in the first years of a child's life are critical, and that the absence of such care can have life–long consequences on health. Furthermore, not ensuring the vaccination of every child present a risk for public health too, as it may lead to the re-emergence of diseases that had been eradicated.**

## 2. ACCESS TO HEALTHCARE FOR CHILDREN

Free of charge paediatric care for children of undocumented migrants is not available at the moment. The Commissioner for the Protection of Children's Rights, after seeking relevant legal advice by the Attorney General in 2009 pled the Ministry of Health to issue a circular confirming health coverage for all foreign children, especially children of undocumented migrants and asylum seekers. It still has not been implemented.

**In our sample, 22 parents interviewed were living with their children in Cyprus: 10 were asylum seekers (4 of whom were appealing against their asylum decision), and 14 were undocumented.**

### ■ Living conditions of children

Among the parents interviewed, 5 reported that their accommodation status was temporary, which is particularly stressful when children are involved. **All except for one described poor housing conditions and cited one or more additional difficulty that could affect health or be the cause of a domestic accident, especially with children**. More than half of the parents complained of a lack of ventilation; 7 suffered from the cold and another 7 from overcrowding and a lack of privacy, which is problematic for the general well-being of children and teenagers (and for example to do homework). 6 respondents also said their accommodation was infested with rats and/or pests, which exposes children to the risk of disease and infection. One had poor electricity installations and one had no access to a functioning toilet or a proper washroom.

**These unsanitary conditions are completely inappropriate and even pathogenic for children**. Some of the parents interviewed had seriously ill or disabled children, for whom such living conditions can have even more serious consequences; in theory, they should be protected and cared for as provide for by law.

> The case of a Lebanese mother whose two children were injured in an Israeli air strike is particularly disturbing. One of her two children has lost both her arms. The mother has been living as an asylum seeker in Cyprus for 7 years, uncertain about her future and with few rights. Her family lives on welfare support, which barely covers the cost of accommodation and food. She deplored the living conditions she had to offer her children: "*They didn't offer her [disabled daughter] anything to help her not live like an animal*."

## ■ Difficulties and barriers faced in accessing healthcare for children

Out of the 24 parents interviewed who were living with their children in Cyprus, **20 had tried to seek healthcare for their children in the past year** (or since arrival): 9 were asylum seekers (four of whom were appealing against their asylum decision), and 11 were undocumented.

**Three of these parents did not get to see a doctor for their children on every occasion they attempted to do so, thus access to healthcare for children is not ensured. All were undocumented migrants, and all cited the cost as a problem in accessing healthcare for their children. One of these parents was even denied healthcare when she went to a medical facility for her child.**

Parents who managed to see a doctor for their children still faced other problems**. Out of the 20 parents who saw a doctor at least once for their children, only two did not perceive difficulties**.

**The cost of healthcare was perceived as a difficulty by all those without access to health coverage (undocumented migrants and appellants of asylum decisions to the Supreme Court)**. This particular problem was also reported by a woman seeking asylum. She explained that when her son had an accident and was taken to casualty, she didn't have a medical card A:

> *'The doctors took good care of him...but then they wanted money.'* As she wasn't able to pay more than €2,000 they restricted her access to her son, making her wait in the corridor. Finally*, a friend helped her to sign a guarantee and collect the money she needed.* As the condition of her son's leg worsened (an injury from Lebanon) and his situation became urgent, she took him to a private facility, because in a public facility he would have waited several months: *'If it is something important, we go there [to a private facility]'*.

**As seen in the example above, the long waiting lists cause problems**. This affected 8 respondents who attempted to gain access to healthcare for their children.

**Another difficulty, which affected undocumented parents and appealing asylum seeker parents in particular, was the fear of being reported and arrested** when attending a medical facility: Seven respondents cited this problem (more than half of the undocumented migrants and a quarter of the appellants).

**The other difficulties and barriers affected undocumented and asylum seeking parents alike**: 7 respondents were affected by the language barrier; 4 parents had trouble getting to a proper medical facility for their children because of the distance,, another 4 encountered administrative difficulties. A further two parents said they suffered from discrimination. An undocumented young mother commented on her experience with her young child when seeking pediatric care:

> *"The doctors are very nice to me, one of them is also an immigrant, so he understands my situation, but the nurses, they are Cypriots - from them you can't get any care.'* She was unable to breastfeed, but was embarrassed to ask for milk: *'I may be refused again, which is so painful".* Mother from the Philippines, 10 years in Cyprus

# CONCLUSION CYPRUS

**Cyprus does not have a unified health system**. Consequently, health service provision is not concentrated on one central authority and there are currently four types of health coverage. However, the government is planning to introduce a unified health system ("National Health Insurance System") in the near future, financed by state and employer-employee contributions and providing universal coverage to all Cypriots, EU nationals residing in Cyprus, as well as any person required to pay contributions, including migrant workers.

The health system in Cyprus is, in theory, accessible to everybody. **However, in practice, the high cost of healthcare makes access for migrants extremely difficult. Because of the way the current system operates, the situation is even more critical for asylum seekers and undocumented migrants who, in their vast majority, do not have the means to pay for adequate healthcare. The findings from both the legal and field research presented in this report give some insight into their situation.**

## ■ Legal entitlements to access health care for migrants in Cyprus

**CYPRIOT AND OTHER RESIDENTS**

- The health system in Cyprus grants Cypriot citizens whose gross income is below the defined threshold and civil servants, as holders of the medical card A, full access to medical care free of charge. People with a higher income can access healthcare through co-payment or by paying the full cost of their care, depending on their income level.
- EU nationals who reside in Cyprus, long term residents and persons with international protection (recognised refugees and persons with subsidiary protection, who have been in Cyprus for at least one year with this status) have the same legal access to the health system as Cypriot citizens.
- For Cypriot citizens, the cost of any examinations or treatment not available in the public sector is covered by the Ministry of Health through a special plan for the provision of financial assistance for services. However, KISA knows of a number of cases in which persons with international protection[96] were refused financial assistance for such examinations or treatment, in spite of having the same rights as nationals.
- Entitlements to healthcare for authorised migrant workers vary by professional sector and can be rather minimal. Only emergency care is available to them free of charge, as it is to everybody. As a consequence, a parallel healthcare system has developed for migrants, with private insurance plans for basic healthcare. Women domestic workers, for instance, have to contribute 50% of the cost of their private medical insurance, which does not even cover gynaecological and delivery care. As a result, the health of migrant women is particularly at risk and access to antenatal and postnatal care extremely limited.

**ASYLUM SEEKERS**

- Asylum seekers can access "emergency care and necessary treatment" free of charge only if they are living in a reception centre, receiving welfare benefits, capable of demonstrating a lack of sufficient resources, or if they belong to a vulnerable group. In such cases, asylum seekers are issued with the Medical card A. All other asylum seekers have to pay the full cost of services. Asylum seekers also have no access to financial assistance for examinations and/or treatment not available in public health services. The same holds for victims of people trafficking.
- The term "necessary treatment" is generally interpreted in a broad sense to include primary and secondary care, medicines and treatment of serious infectious diseases such as HIV.
- According to the legislation, "vulnerable groups" among asylum seekers include minors, persons with special needs, the elderly, pregnant women and victims of different types of violence.

[96] Recognised refugees and persons with subsidiary protection, who have been at least one year in Cyprus on this status

These vulnerable groups are also entitled to access "other care under any circumstances" free of charge.

**UNDOCUMENTED MIGRANTS**

- There are no legal provisions entitling undocumented migrants to access healthcare in Cyprus, only ministerial circulars stating that any person can access emergency care free of charge. However, if they are admitted to hospital, they are asked to pay full hospital costs.
- The only care theoretically provided free of charge to undocumented migrants (adults and children) is treatment for HIV and other infectious diseases.

## ■ Accessing Healthcare in Practice

**ASYLUM SEEKERS**:

- **A large proportion of the asylum seekers interviewed did not benefit from their potential entitlements**: almost half of them did not possess the required medical card due to lack of information about this entitlement and how to access it. And among the asylum seekers interviewed, **the tendency to have recourse to healthcare seems to have depended on the possession of this Medical Card A**. Indeed, almost 60% of non-holders of Medical Card A had not consulted a health professional the last time they were ill.
- However, whether or not they held the Medical Card A, **almost all the asylum seekers interviewed had encountered difficulties and barriers when attempting to access healthcare**. 88% reported at least one and usually several difficulties.
- The **problem of the cost** of medical consultations and/or treatment was largely cited by those who did not benefit from health coverage. For one-quarter of the asylum seekers interviewed, **the lack of information about rights and entitlements** was one of the main difficulties perceived.
- Furthermore, **14% of the asylum seekers who tried to access healthcare had been refused healthcare** by the administration and/or health professionals on at least one occasion. This worrying rate raises issues about the poor effective protection provided to asylum seekers in terms of access to healthcare, and also reveals questionable and probably discriminatory practices in healthcare facilities, as well as it reveals an insufficient knowledge of the entitlements of asylum seekers on the part of health professionals and the administrative services of healthcare facilities.

**UNDOCUMENTED MIGRANTS**:

- Access to healthcare for undocumented migrants would appear to be even more problematic: the survey showed **clear avoidance of healthcare facilities by the undocumented migrants interviewed**. Almost 40% said they had given up on healthcare on at least one occasion since arriving in Cyprus.
- **Numerous barriers to accessing healthcare were cited. The lack of health coverage seriously affected their access and recourse to healthcare**. 62% of the undocumented migrants interviewed cited this as a barrier.
- **The fear of being denounced and reported to the authorities was cited as a barrier in accessing healthcare by 45% of undocumented migrants**. Indeed, cases of denunciation by health facilities have been reported. **Such practice may lead to creating a dangerous health and humanitarian situation for victims**. Those undocumented migrants who consulted a health professional the last time they felt ill tended to attend private healthcare facilities rather than public facilities: most said they avoided public facilities for fear of being reported to the authorities as undocumented.
- **Among those undocumented migrants who did try to access healthcare, 22% met with a refusal when they wanted to consult a doctor, further undermining their already extremely poor access to healthcare.**

**PREGNANT WOMEN AND CHILDREN:**

- **Access to healthcare for pregnant women and children was also problematic. Most women encountered difficulties in accessing antenatal and delivery care, and not all newborns were given the necessary vaccinations. Such a lack of preventive care during pregnancy and for newborns can seriously affect early health and have long-term if not life-long consequences. Vaccination in particular is a very crucial public health measure to eradicate diseases**.

### ■ Pathogenic living conditions

**The survey's findings reveal precarious and potentially pathogenic living conditions for both undocumented migrants and asylum seekers:**

**POOR HOUSING CONDITIONS**:

- **87% of the migrants interviewed cited at least one problem with their accommodation that could affect health**, relating to unsanitary conditions, a lack of basic amenities such as toilets and/or washrooms, and overcrowding. **Respondents with children were also affected, as were pregnant women**. **Such poor housing conditions may contribute to an early deterioration of migrants' health or even lead to the development of health problems, especially in children.**
- For asylum seekers, the housing conditions they describe raise issues about access to decent accommodation as a minimum social right that should be attached to the status of asylum seeker. They were left to find their own solutions with few economic resources and in a context where access to housing for migrants is already difficult.

**DIFFICULT AND DANGEROUS WORKING CONDITIONS**:

- 84% of working asylum seekers and undocumented migrants were employed on a temporary basis. **Job insecurity therefore added to the general precariousness of their situation**. **Furthermore, almost half of them worked more than 10 hours a day from everyday to several times a week on average**.
- More than half considered their work to be dangerous and felt it could affect or had affected their health.

### ■ Worrying rates of self-perceived physical and mental health

The experience of migration, the separation from family and uprooting that migration implies, added to difficult experiences in the country of origin and poor living conditions in Cyprus appear to have had a considerable impact on the way respondents perceived their physical health and, to an ever greater degree, their psychological health.

**A PREMATURE DETERIORATION OF PHYSICAL HEALTH:**

- Almost one-third of the asylum seekers and 6% of the undocumented migrants interviewed felt they were in a poor or very poor state of physical health, which is particularly alarming considering the relatively young age of the sample population.

**AN ALARMING STATE OF SELF-PERCEIVED MENTAL HEALTH AND A LACK OF ACCESS TO MENTAL HEALTH CARE**:

- **Half of the asylum seekers and almost one-third of the undocumented migrants considered they were in a poor or very poor state of psychological health**. Some had lived through traumatising experiences, such as war, persecution and violence, in their countries of origin, yet access to proper mental healthcare appears to be highly insufficient or inaccessible, along with all other types of healthcare.

# RECOMMENDATIONS - CYPRUS

## ■ Regarding the reform of the health system

- Cyprus' current health system has been shown to be insufficient and unable to address the needs, not only of migrants and refugees, but of the Cypriot population as a whole. **There is therefore an urgent need for the current health system to be replaced by a new, innovative and unified system**, such as exists in the majority of European Union Member States. A new health plan has been developed by the government of Cyprus, but its implementation has been postponed. In view of the numerous and serious problems in the existing health system, the new health plan should be adopted without further delay.
- **It is essential for the new health plan to provide access to healthcare to everyone, regardless of their legal status**, as healthcare is a basic human right and, as such, should be accessible to all.
- It is also very important for the health system to **recognise the vulnerability of certain** persons or groups of persons, such as asylum seekers and undocumented migrants, and provide them with access to adequate healthcare accordingly.
- **The current policy in Cyprus providing an interdiction for hepatitis positive and HIV positive migrants to enter the country and deportation of migrants who are known to be hepatitis positive or HIV positive, should be abolished with immediate effect,** as it is unjustifiable on health grounds and in violation of the rights of people living with hepatitis and HIV.

## ■ Regarding the access of asylum seekers to healthcare

- **All existing legislation should be applied in practice**.
- **Asylum seekers should be adequately and effectively informed of their right to access healthcare** and of how to exercise this right.
- **The administrative services and health professionals of public healthcare facilities should be informed** of the rights of asylum seekers to access healthcare.
- **The administrative services and health professionals of public health care facilities should be trained to meet the specific needs of asylum seekers**.
- **Interpreters should be made available in all public health care facilities**.
- An **inter-cultural health mediation programme** should be adopted to meet the specific needs of asylum seekers.
- **Asylum seekers should have access to financial assistance for examinations and/or treatment not available in public health services**.
- **The specific mental health needs of asylum seekers (and vulnerable migrants) should be addressed through adequate provision of care**.

## ■ Regarding the access of undocumented migrants to healthcare

- It is very important that the existing legal framework and more specifically, the principle of equal treatment, is applied in practice so that, at least under certain conditions, **access to healthcare is granted to all**.
- **The Ministry of Health should immediately adopt the suggestion of the Commissioner for the Protection of Children's Rights that all children living in Cyprus, irrespective of the**

**status of their parents**, and especially the children of undocumented migrants, should have full access to health and rehabilitation services.[97]

- A **regulation prohibiting the denunciation of undocumented migrants should be adopted**, especially with regard to health professionals and administrative services in public healthcare facilities, so that undocumented migrants are not afraid to seek healthcare.
- **Pregnant women should be allowed free and full access to healthcare: perinatal and delivery care should be provided unconditionally for all women and babies**.
- **Gynaecological examinations, such as PAP tests and mammograms, should be provided free of charge to all women**, irrespective of their legal status.
- **Full access to healthcare should be secured for detainees** by amending the Law on Medical and Public Health Services.

[97] Letter of the Commissioner for the Protection of Children's Rights to the President of the Parliamentary Committee on Health, the Chief of the Police, the Director of Social Welfare Services and the Executive Director of KISA: *Kalipsi Eksodon Iatikon Ipiresion Pedion ton opoion oi Gonis Ine Aitites Politikou Asilou i Vriskontai stin Kipro Paranoma*. Nicosia, 8/12/09.

# MALTA

## SKOP

SKOP (and its platform HAM) is member of the HUMA network, and implemented the research in Malta for this report.

Health Care Access to Migrants (H.A.M.) is a working group within SKOP - The National Platform of Maltese NGOs. The NGO platform is Malta's broadest network of voluntary and non-governmental organisations working in international development and humanitarian aid. The HAM group was created in 2007 with the impulsion of Médecins du Monde. After the publication of the MDM report "Everybody tries to get rid of us", the HAM objective was to lobby for the implementation of their recommendations which are currently still valid.

## INTRODUCTION - CONTEXT IN MALTA

For many decades Malta has been an emigration country. But over recent years, the country has had to cope with an increasing inflow of migrants despite tighter border controls introduced to comply with restrictive European immigration policies. The large majority of migrants to Malta are from Africa. They arrive from Libya by boat on their way to Italy (Lampedusa or Sicily). Between 2002 and 2009, a total of 13, 000 people arrived in the country[98]. Since the signing of a bilateral agreement between Italy and Libya in 2009, there has, however, been a noticeable reduction in the inflow of migrants.

Most migrants to Malta are arrested as soon as they arrive in the country and transferred to detention centres, as illegal entry is considered an administrative offence. During their detention, most of them file a claim for asylum. All detainees are to be released after a maximum of 18 months, even if their asylum request has been denied. Once released or granted protection status, they are accommodated in open centres. The residents of the open centres as well as migrants (both undocumented migrants and asylum seekers) living outside the centres can receive (low) social welfare benefits on condition that they register three times a week at the centre they live/are registered at[99]. According to the official policy, residents are entitled to stay in open centres up to one year. The conditions of detention, the living conditions in the open centres and the policy of systematic detention of asylum seekers have come under much criticism from various organisations and institutions[100].

A number of migrants in Malta may also be visa over-stayers; these population groups are invisible and less information exist on their living conditions.

Until 2001, Malta had no national mechanism for handling asylum claims. The Maltese government has since drawn up the Refugee Act to provide a legal basis for its asylum procedure. In 2004, the country entered the EU and the Schengen/Dublin area and has since aligned with the Dublin II treaty[101]. So far, rulings on immigration issues have essentially focused on deterring migrants from coming to Malta. There are few legal instruments in place and the country lacks a clear policy on rights and integration.

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[98] Amnesty International (2010). *Seeking safety, finding fear: Refugees, asylum-seekers and migrants in Libya and Malta*. London, Amnesty international publications. Available at http://www.amnesty.org/en/news-and-updates/report/libya-and-malta-failing-refugees-asylum-seekers-and-migrants-2010-12-14 (accessed 20 December 2010).

[99] *Ibidem*, p. 10.

[100] See the report of Amnesty International cited above; or Médecins Sans Frontières (2009). *Not Criminals. Médecins sans Frontières exposes conditions for undocumented migrants and asylum seekers in Maltese detention centres* ; Médecins du Monde, "*Everybody just want to get rid of us: access to healthcare and human rights of asylum seekers in Malta*", 2007; European Parliament Committee on Civil Liberties, Justice and Home Affairs (2006). *Report by the LIBE Committee delegation on its visit to the administrative detention centres in Malta.* Rapporteur: Catania G., Brussels, European Parliament.; …

[101] See footnote 12

# PART 1: LEGAL ANALYSIS

## HEALTH SYSTEM

A tax-funded national health system. Private health services exist alongside the public system.

## LEGAL ENTITLEMENTS TO HEALTHCARE

**Nationals and authorised residents**[102] are entitled to preventive, investigative, curative and rehabilitation services free of charge in public health centres and hospitals. The employed, self-employed and employers pay an income-based social security contribution. Dependents, the unemployed and retirees are also covered.

For some categories of individuals, health coverage is extended to include "sickness assistance", "free medical aid", "tuberculosis assistance", "leprosy assistance" or a "milk grant".

People who can demonstrate a low level of income (the threshold is around €450 a month and €100 for the unemployed) receive a "pink card". This card gives them to access "free medical aid", meaning free medicines, glasses, dentures, and other prosthetic aids[103]. People with specific chronic diseases receive a "yellow card": they are eligible for "sickness assistance" and are thus able to obtain the medicines listed on their card free of charge for a definite or indefinite period, depending on the disease[104].
People with tuberculosis, leprosy, or poliomyelitis are also entitled to extended coverage, consisting of access free of charge to the specific care and treatment they require.

**Asylum seekers** are entitled to "state medical care and services"[105] but are required to "cover or contribute to the cost of healthcare if they have sufficient resources"[106]. However, in "exceptional circumstances" the law allows exceptions to these reception conditions in cases where "asylum seekers are in detention or confined to a border post", provided that "these different conditions cover basic needs"[107].

The legislation does not specify what is meant by "state medical care and services", i.e. whether asylum seekers have the right to access healthcare in the public system on the same basis as nationals, or whether they are covered by a specific scheme. Although it is generally interpreted as meaning access free of charge to all medical services received by nationals, this ambiguity leaves room for discretionary practices.

There is no legal or administrative provision regarding entitlements to healthcare for **undocumented migrants** in Malta, whether for those in detention centres, open centres or living on their own. There is only a non-legally binding "policy document" establishing that all foreigners in detention are "entitled to free state medical care and services"[108]. As with the provisions for asylum seekers, this is informally interpreted as meaning access free of charge to Malta's standard healthcare coverage (preventive, investigative, curative, and rehabilitation services). It applies to all undocumented migrants and asylum seekers placed in detention centres upon arrival, and/or once

[102] No law provides for access to healthcare on equal grounds with nationals, except for refugees
[103] See Article 23(1) of the Social Security Act of 1987 (as amended).
[104] See Part II of the Fifth Schedule of the *Social Security Act* for the list of diseases giving entitlement to "free medical aid".
[105] See Article 13(2) of the *Refugees Act* of 1 October 2001.
[106] See Article 11(4) of *the Subsidiary Legislation 420.06* - Reception of Asylum Seekers (Minimum Standards) Regulations of 22 November 2005. According to the Jesuit Refugee Services in Malta, this provision has never been applied.
[107] See Article 12(6) of the *Subsidiary Legislation 420.06* of 22 November 2005.
[108] Ministry for Justice and Home Affairs and Ministry for the Family and Social Solidarity, *Irregular Immigrants, Refugees and Integration – Policy Document*, 2005, p. 12.

they are living in open centres (ordinary residences after release from detention centres[109]) or other accommodation. The policy document only specifies that the open centre shall maintain regular contact with public authorities regarding health issues in general and in case of suspected infectious conditions[110].

**In practice**, when asylum seekers and undocumented migrants seek healthcare, they are normally required to show their "police number", if they are in detention, or their "ID card" if they have been released and are living in an open centre or elsewhere. The "police number" is an immigration number given to them on arrival. The ID card is issued to all migrants when released from detention centres and is mainly for registration purposes. It is also proof that the person has not escaped from the detention centre. There are no rights attached to the ID card. It looks like a Maltese ID card and does not mention the status of the migrant or the fact that he or she is undocumented.

Asylum seekers and undocumented migrants affected by chronic diseases may also be issued with a "yellow card" or a "pink card", if they satisfy other conditions. However, the procedures for obtaining these cards are long and complex and the eligibility conditions are unclear.

**Finally, the absence of an effective legislative framework in Malta frequently results in arbitrary decision-making and recourse to informal strategies.**

# ADULTS CARE

## EMERGENCY CARE; PRIMARY AND SECONDARY (OUTPATIENT) HEALTHCARE; HOSPITALISATION (INPATIENT CARE); ANTE- AND POSTNATAL CARE

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>➤ To be affiliated to or the beneficiary of social security and able to show an identity card or a social security number from the latest pay-slip (thus requirement to be paying social security contributions, except if a dependent, unemployed or retired).<br>➤ For secondary (outpatient) care: Prior authorisation by a general practitioner. |
| **Asylum seekers** | **Entitlements:**<br>Access to "state medical care and services". |
| | **Conditions:**<br>➤ In practice, normally required to show a "police number" if in detention, or an ID card, once released;<br>➤ To pay or co-pay, if sufficient resources (no applicability). |
| **Undocumented migrants** | **Entitlements:**<br>Access not foreseen by any legal or administrative provision.<br>According to the non-legally binding policy document: access free of charge as beneficiary of "free state medical care and services". |
| | **Conditions:**<br>➤ In practice, normally required to show a "police number" if in detention or an ID card, once released. |

[109] Those undocumented migrants who are rejected asylum seekers are released after 18 months of detention and placed in an open centre.
[110] Ministry for Justice and Home Affairs and Ministry for the Family and Social Solidarity, *Irregular Immigrants, Refugees and Integration – Policy Document*, 2005, p. 24.

# ADULTS TREATMENT

## MEDICINES

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>a) People in general: access free of charge or fully paid depending on the category of medicines.<br>b) Holders of "pink card": access free of charge to all medicines listed in the Government Formulary<br>c) Holders of "yellow card" and "tuberculosis, leprosy and poliomyelitis cards": access free of charge to all medicines listed in the Government Formulary |
| | **Conditions:**<br>Three different situations:<br><br>a) For people in general:<br>➢ To be affiliated to or the beneficiary of social security and thus paying social security contributions (except if a dependent, unemployed or retired);<br>➢ To show a prescription;<br>➢ To pay full cost for some medicines (e.g. antibiotics).<br><br>b) For "pink card" holders:<br>➢ To be affiliated to or the beneficiary of social security and thus paying social security contributions (except if a dependent, unemployed or retired);<br>➢ To prove low income;<br>➢ To show the "pink card".<br><br>c) For "yellow card" holders and people with tuberculosis, leprosy and poliomyelitis:<br>➢ To be affiliated to or the beneficiary of social security and thus paying social security contributions (except if a dependent, unemployed or retired);<br>➢ To show the "yellow card" or "tuberculosis card". |
| **Asylum seekers** | **Entitlements:**<br>Access to "state medical care and services". |
| | **Conditions:**<br>➢ In practice, normally required to show a "police number" if in detention or an ID card, once released;<br>➢ To pay or co-pay, if sufficient resources (no applicability). |
| **Undocumented migrants** | **Entitlements:**<br>Access not foreseen by any legal or administrative provision.<br>According to the non-legally binding policy document: access to "free state medical care and services". |
| | **Conditions:**<br>➢ In practice, normally required to show a "police number" if in detention or an ID card, once released. |

# HIV SCREENING

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access anonymous and free of charge. |
| | **Conditions:**<br>No particular conditions |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>Same as nationals. |
| **Undocumented migrants** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>Same as nationals. |

# - HIV TREATMENT
# - TREATMENT OF OTHER INFECTIOUS DISEASES

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>To be affiliated to or the beneficiary of social security and able to show an ID card or the social security number from the latest pay-slip (thus requirement to be paying social security contributions, except if a dependent, unemployed or retired). |
| **Asylum seekers** | **Entitlements:**<br>Access to "state medical care and services". |
| | **Conditions:**<br>➤ In practice, normally required to show a "police number" if in detention, or an ID card, once released;<br>➤ To pay or co-pay if sufficient resources (no applicability). |
| **Undocumented migrants** | **Entitlements:**<br>Access not foreseen by any legal or administrative provision.<br>According to the non-legally binding policy document: access to "free state medical care and services". |
| | **Conditions:**<br>➤ In practice, normally required to show a "police number" if in detention, or an ID card, once released. |

# CHILDREN

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access free of charge according to the same conditions as their parents.<br>There are compulsory and recommended vaccinations[111]. |
| | **Conditions:**<br>➤ To be the beneficiary of social security contributors and able to show an ID card or the social security number from their parents' latest pay-slip;<br>➤ To show "pink" or "yellow card", if low income or specific chronic diseases |
| **Asylum seekers' children** | **Entitlements:**<br>Access to "state medical care and services". |
| | **Conditions:**<br>➤ In practice, normally required to show a "police number" if in detention or an ID card, once released;<br>➤ To pay or co-pay, if sufficient resources (no applicability). |
| **Unaccompanied (asylum seeking) children** | **Entitlements:**<br>All children under the age of 18 who are in need of care are authorised to apply for asylum and are placed in state custody[112]. Access to "state medical care and services".<br>According to the non-legally binding policy document: same treatment as nationals[113]. |
| | **Conditions:**<br>➤ In practice, normally required to show a "police number" if in detention, or an ID card, once released;<br>➤ To pay or co-pay, if sufficient resources (no applicability). |
| **Children of undocumented migrants** | **Entitlements:**<br>Access to "state medical care and services". All children under the age of 18 who are in need of care are authorised to apply for asylum. |
| | **Conditions:**<br>➤ In practice, normally required to show a "police number" if in detention, or an ID card, once released. |
| **Unaccompanied (migrant) children** | **Entitlements:**<br>Access to "state medical care and services". All children under the age of 18 who are in need of care are authorised to apply for asylum and are placed in state custody.<br>According to the non-legally binding policy document: same treatment as nationals. |
| | **Conditions:**<br>➤ In practice, normally required to show a "police number" if in detention, or an ID card once released. |

[111] For the list of vaccinations, see www.euvac.net/graphics/euvac/vaccination/malta.html

[112] They shall also be assisted, according to the provisions of the Children and Young Persons (Care Orders) Act, in the same conditions as Maltese children. See Article 13(3) of the *Refugees Act.* In addition, the specific situation of all minors and accompanied minors shall be taken into account after an individual evaluation of their situation (see Article 14(1) of the *Subsidiary Legislation 420.06*).

[113] Ministry for Justice and Home Affairs and Ministry for the Family and Social Solidarity, *Policy Document*, p. 13.

# DETENTION CENTRES

| | |
|---|---|
| **Adults** | Asylum seekers are entitled to "state medical care and services", although this protection can be restricted in exceptional circumstances[114];<br>According to the non-legally binding policy document, all foreigners in detention (asylum seekers and undocumented migrants) are entitled to "free state medical care and services". |
| **Children** | Unaccompanied children: cannot be confined in detention centres but are to be placed in centres for minors. In practice, the vulnerability assessment (in this case the fact of being unaccompanied) can take some time (sometimes months), thus unaccompanied minors are seen in detention centres.<br>Accompanied children: same access as adults. |

# TRANSFER OF OR ACCESS TO INFORMATION BY THE AUTHORITIES

**Transfer or access to information on administrative status**: No legal provision either requires or prohibits public officials from reporting the presence of undocumented migrants or transferring data on undocumented migrants to the immigration authorities.

# NON EXPULSION ON MEDICAL GROUNDS

## NO RECOURSE TO EXPULSION OR SUSPENSION OF REFUSAL-OF-ENTRY, OR EXPULSION ORDERS:

⇒ **WHO?**

"Any person" [therefore including undocumented migrants] in need of immediate medical or surgical treatment which cannot be deferred without prejudice to their health shall be given leave to land and remain in Malta"[115].

⇒ **CONDITIONS:**

Two medical practitioners (one of them a government medical officer) must certify that the person is indeed in need of immediate medical or surgical treatment which cannot be deferred without prejudice to their health. The competent authority is the "Principal Immigration Officer" who, with respect to the law, "shall not refuse leave to land and remain in Malta" in these circumstances.

⇒ **DURATION:**

This leave to remain expires seven days after the issuing of a medical certificate by a government medical officer to the effect that there is no longer any need for the person to remain in Malta for the purpose of or in connection with such treatment.

## RESIDENCE PERMIT ON MEDICAL GROUNDS

No existing legal provisions, but in practice, the "Refugee Commissioner" may grant "temporary protection on humanitarian grounds".

[114] Article 12(6) of the *Subsidiary Legislation 420.06*
[115] Article 6(4) Chapter 217 of the *Immigration Act of* 21 September 1970.

# PART 2: FIELD STUDY IN MALTA

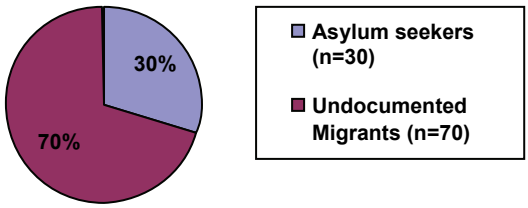
## METHODOLOGY AND SAMPLING

In Malta, the field work for the survey was carried out between 1st September and 4th October 2010. Eight surveyors, three women and five men, conducted a total of 100 interviews. Four of the surveyors were Maltese nationals and four were African migrants. All were volunteers or working in NGOs members of SKOP's platform, and one interviewer was working as a cultural mediator in the maternity unit of a hospital. The surveyors were trained with the same methodology before the start of the survey. Each interviewer selected potential respondents from within their own social circle and work in the NGOs, as well as at random from among migrants on the streets. This method resulted in a varied sample.

The interviewers reported problems persuading women to be interviewed, even by a woman interviewer. However, asylum seekers and undocumented migrants in Malta are in any case predominantly male, especially among the African immigrants.

In Malta, it was decided to focus the survey mainly on undocumented migrants. **A hundred interviews were held, 30 with asylum seekers and 70 with undocumented migrants**. Beneficiaries of subsidiary protection may also be asylum seekers if they appealed from the decision taken as regards their international protection – there might be such cases in the survey in Malta.

1. Distribution by administrative status




In spite of the overrepresentation of undocumented migrants in the sample**, it is important to note that the undocumented migrants and asylum seekers interviewed had in fact followed similar paths and shared similar experiences**. **They had all been held in detention on arrival and had all sought asylum in Malta**. All the undocumented migrants in our sample were former asylum seekers whose applications for protection had been denied. Also all the migrants in our sample came from African countries, as most migrants arriving in Malta in reality. Thus, the survey's findings are a quite accurate reflection of what generally occurs with migrants arriving in Malta (presented in the introduction on Malta). However, no visa overstayers were reached in this survey; the ever-increasing number of undocumented visa overstayer migrants would require further attention and research.

In our sample, both the asylum seekers and the undocumented migrants had been **issued with an ID** card, with the exception of one respondent. This ID card is requested prior to medical consultations in the public healthcare system. By law for asylum seekers are all entitled to healthcare free of charge and a non-legally binding policy document provides access to healthcare free of charge for undocumented migrants (see section on legal analysis).

# I. DEMOGRAPHIC CHARACTERISTICS

## 1. SEX AND AGE

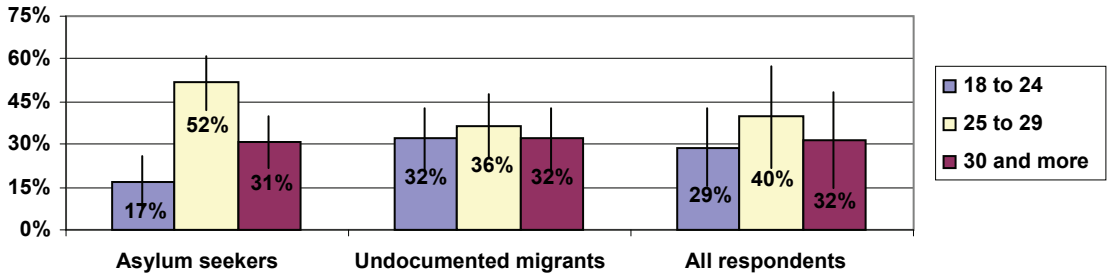
2. Distribution by sex, by administrative status (%)

| Sex \ Adm. status | Asylum seekers n=30 | Undocumented migrants n=70 | All respondents n=100 |
|---|---|---|---|
| **Male** | 97% | 93% | **94%** |
| **Female** | 3% | 7% | **6%** |
| **TOTAL** | **100%** | **100%** | **100%** |

**Only six women were interviewed (**five were undocumented and one was an asylum seeker). In most cases, due to the small number of women in our sample, no distinction will be made between men and women[116].

**This underrepresentation of women in our sample can also be seen in migration flows into Malta**. According to Eurostat, in the first quarter of 2010 only 13% of asylum seekers were women[117].

3. Distribution by age groups, by administrative status (%)




**The population interviewed for our survey was young: the average age of our sample was only 28**. Among the people interviewed, the asylum seekers were slightly older than the undocumented migrants with an average age of 29 years old, against 27.5 years old for undocumented migrants. However, this difference is not significant. Our eldest respondent was 60 years of age at the time of the interview, the second eldest 39, and the youngest 18.

**Again, the young age of the population interviewed reflects the reality of immigration in Malta**. Eurostat reports that in the first quarter of 2010 almost 90% of adult asylum seekers were aged between18 and 35.[118]

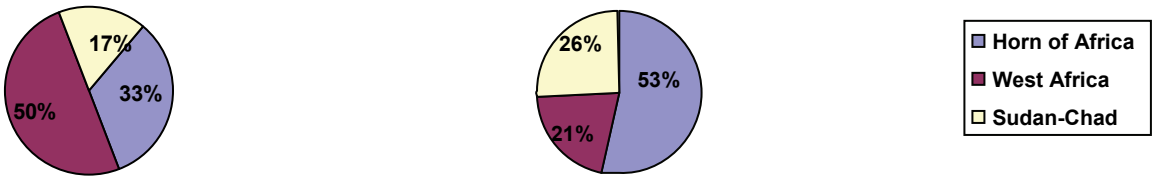
[116] As this small number prevents us from drawing significant conclusions
[117] EUROSTATS, *Asylum applicants and first instance decisions on asylum applications in Q1 2010*, available in http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-QA-10-032/EN/KS-QA-10-032-EN.PDF
[118] *Ibidem*

## 2. NATIONALITIES

**All the respondents in our sample came from Sub-Saharan Africa**. Fifteen nationalities were represented in total[119]. An analysis of regions of origin shows that both the asylum seekers and the undocumented migrants came from three main regions of Africa: the Horn of Africa, West Africa and the region of Chad and Sudan.

4. Distribution by regions of origin, by administrative status (%)

**Asylum seekers** **Undocumented migrants**




**The Horn of Africa: almost half of the people interviewed came from the three Horn of Africa countries: Ethiopia, Eritrea and Somalia**. In our sample, they were the most highly represented group among undocumented migrants (53%) and the second most highly represented group among asylum seekers (33%). The most common nationality among undocumented migrants was Ethiopian (53%), and Ethiopians also constituted one-quarter of our whole sample.

**West Africa: the second most common region of origin was West Africa**. 50% of the asylum seekers interviewed and 21% of the undocumented migrants came from one of the **10 Western African countries represented**. Côte d'Ivoire was the most common country of origin in this region (7% of all respondents; 13% of asylum seekers).

**Sudan and Chad: the third group was composed of respondents from the Sudan and Chad. Sudan is the second largest nationality group in the whole sample**, with 19% of all respondents. 80% of the Sudanese had been denied asylum and are now undocumented.

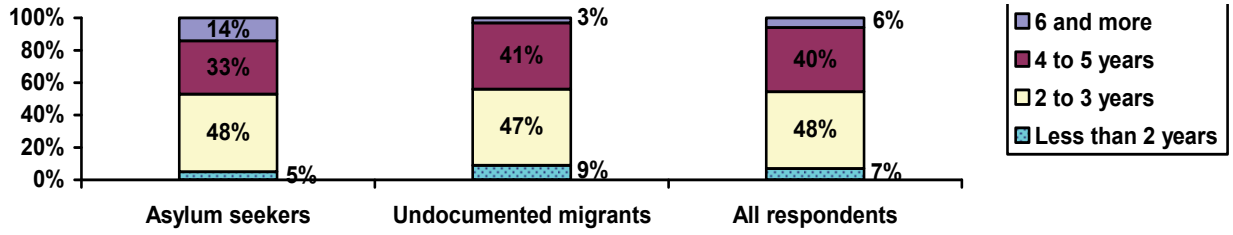
Our sample does not include some nationalities of migrants living in Malta, with no migrants from central Asia, for example, although there are known to be arrivals from this region and from Pakistan in particular.[120]

# II. MIGRATION EXPERIENCE

## 1. TIME PERIOD SINCE MIGRATION

On average, respondents had arrived in Malta for three and a half years prior to our survey in 2010; half of the interviewees had arrived less than three years prior to the survey (median = 3; range = 0.9 to 8 years).

5. Length of time spent in Malta since migration, by administrative status (%)




**Almost nine out of ten respondents had arrived in Malta between two to five years prior to**

[119] For a complete table by nationality of the population interviewed, refer to table 5 of the appendix 2 (part dedicated to Malta)
[120] EUROSTATS, *Asylum applicants and first instance decisions on asylum applications in Q1 2010*, available in http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-QA-10-032/EN/KS-QA-10-032-EN.PDF

**the survey**, both in the case of asylum seekers and undocumented migrants. **This is consistant with the fact that the biggest inflows of migrants are quite recent and increased when the island joined the European Union in 2004**. The highest concentration was between 2005 and 2008, i.e 2 to 5 years prior to the survey.

Indeed, very few respondents had arrived six years or more prior to our survey, and adversely very few arrived very recently. The 2009 Italy-Libya agreement is responsible for a sharp reduction in the number of migrants reaching the shores of Malta since mid-2009.

**On average, the asylum seekers interviewed had been living in Malta for 3.75 years**. **This time period reflects lengthy asylum procedures**[121] during which people remain uncertain about their future and live in fear of being denied asylum. Yet some of the asylum seekers were in the process of making their second claim for asylum, after being denied the first time around[122]. One of the asylum seekers interviewed had lived in Malta for more than seven years.

6. Average length of time in Malta since migration, in years, by nationality

| Adm. stat. / Nat | Horn Of Africa (n=47) | West Africa (n=30) | Sudan – Chad (n=23) | All respondents |
|---|---|---|---|---|
| Horn Of Africa (n=47) | 3.0 | 3.1 | 4.6 | 3.4 |

**In our sample, the Sudanese and Chadian respondents had lived in Malta the longest** (4.6 years on average). In reality, the inflow of asylum seekers from these countries is indeed one of the earliest (among recent migration inflows of asylum seekers), as immigrants fleeing these countries have been arriving since before the country joined the European Union, peaking in 2005[123].

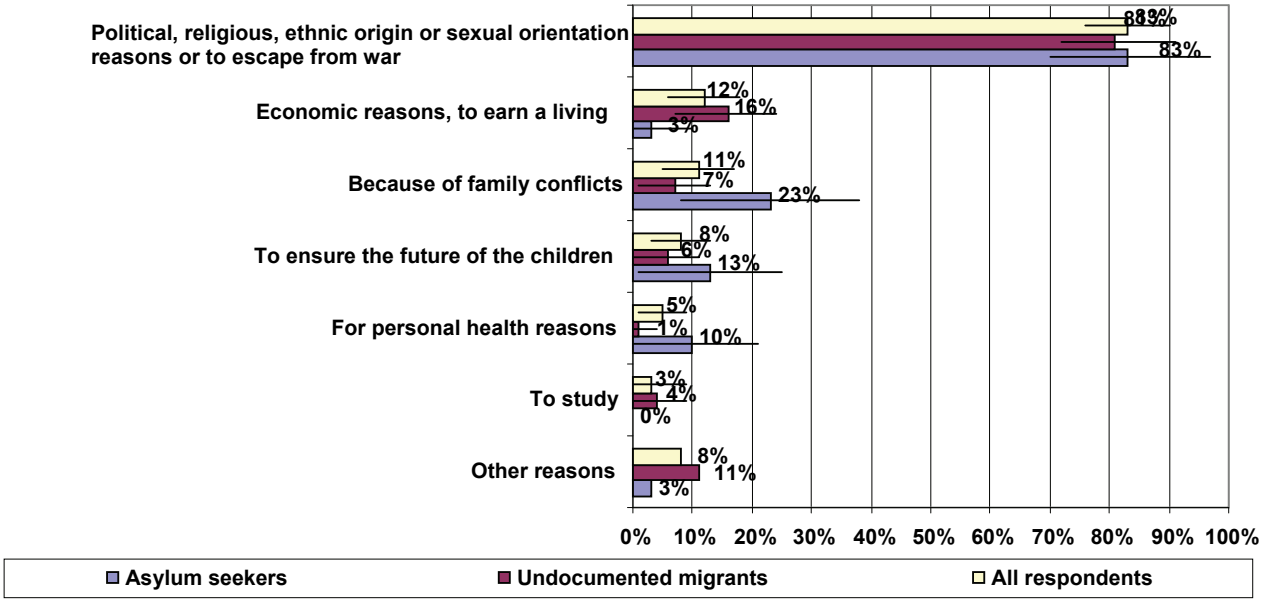
**The migrants from the Horn of Africa had been in Malta for an average of three years** (range: 1 to 6 years), and three-quarters of them had arrived two to four years previously. Available statistics show that most asylum seekers from the Horn of Africa arrived in Malta between 2005 and 2008.[124]

**Respondents from West Africa had been in the country for 3.1 years on average**, with significant differences between respondents and countries of origins and no clear trends.

[121] Although the time needed for processing asylum claims has reduced. The commissioner of Refugee underlines that all persons that arrived in Malta in 2009 had their case decided on average within 151 days (i.e. 5 months from the arrival date).
[122] Migrants can apply for asylum several times in Malta or appeal against the decision if there first application is denied.
[123] See Eurostats statistics on arrivals of asylum seekers in Malta on http://epp.eurostat.ec.europa.eu/portal/page/portal/
[124] Ibidem

## 2. REASONS FOR MIGRATION

7. Reasons for migration, by administrative status (%)*




* The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of respondents.

**The very slight difference in the reasons given by asylum seekers and undocumented for leaving their country was not statistically significant, and is due to the fact that all the undocumented migrants interviewed were rejected asylum seekers**.

**83% declared they had fled their country to escape persecution on political, religious, ethnic or sexual orientation grounds, or to escape from war**. In theory, this should lead to the granting of some form of protection. As many undocumented migrants as asylum seekers gave these reasons for their migration.

The next most common reason given for migration was economic difficulties and the lack of prospects in the country of origin and concerned far fewer respondents (12%). The large majority of those who cited economic reasons also cited persecution for political, religious, ethnic origin or sexual orientation reasons or to escape from war. For asylum seekers, the second most common reason given was fleeing from family conflicts (23%; not cited by women).

**Only 5 respondents included health reasons among their motives for migrating.**

8. Reasons for migrating, by nationality (%)*

| Reasons / Region of origin | Political, religious, ethnic (…) reasons** | Economic reasons, to earn a living | Family conflicts | To ensure a future of children | Personal health reasons | To study | Other reasons |
|---|---|---|---|---|---|---|---|
| **Horn of Africa** | **96%** | 6% | 2% | 2% | 4% | 4% | 4% |
| **West Africa** | **60%** | **23%** | **30%** | **23%** | 7% | 0% | 10% |
| **Sudan - Chad** | **87%** | 13% | 4% | 0% | 4% | 0% | 13% |
| **TOTAL** | **83%** | **12%** | **11%** | **8%** | **5%** | **3%** | **7%** |

* The percentages exceed 100%: this was a multiple choice question. The percentages refer to the number of respondents.
** Full item is: Political, religious, ethnic or sexual orientation reasons or to escape from war

The reasons given for migration are linked to the situation in the migrants' home countries. Nearly all of the respondents from politically unstable regions or countries at war cited persecution on political, religious or ethnic grounds, persecution because of sexual orientation or to escape from war among their reasons for migrating (96% of people from the Horn of Africa, and 87% of those from Sudan or Chad).

60% of migrants from West Africa gave also commonly these reasons for their migration, but they were also more likely to say they had left their countries because of family conflicts (30%), or for economic reasons (23%), among other reasons.

## 3. EXPERIENCE OF DETENTION AND FEAR

**All of the migrants interviewed had been held in a detention centre on arrival in Malta, even though they had submitted an asylum request**. **The conditions of detention for migrants in Malta are now well documented and have been widely criticised as disgraceful**: overcrowded rooms, poor access to healthcare, no activities, poor and insalubrious basic amenities[125]. However, with the reduction in the number of arrivals in Malta, the situation in detention centres in 2010 seems to have improved somewhat. All the people interviewed except for one arrived more than a year prior to this survey, meaning they experienced detention in the conditions described above.

9. Proportion of people limiting their activities for fear of being arrested, by administrative status (%)

| Limiting his/ her activities / Administrative status | Very often | Often | Sometimes | Never | TOTAL |
|---|---|---|---|---|---|
| **Asylum seeker** | 19% | 27% | 42% | 12% | **100%** |
| **Undocumented / No permit to stay** | 21% | 18% | 36% | 26% | **100%** |
| **TOTAL** | **20%** | **20%** | **37%** | **22%** | **100%** |

**In theory, asylum seekers are protected by their status, and yet 88% of them claimed to limit their activities for fear of being arrested**. 46% specified that they limited their activities often to very often. **Among undocumented migrants, three-quarters said they limited their activities** at least sometimes, and 39% often to very often.

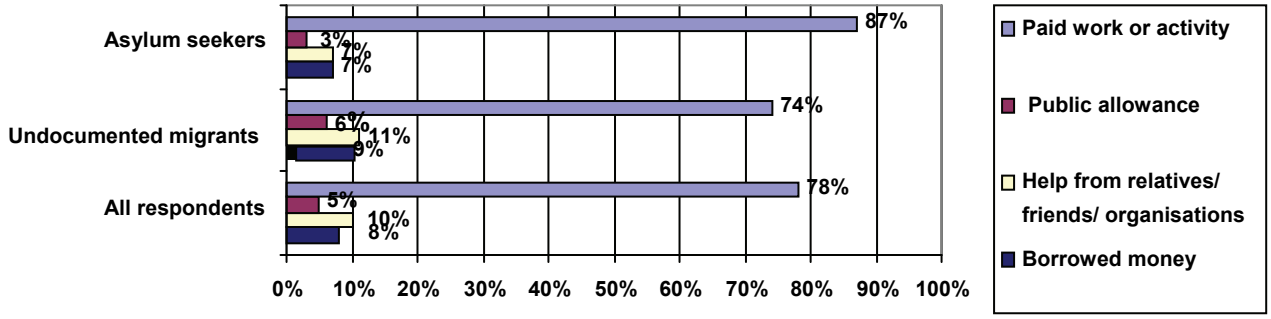
It is alarming to note that this proportion does not change the longer people have lived in Malta. Among the respondents who had been in the country for more than three years (i.e. half of the sample), 76% claimed to limit their activities at least sometimes, and 43% often to very often. **It is likely that such fear, especially when lasting for long periods, has adverse effects on migrants' psychological health**.

# III. LIVING CONDITIONS IN MALTA

## 1. INCOME AND WORKING CONDITIONS

### ■ Sources of income

10. Sources of income, by administrative status (%)*




* The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of respondents

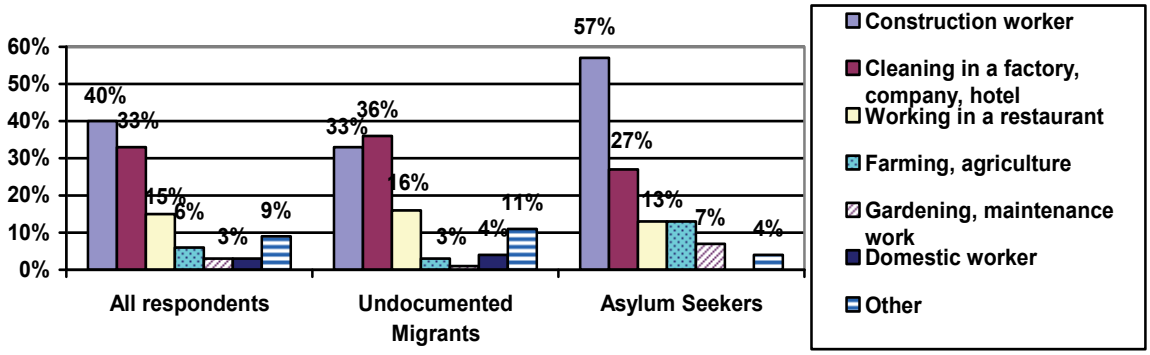
[125] See Amnesty International, "*Seeking safety, finding fear: refugees, asylum seekers and migrants in Libya and Malta*", December 2010, p.8 to 11; Médecins Sans Frontières (2009), *op. cit.*; Médecins du Monde (2007), "*Everybody just want to get rid of us: access to healthcare and human rights of asylum seekers in Malta*", op cit.

**Paid work was the source of income of 74% of the undocumented migrants and 87% of the asylum seekers interviewed** (difference is not statistically significant). The fact that a large majority of our respondents worked is probably due to the fact that we mainly targeted individuals living outside of open centres: to be able to afford private accommodation, migrants cannot depend on welfare and therefore need to work. Among the six women interviewed, four worked and two received public allowances.

**Very few respondents said they received a public allowance (5%).** As social benefits are very low[126], most people on allowances are also dependent on another source of income to survive (borrowing money or help from friends). Another difficulty lies in the system of entitlements to social benefits for migrants. **A condition of irreversibility is attached to social benefit entitlements: once lost, they cannot be recovered**. Thus, migrants who lose their jobs can find themselves with no income to live on[127]. This condition means that migrants are more likely to accept very low-paid jobs and difficult or even dangerous working conditions, making them more vulnerable to exploitation.

## ■ Sector of activities

11. Type of work, by administrative status




* The percentages exceed 100% because this was a multiple choice question; the percentages refer to the number of respondents.

**The migrants interviewed had low-skilled jobs**: 40% worked as construction workers, 33% as cleaners, 15% in restaurants, 6% in farming or agriculture. Among the working women, three worked as cleaners, and one as a domestic worker.

The difference in the type of jobs occupied by asylum seekers on the one hand and undocumented migrants on the other seems to be related to the respondents' community: immigrants from the Horn of Africa were more likely to work as cleaners, whereas respondents from other communities were more likely to work in construction[128].

12. Job stability, by administrative status (%)

| Job Stability / Administrative Status | Stable | Temporary | TOTAL |
|---|---|---|---|
| **Asylum Seekers (n=26)** | 4% | 96% | **100%** |
| **Undocumented Migrants (n=52)** | 17% | 83% | **100%** |
| **All respondents** | **13%** | **87%** | **100%** |

**Almost all asylum seekers and undocumented migrants interviewed had unstable working conditions: 87% of respondents said that their current job was temporary and unstable**. All four working women had temporary work.

[126] This fact was highlighted by some of the migrants interviewed. In 2009, the daily allowance for an asylum seekers was €4.65, an asylum seeker awaiting a reply from the Refugee Commission received €4.65 (thus about €140 a month), and a rejected asylum seeker received €3.5 (about €105 a month). Couples with children received €2.33 for every child (about €70 a month). For more complete information, see Sammut J.-M. (2010). Poverty and Social Exclusion in Malta. *European Social Watch Report 2010. Brussels, Eurostep.* Available at: http://www.socialwatch.eu/wcm/Malta.html
http://www.socialwatch.eu/wcm/Malta.html

[127] This clause is now being reviewed. However, should the condition be lifted, there are still concerns about how long it will take to recover entitlements, time during which people are left without any means.

[128] See Graphic 6 in appendix 2 (Section dedicated to Malta)

Job stability changed slightly according to how long the migrants had been living in Malta. 73% of workers who had been in Malta for 5 years or more were in a temporary situation. This figure rises to 90% for migrants living in Malta for 3 to 4 years and all workers who arrived 2 years ago or less have unstable working conditions.

**40% of working respondents had more than one job**.

## ■ Working conditions

13. Proportion of workers working more than 10 hours a week, by administrative status (%)

| Frequency of working + than 10 hours a week / Administrative status | Every day to several times a week | Several times a months | Rarely or never | TOTAL |
|---|---|---|---|---|
| **Asylum seekers (n=26)** | 42% | 15% | 42% | **100%** |
| **Undocumented migrants (n=52)** | 19% | 21% | 59% | **100%** |
| **All respondents (n=78)** | **27%** | **19%** | **54%** | **100%** |

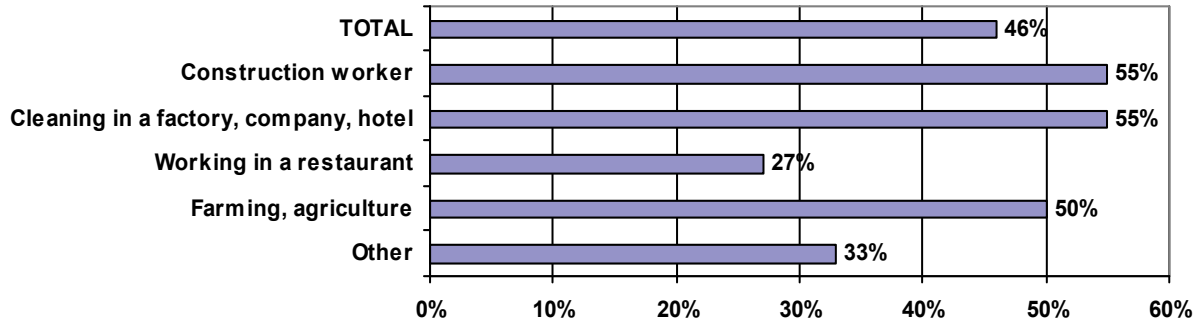
**Many of the migrants interviewed described difficult working conditions: 46% of them were working more than 10 hours a day on a regular basis**[129]. 27% were working more than 10 hours a day several times a week to every day. This proportion reached 42% among asylum seekers.

**Such long working hours can increase the risk of accidents at work, particularly for people working in dangerous conditions, such as construction workers**. 50% of construction workers reported working 10 hours a day or more on a regular basis. Furthermore, some testimonies show that undocumented migrants working on construction sites were not issued with standard protective equipment, such as helmets, proper construction shoes, etc.

**45% of the workers interviewed believed their work could adversely affect their health or put them at risk of an accident in the workplace** (41% of undocumented migrants and 55% of asylum seekers). This assessment is linked, among other factors, to the difficult working conditions described previously.

On the other hand, less than 25% of the respondents who work said that they felt to be working in safe conditions, and 30% said they did not know if their work could affect their health.

14. Proportion of respondents believing their work could affect their health or put them at risk of an accident at work, by type of work (%)



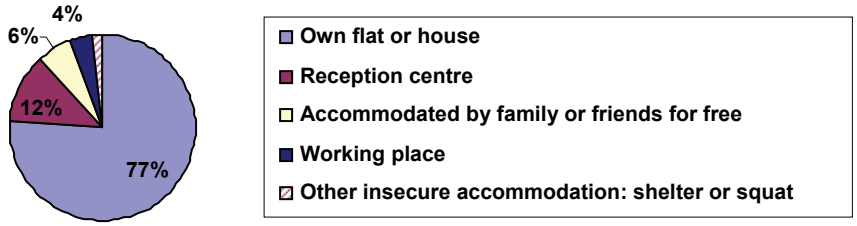

Cleaners in businesses or companies, construction workers, and farmers - representing 75% of working respondents - were most likely to consider that their work could affect their health or safety. However, in all the other sectors of activity, the proportion of respondents who said they felt their work could affect their health or put them at risk of an accident was still quite high (minimum 27%).

[129] Addition of those the respondents who work more 10 hours a day from every day to several times a weeks (27%) and those working more than 10 hours a day several times a months (19%)

## 2. HOUSING CONDITIONS

### ■ Type of accommodation

15. Distribution by type of accommodation, all respondents (%)




There was almost no difference between asylum seekers and undocumented migrants with regard to distribution by type of accommodation.

**More than three-quarters of our respondents were living in their own flat, and 12% were living in a reception centre**. Very few were accommodated by close relations for free (5%). Another 6% were accommodated by their employers, although these were mostly construction workers sleeping at or close to the construction sites. Few were living in shelters or squats (2%). None of the respondents in our sample were sleeping rough, although there are such cases in Malta[130].

**Most respondents shared their accommodation (88%), including when this accommodation was a rented flat**. Flats were almost always shared with friends or compatriots or with fellow migrants. Only 12% of our respondents were living alone or with their own children. Only one respondent replied that he was living with his partner (and no-one else).

### ■ Occupancy status

**The occupancy status of our respondents was particularly poor. Most of the people interviewed considered their occupancy status to be insecure and offering only a short-term solution**: this was the case for 83% of the asylum seekers and 61% of the undocumented migrants. Those migrants living in their own rented accommodation were most likely to feel that their occupancy status was insecure and short-term (72%).

### ■ State of accommodation

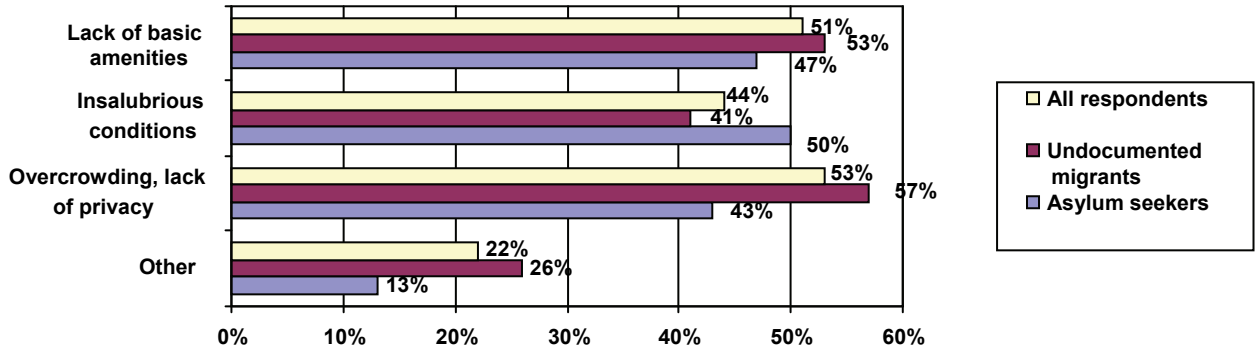
**Almost half of the respondents rated the state of their accommodation as poor to very poor**. Only 24% considered that they lived in good housing conditions. Respondents living in their own flat were most likely to rate the state of their accommodation as fair to good, although 40% still rated it as poor to very poor.

The mostly recently arrived migrants were more likely to consider their housing conditions to be poor to very poor: 86% of the respondents who arrived 2 years ago or less considered them to be poor, and none as good.

**With regard to accommodation problems liable to affect their health, 85% of the respondents mentioned at least one problem, 58% cited several problems - some as many as nine**.

[130] JRS Malta has been working with homeless people in Malta. Some testimonies can be found in JRS (2010). *Living in Limbo. Forced migrant destitution in Europe*. Brussels, Jesuit Refugee Service.

16. Problems encountered with accommodation, by administrative status (%)*




* The percentages exceed 100% because this was a multiple choice question; the percentages refer to the number of respondents.

The problems cited were numerous and have been arranged into 3 categories to make their analysis easier: overcrowding and lack of privacy; lack of access to basic amenities; and insanitary and dangerous conditions. If the respondents cited several problems in the same category, only one was counted. This was actually the most common situation.

The situations described by our respondents illustrate their indecent housing conditions:

**- Problems linked to overcrowding and to the lack of privacy were the most commonly cited (53%), concerning 57% of the undocumented migrants and 43% of the asylum seekers**.

**- The lack of basic amenities was cited almost as often** (51%) and included no ventilation for 26% of the respondents**, no access to fully functioning toilets or washroom** for 22%, no access to air-conditioning for 14%, **no running water** for 9%, no electricity for 8% or no windows for 8%. Indeed, most respondents who were lacking at least one of these basic amenities very often lacked several. These types of problems were cited for all types of accommodation.

- **Problems linked to insanitary conditions** were mentioned by 44% of the respondents: pest or vermin-infested accommodation for 35%, dangerous conditions or faulty electrical fittings for 20%, and 19% complained of degradation and damp.

**Testimony about the living conditions of the children of two undocumented migrants**

Only eight respondents had children and in six cases their children did not live with them. This very low proportion of parents is probably due to the young age of the population interviewed.

The two parents who were living with their children were women. Both of them were undocumented, after having been denied asylum. Both depended on public allowances (social benefits), which are extremely low for children[131].

One of the mothers was living in abandoned premises, where she said she had no access to running water, functioning toilets or a washroom. She also explained that the place was very hot due to the lack of ventilation and infested with pest and vermin, such as rats and cockroaches - conditions totally unsuitable for bringing up children.

The second woman lived in a reception centre with her children, in conditions she considered as poor for herself and her children. She told us that her husband was in Malta, but he was not allowed to live with them as the reception centre is sex segregated[132].

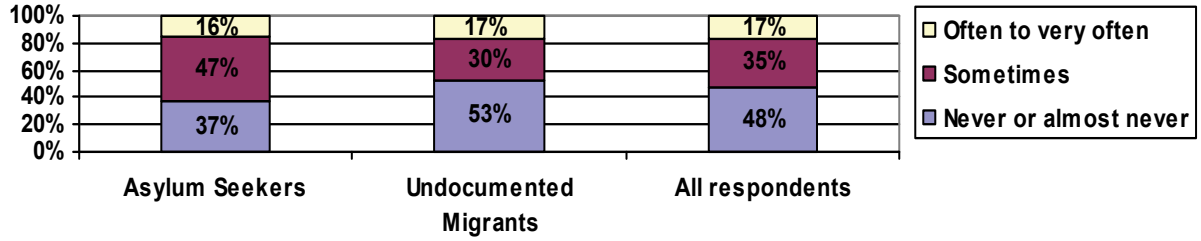
These two testimonies highlight the highly vulnerable situation of certain families, and particularly of women with children in Malta.

[131] Couples with children and no economic means receive €2.33 daily allowance for every child (about €70 a month) – in 2009
[132] All reception centres in Malta are sex segregated apart from the Hal Far Tent village.

Surveys in Europe show foreign nationals to be living in worse housing conditions than nationals, whether in terms of occupancy status, comfort or overcrowding. As shown in this and other studies, for migrants, and for undocumented migrants in particular, the barriers to obtaining decent accommodation are considerabler. "*These include having a low or unpredictable income, no official documents proving they have leave to remain in the country or their level of income, discrimination and abusive practices by landlords, no right to social housing, weak social networks, fear of being reported, etc. Problems relating to insecure can be accompanied by overcrowding and poor and unsuitable housing conditions (insalubrious, dangerous…) – factors that pose risks for the health and well-being of occupants.*"[133]

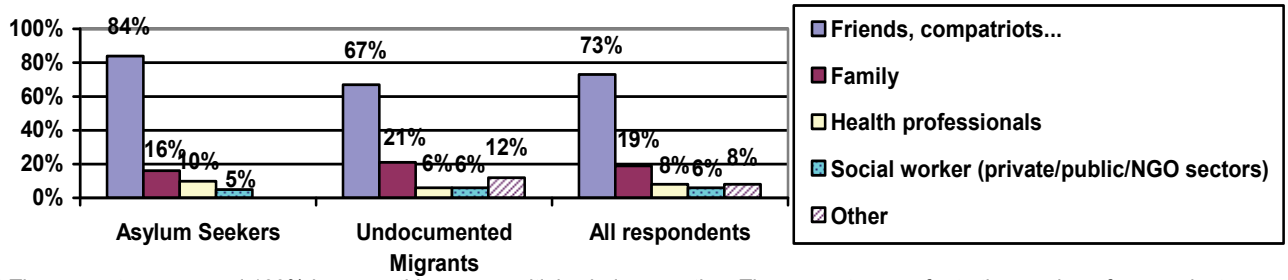
## 3. ACCESS TO EMOTIONAL SUPPORT

17. Availability of emotional support, by administrative status (%)




Among the respondents, **48% said that they could never or almost never count on anyone for emotional support when they needed it**. This very high percentage highlights the **emotional isolation experienced by most of our respondents and we know that there is a correlation between social isolation and a higher risk of disease** (not only mental health conditions). **We also know that social isolation, a weak network and poor social support are factors in estrangement from the health system and more limited access to health services**[134]

18. Type of person providing support, among the respondents who could count on emotional support (n=52), by administrative situation (%)




* The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of respondents who could count on emotional support: 19 asylum seekers and 33 undocumented migrants

**Emotional support, when available, was usually provided by friends or compatriots** – for 73% of the respondents – and was more likely to be available sometimes (76% of the cases) rather than frequently. **Few people could count on family members for emotional support** (19%), but when available this type of support was stronger: 80% said they were able to count on it often to very often. **Only four people counted on health professionals for emotional support (8%) and three on social workers (6%).** Professionals thus played a minor role in providing emotional support.

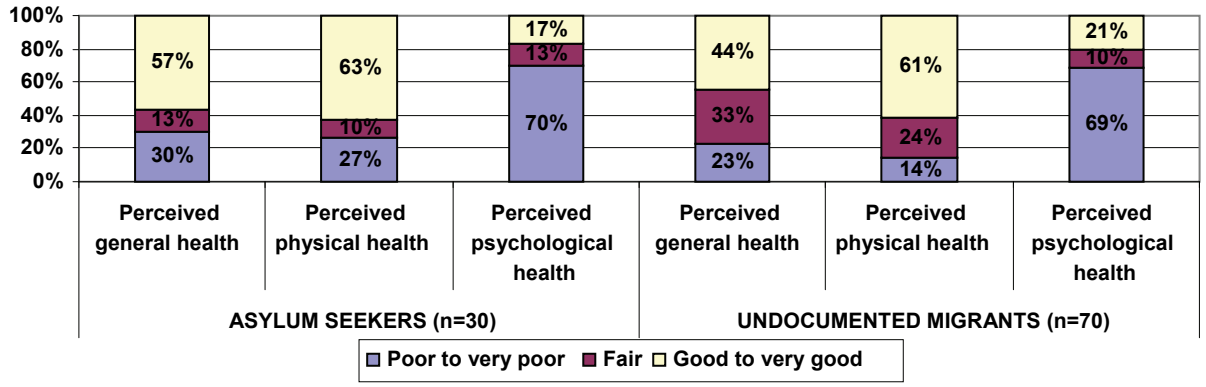
[133] Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009), *op. cit.*
[134] On this subject see the recent study specifically carried out among undocumented migrants in Milan; Devillanova C. (2008), *op. cit.*

# IV. PERCEIVED HEALTH AND ACCESS TO HEALTHCARE

## 1. PERCEIVED HEALTH STATUS

### ■ Appreciation of general, physical and psychological state of health

19. Proportion of respondents considering themselves to be in a poor or very poor state of health by general, physical and emotional state of health, by administrative status (%)




No statistically significant difference can be established between asylum seekers and undocumented migrants with regard to their self-perceived health status.

**One quarter of our respondents perceived their general health to be poor to very poor** (and only half as good to very good). **This self-rating is worryingly low given the young age of the population**. According to Eurostat's indicators on self-perceived health in 2008, only 4.3% of Malta's general population considered its health status to be poor to very poor, and this proportion is even lower for the young male population, demographically closer to our sample.

The self-perceived state of physical health is also worrying in such a young population: **27% of the asylum seekers and 14% of the undocumented migrants judged their physical health condition as poor to very poor.**

**The self-perceived state of psychological health is extremely alarming,** and is probably a factor in the way the respondents rated their general and physical health condition.

In terms of general health (and as well physical and psychological health), the migrants interviewed are thus seen to be quite vulnerable. Our survey shows that living conditions have a significant impact on how people rate their physical and psychological heath. **The link between poor living conditions and poor self-perceived general health is statistically significant.** These results are particularly worrying as other studies have shown that people who emigrate are generally among the healthiest in their home country's population. The implication is, therefore, that their state of health deteriorates significantly during the migration process and once in the host country.[135]

[135] Jusot, F., Silva, J., Dourgnon, P., & Sermet, C. (2009). Inégalités de santé liées à l'immigration en France. Effets des conditions de vie ou sélection à la migration ? [ « Health inequalities linked to migration in France. Effects of the living conditions or selection before migration *?*"]. *Revue économique*, 60(2), 385-411.

### ■ An alarming state of perceived psychological health

**70% of the asylum seekers and 69% of the undocumented migrants, thus a very large majority, considered the state of their psychological health to be poor to very poor, and all the women interviewed claimed to be suffering from poor (one respondent) or more often very poor psychological health (five respondents).**

The alarming findings on the perceived psychological health can be probably be partly inputted to the **experience of difficult or traumatising experiences in the countries of origin of the respondents or through migration for some,** but might be also resulting from difficult experiences lived in Malta. All of our respondents had also **been held in detention,** and the adverse effects of this experience on psychological health have already been demonstrated[136]. **Precarious economic, housing and working conditions, as well as fear of arrest,** have already been mentioned. Further factors influencing migrants' poor perception of their psychological health include **being separated from their family, waiting to hear about their asylum application (for asylum seekers) and the absence of emotional support.**

20. Estimated state of psychological health according to time spent in Malta

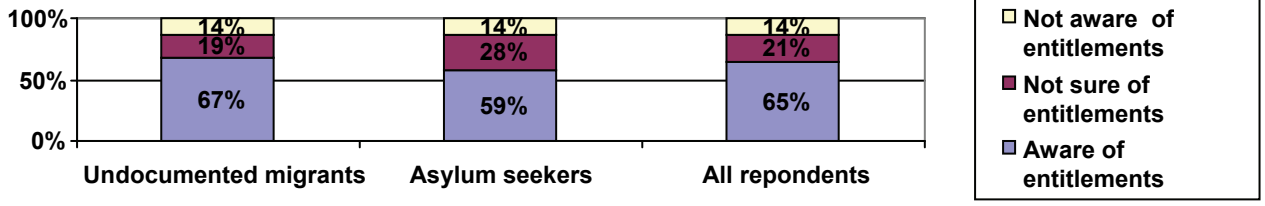
| Psychological Health / Time in Malta | Very good to good psychological health | Fair psychological health | Poor to very poor psychological health | TOTAL |
|---|---|---|---|---|
| 2 years or less (n=28) | 18% | 4% | 79% | 100% |
| More than 2 years to 4 years (n=40) | 23% | 12% | 65% | 100% |
| 5 years and more (n=23) | 26% | 17% | 57% | 100% |
| TOTAL | 22% | 11% | 67% | 100% |

According to our findings, self-perceived psychological health tends to improve the longer the migrant has been living in Malta. This is probably due to the relative improvement noted in working and living conditions, as well as to the gradual development of a social network and better knowledge of how the country works.

## 2. ENTITLEMENTS TO HEALTH COVERAGE

### ■ Knowledge of health coverage entitlements

21. Knowledge of entitlements to health coverage, by administrative situation (%)




A large majority of the population interviewed (65%) said they knew they were entitled to medical care free of charge. However, **more than a third of respondents (35%) were not sure or did not know they were entitled to healthcare free of charge, revealing serious shortcomings in the provision of information to migrants on their rights.**

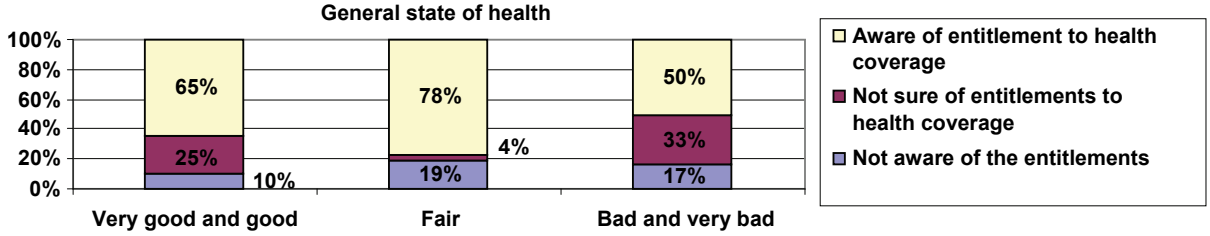
Another striking finding concerns those migrants who had been living in Malta for 5 years or more: almost 40% of them were not aware or not sure of their entitlements to health coverage. This reveals how long migrants can remain without proper information on their rights, and so be prevented from accessing these rights. **In terms of the consequences this can have on health, a lack of information can result in delays in seeking healthcare, allowing diseases to take hold**

[136] Médecins Sans Frontières (2009), *op. cit.*

**and making medical intervention inevitable. This is neither economically sound nor is it efficient in terms public health.**

The respondents who appear to be best informed about their rights and entitlements to health coverage are those who arrived between 2006 and 2008. This is the period that saw the highest inflows of immigrants into the country and, in response to this peak in migration, a number of NGOs ran programs offering access to healthcare in some of Malta's reception and detention centres and providing information on rights and entitlement to health coverage. It may therefore be assumed that the respondents held in detention at this time were better informed.

22. Knowledge of the entitlements to health coverage according to perceived state of general health (%)




**The respondents who considered themselves to be in a poor or very poor state of health had little knowledge of their entitlements to health coverage**: half of them did not know or were not sure of their entitlements to health coverage - an alarming finding.

## 3. ACCESS AND RECOURSE TO HEALTHCARE: CASE STUDY

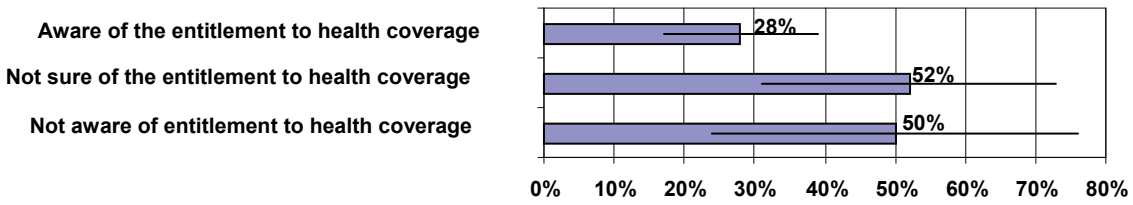
### ■ Most recent health problem

**Respondents were asked about their most recent health problem in Malta. 36 people replied that they had not had a health problem that merited a consultation since arriving in Malta**: 10 asylum seekers (33%) and 26 undocumented migrants (37%). Although the small size of this sample does not allow us to draw significant conclusions, some trends can be cautiously established.

The fact that, on average, these respondents had lived in Malta for more than 3 years (and up to 8 years) raises questions about how they assessed their health: was it that the respondents really had not had any health problems that merited a consultation since their arrival, or was it that some respondents were reluctant to seek healthcare if they could manage without?

In this regards, it should be underlined that one third of the respondents who considered they were in a poor or very poor state of health condition said they had not had a health problem that merited a consultation since arriving in Malta.

23. Proportion of the respondents declaring they had not had a health problem meriting a consultation in relation to level of knowledge of healthcare entitlements (%)



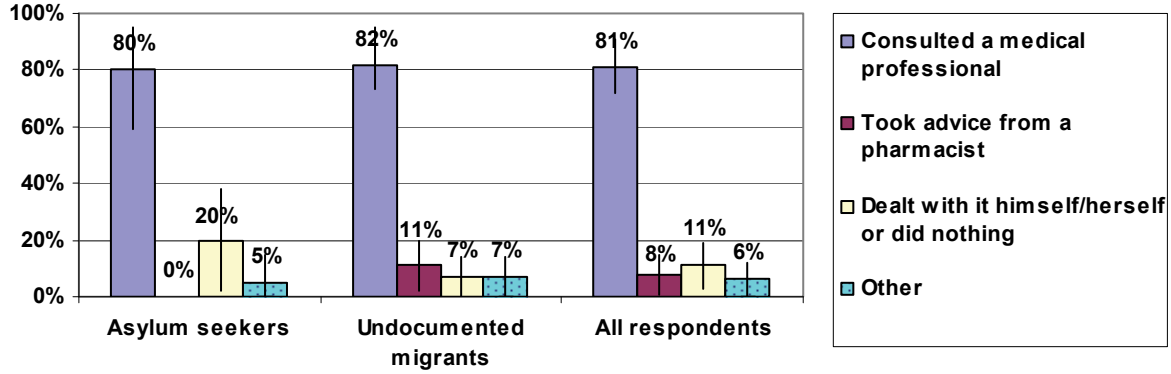

An important correlation can be observed between the knowledge about the entitlements and being likely to declare not having had any health problem meriting a consultation: **50% of the respondents, who did not know they were entitled to health coverage (and 52% of those who were not sure), also said that they had not had a health problem that merited a consultation since arriving in Malta**.

These three elements shed a different light on the reply "*had not had any health problems meriting a consultation*" given by the respondents and highlight factors that may influence the tendency to consider that a health problem does or does not merit a consultation.

## ■ Action taken during the most recent health problem

The 36 respondents who stated they had not had a health problem that merited a consultation since their arrival in Malta were not taken into account in the analysis of actions taken during the most recent health problem.

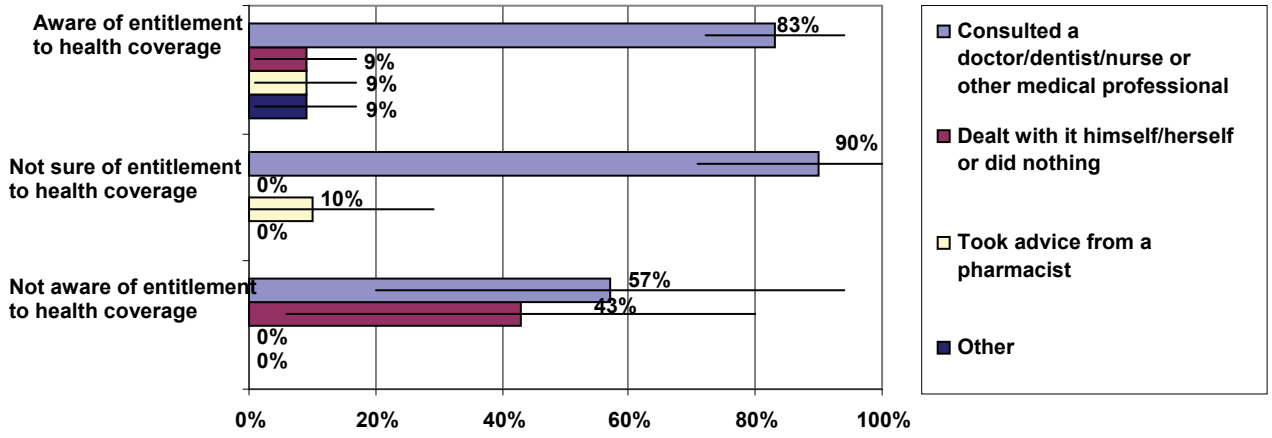
24. Actions taken during most recent health problem, by administrative status (%)*




* The percentages may exceed 100% because this was a multiple choice question. The percentages refer to the number of respondents who declared they had had a health problem meriting a consultation since their arrival.
* "Other': mostly people who consulted a third-party such as a neighbour, friend or family member, a traditional practitioner, etc.

**81% of the respondents said they had consulted a medical professional the last time they felt ill** (the difference between asylum seekers and undocumented migrants was not significant), implying that almost 20% of the respondents did not do so, either because they did nothing at all or because they had dealt with the problem themselves (11%) or because they had consulted a pharmacist, or other people (traditional practitioner).

25. Actions taken during the most recent health problem, by level of knowledge of entitlement to health coverage (%)*



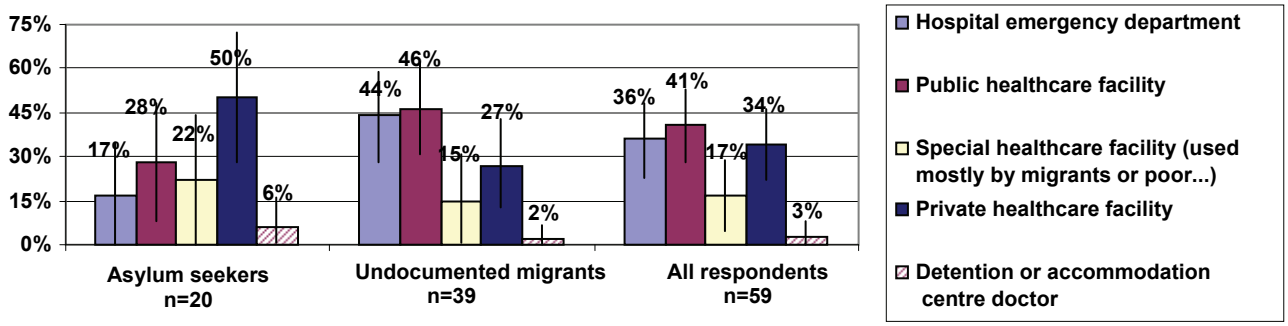

* The percentages may exceed 100% because this was a multiple choice question. The percentages refer to the number of respondents who declared they had had a health problem meriting a consultation since their arrival.

**The tendency to consult a medical professional was less frequent among the respondents who did not know about their entitlement to health coverage**: 43% of the respondents who did not know about their entitlement to health coverage did nothing the last time they felt ill or tried to deal with the problem themselves (this is the case for only 9% of those who knew about their entitlements). It seems therefore that people who were poorly informed or unaware of their entitlement to health coverage tended to avoid consulting a doctor or delay resorting to healthcare, probably only doing so once their illness became more serious.

## ■ Consulting a medical professional: different practices

The findings given in this section only take account of the 59 respondents who consulted a medical professional on their most recent health problem: 20 asylum seekers and 39 undocumented migrants.

26. Medical facility attended, by administrative status (n=59) (%)*




* The percentages may exceed 100% because this was a multiple choice question. The percentages refer to the number of respondents who attended a medical facility.

In total, 41% of the respondents to the survey consulted at a public healthcare facility, and 36% went to the emergency department of a hospital. 28% of the respondents who consulted a medical professional on their most recent health problem attended several types of medical facility.

The people interviewed did not necessarily attend mainstream public healthcare facilities: 34% consulted a private facility at some point and this proportion rises to 50% among the asylum seekers (27% for the undocumented migrants). 17% attended a specific healthcare facility, which probably means the programs run by MSF or JRS until October 2010.

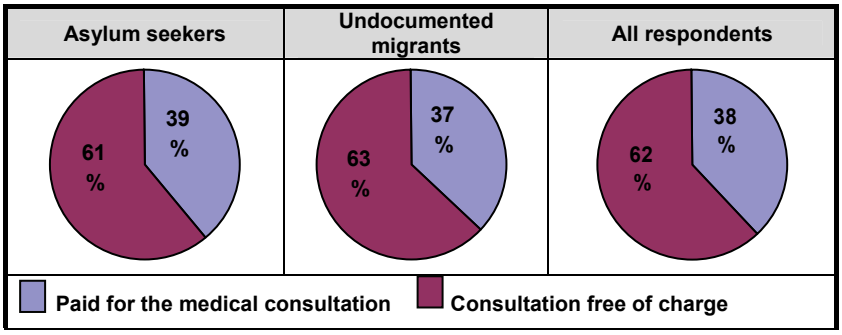
27. Reasons given for attending a private healthcare facility (%)

| Reasons given for attending a private facility | N=20 |
|---|---|
| Better medical attention | 18 |
| Takes less time than in the public system | 13 |
| Was advised to go to this medical facility | 9 |
| More secure: does not fear of being reported | 7 |
| The treatment wasn't available in the public facility | 7 |
| Other reasons | 2 |
| TOTAL | 20 |

Most of the respondents said they chose to **consult at a private facility because they received better medical attention in this type of facility** (91%), and because they were seen faster than in the public system (13 out of 20 respondents).

**It is important to note that 7 respondents chose to consult in a private rather than in a public facility for fear of being reported to the authorities when consulting at a public facility**. This reason was given by a proportionally higher number of asylum seekers than undocumented migrants, in spite of the fact that they are protected by their status. The consequences should not be underestimated, as this fear of arrest may lead to delays in seeking healthcare.

28. Payment for medical care received during most recent consultation according to, by administrative status (n=56) (%)




The majority of the population interviewed did not have to pay for their last medical consultation (62%), but 38% of them did have to pay.

29. Proportion of respondents who paid for medical care during most recent consultation according to the type of medical facility attended, by administrative status (%)

| Administrative situation / Med. structure attended | Asylum seekers (n=10) | Undocumented migrants (n=18) |
|---|---|---|
| **Hospital emergency dept.** | **0% (0)** | **44% (7)** |
| **Public healthcare facility** | **0% (0)** | **11% (2)** |
| **Special healthcare facility** | 67% (2) | **40% (2)** |
| **Private healthcare facility** | 88% (7) | **60% (6)** |
| **GP from the centre** | 100% (1) | **100% (1)** |
| **TOTAL** | **38% (10)** | **37% (18)** |

Although the small sample does not allow us to draw any significant conclusions, it is interesting to note that **none of the asylum seekers who consulted at public medical facilities or at the emergency department of a hospital had to pay for their medical consultation**. All of them succeeded in accessing their rights to healthcare free of charge. Only those asylum seekers who went to a private facility (70%), to a special facility or to their centre's general practitioner had to pay for their medical consultation.

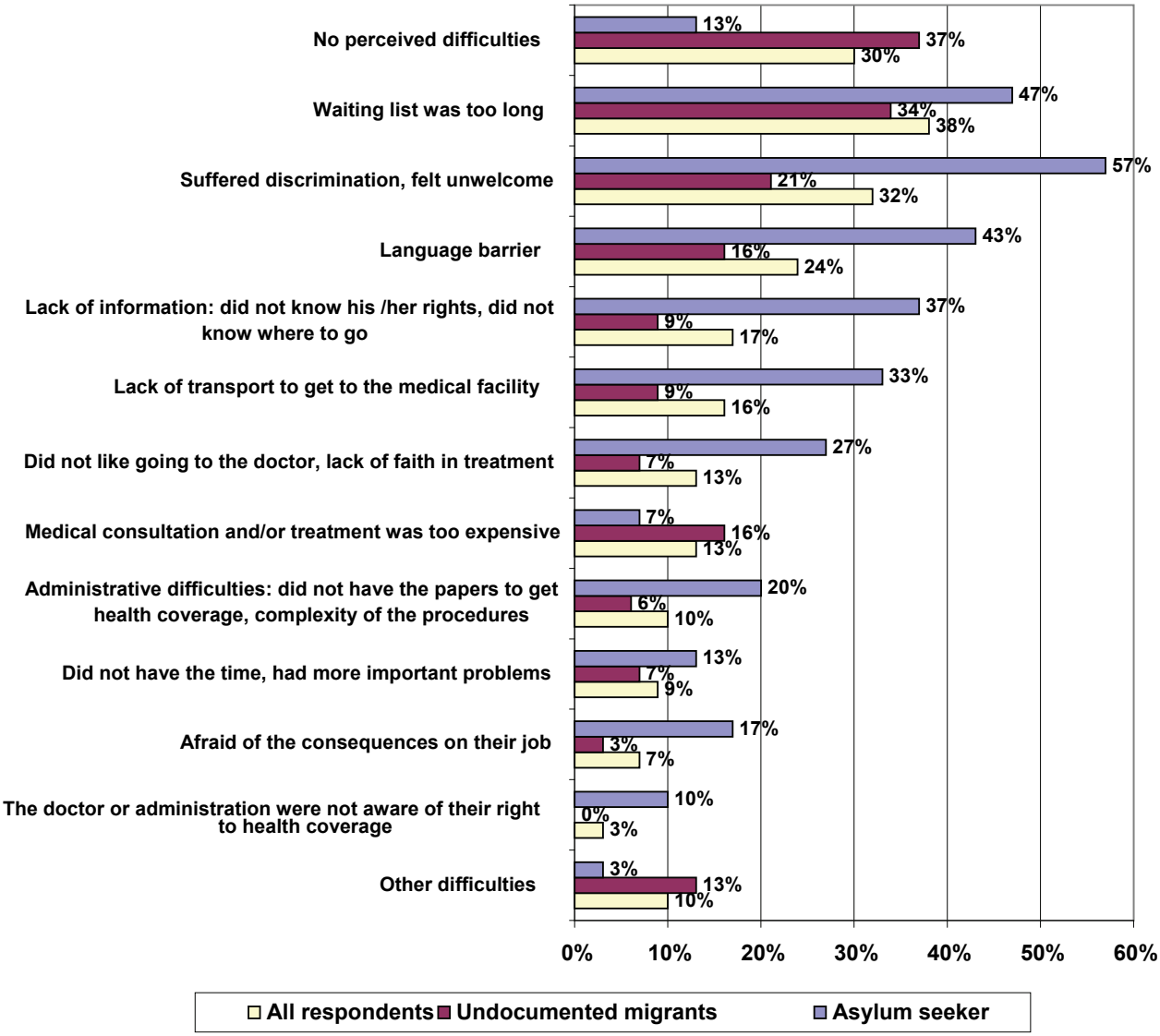
Unlike asylum seekers, **9 undocumented migrants had to pay for their healthcare when they consulted at a public healthcare facility or the emergency department of a hospital, and therefore did not succeed in accessing their rights to free health coverage.** Free access to medical care for undocumented migrants does not appear to be assured in the public system.

# 4. BARRIERS IN ACCESSING HEALTHCARE

## ■ Difficulties encountered when trying to access healthcare

**70% of the respondents who had tried to access healthcare over the previous year had experienced difficulties**. More than ¾ of the respondents who declared having at least one difficulty actually encountered several barriers.

30. Frequency of barriers to healthcare, by administrative status (%),*




* The percentages may exceed 100% as this was a multiple choice question; the percentages refer to the number of respondents.

Some differences can be noted between the barriers reported by asylum seekers and those encountered by undocumented migrants, but the sample does not allow drawing any significant conclusions on the reasons for these differences.

**The asylum seekers interviewed** were more likely to report experiencing difficulties in accessing healthcare: 87% of those who had tried to access healthcare in the previous year had encountered at least one difficulty. Among undocumented migrants the figure was 63%.

The difficulty mentioned most often by asylum seekers was **discriminatory practices** (57%). The length of the **waiting list** was another of the main problems (cited by 47% of asylum seekers), as was the **language barrier** (43% experienced difficulties with understanding or being understood when trying to access healthcare). 37% gave the **lack of information** and guidance offered by the

health services as a difficulty, and administrative difficulties were also commonly mentioned (20%). Although NGOs and public programmes offer translation and cultural mediation services, it seems that these programmes are not meeting all the needs.

**The problem of transport** (concerning 33% of the asylum seekers who tried to access healthcare) could refer to poor public transport in the vicinity of the reception centre and in the poorer neighbourhoods, but could also refer to difficulties getting hold of an ambulance in an emergency in the neighbourhoods where migrants are concentrated (near Marsa or Hal far), among other factors.

**The lack of faith in treatments and doctors was also often cited** (27%): a lot of respondents felt that they were given the same treatment whatever was wrong with them and that health professionals in the public system did not bother to make a proper diagnosis. They felt they were "*always given aspirin*".

**The undocumented migrants interviewed mostly mentioned the problem of long waiting lists (34%)[137], and the second most frequent difficulty was discriminatory practices (21%).** Due to the fact that many of the undocumented migrants interviewed encountered difficulties obtaining health coverage in the public system, **16% of them mentioned the costs of the medical consultation** and treatment as a difficulty. The language barrier (16%) was also a frequent problem.

TESTIMONY ON ACCESS TO PERINATAL CARE BY FOUR WOMEN DURING THEIR PREGNANCY IN MALTA

This insert describes the experience of four asylum seeking or undocumented pregnant women who were or had been pregnant in Malta in attempting to access antenatal or postnatal care.

Among the six women interviewed for the survey, three were pregnant at the time and one had experienced being pregnant in Malta. This high proportion of pregnant women was due to the fact that the interviewer who interviewed them worked as a cultural mediator in the maternity unit of a hospital. Therefore, the three pregnant women in our sample were accessing antenatal care in the best of conditions. Yet, two of them complained of the long waiting list for antenatal consultations and one of the three had to pay for her antenatal consultations[138].

The woman who had given birth in Malta explained that she had been in a detention centre during two months of her pregnancy. In theory, pregnant women should not be held in detention or their stay should be kept to a minimum, but other testimonies confirm that her case is not an exception. She was not asked to pay for her antenatal consultation, but she encountered several other problems, such as feeling discriminated against, a lack of information and guidance on access to the proper medical care and difficulties getting to her antenatal consultation because of a lack of transport. She encountered no difficulties with delivery care and her newborn child was vaccinated, but she had to pay for her child's next consultation.

### ■ Healthcare refusal

Among the 84 people who had tried to access healthcare over the past year, **22 reported that they had been refused healthcare,** which is more than 26% of these respondents.

A high proportion of asylum seekers interviewed said they had been confronted with this situation: 44% who had tried to access healthcare in the past year said they **had been refused healthcare by health professionals or administrative staff at the healthcare facility**. This high proportion is alarming and raises serious questions about discriminatory practices among health professionals.

Among undocumented migrants, more than 14% of respondents to this question reported being refused access to healthcare.

[137] Although this particular problem is said to affect the entire public healthcare system and not only to migrants
[138] We do not know if this person attended a public or a private facility.

22% of the whole sample (i.e.including respondents who had not tried to access healthcare) was refused access to healthcare. Compared with the findings of an identical survey carried out in eleven other European countries[139], this score is one of the highest.

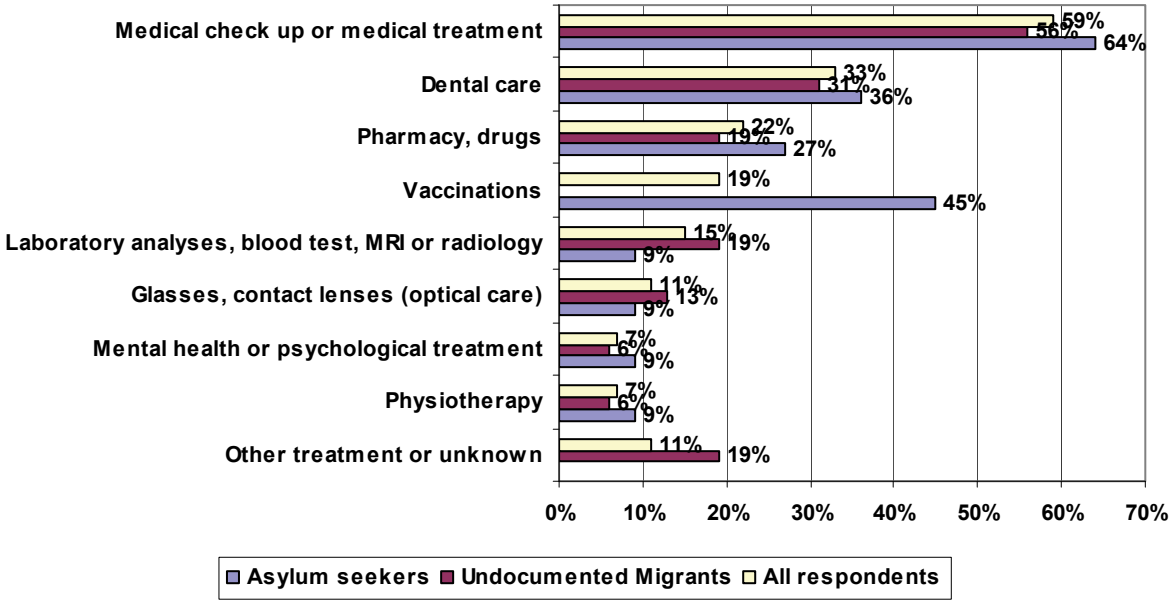
## ■ Abandoning healthcare

31. Proportion of respondents who had given up on healthcare among those who had tried to access healthcare in the past year, by administrative status (%)

| Administrative status | Had given up on healthcare | Had not given up on healthcare | TOTAL |
|---|---|---|---|
| **Asylum seeker** | 41% | 59% | **100%** |
| **Undocumented migrants** | 32% | 68% | **100%** |
| **TOTAL** | **35%** | **65%** | **100%** |

**41% of the asylum seekers and 30% of the undocumented migrants interviewed said they had been refused healthcare at least once in Malta.**

32. Type of healthcare given up on, by administrative status (n=35) (%)




* The percentages may exceed 100% because this was a multiple choice question. The percentages refer to the number of respondents who gave up on healthcare (n=35)

60% of the respondents who had given up attempting to access healthcare explained they had given up on several different types of healthcare. Most frequently, the respondents had given up on medical check ups or treatment (64%). Dental care was also widely cited (36%). No undocumented migrants mentioned giving up on vaccinations, but five asylum seekers had done so (45%).

Giving up on obtaining healthcare is linked to the difficulties experienced when trying to access healthcare. The fact that asylum seekers experienced many difficulties helps explain why they were proportionally more likely to abandon attempts to access healthcare. Generally speaking, all the respondents who had given up on healthcare had experienced at least one difficulty or barrier when seeking access.

The experience of being refused healthcare also had significant consequences on the tendency to abandon attempts to obtain healthcare. Indeed, among our sample, almost three-quarters of those who had been refused healthcare had made no further attempts to access it in the past year.

[139]Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009), *op. cit*, p.97. For 8 other European countries, 14% of the undocumented migrants interviewed were refused access to healthcare. Yet important differences can be noted between countries: the Netherlands, United Kingdom and Sweden had the highest rate of healthcare refusal (33% to 25% of the respondents). In Belgium, Spain, France, Greece and Italy, the rates were found to be a lot lower than for Malta (from 17% to 0%).

It would appear that the longer migrants had spent in the country, the more likely they were to give up on healthcare, probably because they had experienced more difficulties: where 40% of the respondents who been in Malta for three years or less had given up on healthcare, the proportion is nearer 60% for those who had been there for longer.

# CONCLUSION - MALTA

A number of reports have already highlighted the alarming reception and living conditions of the migrants in Malta, like Médecins du Monde report "*Everybody wants to get rid of us*" (2007), Médecins Sans Frontière's report "*Not Criminals*" (2009), as well as publications by Amnesty International (2010) and JRS Malta (2006; 2010). They were mainly focusing on the situation in the centres.

This HUMA survey is one of the first studies to focus on living conditions and access to healthcare of asylum seekers or undocumented migrants living outside detention or open centres. In this respect it will be a valuable tool for assessing how their situation changes or does not change after spending one, two or even five years in Malta with an undefined protection status – passing from one unstable administrative situation to another (asylum seeker, undocumented migrant, …).

### ■ A lack of clear provisions ensuring access to effective healthcare for all in the national health system

The conditions provided by Maltese legislation on access to healthcare for asylum seekers and undocumented migrants do not differ greatly from one to the other. This is due to a great extent to the absence of a legal framework that clearly differentiates the groups of foreigners present in the territory and establishes their basic rights. However, whereas there is a law recognising the right of asylum seekers to access "state medical care and services", there is no legal provision on access to healthcare for undocumented migrants other than a non-legally binding "policy document" establishing that all foreigners in detention are entitled to "free state medical care and services". The interpretation of this entitlement is usually quite broad; however the effective access to healthcare and medicines by these populations, especially those living outside of detention centres, depends largely on discretionary decisions made at hospitals, the scarce medical resources available in detention centres and the attitude of the guards[140].

### ■ Social determinants of health: The difficult living conditions are factors of the deterioration of the general health conditions

- **Difficult and unstable working conditions**: 27% of migrants work more than 10 hours a day between several times a week and every day, and 46% felt their working conditions could affect their health. Furthermore, 83% of working migrants, both undocumented and asylum seekers, had temporary jobs.

**- Unhealthy housing conditions**: migrants' accommodations were of very poor quality, even after leaving the open centre. 85% encountered problems with their accommodation that could be harmful to their health: 51% were living in overcrowded conditions and lacked privacy; 44% described unsanitary conditions, 51% did not have access to the most basic amenities.

### ■ Worrying state of self-perceived general and psychological health

- The social determinants of health help explain the premature deterioration in the state of health of the migrants interviewed. Although still very young (under 30 years of age on average), 30% of the asylum seekers and 23% of the undocumented migrants interviewed considered themselves to be in a poor or very poor state of general health. These proportions are very high when compared with those of the rest of Malta's population.

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[140] On the situation prevailing in the detention centres, see for example Médecins du Monde (2007). *Everybody just tries to get rid of us. Access to health care and Human rights of asylum seekers in Malta*. *Experiences, results and recommendations,* on the situation in 2007. In that report, evidence has been collected that showed "*people have missed appointments with healthcare professionals during their time spent in detention*; *this* [was] *often due to the lack of resources, including transport and manpower".* Furthermore *"detainees themselves* [have reported] *that it was sometimes difficult to consult a medical doctor as the soldiers [chose] a defined number of patients per zone, area or block".*

**- 70% of the people interviewed considered themselves to be in bad or very bad psychological health**. This is potentially linked to their poor living conditions, their undefined administrative situation, the discrimination and the fact that they passed through detention. It is also potentially linked to the experiences lived before (and during) migration: all respondents were or had been asylum seekers, and **83% of the respondents declared they had fled their country to escape from war or from persecution** on political, religious, ethnic or sexual orientation grounds.

### ■ Asylum seekers were poorly protected

- **Asylum seekers were not clearly enough identified** within the health facilities and so were not always allowed access to their rights, including full access to healthcare.

- In practice, **asylum seekers were not sufficiently informed about their rights** and entitlements: 41% of asylum seekers interviewed were not aware or not sure of their entitlements.

- **Healthcare professionals and the administration departments of healthcare facilities also lacked information about health entitlements of migrants**: 10% of the asylum seekers confirmed that the health professionals and/or administration were not aware of their rights to health coverage.

### ■ The access to healthcare is restricted by discretionary and discriminatory practices

- **The current system lacking of clear provisions creates potential for discriminatory practices by health professionals**.

- **The feeling of being discriminated against was the most frequently cited problem** by asylum seekers and the second most frequently cited by undocumented migrants. Overall, almost one third of the respondents felt discriminated against when they tried to access healthcare in Malta

- **The level of healthcare refusals is high**: due to wide-spread discrimination and a lack of information on rights**, 26% of the sample interviewed had been refused access to healthcare**. This is a very worrying situation, arising from a combination of all the above issues.

# RECOMMENDATIONS - MALTA

The inflow of migrants has slowed down in Malta over the last two years, since 2009. However recent events in the North African region call for promptness to establish inclusive and adequate policies for the well-being of migrants (asylum seekers and others), thus reducing the need to rely on crisis management arrangements. It is essential for the government to take measures to ensure the well-being, proper living conditions and the integration of the asylum seekers who might arrive as well as of the migrants already living in Malta (asylum seekers or undocumented migrants), including on effective access to healthcare.

### ■ A call for a better participation of the civil society to migration policy

- A number of recommendations have already been put forward in the reports cited above focusing on migrants in Malta. We urge the Maltese Government to **review these recommendations and the new ones presented in this new report** and then assess the progress or lack of progress made by Malta.
- The Maltese Government should pay serious heed to the voices of civil society organisations and of migrants themselves, to local, European and international voices. It should enter into serious discussions with civil society and migrants' organisations and engage with them as partners having a real expertise to share with it, as citizens, with the right to express their concern and participate in the development of policy.

### ■ A need for an inclusive legislation, designed in the best interests of the migrants

- The Maltese Government should introduce **inclusive legal provisions to bring access to healthcare for all.** This would come in line with Article 25 of the Universal Declaration of Human Rights of 1948 to which Malta is a signatory, and which states that *"Everyone has the right to a standard of living adequate for the health, and wellbeing of himself and his family (…)".* The Preamble to the World Health Organization's constitution also proclaims that it is the fundamental right of every human being to enjoy ***"the highest attainable standard of health".*** **Inherent in the right to health is the right to the underlying conditions of health, including medical care**. Such commendable principles should apply to all people living in Malta, especially vulnerable groups such as migrants.
- We are asking for **any policies formulated and legislation put in place on access to healthcare for migrants to be designed in the best interests of the migrants** and not as a barrier or deterrent. Ensuring access to healthcare to all, including preventive care, is an efficient public health policy ensuring the well-being of society as a whole and reducing healthcare costs; adversely, a lack of access results in late recourse to healthcare once complications have set, which threatens the public health of one society and is, in the end, more expensive. Furthermore, ensuring an inclusive legislation would help eliminate discriminatory practices.

### ■ A clear need to improve now accessibility to the healthcare system by:

- Providing **better information on entitlements both to migrants and health professionals**
- **Ensuring and reinforcing migrant-friendly services in mainstream public healthcare facilities**: translation/cultural mediation programs; equality training for healthcare professionals as a means of addressing discriminatory practices.
- **Reducing administrative difficulties** by means of clearly-established rights and a user-friendly entitlement policy. This will reduce the mistrust in the system and prevent migrants in difficult social situations from having to pay for their healthcare.
- **Providing professional mental healthcare for people that have endured hardships**.

### ■ A need for measures to improve migrant's living conditions, as poor conditions can lead to increased healthcare expenditure

- **Ensuring decent living conditions in the open centres and accessibility to decent housing** and sanitary conditions.
- **Facilitating conditions for access to social/unemployment benefits by introducing a "reversibility", i.e. the possibility of recovering entitlements lost** when migrants leave open centres.

# POLAND

## SIP[141] - Association for Legal Intervention

SIP is the Polish a member of the HUMA Network and implemented the research in Poland.

The association's goal is to help anyone who is discriminated against and in threat of marginalisation by providing them with indispensable legal and social aid. SIP is divided into 4 sections: Foreigners section, Family section, Restorative justice section (Mediation Centre) and "Freedom" section.

SIP's activities:
- SIP gives legal assistance and represents their clients in their dealings with the Polish authorities.
- SIP aims at implementing amendments to the legal system and social policy (i.e. by taking part in conferences, consultations on legal acts, preparing expert opinions…).
- SIP does research and provides information.
- SIP promotes the idea of restorative justice.
- At the moment, SIP focuses mainly on helping asylum seekers, refugees and other migrants; adoptive families, mediators, and former prisoners.
- SIP also focus on children and young people placed in custodial care and adoptive families.

# INTRODUCTION – CONTEXT IN POLAND

According to Eurostat, **Poland is still one of the countries in the European Union with the lowest percentage of foreign citizens, after Romania, Bulgaria and Slovakia**. In 2009, foreign residents (EU and non-EU citizens)[142] were estimated at 0,1% of Poland's population. However, this figure does not fully reflect Poland's migration situation as it refers only to foreigners with authorisation to reside in the country[143]. Visa holders and undocumented migrants are not included in these statistics. Nonetheless, other sources confirm that the number of foreigners in Poland[144] is very low.

### MIGRATION – HISTORICAL BACKGROUND:

Until 1989, Poland was virtually closed to migration. After the collapse of communism and the relaxing of border controls, there was a sudden change in the number of foreigners visiting the country.

[141] Stowarzyszenie Interwencji Prawnej www.interwencjaprawna.pl/glowna.html
[142] *Population of foreign citizens in the EU27 in 2009, Foreign citizens made up 6.4% of the EU27 population,* http://epp.eurostat.ec.europa.eu/cache/ITY_PUBLIC/3-07092010-AP/EN/3-07092010-AP-EN.PDF (consulted on 09.12.2010).
[143] Eurostat only takes into consideration data regarding people (foreign and Polish citizens), with a PESEL number. A foreigner usually obtains a PESEL number when his or her employer applies for it as a social or medical insurance provider or when they register their stay for over 3 months at the municipality office (this is compulsory). However, certain requirements mean many foreigners do not register. For more on the challenges relating to migration statistics:. *Kicinger A., Weinar A. (eds.) (2007). State of the Art of the Migration Research in Poland.* Central European Forum for Migration and Population Research. Working Paper 1/2007. Available at: http://www.cefmr.pan.pl/docs/cefmr_wp_2007-01.pdf.
[144] According to the Office for Foreigners, in 2009 there were around 90,000 foreigners with residence cards (issued to foreigners who have been granted a temporary residence permit, permit to settle, long-term resident EU resident permit, refugee status, subsidiary protection or permit for tolerated stay). Almost 30% of all resident cardholders were citizens of Ukraine.

**INTERNATIONAL PROTECTION & ASYLUM SEEKERS IN POLAND:**

During the communist era there were no institutions in Poland specialising in granting protection. Poland signed the Geneva Convention and the 1967 New York Protocol in 1991, prerequisites for applying for membership of the European Union.

Furthermore, an increasing number of foreigners seeking protection arrived in Poland in the beginning of the 1990s. During these years Poland saw the arrival of a significant number of victims of the war in former Yugoslavia, mainly Bosnia and Herzegovina. From 1994 to 2000, the largest groups to apply for protection were either from Armenia or Asian countries. These were mainly Afghanistan and Sri Lanka.

While the number of applications for refugee status has been growing quite steadily since 1994, this increase is caused in part by asylum seekers re-applying.[145]

**In the period 2003-2008, Russian citizens constituted around 90% of all people who applied for refugee status in Poland. Since 2000, i.e. after the beginning of the second Chechen conflict, Chechens have been the largest group among asylum seekers in Poland**. In 2009, despite the increase in the number of applications submitted by Georgians caused by the events of summer 2008 (the political and military conflict between Georgia and the separatist republics of South Ossetia, and the Russian Federation), 54% of asylum seekers were citizens of the Russian Federation (5,726 people). In 2010, they still represented 73% of asylum applicants (4,795 people), and **Georgians represented 17% of all asylum seekers** (1,082 people).

Analysis of statistical data on the number of applications shows that certain events in Polish history have also influenced migration policy: **the country's accession to the European Union on 1 May 2004 and becoming part of the Schengen Area on 21 December 2007**. Both of these events were preceded by a substantial increase in asylum applications.

The Office for Foreigners can grant three different forms of protection[146] to people submitting applications for refugee status: refugee status, subsidiary protection, and tolerated status.[147]

In 2009, 6,300 applications for refugee status were submitted; these concerned[148] 10,587 people[149]. 16% of those whose applications were considered in 2009 (submitted before or in 2009), were granted any form of protection: most of them were granted subsidiary protection (15%), and **less than 1% were granted refugee status**. 26% of cases were refused and 57% dismissed. This was partly due to the fact that some foreigners re-apply for refugee status. In 2010, 6,534 applications were submitted.

**Asylum seekers are entitled to accommodation.** There are 14 asylum seeker centres in Poland and places for unaccompanied minors in a Warsaw orphanage. There are two reception centres, where all foreigners applying for refugee status are initially sent before being sent to other centres. Only four asylum seeker centres actually belong to the Office for Foreigners. Most asylum seeker centres are contracted by the Office to the private sector or state enterprises. Social workers in the

[145] All information concerning asylum seeker statistics (incl. citizenship and nationality) are available on the Polish Office for Foreigners website: www.udsc.gov.pl.

[146] After implementing the necessary modifications resulting from the signing of the Geneva Convention, the first department of Ministry of Internal Affairs took over responsibility for the asylum application process. In 2001, the Office for Repatriation and Foreigners was established and was replaced in 2007 by the Office for Foreigners.

[147] According to art. 3 of Act of 13 June 2003 on granting protection to foreigners within the territory of the Republic of Poland (Journal of Laws of 2003, No 128, item 1176), there are several forms of protection granted by the state: (1) refugee status, (2) tolerated stay which came into force in 2003, (3) subsidiary protection which came into force in 2008, (4) temporary protection, (5) asylum. Three forms of protection are possible when a person applies for refugee status: the temporary protection is granted to foreigners who arrived in Poland in large numbers and who have left their country of origin or a specific geographical area because of invasion, war, civil war, ethnic conflict or serious violation of human rights. Asylum is subject to a separate application. Until 2008, tolerated stay was the most commonly granted form of protection; however, this does not offer any additional support as opposed to refugee status which gives the right to benefit from a yearly Individual Integration Program (initiated in 2001). In 2008, subsidiary protection was introduced and those who are granted such protection are also entitled to the Individual Integration Programme. Subsidiary protection is currently the most common form of protection.

[148] Statistics from the annual report of the Office for Foreigners (2009).

[149] According to the Act of 13 June 2003 on granting protection to foreigners within the territory of the Republic of Poland (art. 24 and art. 25) the person applying for refugee status can include in the application their unmarried minor children, a spouse and the spouse's minor children.

centres are employed by the Office while cleaning staff, for example, are employed by the contractor. **Centres specifically for single women with or without children and for people with special needs have recently been opened.** The centres for asylum seekers are usually open centres. Some asylum seekers may also be placed in detention centres for foreigners; for exemple, in case a person applies for asylum while held in detention (for the first time or for a re-application)

**Asylum seekers are entitled to an allowance to cover and the costs of an independent accommodation outside of the centres. At the end of 2010, 1,660 asylum seekers lived in centres, while 1,823 received financial support** (a total of 3,489 people). This allowance, calculated on the number of family members, is approximately **€7 per day for a single person and approximately €4 per day per person for a family of three**. This is **inadequate given the cost of renting an accommodation, and leads to asylum seekers living in substandard conditions. Aside from accommodation, the different kinds of social welfare available to asylum seekers** for which they have to make separate applications[150] are: food (3 meals a day provided in the canteen), a monthly allocation for the purchase of toiletries (approximately €5 per month per person), and "pocket money" (approximately €12 per month per person), a one-off allocation for the purchase of clothing and shoes, access to state education (in theory, school supplies and books are provided). **Asylum seekers have access to "health services" free of charge in the centres for asylum seekers and in specific contracted medical facilities.**

**UNDOCUMENTED MIGRANTS:**

There is no reliable data on irregular migration in Poland**. According to available statistics and estimations and on the experience of organisations working with migrants, Ukrainians[151] and Vietnamese represent the main body of undocumented migrants[152].**

Ukrainians first came to Poland for short periods, mainly for trading purposes, since the 1990's. They then started doing temporary jobs, mostly in construction and agriculture and extended the time spent in the country. Some Ukrainians were also qualified migrants and students. In 2003, visas became a requirement for citizens of Belarus, Ukraine and Russian[153]. Poland became part of the Schengen Area at the end of 2007, which led to the enforcement of the Schengen Visa border control provisions that impacted, among others, the cost of crossing borders for the citizens of neighbouring Eastern-European countries. However, within the framework of Poland's labour market policy, specific regulations allowing migrants from these non-EU countries to work without a permit have been maintained. Their visa application procedure is facilitated through presentation of an employer's declaration of intent to hire a foreigner.

These visas give the right to reside legally in Poland for a period of 6 months to over a year. The foreigners entitled to work without a work permit and to apply for a visa with an employer's declaration of intent are the citizens of Ukraine, the Russian Federation and Belarus since 2006, and from Moldova and Georgia since 2009. The introduction of fee-paying visas has led to some migrants overstaying their visas and thus becoming undocumented.

The Vietnamese, the other large group of undocumented migrants, were the only significant group of foreigners in Poland under communism. They mainly came within the context of a government programme of socialist cooperation and academic exchange. After finishing their studies, some

[150] http://www.udsc.gov.pl/A,GUIDE,ON,BUREAU,OF,ORGANIZATION,OF,CENTRES,FOR,ALIENS,APPLYING,FOR,REFUGEE,STATUS,OR,ASYLUM,267.html (consulted on 12.12.2010).

[151] In the case of Ukrainians, "irregular" stay is much less common than that of a documented stay and illegal employment.

[152] The statistics on previous regularisation programmes, described below, showed that the two largest groups of undocumented migrants which had benefited from it were Vietnamese and Armenians. While the probability of being able to have access to undocumented migrants from Vietnam by the NGO involved in the study was quite high, it was much more difficult to have access to Armenian respondents. This is because they are less likely to become clients of the organisations involved – as none targeted Armenian migrants specifically - and they do not figure in the surveyors' social networks. Ukrainians are the biggest group of migrants in Poland. Although the majority of them are legally entitled to reside in Poland, the fact that they often work undeclared and have problems with obtaining or the expense of getting documents to stay in Poland or cross the border often lead many of them to overstay their visas or other residence permits, and become undocumented

[153] After the collapse of communism, visa-free agreements signed in 1979 with former communist countries, were maintained. See Iglicka, K. (2000), *Migration movements from and into Poland in the light of the East-West European migration*, Instytut Studiów Społecznych UW, p. 12

stayed. Later on, after the collapse of communism, new groups of Vietnamese immigrants started arriving in Poland, principally for economic reasons (they often run small businesses). Some stayed on after their visas expired, some entered the country irregularly.

Whatever their nationalities, apart from visa over-stayers and "irregular" border crossers, there were former asylum seekers whose applications had been refused and did not leave.

According to Border Guard statistics, in 2009, 1,407 third country nationals were detained for illegally crossing borders European Union borders (i.e., with Belarus, Ukraine and the Russian Federation). Citizens from the Ukraine and the Russian Federation (including Chechens) constituted the largest groups among these. [154]

So far, two regularisation programmes legalising residency have been implemented, one in 2003 and the other in 2007. Due in part to the strict conditions imposed by the programs, only a small number of undocumented migrants were able to benefit from them. Altogether just over 4,000 applicants received authorisation to stay. The Vietnamese and Armenians were the nationalities most represented among the applicants[155]. In 2009, the "Immigrants for Abolition" Committee and several Polish non-governmental organisations launched a pro-regularisation campaign ("I am pro!"). The campaign was co-organised by undocumented migrants themselves, something new in Poland, where political activism by migrants is still almost non-existent. The Office for Foreigners recently stated that a government bill to amend the Act of Aliens, including a regularisation programme, is to be submitted to Parliament in 2011.

[154] Source: Straż Graniczna [Polish Border Agency website]. Available at: http://www.strazgraniczna.pl/wps/portal/tresc?WCM_GLOBAL_CONTEXT=pl/serwissg/polskie_formacje_graniczne/zestawienie_statystyczne (consulted on 10.01.2011).

[155] Additionally, the 'small abolition' programme was launched in Poland in 2003. It lasted two months and targeted irregular immigrants who wanted to leave Poland and who were given the promise that they would not be put on the unwanted foreigners list which would have meant they would not have been able to return to the country for a certain period of time.

# PART 1: LEGAL ANALYSIS

## HEALTH SYSTEM

Poland has a statutory health insurance system that covers most of the population[156]. It is a legal obligation for some categories.

Insurance premiums constitute the main source of healthcare financing, although there is also some funding from the state budget. The system, managed by the National Health Fund, *Narodowy Fundusz Zdrowia – NFZ*, has branches in all provinces[157]. Healthcare institutions contracted by the NFZ provide healthcare services. Patients are freedom to choose their healthcare provider.

## LEGAL ENTITLEMENTS TO HEALTHCARE

The Polish Constitution clearly establishes that "everyone has the right to health protection[158]".

Only specified categories of individuals are eligible for statutory health insurance. These include the majority of **citizens, authorised residents** and members of their families[159]. Insurance is compulsory for employees, the self-employed, people working in state education and those on benefit or receiving a pension[160]. Other citizens and authorised residents can take out statutory insurance on a voluntary basis. The income-based premium amounts to 9% of the salary or benefits of the insured person.

All recipients have access to all those health services listed in the Ministry of Health's regulations, free of charge. This list includes almost all basic services. Pharmaceuticals are generally co-paid except for some of those provided free of charge to people with specific contagious and chronic diseases. To access health services, recipients have to prove entitlement by showing their health insurance card or other proof of insurance[161].

Children and pregnant women (for ante and postnatal care) make up another category of recipients since their healthcare is viewed as the state's "special responsibility"[162]. The scope of this "special responsibility" is regulated by law and entails access free of charge to certain services, regardless of insurance status. It only applies to Polish citizens domiciled in the country[163].
In addition, some health services are always provided free of charge, irrespective of insurance: emergency care provided by medical rescue services[164], treatment of some infectious diseases[165]

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[156] See *Ustawa z 27 sierpnia 2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych* (Law on healthcare services financed from public funds), (Journal of Rights 210 of 2004, item 2135 as amended) hereinafter referred to as "Law on healthcare services".
[157] Known as w*ojewództwa* in Polish and "voivodship" in English.
[158] Article 68(1) of the Constitution of the Republic of Poland of 2 April 1997 (Journal of Rights No 78 of 1997, item 483 as amended).
[159] See Articles 3(1) and (2) of the Law on healthcare services.
[160] See Article 66(1) of the Law on healthcare services.
[161] The insurance card or proof of insurance must be presented before accessing the service, 30 days after the beginning of treatment or 7 days after discharge (otherwise, the patient usually bears the cost. Albeit remote, reimbursement is sometimes possible. It is also important to note that there are plans to introduce microchip insurance cards or to make use of the new ID card for this purpose.
[162] See Article 68(3) of the Constitution.
[163] However, in practice these entitlements are not often applied. On one hand, proof of insurance is also required and on the other, the vast great majority of these people are unaware of their legal entitlements and either abandon their treatment or pay.
[164] Article 46(1) of the *Ustawa z 8 września 2006 r. o Państwowym Ratownictwie Medycznym (*Law on the State Medical Rescue Services of 8 September 2006 (Journal of Laws No 191 of 2006 item 1410 as amended). The law does not clearly establish whether this is also the case for care provided to uninsured nationals in emergency units. However, some rulings state that if they

and drug and alcohol addiction[166], care for the mentally ill[167] and people with special needs as well as care provided to detainees and prisoners, and to holders of the "Pole card", in the event of an emergency[168].

**Refugees and people with subsidiary protection status** are eligible for statutory health insurance on the same basis as nationals. During the yearly Individual Integration Programme, the premium can be covered by welfare services if for some reason a person cannot be insured as an employee or unemployed person. Foreigners who are granted temporary protection have the right to "medical care" free of charge. This care is managed on a case-by-case basis[169].

**Asylum seekers** do not have statutory health insurance; however, they have access to "health services" free of charge (generally understood as being the health services available to the insured). Costs are covered by public funding and services are provided only in the reception centres (mainly primary care) and in other medical facilities contracted by the Chief of the Office for Foreigners (specialist care and hospital treatment).[170] All asylum seekers, living in reception centre or not, have to have a referral from an accredited doctor at the asylum seeker centre to be able to access secondary care. This also applies to unaccompanied minors seeking protection[171].

*Since 2005, the Central clinic hospital of the Ministry of Internal Affairs and Administration in Warsaw* has a contract with the Office for Foreigners *and is responsible for implementing the Programme of Medical Care for asylum seekers and their children from birth to the day when the application for refugee status is submitted. Its Unit for medical services for asylum seekers is responsible for coordinating and running outpatient clinics at all asylum seeker centres. Each centre has a accredited doctor (often part-time) and a nurse who provide consultations free of charge to asylum seekers receiving government support, whether or not they live in a centre. The accredited doctors treat health issues that do not require specialist medical equipment and may refer to a specialist when required. Aside from the medical services provided at the centres, the Unit uses subcontractors to provide asylum seekers with medical care (vaccinations, specialist consultations, hospital treatment, etc.) if needed, and works with other Polish medical institutions on an ad hoc basis.*

*Highly-specialised and more specific services are not provided for by the Programme and are handled by the Office for Foreigners. Referral to medical facilities with such services must be authorised by the Office (rehabilitation, prosthesis, etc.).*

The situation is very different for **undocumented migrants**. They receive neither statutory insurance nor any health coverage and cannot access any type of healthcare free of charge, with the sole exception of emergency care provided by rescue teams or that given in detention centres.

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are unable to pay, the unpaid bills are considered the responsibility of the National Health Fund. See Judgment of the Supreme Court of 8 August 2007, CSK 125/07.

[165] See *Ustawa z 5 grudnia 2008 r. o zapobieganiu oraz zwalczaniu zakażeń i chorób zakaźnych u ludzi* (Law on the prevention and combating infectious and contagious diseases in humans), (Journal of Laws No 234 of 2008, item 1570 as amended).

[166] See Article 21 (3) of the *Ustawa z 26 października 1982 r. o wychowaniu w trzeźwości i przeciwdziałaniu alkoholizmowi* (Law on the sobriety education and combating alcoholism of 26 October 1980), (Journal of Laws No 70 of 2007, item 43 as amended; Article 26, section 5 of the *Ustawa z 29 lipca 2005 r. o przeciwdziałaniu narkomanii*, (Law on counteracting drug addiction of 26 July 2005), (Journal of Laws No 179 of 2005, item 1485 as amended).

[167] See Article 10 of the *Ustawa z 19 sierpnia 1994 r. o ochronie zdrowia psychicznego*, (Law on the protection of mental health of 19 August 1994), (Journal of Laws No 111 of 1994, item 535 as amended).

[168] See Article 102(1) and 115(1) of the Penal Executive Code of 6 June 1997 (Journal of Laws No 90 of 1997, item 557 as amended) and Article 6(1)(5) of the Law of 7 September 2007 on the Pole Card (Journal of Laws no 180 of 2007 item 1280 as amended). The holders of the "Pole card" are Polish citizens who live abroad as part of the Polish Diaspora commenced after the Second World War.

[169] Article 112(1) of the *Ustawa z 13 czerwca 2003 r. o udzielaniu cudzoziemcom ochrony na terytorium Rzeczypospolitej Polskiej*, (Law on the granting of protection to foreigners on the territory of the Polish Republic of 13 June 2003), (Journal of Laws No 189 of 2009 item 1472 as amended).

[170] See Article 70(1), Articles 73(1) and (2) and Article 85 of the Law on the protection of foreigners.

[171] Article 67(2) of the Law on the protection of foreigners.

There is no specific law stipulating health entitlements for undocumented migrants; however, the legislation clearly states that services provided by rescue teams are free of charge to all individuals. It is less clear whether undocumented migrants have access free of charge to hospital emergency departments. Even though care cannot be denied to any person in the event of immediate danger to life or health[172], recipients must bear the cost since there is no legal provision establishing who should.

Besides emergency care, children of undocumented migrants receive free of charge only medical and dental prophylactics (including mandatory vaccinations, medical check-ups and screening tests) while they attend public school in Poland.[173]

[172] See Article 30 of the *Ustawa z 5 grudnia 1996 r. o zawodach lekarza i lekarza dentysty*, (Law on the professions of medical doctors and dentists of 5 December 1996), (Journal of Laws No 136 of 2008 item 857 as amended); Article 7 of the *Ustawa z 30 sierpnia 1991 r. o zakładach opieki zdrowotne* (Law on health care institutions of 30 August 1991), (Journal of Laws No 14 of 2007, item 89 as amended); and Article 7 of the *Ustawa z 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjent* (Law on the patient's rights and Patients' Ombudsman of 6 November 2008), (Journal of Laws No. 52 of 2009, item 417 as amended).

[173] Articles 92 (1) and (2) of the Law on education system of 7 September 1991 (Journal of Laws No 256 of 2004, item 2572 as amended) and Regulation of the Minister of Health on the organization of the prophylactic healthcare for children and youths of 28 August 2009 (Journal of Laws No 139 of 2009, item 1133).

# ADULTS CARE

## EMERGENCY CARE

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>a) Care provided by rescue teams: No particular conditions required.<br><br>b) Care in hospital emergency units:<br>➤ Statutory health insurance, i.e., payment of income-based premium. Exemption for Polish citizens living in Poland[174]: children and female citizens during pregnancy, labour and after delivery.<br>➤ Insurance card, proof of insurance or proof of beneficiary of public health services. |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals |
| | **Conditions:**<br>a) Care provided by rescue teams: same as nationals.<br><br>b) Care in hospital emergency units:<br>➤ Show asylum seekers' temporary identity certificate[175] and a referral from an accredited doctor[176]. |
| **Undocumented migrants** | **Entitlements:**<br>Access free of charge to care provided by rescue teams ONLY.<br>Full payment of costs of care in hospital emergency units. This care cannot be denied, as it is a legal obligation. |
| | **Conditions:**<br>a) Care provided by rescue teams: same as nationals.<br><br>b) Care in hospital emergency units:<br>➤ Full payment of costs. |

## PRIMARY AND SECONDARY (OUTPATIENT) HEALTHCARE

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>➤ Statutory health insurance, i.e. payment of income-based premium. Exemption for Polish citizens living in Poland: children, and female citizens during pregnancy, ante and post-natal.<br>➤ Insurance card, proof of insurance or beneficiary of public health services.<br>➤ Authorisation from GP to access secondary care. |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>➤ Show asylum seekers' temporary identity certificate.<br>➤ Healthcare is provided in specific contracted medical institutions ONLY.<br>➤ Authorisation from an accredited medical doctor, |
| **Undocumented migrants** | **Entitlements:**<br>Full payment of costs. |

[174] These exemptions are rarely applied in practice. See footnote 8.
[175] See Article 55 of the Law on the protection of foreigners.
[176] In the case of an emergency, a referral can be issued after the services have been provided.

# HOSPITALISATION (INPATIENT CARE)

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>➤ Statutory health insurance therefore payment of income-based premium. Exemption for Polish citizens living in Poland: children, and female citizens during pregnancy, ante and post-natal.<br>➤ Insurance card or proof of insurance or beneficiary of public health services.<br>➤ Authorisation from GP for hospitalisation |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>➤ Show asylum seekers' temporary identity certificate.<br>➤ Healthcare is provided in specific contracted medical institutions ONLY.<br>➤ Previous authorization by an accredited medical doctor |
| **Undocumented migrants** | **Entitlements:**<br>Full payment of costs. |

# ANTE AND POSTNATAL CARE

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access free of charge |
| | **Conditions:**<br>a) Polish citizens:<br>➤ Proof of citizenship and domicile in Poland[177]<br>➤ OR Statutory health insurance, i.e., payment of income-based premium (unless exempted on grounds of low-income).<br><br>b) Other authorised residents:<br>➤ Statutory health insurance, i.e., payment of income-based premium. |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>➤ Show asylum seekers' temporary identity certificate.<br>➤ Healthcare is provided mainly in specific contracted medical institutions[178].<br>➤ Referral from an accredited medical doctor[179]. |
| **Undocumented migrants** | **Entitlements:**<br>Full payment of costs.<br>However, care provided during labour cannot be denied[180]. |

[177] In practice, proof of insurance is also required.
[178] Even if asylum seeker pregnant women should in theory receive delivery care in contracted medical institutions; in practice, no hospital turns them away.
[179] When delivery care is needed, the referral can be issues after the services have been provided.
[180] Services associated with labour are provided regardless of status, although charged to undocumented migrants. See Article 7(2) of the Law on the patients' rights and Patients' Ombudsman.

# ADULTS TREATMENT

## MEDICINES

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access co-paid for listed medicines[181]. |
| | **Conditions:**<br>➤ Statutory health insurance, i.e., payment of income-based premium. Exemption for Polish citizens living in Poland: children, low-income citizens, and female citizens during pregnancy, ante and postnatal.<br>➤ Prescription issued by a medical doctor from the public health service.<br>➤ Pay part of the cost (statutory fixed fees or from 30% to 50% of commercial price, depending on the category of medicine). Exceptions: some medicines for people with specific contagious and chronic diseases are free of charge. |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>➤ Prescription (if prescribed by an external specialist).<br>➤ Medicines are available in the outpatient departments in all asylum-seeker centres with authorisation from accredited medical doctors[182]. |
| **Undocumented migrants** | **Entitlements:**<br>Full payment of costs. |

## HIV SCREENING

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Free of charge and anonymous in specialist centres[183]. |
| | **Conditions:**<br>None. |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>Same as nationals. |
| **Undocumented migrants** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>Same as nationals. |

[181] The list of medicines is established by a regulation of the Minister of Health. See Articles 36(5) and 37(1) and (2) of the Law on health care services.
[182] In the event of a shortage of appropriate medicines in the centres' pharmaceutical stores, they are ordered from the Central Hospital of the Ministry of Internal Affairs and Administration's pharmacy.
[183] Articles 6 (1)-(5) and Article 8 (1) and (2) of the Law on contagious diseases.

# HIV TREATMENT

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Free of charge |
| | **Conditions:**<br>➤ Statutory health insurance, i.e., payment of income-based premium. Exemption for Polish citizens living in Poland: children, low-income citizens, and female citizens during pregnancy, ante and postnatal.<br>➤ Only Postexposure Prophylaxis (PEP) is provided free of charge to the uninsured[184]. |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>➤ Asylum seekers' temporary identity certificate.<br>➤ Treatment is provided in specific contracted medical institutions ONLY.<br>➤ Authorisation from an accredited doctor accredited by the Chief of the Office for Foreigners. |
| **Undocumented migrants** | **Entitlements:**<br>Only Postexposure Prophylaxis (PEP) is free of charge |
| | **Conditions:**<br>None. |

# TREATMENT OF OTHER INFECTIOUS DISEASES[185]

| | |
|---|---|
| **Nationals/Authorised residents** | **Entitlements:**<br>Free of charge for compulsory notifiable diseases and vaccinations[186]. |
| | **Conditions:**<br>None. |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>Same as nationals. |
| **Undocumented migrants** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>Same as nationals. |

[184] See Article 41(4) of the Law on contagious diseases.

[185] Viral hepatitis B and Hepatitis C are subject to the regulations of the law on infectious diseases. There is no mandatory treatment of hepatitis B and C; There are mandatory vaccinations against hepatitis B for children. There are special programmes of treatment available for the individuals covered by the health insurance.

[186] Hospitalisation is mandatory for some diseases: tuberculosis at the infectious stage, individuals diagnosed with or suspected diphtheria, cholera, typhoid and paratyphoid fever of types A,B,C, Brill-Zissner disease, plague, H7 and H5 flu, polio, smallpox, SARS, tularemia, anthrax, rabies, meningitis and cerebritis, viral hemorrhagic infections (e.g., yellow fever); for healthy individuals having had contact with: cholera pneumonic plague, smallpox, viral hemorrhagic infections and SARS (see Article 34(1)(1) and (2) of the Law on contagious diseases). Similarly, treatment for the following conditions is mandatory: pneumonic tuberculosis, syphilis, gonorrhea. Also prophylactic treatment of individuals having had contact with sick people with a contagious stage of pneumonic tuberculosis, syphilis, gonorrhea, typhoid fever, neisseria meningitis and hemophilia influenza type b (see Article 40(1) and (2) of the Law on contagious diseases).

# CHILDREN

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>All care and treatment free of charge for children under 18. |
| | **Conditions:**<br>a) Nationals:<br>➤ Insurance card, proof of insurance or beneficiary of public health services OR proof of citizenship and domicile in Poland[187].<br><br>b) Authorised residents:<br>➤ Insurance card or proof of insurance or beneficiary of public health services.<br>➤ Public school attendance for access to mandatory vaccinations and prophylaxis services. |
| **Asylum seekers' children / Unaccompanied (asylum seeking) children** | **Entitlements:**<br>Free of charge. |
| | **Conditions:**<br>➤ Asylum seekers' temporary identity certificate.<br>➤ Healthcare is provided in specific accredited medical institutions ONLY.<br>➤ Authorisation from an accredited doctor.<br>➤ Public school attendance for access to mandatory vaccinations and prophylaxis services. |
| **Children of undocumented migrants / Unaccompanied (migrant children)** | **Entitlements:**<br>Mandatory vaccinations and prophylaxis services free of charge ONLY. [188] |
| | **Conditions:**<br>➤ Public school attendance. |

# DETENTION CENTRES

| | |
|---|---|
| **Adults** | - When justified by a person's state of health[189], medical treatment, medicines, toiletries and meals are provided free of charge in accordance with the principles of the Executive Penal Code regarding detainees or people on remand.<br>- A person is not detained if it constitutes a threat to a person's life or health[190].<br>- Pregnant women can be detained while awaiting deportation until the seventh month of pregnancy. They are then sent to a guarded centre[191].<br>- Detainees take a medical examination upon arrival and must provide information on their health[192]. |
| **Children** | - Same access to healthcare as adults.<br>- Unaccompanied asylum-seeking children are usually placed in foster institutions. Children of undocumented migrants and unaccompanied migrant children can be placed in detention centres. Children of undocumented migrants either live with their accompanying adults or in a separate part of centres[193]. |

[187] In practice, proof of insurance is also required.
[188] This includes mandatory vaccinations, medical check-ups and screening tests.
[189] See Articles 117(1)(4) and 118(1) of the Law on the protection of foreigners.
[190] Article 103 of the Law on the protection of foreigners.
[191] Article 121 of the Law on the protection of foreigners. There are two types of detention centres in Poland: "secure centres" (where the regime is less strict) and detention centres and remand prisons for people facing deportation.
[192] Articles 111 (2) and 113 (1)-(3) of the Law on the protection of foreigners. The cost of the examination is funded from the state budget.
[193] Articles 115(2) and (3) of the Law on the protection of foreigners.

# TRANSFER OF OR ACCESS TO INFORMATION BY THE AUTHORITIES

**Transfer of or access to information regarding administrative status**: An individual's medical data can be disclosed to different legal entities - ranging from welfare authorities to the courts[194]. Healthcare providers are obliged to provide information to the National Health Fund (*NFZ*) on recipients of care, the cost of which is paid for from public funds. The *NFZ* is entitled to gather and process such information for the purpose only of supervising the provision of services by healthcare institutions[195].

# NON-EXPULSION ON MEDICAL GROUNDS

With respect to health, the legislation provides for the possibility for a person to lose his/her permanent residence permit and to be deported for refusing to comply with the obligation to treat a contagious disease[196].

## RESIDENCE PERMITS ON MEDICAL GROUNDS[197]

⇒ **WHO?**

a) People suffering from a serious and chronic illness when deportation would prevent them from accessing proper treatment. This may be viewed as subjecting a person to "inhuman and degrading treatment".
b) Undocumented children in cases where deportation may jeopardise their psychological/ physical development and infringe the rights of the child as stipulated by the UN Convention on the Rights of the Child.

⇒ **CONDITIONS:**

- The applicant must not meet the criteria for obtaining refugee or subsidiary protection status.
- Submission of application to the competent authorities, i.e. the governor of the province (*Wojewoda*) or the Chief of the Office for Foreigners.[198]

⇒ **TIME LIMIT:**

No time limit – granted until receipt of a residence permit on other grounds or expiry of the reasons for granting this protection[199].

⇒ **ACCESS TO HEALTHCARE:**

On the same basis as other authorised residents (eligible for statutory health insurance[200]).

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[194] Article 26 of the Law on the patient's rights and Patients' Ombudsman of 6 November 2008.
[195] Article 188 of the Law on health care services.
[196] Article 58(1)(2) of the Law on the protection of foreigners.
[197] Article 97(1) and (1a) of the Law on the protection of foreigners.
[198] Article 104 of the Law on the protection of foreigners.
[199] If the reason for issuing the permit is no longer valid. See Articles 102 and 103 of the Law on the protection of foreigners.
[200] Articles 102 and 103 of the Law on the protection of foreigners.

# TEMPORARY RESIDENCE PERMITS ON HUMANITARIAN GROUNDS[201]

⇒ **WHO?**

Undocumented migrants facing an exceptional personal situation, including serious illness.

⇒ **CONDITIONS:**

- "An exceptional personal situation".
- Submission of application to the competent authorities, i.e. the governor of the province (*Wojewoda*). [202]
- This permit can be denied if the applicant refuses to comply with the obligation to treat a contagious disease.[203]

⇒ **DURATION:**

Limited: no longer than three months. The expiry date is set by the decision granting the permit[204].

⇒ **ACCESS TO HEALTHCARE:**

They are not entitled to statutory health insurance and they have to pay the full cost of health services[205].

[201] Article 53a (2)(2) of the Law on the protection of foreigners.
[202] Article 62(1) of the Law on the protection of foreigners.
[203] Article 57(1)(7) of the Law on the protection of foreigners.
[204] Article 56(2)(7) of the Law on the protection of foreigners.
[205] Article 3(1)(2) of the Law on health care services.

# PART 2: FIELD SURVEY IN POLAND

## METHODOLOGY AND SAMPLING

For one of the first time, this study reached out to the different categories of vulnerable foreigners in Poland, namely asylum seekers and undocumented migrants, in order to learn about their access to healthcare through using a quantitative methodology.

The methodology applied in Poland was slightly different to the one used in the 3 other countries as the questionnaire was adapted to take into account the context of the country. Some differences relate to the questions on living and working conditions. The questions regarding healthcare were unchanged, and thus allow for comparison with the results obtained in the other countries. The other main differences reside in the fact that the respondents filled in the questionnaire themselves, and following, the interviewers' role was to recruit respondents, provide information on the research and give instructions on how to fill in the questionnaire[206] or assist them with filling it in when required.

Due to the very limited access to potential respondents, the purposive sampling method was applied to the survey. The criterion for selecting respondents, apart from their administrative status, was the need for access to healthcare. Only adults took part in the interviews, although a few exceptions were made for people approaching 18.

### SAMPLE

The sample included roughly half undocumented migrants (51 people) and half asylum seekers (58 people), with a total of 109 interviews[207].

1. Distribution by administrative status (nb; %)


The survey was conducted in Warsaw between 1 September and 31 October 2010, at the headquarters of the three NGOs involved in the study, and at the places where they meet with their clients[208]. These NGOs offer support for migrants in the following areas: the Association for Legal Intervention (SIP) provides general counselling; FROG provides different kinds of counselling and the Association for Free Word (SWS), human and civil rights activities. None of the organisations offer medical aid or advice to their clients; however, SIP does provide interpretation services for their clients when required at medical facilities.

[206] The respondents were supposed to read and answer the questions on their own. The surveyors presented the study to them, told them it was anonymous, what it was for, gave them instructions on how to fill in the questionnaire, and answered their queries. If necessary, the researchers explained the questions and proposed answers and took notes during the interview and recorded any additional comments made by the respondents.

[207] Please refer to table 7 in the appendix 2 2 in the part dedicated to Poland for more details on the structure of the sample.

[208] Association for Legal Intervention (SIP); the Vietnamese section of the Association of the Free Word (SWS); and Foundation Development "Beyond Borders" (FROG) - FROG is a partner organisation which, together with Foundation Forum for Social Diversity, implemented the Welcome Centre in Warsaw (CPW) project.

Six interviewers from the 3 NGOs mainly recruited the respondents from among their clients. The interviewers asked each person who came to the NGOs[209] at the time of the survey to participate in the study, after making sure that the person met the agreed criteria. Some potential respondents refused to participate and some felt distrust and feared to be reported by the interviewers. However, the context - contact with an NGO representative - usually encouraged undocumented migrants or asylum seekers to take part in the survey.

In some cases, respondents were recruited through personal contacts of the interviewers, which meant either previously known potential respondents or people recommended by them (so-called snowball sampling).

#### CONDUCTING THE QUESTIONNAIRE

The English questionnaire was translated into several languages: Polish, French, Vietnamese, Russian, and Ukrainian and the respondents chose the one they wanted. The interviewers assisting the respondents usually spoke Polish, English, Russian and sometimes other languages. There were no interpreters on hand during the survey; however, if necessary and when possible, the interviewers provided explanations in a language other than the chosen language of the questionnaire.

This way of conducting interviews turned out to be of value to those who could read well in one or more of the languages used in the study. Although the inability to read independently was not anticipated before the survey, the interviewers noted that the reading skills of asylum seekers were sometimes poor. Moreover, a lot of questions and, in some cases, long lists of possible answers proved to be very difficult to answer for all the respondents.

#### TESTIMONIAL INTERVIEWS

All in all, there were 15 testimonial interviews, 9 with undocumented migrants, and 6 with asylum seekers. Selection of these respondents was purposive: they were recruited from among the clients of NGOs or approached through interviewers' personal or professional contacts, and had not necessarily participated in the interview by questionnaire.

[209] Due to the limited number of potential respondents at the NGOs and the limited timeframe for the research, it was impossible to apply a probability method of sampling (for example to interview every third person meeting the criteria).

# I. DEMOGRAPHIC CHARACTERISTICS

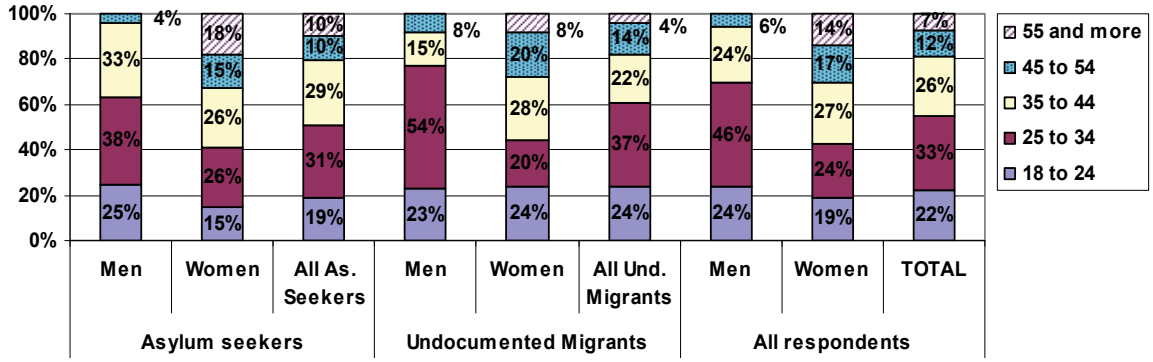
## 1. SEX AND AGE

2. Sex of respondents, by administrative status (%)

| Sex \ Adm. status | Asylum seekers n=58 | Undocumented Migrants n=51 | All respondents n=109 |
|---|---|---|---|
| **Male** | 41% | 49% | **46%** |
| **Female** | 59% | 51% | **54%** |
| **TOTAL** | **100%** | **100%** | **100%** |

In the sample, **there were more women than men among asylum seekers and undocumented migrants**[210]. In comparison to the statistics available on asylum seekers in Poland, women are proportionally slightly overrepresented in our sample. Eurostat reports that in 2009 only 44% of asylum seekers in Poland were women.[211] As for undocumented migrants, no comparison between the demographics of the sample and the population can be drawn, due to the lack of available data.

3. Distribution by age group, in relation to sex and administrative status (%)




Respondents ages ranged from 17 to 80.

**The vast majority of the men interviewed were under 35**, asylum seekers and undocumented migrants alike (77% of male asylum seeker respondents and 63% of male undocumented respondents).

**The women interviewed were on average older than the men, both asylum seekers and undocumented migrants. Contrary to the men, the majority of women were aged 35 or over** (58% of female asylum seekers and 56% of undocumented women). There were only women in the oldest age group (over 55).

[210] This overrepresentation in the research may be partly explained by the fact that women are generally more open to talk about their experiences (especially as men talking about medical problems in Chechen culture can be seen as a sign of weakness), and that they have more to say about medical issues as they probably have more contact with healthcare (for example, because of pregnancy or the role they play in parenting). And the fact that all the researchers were women also contributed.

[211] This data is available on the Eurostat website: http://appsso.eurostat.ec.europa.eu, and in the Polish Office for Foreigners statistics in the Demographic Yearbook of Poland 2010, Warsaw, Central Statistical Office, table 38 (196), p. 449, http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_sy_demographic_yearbook_2010.pdf (accessed on 09.12.2010)

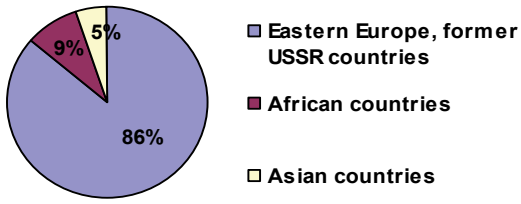
## 2. NATIONALITY AND CITIZENSHIP

A strong correlation can be seen between the countries of origin of the respondents and their administrative status in Poland. Indeed, apart from the respondents from Africa, **the asylum seekers and undocumented migrants did not come from the same countries**. All in all, 21 countries were represented.

### ASYLUM SEEKERS

**The asylum seekers interviewed came from 3 main regions, with the vast majority coming from former USSR countries (86%).** Small percentages came from African countries (9%) and Asian countries (5%).[212] **Apart from the countries of citizenship, most of the respondents declared a different nationality: Chechen, Ingush, Kurdish, Armenian and from Dagestan**.

4. Regions of origin of the asylum seekers interviewed (%)




Eastern Europe; former USSR countries (n=50)

Most of the asylum seekers interviewed were Russian citizens (nearly three-quarters of asylum seekers; n=43), with a majority of women (67%). This group was, on average, slightly older than migrants of other nationalities, being aged over 37.

**Almost 70% of the respondents who declared Russian citizenship also declared Chechen nationality**. The other nationalities given by respondents declaring Russian citizenship were Ingush and from Dagestan. These regions are under the federal control of Russia but have been involved in conflict with the Russian Federation. The other respondents who declared Russian citizenship declared Armenian nationality. The nationalities represented by the respondents are in line with the general statistics as most of Poland's asylum seekers are citizens of Russia.

**Georgia was the second biggest Eastern Europe country of origin represented in the sample** (n=6; **10% of the asylum seeker** respondents), which is in line with the statistics concerning asylum seekers in Poland in 2009. One declared Armenian nationality and the five others declared Kurdish nationality. The 2008 political and military conflict between Georgia and the separatist republics of South Ossetia and Russian Federation, led to a wave of migrants seeking refuge in Poland[213]. One asylum seeker was from Ukraine.

African and Asian countries (n=8):

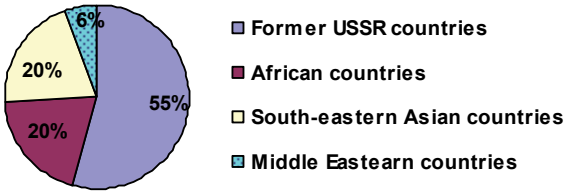
A small group of asylum seekers came from two other regions: Africa (n=5) and Asia (n=3). The asylum seekers originating from African countries were all men, 30 on average. Among respondents originating from Asian countries, 2 came from Vietnam and 1 from Nepal.

### UNDOCUMENTED MIGRANTS

**The undocumented respondents came from 13 different countries and 4 main regions: the majority came from former USSR countries (55%), 20% from African countries and another 20% from South-Eastern Asian countries. 2 respondents came from Middle Eastern countries.[214]**

[212] See table 8 of the appendix 2 in the part dedicated to Poland for details of the nationalities and citizenships of the asylum seeker respondents.
[213] As a country of origin Armenia appears to be underrepresented. In 2009, Armenians constituted the third largest national group of asylum seekers in Poland (147 people - under 2% of all asylum seekers who applied for refugee status in 2009).
[214] See table 9 of the appendix 2 in the part dedicated to Poland for details of the nationalities and citizenships of the undocumented migrants interviewed

5. Regions of origin of the undocumented migrants interviewed (%)




Former USSR countries (Eastern European and Central Asian countries; n=28)

**Almost half of undocumented respondents came from Ukraine** (n=25). Despite the unavailability of precise statistics on undocumented migrants for Poland, it is estimated that Ukrainians constitute the biggest group among undocumented migrants. On average, they were aged 36. **The women were older**, on average closer to 40, than the men who were on average aged 31.

Minorities in the sample were other Eastern European or Central Asian countries – one respondent came from Armenia, one from Belorussia and one from Uzbekistan. Women were the most represented (61%)[215] in the group of former USSR citizens.

South-eastern Asian countries (n=10)

**The second largest nationality among undocumented respondents was Vietnamese**. In the sample there were slightly more men (n=6). On average, Vietnamese migrants were aged 32. There were no significant age differences between men and women.

African and Middle-Eastern countries (n=13)

Many other nationalities were represented in the group from African and Middle Eastern countries. Men were most represented. They were the youngest group by nationality, with an average age of under 29.

# II. MIGRATION EXPERIENCE

## 1. TIME PERIOD SINCE MIGRATION

6. Average time spent in Poland, including all journeys, by administrative status (in years)

| Average time in Poland / Administrative Status | Average time since first arrival in Poland | Average time since last arrival in Poland |
|---|---|---|
| Asylum seeker | 2.1 | 1.9 |
| Undocumented Migrants | 6.3 | 5 |
| TOTAL | 4.2 | 3.4 |

### ASYLUM SEEKERS

**The asylum seekers had on average lived in Poland for 2.1 years**. 10% had made several journeys to the country, probably before initiating the asylum process or because of the Dublin II Regulation's transfer procedure provisions[216]. In some cases, a person had resided legally in Poland before submitting an asylum claim.

[215] Armenians, an often-mentioned group in the context of undocumented migrants in Poland, were not represented in this study. This is most likely because of the methodology applied and fairly limited contacts with undocumented migrants from Armenia in the participating organisations, as mentioned above (See footnote 152).

[216] It might also be in part related to the fact that there are no border controls within the Schengen Area, which makes it easier leave and return to the country (although asylum seekers should not leave Polish territory).

Some respondents had lived in Poland for many years: **22% of the asylum seeker respondents last arrived in Poland at least 3 years previously, a sign of drawn-out procedures but also of applicants re-submitting an asylum claim**.

#### UNDOCUMENTED MIGRANTS

Undocumented respondents had lived longer in Poland than the asylum seeker respondents. **On average, they had spent more than 6 years in Poland all journeys together**.

One third of the undocumented migrants had made several journeys to Poland, probably going back and forth from their countries of origin.[217] This practice appears to be more common among Ukrainians, whose migration pattern has usually been circulation rather than long-term migration. Most probably undocumented migrants from Ukraine came back and forth in previous years, until they extended their latest stay despite not having the necessary documents. Ukrainians can quite easily benefit from working visas, although because of geopolitical changes, the price of a visa has increased significantly. Overstaying a visa or any other residence permit would seem to be the most common reason for becoming an undocumented migrant.

**Vietnamese and Ukrainians have lived on average the longest in Poland, as they arrived long before other nationalities, before Poland became a member of the EU**. Some may have lived many years in Poland with either working visas and/or student visa. [218]

## 2. REASONS FOR MIGRATION

The comparative analysis of the reasons given by asylum seekers and undocumented migrants for migration shows significant differences according to their administrative status. Indeed, the reason given by the respondents for their migration relates to problems experienced in the country of origin and is therefore largely linked to their nationalities. Around one-third of respondents from each group gave more than one reason for their decision to migrate: The decision of leaving one's country is difficult, often complex and influenced by several factors for asylum seekers and undocumented migrants alike.

**A great majority of asylum seekers (67%; n=39) said they fled from their countries for political, religious, ethnic, or sexual orientation reasons or to escape from conflict**. 17% (n=10) of asylum seekers said they left their country in order to give a better future to their children. Also 17% (n=10) of respondent asylum seekers left their countries for economic reasons. More than three-quarters of the people from Chechnya, Ingushetia and Dagestan said they fled from their countries for political, religious, ethnic, or sexual orientation reasons or to escape from conflict.

**Undocumented migrants were most numerous to cite economic reasons for their migration** (69%; n=35). 73% (n=18) of Ukrainians cited economic reasons to explain their migration, and correlatively, 40% explained that they came to Poland to give a better future to their children. Those two responses may refer to the fact that some came to work in Poland to be able to send money back to their countries where their children had stayed. 29% (n=15) of undocumented respondents came to Poland to study.

No significant differences were noted between male and female respondents (asylum seekers and undocumented migrants).

[217] This probably refers to the period when they had valid documents. When possible, Ukrainian migrants usually prefer to have temporary jobs in Poland and make frequent trips to their home country, where they usually support their families. This is facilitated by the proximity of the host and home countries, and the fact that it easier for Ukrainians to obtain a work permit.

[218] This reflects to some extent the specificity of immigration to Poland of some nationals (see introduction regarding the context in Poland above).

# III. LIVING CONDITIONS IN POLAND

## 1. FAMILY AND SOCIAL NETWORK

### ■ Family situation

Among the respondents, 47% said they had children (n=51): 53% of asylum seekers (n=31) and 39% of undocumented migrants (n=20).

**More than 27% of the respondents with children lived apart from all or some of their children (n=14)**. Yet there were significant differences between undocumented migrants and asylum seekers: indeed, **asylum seeker respondents were more likely to live with all of their children in Poland (87%) than undocumented migrants respondents (45%).**

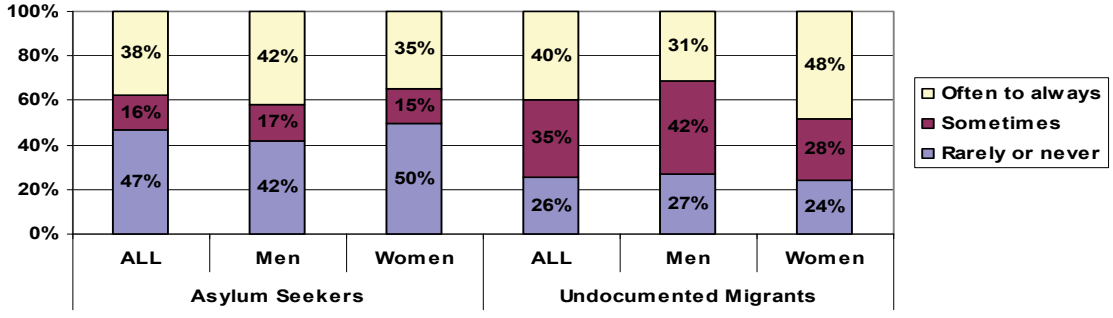
**Most of the asylum seekers interviewed lived at the least with their nuclear family – i.e. their partner and/or their children -** (64%, n=37) which might be explained by the fact that, when possible, whole families left their countries, perhaps to escape from a dangerous situation. Indeed, all the asylum seekers who said they had a partner (n=34), lived with him/her, and most of the asylum seekers who said they had children lived with them in Poland. **Most of the asylum seeker respondents who said they had children had large families at charge with half of them saying they had 3 children or more**. These findings are consistent with the fact that the largest group of asylum seekers, i.e., Russian citizens (mostly Chechens) traditionally have large families and bring them with them. However, 4 of the asylum seeker respondents lived apart from their children.

**The family situation of the undocumented migrants was different; indeed migration for them often implied a separation from their families. Only 31% of the undocumented respondents said they lived with their partner and/or children (n=16)**. At the same time, 22% of those who had a partner (n=27) were not living with him/her and more than half of the undocumented respondents who were parents lived apart from all or some of their children in Poland. **Being separated from the family, in particular from the children, can have an unsettling affect on the psychological state of health of a person and can lead to social isolation.**

However, for undocumented migrants, living with or without their children in Poland depended much on the country of origin. Indeed, the Ukrainians respondents were more likely to live separate from all (55%) or some (9%) of their children. This may be due to the fact that Ukrainians often come to Poland to provide financial support to their family and children left behind in Ukraine. On the other hand, 8 out of the 9 Vietnamese migrants who said they had children, lived with all of them in Poland. On average, undocumented migrants from Vietnam come to Poland quite young, as mentioned previously; it is therefore more likely that they start their families after arriving in the country.

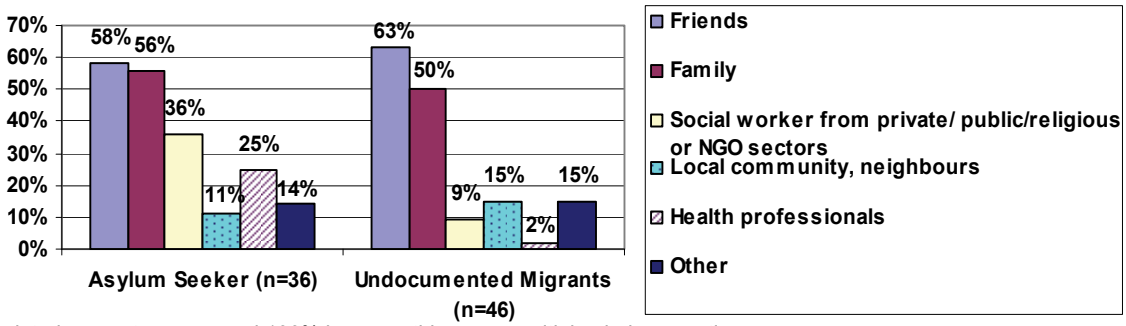
### ■ Presence and frequency of emotional support

7. Frequency of emotional support when needed, by administrative status and sex (%)



**Despite asylum seekers lived with their family quite commonly, almost half of them said they lacked of emotional support when they needed it. As for the undocumented respondents**, **26% felt they could not or could only rarely count on emotional support when needed, which is more than 1 out of 4.** The presence of emotional support when needed depended on the length of time spent in Poland. The fact that undocumented migrants appeared less likely to feel isolated may be because they have, on average, lived longer in Poland. Consequently, they were more likely to have built up a social network. Additionally, the perception of emotional support by **asylum seekers** has to be linked to the fact that they **may have lived traumatic experiences, due to situations of conflict for example**. This might explain why they have a greater need of support, and thus suffer more from the lack of it.

8. Type of person or institution providing emotional support, referred to by the respondents benefiting from emotional support, by administrative status (%)*




* Cumulated percentages exceed 100% because this was a multiple-choice question.
* Percentages are based on the 82 respondents who said they had emotional support (36 asylum seekers and 46 undocumented migrants).
* In 'other' (n=12): 5 cited their employers, 3 members of their religious community (not a social worker), 3 members of an organisation, and 1 people from the country of origin.

**When it existed, friends and/or family members provided emotional support for asylum seekers and undocumented migrants alike**. Apart from this type of help, **36% asylum seekers who could count on emotional support, called on social workers** or members of a private, public, religious or non-governmental organisation for emotional support when needed.[219]

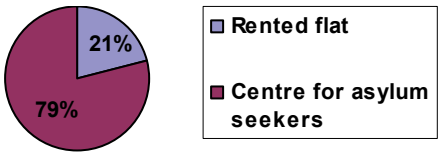
**9 asylum seekers (i.e. 25% of those who had emotional support) said they were supported by a health professional**. **However, the fact that many asylum seekers lacked emotional support suggests that the access to health professionals, and even more to mental health professionals, does not adequately meet their needs.**

**Only 9% of undocumented respondents who could count on emotional support could rely on the help of social workers, and only one undocumented migrant could count on the support of a health professional.**

## 2. HOUSING CONDITIONS

### ASYLUM SEEKERS

9. Type of accommodation, for asylum seekers (%)

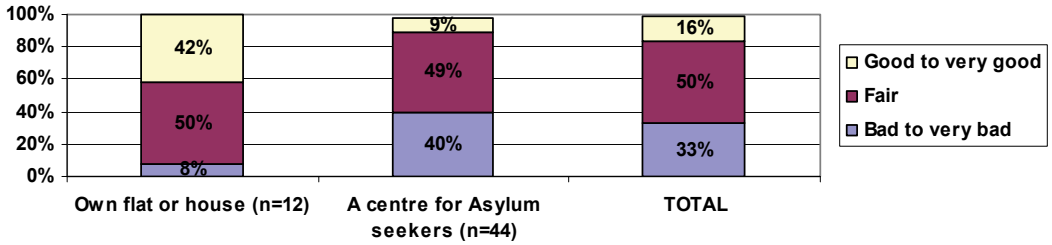



[219] There are social workers employed in all asylum seeker centres. The answers may well have included NGO workers who organise programmes for asylum seekers, but mainly on a project-to-project basis. Support of this nature is not available to undocumented migrants.

**Close to 80% of asylum seeker respondents (n=45) lived at asylum seeker centres. The rest lived in an often-shared private rented flat[220].**

**The accommodation of the asylum seeker respondents appeared unfavourable: 84% considered that their accommodation was unstable and only a short-term solution**. This concerned in particular asylum seekers living in asylum seeker centres, with 91% considering their accommodation insecure. The majority (58%) of those who lived in a private rented flat also felt they lived in insecure conditions.

10. Rating of housing conditions for asylum seekers, by type of accommodation (%)

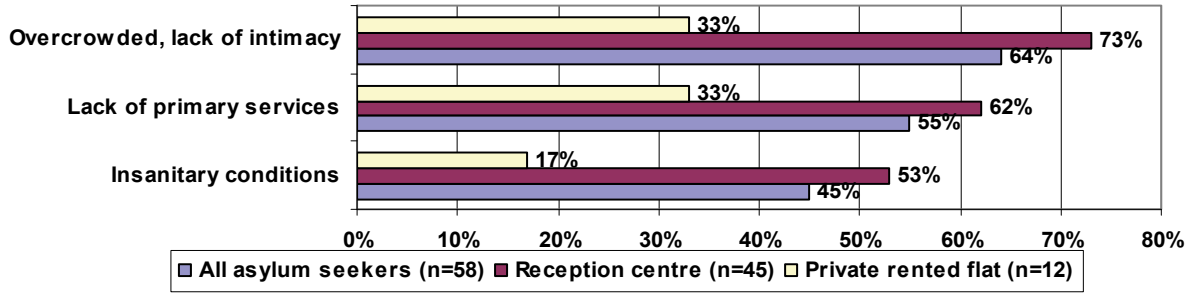



**Furthermore, asylum seekers living in centres largely rated their housing conditions as bad or very bad (40%),** compared to 9% of asylum seeker respondents not living in them.

**When asked about the problems encountered with accommodation, whatever the accommodation, more than 86% of the asylum seekers respondents cited one or several problems, which could potentially be pathogenic.**

The problems mentioned were numerous and **may all impact the health of the occupants**. They were put into 3 categories: overcrowding and lack of privacy, lack of basic facilities (water, electricity, central heating, etc), and insalubrious conditions and dangerous installations. It should be taken into account that most of the time the respondents cited several problems in the same category but they were only counted once in the following graphic.

11. Problems encountered by asylum seekers with their accommodation, by type of accommodation (%)*




* Cumulated percentages exceed 100% because this was a multiple-choice question.

In fact, asylum seekers living in an asylum seeker centre encountered more problems than respondents living in private accommodation.

**For those living in an asylum seeker centre, the main problems encountered and potentially detrimental to health were overcrowding and lack of privacy (73%). The lack of basic facilities was also pointed out**: no access to fully functioning toilets or washrooms (40%), no access to running water (7%), no ventilation or central heating (16%). **Another big issue was related to insalubrious conditions: 51% complained of pest infestations and vermin in the**

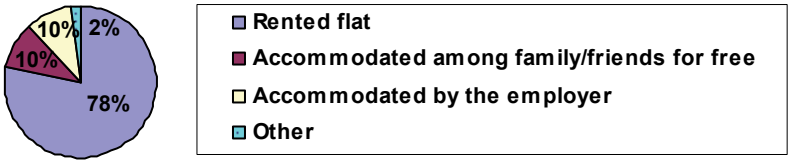
[220] Asylum seekers in Poland are entitled to accommodation. They stay at asylum seeker centres or use their financial support to find accommodation independently. However, the financial support is inadequate given the cost of renting a room or an apartment, which leads to asylum seekers being poorly housed. Asylum seekers can also live outside the centres and not receive from any support, but this is rare. Finding decent accommodation on the free market is extremely difficult (rents are high and people are distrustful of renting to foreigners).

**asylum seeker centre.** It should be noted that an epidemic was recorded in asylum seeker centres (jaundice at Leonów asylum seeker centre in 2008)[221].

**Conversely, 10 of the 12 asylum seekers respondents who lived in private flats cited at least one problem with their accommodation: overcrowding** (cited twice), **lack of privacy** (cited twice), **lack of central heating** (cited 3 times), **degradation of the flat or lack of access to a kitchen** (each cited once).

## UNDOCUMENTED MIGRANTS

12. Type of accommodation, undocumented migrants (%)



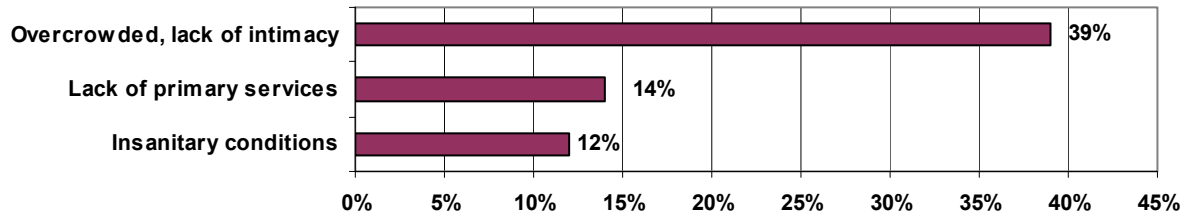

**Unlike asylum seekers, undocumented migrants mostly lived in a private flat** (78%; n=40). **The others were accommodated by their employers** (n=5 or 10%) - 3 domestic workers lived in their employer's flat or house, 2 construction workers were accommodated by their employer – or **lived with friends or family at no cost** (n=5; 10%). 2 lived in student houses.

**Accommodation was usually shared, for over 80% of the undocumented respondents** (n=41), whatever the type of accommodation, whether with friends or fellow countrymen (33%; n=17), with partner and/or children (31%; n=16) and/or other family members (12%; n=6).

**Most of the undocumented migrants felt that their accommodation was unstable and only a short-term solution** (76% of respondents; 77% of those who live in a rented flat).

**Additionally, 71% (n=36) of undocumented respondents said they faced problems regarding their accommodation that could potentially affect health**.

13. Problems encountered by undocumented migrants with their accommodation (%)*




* Multiple-choice question

Again, the problems cited were put into three categories. **Overcrowding and the lack of privacy concerned overall 39% (n=20) of the undocumented migrants interviewed**: 16 respondents said they lacked privacy (31%) and 12 considered they lived in overcrowded conditions (24%). Also, **12% of undocumented respondents cited insalubrious conditions:** 4 said they lived in a dilapidated and damp flat (8%) and 2 had rats and/or vermin (4%). Another **14% lacked of** the **basic facilities**: 6 had no central heating or ventilation (12%), and 1 had no running water.

**Surveys in Europe show that foreigners live in worse housing conditions than nationals, whether in terms of occupancy status, comfort or overcrowding and face greater difficulties in obtaining decent accommodation**: "*These include having a low or unpredictable income, a lack of official proof of income or residence in the country, discrimination and abusive practices by landlords, no entitlement to social housing, weak social network, fear of being reported, etc. Problems related to insecure accommodation can be accompanied by overcrowding, poor and*

[221] Source: *Polskalokalna* (2008). Newspaper article (in Polish) available at: http://polskalokalna.pl/wiadomosci/lubelskie/lublin/news/kwarantanna-w-osrodku-dla-uchodzcow,1161879

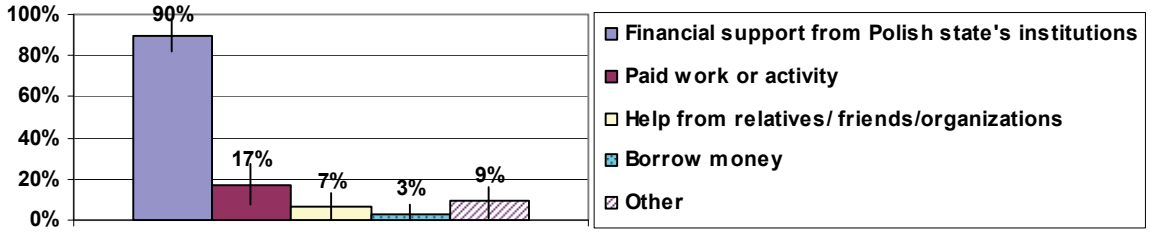
*unsuitable housing conditions (insalubrious, lead, unsafe, etc.) – factors that can impact the health and well-being of the inhabitants.*" [222]

## 3. SOURCES OF INCOME AND WORKING CONDITIONS

### ■ Source of income

**ASYLUM SEEKERS**

14. Source of income of the asylum seekers interviewed (%)*



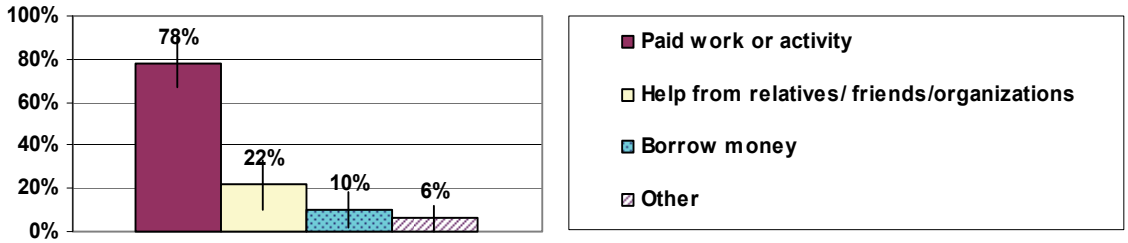

* Percentages exceed 100% because this was a multiple-choice question.

**The asylum seeker respondents mainly depended on financial support from the Polish state (90% of respondents). Among those who received support, 84% lived solely on this source of income.**[223]

10 asylum seekers worked. The longer the interviewed asylum seekers had lived in Poland, the most likely they were to work. Those who did work had, on average, lived in Poland for over 3 years. Asylum seekers are not allowed to work in Poland unless the administrative decision is not given by the first instance institution (Office for Foreigners) within 6 months after submitting the application[224].

**UNDOCUMENTED MIGRANTS**

15. Source of income of the undocumented migrants (%)*




* Cumulated percentages exceed 100% because this was a multiple-choice question.

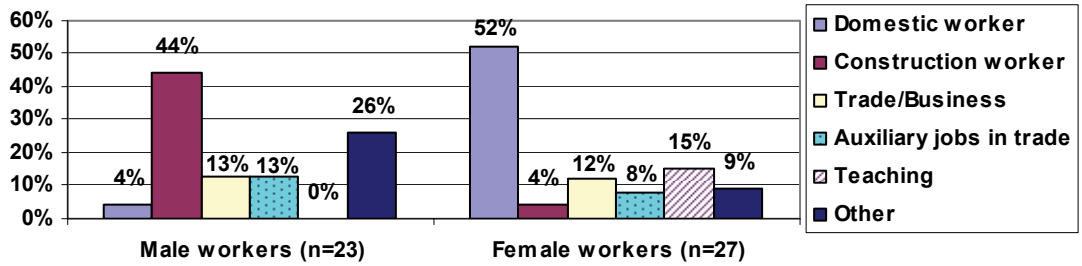
**Most of the undocumented migrants interviewed worked** (78%). This is no doubt because most undocumented migrants migrated for economic reasons, in particular when they come from Eastern European countries. Furthermore, undocumented migrants cannot count on any kind of financial support from the state.

[222] Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009), *op. cit.*
[223] For details on support, go to the introduction regarding the context in Poland above
[224] Once the decision is issued by the first instance institution, no matter how long the administrative procedure lasts, the asylum seeker will not be given the right to work during that period.

## ■ Sector of activities

**All the migrants with jobs** (asylum seeker and undocumented respondents) will be looked at in this section (n=50). The differences arising from administrative status will be commented only when relevant.

16. Sector of activity of working respondents (n=50), by sex (%)




* Cumulated percentages exceed 100% because this was a multiple-choice question.
* Percentages were based on the number of workers interviewed (n=50)

The sectors of activity in which the respondents worked depended largely on the gender of the respondent rather than on their administrative status. **The majority of women worked as domestic workers** (n=14), asylum seekers and undocumented migrants, **whereas men were more likely to work in construction** (n=10).

An analysis in terms of region of origin of the respondents gives further information: Among the Ukrainian respondents, all the women with jobs (n=13) worked as domestic workers, whereas 9 out of 10 men worked in construction. On the other hand, 10 out of the 12 Vietnamese respondents – both men and women - worked in trade or business, or associated activities, (assisting with trading activities, carrying and packing goods in market places and trading halls. The 4 women in employment from African countries (all English native speakers) worked as English teachers, probably giving private lessons.

## ■ Working conditions

**Most of the asylum seeker and undocumented respondents who worked had precarious employment** (72% overall; n=36). The respondents working in trade and business (n=11) or in construction (n=11), were almost all affected by unstable works. Still, 8 of the domestic workers considered that they worked in unstable conditions (57%).

17. Working conditions: days worked per week reported to the hours worked per day (%; nb)*

| Work days per week / Work hours per day | Work 5 days a week or less | 6 to 7 work days a week | TOTAL |
|---|---|---|---|
| 9 hours a day or less | 25% (12) | 23% (11) | **48% (23)** |
| From 10 to 11 work hours a day | 4% (2) | **36% (17)** | **40% (19)** |
| 12 to more work hours a day | 2% (1) | **10% (5)** | **12% (6)** |
| TOTAL | **31% (15)** | **69% (33)** | **100% (48)** |

* Percentages were based on the number of workers interviewed and who responded to the questions (n=48)

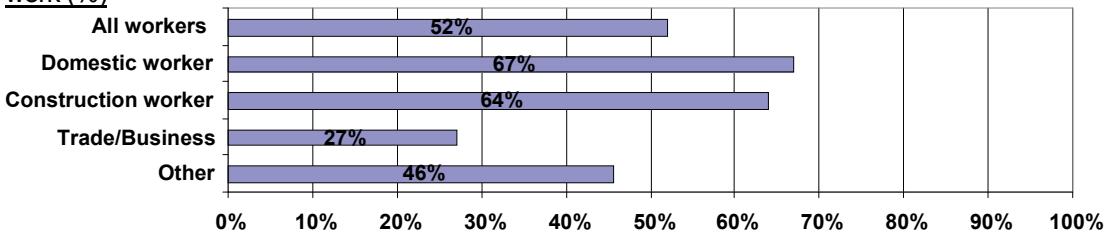
**Furthermore, the working respondents were confronted with difficult working conditions**: close to 70% worked six to seven days a week at the time of the interview, and among them two-thirds said they worked more than 10 hours a day. **In total, nearly half of the workers surveyed (i.e. 22 workers) worked six to seven days a week, and more than 10 hours a day. These hard working conditions affected mostly construction workers, those who worked in trade, and the domestic workers[225] – i.e. the main sectors of activities of the respondents.**

**These conditions may expose the workers to work-place accidents, especially those employed in dangerous sectors of activities such as construction.**

[225] Regarding the conditions of Ukrainian women working as domestic workers in Warsaw, see Kindler M. (2009). The relationship to the employer in migrant's eyes: the domestic work Ukrainian migrant women in Warsaw, in *Cahiers de l'Urmis* [website], No 12. Available at: http://urmis.revues.org/index853.html

**With regards to this, more than half of the workers considered their jobs could result in health problems or expose them to work-place accidents**.

18. Workers considering their work put their health at risk /exposed them to work-place accidents, by types of work (%)




Domestic and construction workers were the most likely to feel their work may put their health or safety at risk (respectively n=10 (67%) and n=7 (64%)). Half of the migrants working in trade considered their working conditions were not dangerous (5 out of 11), but 3 consider their work puts their health at risk and exposes them to work-place accidents.

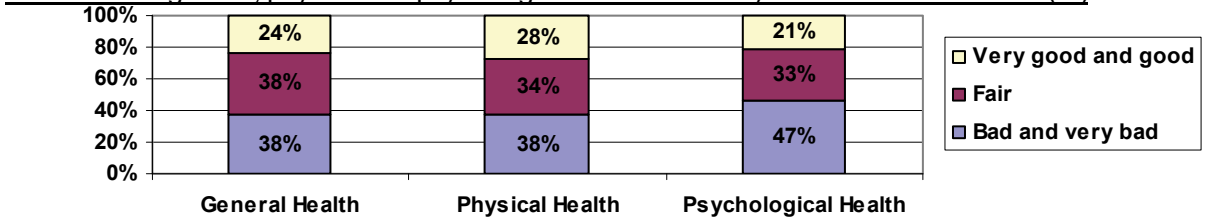
# IV. PERCEIVED HEALTH AND ACCESS TO HEALTHCARE

## 1. PERCEIVED HEALTH STATUS

The perceived health of the population is a subjective indicator, but most studies show a correlation (although not necessarily at level of the individual) between this indicator and/or medical indicators of health.[226]

### ASYLUM SEEKERS

19. Perceived general, physical and psychological health of the asylum seekers interviewed (%)




Perceived general and physical health status

**The asylum seeker respondents' perception of their health was preoccupying: 38% of respondents said they felt in poor or very poor general and physical health.** In comparison, the 2008 Eurostat shows that no more than 16% of the Polish population rates their general health as poor or very poor[227].

Female asylum-seekers were more likely to rate their general and physical health as poor or very poor (44%) compared to 30% of male respondents. This may be because the female asylum seekers in the sample are on average older than the men. General and physical health tends to deteriorate naturally with age. **Nonetheless, it is important to emphasize that close to 30% of the asylum seekers under 35 rated their physical health as poor or very poor.**

[226] Kaplan G.A, Goldberg D.E., Everson S.A et al. (1996). *op. cit.* 25:259-65; DeSalvo K.B, Bloser N., Reynolds K., He J., Muntner P. (2005), *op. cit.*

[227] http://appsso.eurostat.ec.europa.eu/.

Perceived psychological health status

**The perception of psychological health status was even worse than that of general and physical health status: 47% of all the asylum-seeking respondents felt they were in poor or very poor psychological health** (50% of women, 42% of men). At the other end of the scale, no more than 21% felt in good or very good psychological health.

**Such an alarming perception of psychological health has to be put in context: most of the asylum seekers had fled from countries at war where they may have experienced persecution and violence, which often leads to mental health issues**. The psychological health of refugees (or people who have undergone similar experiences) is broadly documented[228] in international papers. The most typical symptoms observed among asylum seekers and refugees are Post-Traumatic Stress Disorder (PTSD), depression, insomnia, and somatisation disorder. Other factors also influence foreigners' mental health in the country while they await the decision on their refugee status, relative to acculturative shock and stress. **Poor housing and economic conditions may also affect their mental health. Indeed, the respondents living in an asylum seekers' centre – who described particularly poor living conditions - were significantly more likely to say that their psychological health was poor or very poor** (51%) than those living in rented accommodation (25%).

**In addition, the lack of support for those who felt in poor or very poor health (n=27) gave cause for concern.** Close to half (n=13) commented that they could never or rarely count on any emotional support. Only 4 respondents who felt in a poor or very poor state of psychological health said they could count on the help of a health professional.

**In Poland, access to psychological healthcare is an issue for asylum seekers. The lack of health professionals (psychologists, psychiatrists, as well as other doctors) specialised in intercultural issues or in symptoms arising from migration (or more specifically that of refugees) was assessed in a report in 2009.**[229] **The psychological support provided at the centres is not always adapted to the specific problems of asylum seekers, and NGOs seldom offer this kind of support (and if they do, it is mostly on a project-to-project basis).** A lack of long-term assistance and programs for asylum seekers suffering from PTSD was also noted.

**Additionally, when examining access to psychological support, mention must be made of the case of those people who are sent to detention centres.**

> *"In Belgium I met a psychiatrist (...), he diagnosed me with PTSD. I got good medicines that helped me go to sleep and helped me with my strong headaches. (...) But then all of a sudden I was put in a detention arrest. (...) After the intervention of my psychologist they let me out of isolation. (...) When I was transferred to Poland – Polish Border Guard assisted me medically – as I was bruised, later they contacted Psychiatric Hospital and I was transferred there. I wanted to get out as soon as possible because I was locked with all these sick people and I was afraid of them. All doctors were nice, but we couldn't communicate well, there was no translator. (...) The doctors in the hospital said that the medication given me in Belgium was not right and prescribed me different drugs. But these drugs do not help me when I have terrible headaches, sleep difficulties and nightmares. After I got out from the hospital, I never was seen by the psychologist or psychiatrist [*in his epicrisis it is advised that he would be under day treatment*]. Fortunately my friend from Belgium was also diagnosed with PTSD and gets the same drugs that I used to get, shared with me some of his drugs sending them by post."* (26-year old male asylum seeker from Russia/Ingushetia)

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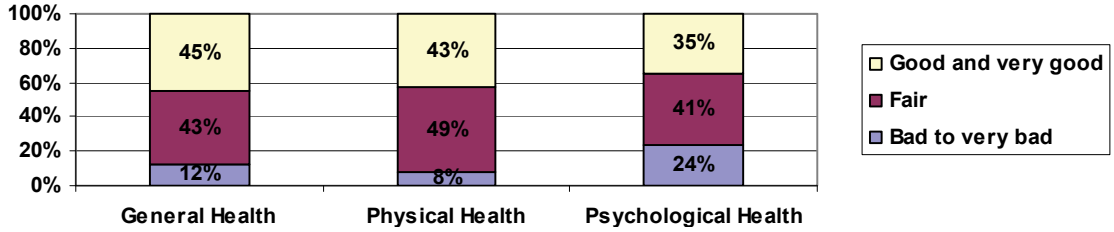
[228] See: Tribe, R. (2002). Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment*, 8:240-247. Available at: http://apt.rcpsych.org/cgi/content/full/8/4/240#SEC4 (consulted on 09.12.2010) ; Ager, A. (1993). *Mental Health Issues in Refugee Populations: A Review*. Working paper of the Harvard Centre for the Study of Culture and Medicine. Project on International Mental and Behavioral Health. Cambridge, MA: Harvard Medical School, Department of Social Medicine, http://repository.forcedmigration.org/pdf/?pid=fmo:1082 (accessed on 09.12.2010); WHO. Mental health of refugees, internally displaced persons and other populations affected by conflict. Geneva. World Health Organization. Available at: http://www.who.int/hac/techguidance/pht/mental_health_refugees/en/ (consulted on 09.12.2010).

[229] International Humanitarian Initiative Foundation (2009). *The Access to Medical and Psychological Assistance of Pregnant Women, Mothers, Children & the Victims of Torture & War Trauma in the Centres for Aliens Applying for Refugee Status or Asylum in Poland. The monitoring report* (in Polish), p. 8.

**The importance of access to permanent and adapted mental care, especially psychotherapy, for asylum seekers is confirmed by representatives of the administration responsible for coordinating state assistance for asylum seekers in Poland**[230].

## UNDOCUMENTED MIGRANTS

20. Perceived general, physical and psychological health of the undocumented migrant respondents (%)




General and physical perceived health status

Undocumented migrants were less likely to rate their general and physical health as poor or very poor in comparison to the asylum seeker respondents. **12%** (6 respondents) **of the undocumented respondents felt they were in poor or very poor general health**. **Given the age of the population, the perceived general health still appears worrying.**[231]

The undocumented women interviewed were less likely to consider themselves in good health than the men interviewed. Similar to female asylum seekers, this may be because the women respondents were on average older than the men.

Perceived psychological health status

**Similar to asylum seekers, the perceived psychological health of undocumented migrants was most affected than the general health: almost a quarter of respondents (men and women) said they felt in poor or very poor psychological health.** 33% of them did not benefit from any emotional support (4 out of 12). **Furthermore, none of those who rated their psychological health as poor could turn to health professional for psychological support**[232].

> *"My partner, who is also "illegal", had a serious breakdown. He survived a terrible car crash, he was battered. He survived as the only one. It was terrible for him. (...) We go to a private doctor, if we can afford it, if we can manage in financial terms. We got twice a month to a psychologist or psychiatrist. He takes medicines and it can be noticed that this has results. (...) We have not tried to go to a public psychiatrist, because we know that we will be either not admitted or we will have to wait long."* (42-year old undocumented woman from Ukraine)

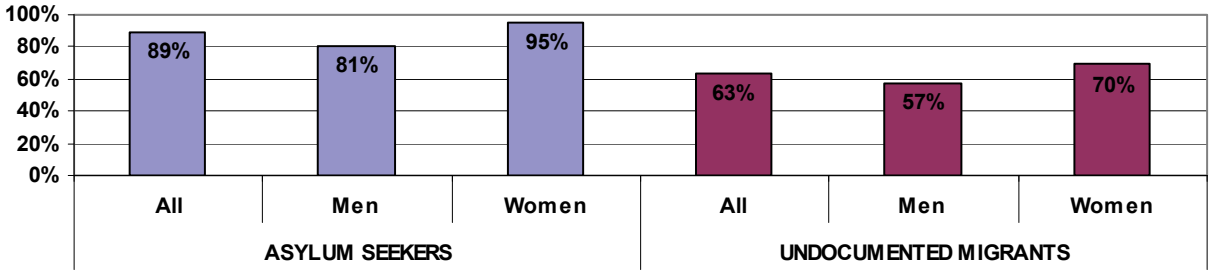
[230] Hajduk, Sz. (2009), Information on system of reception centres for asylum seekers, in: *Poverty book*, Warszawa (in Polish), pp. 691. Available at: http://gospodarkaspoleczna.pl/pliki/badania/inne/Ksiega_Ubogich_2009.pdf ("One of the good practices [amongst projects directed to asylum seekers in Poland] is psychological assistance, answering to one of the most urgent need reported by the asylum seekers. Psychological support has therapeutical and motivating value for people who recently found themselves in new reality")

[231] Furthermore, only 45% of respondents felt they were in good or very good health, which is again quite a low proportion compared to how Polish Nationals rated their health, according to Eurostat in 2008 : 58% of Polish respondents felt they were in good or very good health - http://appsso.eurostat.ec.europa.eu/

[232] Please refer to the section on emotional support, III. Living conditions 1. Family and social network

## 2. ASSISTANCE WITH HEALTH FORMALITIES

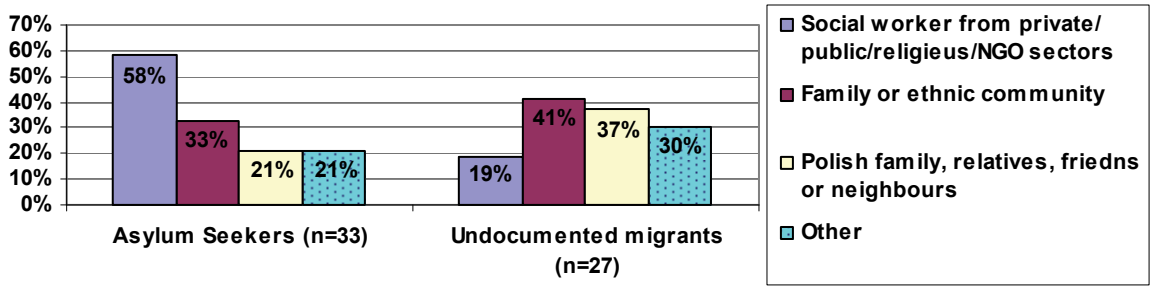
21. Proportion of respondents to benefit from help in accessing healthcare, by administrative status and by sex (%)*




* Percentages exclude non-respondents and refer to 37 asylum seekers and 43 undocumented migrants who answered this question

**89% of the asylum seeker respondents and 63% of the undocumented respondents said they could count on someone to help them with the formalities required to access healthcare** (administrative procedures, translation). Men were slightly less likely than women to benefit from this kind of support: close to 20% of asylum seeking men and 43% of undocumented men have no-one to help them with their healthcare formalities.

22. Type of person to help in accessing healthcare among those who could access such help (n=60), by administrative status (%)*




* Other: respondents referred to their employers or the health insurance companies or, for 3 of them, to health professionals (only asylum seekers)

**Most asylum seekers interviewed relied on professionals for help**: 58% of asylum seekers said they could count on social workers for help with formalities to access healthcare (n=19)..

**Undocumented migrants, however, appear to have less access to support from social workers. This is because in Poland there are no public or private institutions to officially assist undocumented migrants.**

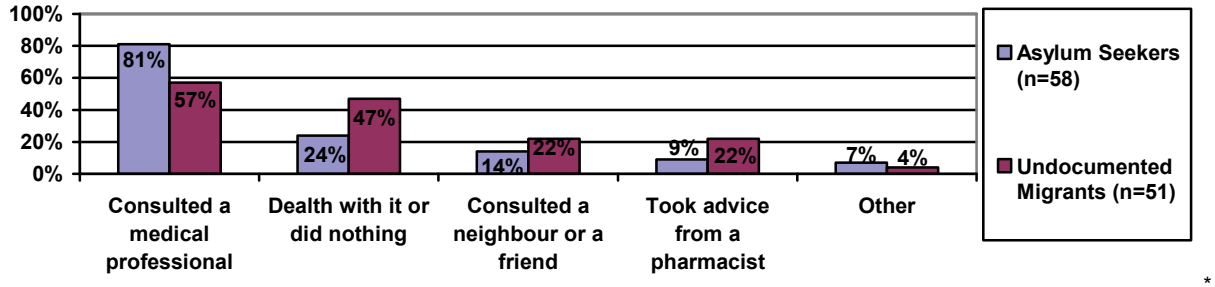
**Although the differences do not allow any conclusions, in the sample the presence of someone who helped with formalities may have impacted positively on the action taken by the respondents the last time they felt sick.** Those who did count on someone to help them with the formalities were more likely to consult a health professional, (73%) (n=44), rather than dealing with the problem on their own or doing nothing (27%; n=16). Conversely, those who did not benefit from such help were more likely to deal with the problem themselves (40%, n=8). But, many other factors may have influenced how respondents reacted to their last health issue.

**Generally speaking, in the sample, the proportion of respondents benefiting from professional help in gaining access to healthcare, whether from social workers or other professionals, was low**: less than one-third of all asylum seeking respondents, and less than 10% of undocumented respondents relied on social workers for help with their formalities to gain access to healthcare.

# 3. MOST RECENT HEALTH PROBLEM - ACCESS AND RECOURSE TO HEALTHCARE

This part of the report focuses on the experiences of respondents during their most recent health problem that in their opinion required medical consultation in Poland (no time limit).

23. Actions taken by the respondents interviewed during the latest health problem in Poland (%)*




*

Cumulated percentages exceed 100% as this was a multiple-choice question.

## ASYLUM SEEKERS

**Most asylum seeker respondents consulted a medical professional about their most recent health problem (81%),** with no significant differences between men and women. And 20% of those who consulted a medical professional also took advice from a neighbour or a pharmacist before or after the medical consultation.

**19% of asylum seeking respondents did not consult a medical professional the last time they felt ill**. Among those who said they did not do anything the last time they felt ill or dealt with the problem on their own, in reality, only 7 asylum seekers did not consult anyone; the others said that they turned to a health professional at some point for this health problem. These results may refer to different situations. For example, one may have first dealt with the problem him or herself and then consulted a health professional when it got worse (late recourse to healthcare). It can also refer to the case of a person who did not take the treatment because of mistrust towards health professional or diagnosis.

## UNDOCUMENTED MIGRANTS

**The actions taken by undocumented respondents during their most recent health problem were more worrying. Only 57% (n=29) turned to a health professional the last time they felt ill in Poland**. The women interviewed were slightly more likely to consult a medical professional for their most recent health problem (64%, n=17) than men.

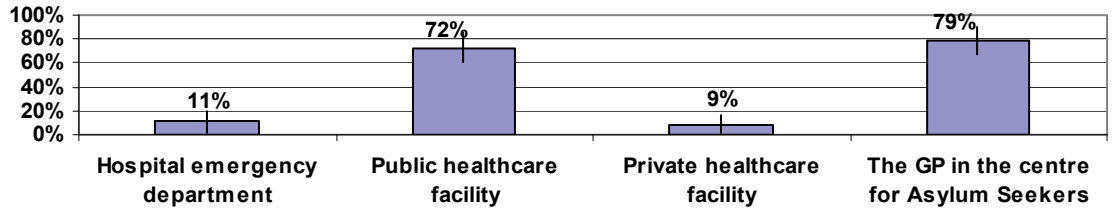
**Almost half of undocumented respondents did nothing or dealt with their problem themselves.** Some respondents also consulted a doctor (before or after they had tried to deal with the problem themselves). However, in the end, **more than one quarter of the undocumented migrants interviewed (n=13) did not consult anyone the last time they were ill**. Furthermore, 11 undocumented respondents only consulted a pharmacist and 11 only a neighbour or friend.

### ■ Consulting a medical professional: the medical facility attended?

In this section, only those who consulted a medical professional are taken into account, i.e., 47 of the asylum seeking respondents, and 29 undocumented respondents.

## ASYLUM SEEKERS

24. Health facility attended by the asylum seekers who consulted a health professional for their most recent health problem (n=47) (%)*




* Percentages exceed 100% because this was a multiple-choice question

Most of the asylum seeker respondents consulted a medical professional at an asylum seeker centre (79%) and/or at a public healthcare facility (72%) about their most recent health problem. Whether they live in centres or not, asylum seekers must consult the first-contact doctors at the centres or at the Office for Foreigners headquarters, which will refer them to a specialist if needed. Asylum seekers must have the referral as proof for medical coverage and a provisional identity certificate issued by the Office for Foreigners[233] when accessing a health institution outside the centre. **Consequently, most common was to have attended several health facilities and thus probably consulted for care that required the consultation of a specialist** (60% of the asylum seekers who consulted a medical professional; n=28): these persons most probably first consulted a general practitioner at the asylum seeker centre and then were referred to an external specialist of for complex examinations.

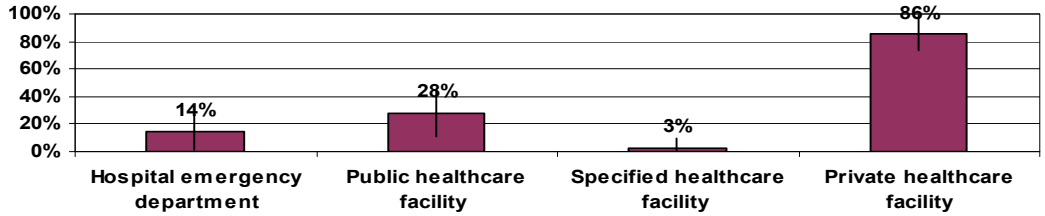
**Among the respondents who consulted public facilities, 3 persons had to pay for the care provided**. Two did not consult the general practitioner at a centre for asylum seekers, but one did. This may indicate that they were denied the health coverage they are entitled to, but may also be related to specific occasions where asylum seekers have to pay for services not covered by health insurance as do Polish citizens.

Only 4 asylum-seeker respondents consulted a health professional in a private healthcare facility; they did not attend any other type of medical institution. In this case, people have to pay full costs for the medical services, and are not required a referral from the asylum seeker centre.

Also 5 asylum seeker respondents attended a hospital emergency department. In case of emergency, asylum seekers are entitled free of charge to hospital treatment, and the centre provides him/her with the referral to serve as proof of medical coverage afterwards.

## UNDOCUMENTED MIGRANTS

25. Health facility attended by the undocumented migrants who consulted a health professional for their most recent health problem (n=29) (%)*




* Percentages exceed 100% as this was a multiple-choice question.

**The undocumented respondents who consulted a health professional mostly attended private healthcare facilities** (86% of respondents; n=25), unlike the asylum seeker respondents.

[233] A pass from the asylum seeker centre is sufficient for some hospitals.

**This seems to be a reluctance to use public health facilities and may be due to the lack of access to healthcare free of charge for undocumented migrants[234], except in the event of an emergency**. Only one respondent went to a specific healthcare facility providing healthcare free of charge to the uninsured[235]. **The testimonies also show that the tendency to attend private medical facilities may stem from the fear of being reported. People feel safer.**

> *"I go to the big private clinic – there is a network all around Poland, and in this place no one cares about my documents if I pay. I show there my card for a public transport and say that I forgot my passport at home and that my case is urgent. These visits are prepaid, so after the visit no one checks documents. It is anonymous, quick and safe."* (51-year old undocumented woman from Ukraine)

However, one undocumented respondent explained he did not feel any trouble when attending public healthcare facilities:

> *"If migrants have no insurance, they have to pay for everything. But medical services are also delivered if people have no money. In such cases people may get a delayed term of payment. I have good experiences with public hospitals in Poland. I would go to a public hospital again, if I needed. But I know that I would have to pay for everything."* (32 year-old undocumented man from Vietnam)

**Most of the undocumented respondents had to pay for their medical treatment** (86% - n=25). The 4 respondents who said they did not pay for the medical services also said they count on someone to help them with the formalities to gain access to healthcare. So, someone else may have paid for them, or the medical professional may have decided not to charge for their services.

> *"I do cleaning for a doctor in his house, so if I have a serious problem I consult it with him. I used to be a healthy person, but constant contact with detergents, chemical substances for cleaning had made me vulnerable to allergies, frequent headaches. Once I hit a bit my ear during the cleaning (...). After a while I realised that my entire ear is blue and I have a sort of a hard bump. [My employer] noticed my bump by himself and told that it should be cut off; otherwise I can lose my ear (...). He asked his colleague in a clinic to make an operation for me the same day (that was on Saturday). The nurse also was there, she assisted during the operation. I did not pay anything for the operation".* (28-year old undocumented woman from Ukraine)

## 4. DIFFICULTIES AND BARRIERS TO ACCESS HEALTHCARE

### ■ Difficulties and barriers encountered while trying to access healthcare during the previous year

This section looks at the problems encountered by respondents when they tried to access healthcare. Contrary to the previous section, it does not concern necessarily (only) the barriers faced by the respondents the last time they had a health problem but refers to all the experiences the respondents may have had when they tried to access healthcare during the previous year spent in Poland or since their arrival (if they had been in Poland for under a year). The difficulties they cited are described here and may refer to several experiences of access to healthcare.

Consequently, the results of this section should not be cross-referenced with the results obtained in the previous section (the case study on the last time they felt ill).

[234] However, in Poland there is a lack of access free of charge to the public healthcare system for all uninsured people, even in emergency units. Many outpatient clinics offer paid medical services at public institutions, as they are under contract to the National Health Fund. Some public health facilities offer private medical care: this does not mean access to free healthcare.

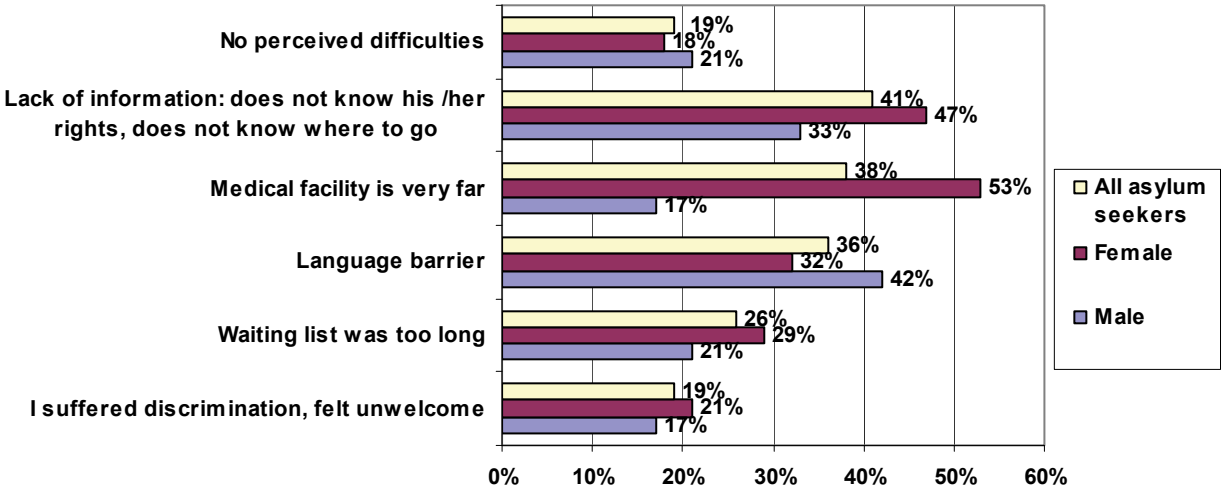
[235] One healthcare centre in Warsaw now offers free medical services including specialist services to people without health insurance. While the centre mainly offers services to Polish citizens, the homeless for example, they do not turn away people in need, and some vulnerable foreigners Warsaw benefit from their help. There used to be other places providing assistance to the uninsured, including foreigners, but they have now closed.

## ASYLUM SEEKERS

**It is striking that close to one asylum seeker out of three (n=19) said that they were unable to see a medical professional each time they tried. This high proportion raises questions on actual access to healthcare for asylum seekers.**

**Moreover, 81% (n=47) of the asylum seeker respondents had encountered difficulties when they tried to access healthcare during the previous year**[236]. Men and women had been similarly affected**. In general, the difficulties and barriers encountered in accessing healthcare were various**: more than three-quarters of those who had difficulties gave at least 2. Only the most frequently cited difficulties are exposed in the following graph.

26. Main difficulties encountered by asylum seekers when trying to access healthcare during the previous year, by sex (%)




* Cumulated percentages exceed 100% because this was a multiple-choice question.

**The paucity of information on the healthcare system and on the health facilities available to asylum seekers (41%, i.e., 24 people) was the most frequently cited difficulty**. **This reveals a lack of information on access to healthcare for asylum seekers**. This is disturbing, given that information on access to healthcare is often only provided by the medical personnel at the centres. Lack of information may also refer to the complexity of the referral system for asylum seekers; for example, an asylum seeker needed to have a second referral be seen again by a specialist, instructions on specific treatment or directions on how to get to the medical facility.

**The main difficulty perceived by the female respondents (n=18) was that the health facilities providing healthcare to asylum seekers were far away and hard to get to**: more than half of them had encountered this. For those living at the centre**, it must be reminded that asylum seekers, with the referral from the doctor of the centre are only entitled to visit the public healthcare facilities**[237]**, which are contracted to provide healthcare to asylum seekers.** These contracted healthcare facilities can often be far from the centres. For those asylum seekers not living in an asylum seeker centre, getting access to a healthcare facility might present even more of a challenge, as they have to go first to the centre to access to healthcare free of charge (either at the centre directly, or through a referral).

**The language barrier affected 36% of the asylum seekers interviewed. Outside the centres, there is no systematic translation to help asylum seekers accessing health facilities. Several NGOs provide translation assistance, but this is purely a non-governmental initiative on a voluntary basis, which does not guarantee an access to all those who need such assistance. A standardised procedure needs to be established.**

26% of the asylum seekers mentioned long waiting lists. This partly could refer to specialist care; long waiting lists for specialist medical care is experienced by most patients in Poland. Patients

[236] or, since their arrival, if they had been in the country for under a year
[237] Except for emergencies.

often have to wait months for an appointment with a specialist, as not all outpatient clinics have specialists.

The asylum seekers pointed out many other difficulties and/or barriers such as the lack of access to female doctors (cited by 6 women), the high price of consultations or treatment (cited by 9 respondents), administrative issues (7%), etc.

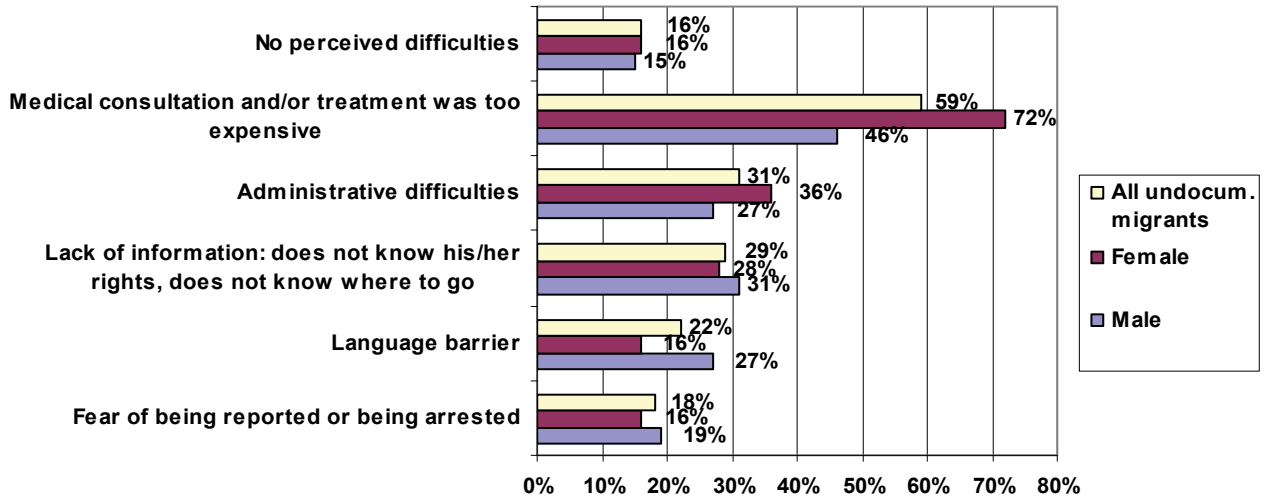
**UNDOCUMENTED MIGRANTS**

*"The medical service here is for the rich people."* (51-year old Ukrainian undocumented woman)

**It is alarming to note that 43% (n=22) of the undocumented respondents said that they were unable to see a medical professional each time they tried, which is even a higher proportion than for asylum seekers**.

**Similar to asylum seeker respondents, close to 80% (n=40) of the undocumented respondents encountered difficulties when trying to access healthcare. Close to three-quarters of those who said they had faced difficulties encountered various barriers** while trying to access healthcare during the previous year (up to 8 difficulties).

27. Difficulties faced by undocumented migrants when trying to access healthcare during the past year, by sex (%)*




* Cumulated percentages exceed 100% because this was a multiple-choice question.

The difficulties confronting undocumented migrants were different to those encountered by asylum seekers. **The main difficulty faced by undocumented migrants was the cost of healthcare and/or treatment, as stated by 59%** (n=30) of them (and by 72% of the undocumented women (n=18)). It should not be forgotten that they are not entitled to any health coverage. And, the poor financial and housing conditions of undocumented migrants probably mean they could also hardly afford medical care. In such conditions, they may have viewed that spending money on health was not a priority, unless their lives were at risk.

*"I would rather go to the private clinic. But only in the case if it was a question of life and death. I support my kids, grandchild and my mother. I cannot afford to be sick and got to the private doctor."* (Undocumented migrant, 40 years old female, Ukraine)

*"My savings are for my children. I cannot spend them on my travel, tests, treatment."* (42-year old undocumented man from Ukraine)

**The lack of health coverage for undocumented migrants can be viewed as one of the factors to explain why undocumented migrants have little recourse to healthcare. We know that the lack of health coverage, particularly for people with low income, greatly increases the propensity to avoid using healthcare services and to use medical services only as a last recourse.**

**Administrative difficulties and a lack of information were also often cited** (31%; n=16). This can be associated to the fact that most of the respondents did not have any help with the formalities to access healthcare, but mainly to their lack of entitlement to health coverage. **Language and communication issues** were also cited by 22% (n=11) of undocumented migrants. These affected more men (27%), than women, maybe because the women came principally from former USRR countries and so had less problems with the Polish language.

**Also 18% of undocumented respondents mentioned the fear of being reported and arrested as a barrier precluding them from accessing healthcare. This barrier can be one of the factors that may drive some people to abandon healthcare and/or to access health services later rather than sooner.**

### ■ Refused access to healthcare

**ASYLUM SEEKERS**

**The large number of respondents who had been refused healthcare is particularly alarming. In total, close to 25% of the asylum seeker respondents had been refused care at least once when they visited a medical facility during the previous year (i.e. 14 people). Health professionals had refused to provide care to them** (8 respondents) **more often than the administration of healthcare facilities** (2 respondents). 4 respondents explained they had been refused access to healthcare by both the administration of health facilities and health professionals.

The survey does not provide in-depth data on the circumstances of the refusals. However, the refusals may be partially due to a lack of knowledge on the legal entitlements of asylum seekers on the part of healthcare facilities outside the asylum seeker centres. They should be fully informed on the procedures concerning asylum seekers: the institution responsible for coordinating the access to healthcare for asylum seekers' programme[238] contracts other medical facilities to provide asylum seekers with assistance or, in exceptional cases, refunds medical services to un-contracted healthcare institutions in specific cases. There are therefore a limited number of facilities to be informed on the procedures for treating asylum seekers.

A probable additional reason explaining why respondents said they were refused healthcare may be the fact that they sometimes perceive the healthcare provided at the centres as unsatisfactory.

> *"What bothers me most is the disrespectful attitude of the doctor working at the centre. She always knows better what is bothering me, she doesn't want to give us medicine or refer us to specialists. Recently I came to her with an intense stomach ache; she gave me medicine which didn't help at all. (...) I asked her for a referral for an ultrasound, because the pain had been persisting, I thought that maybe it wasn't the stomach but the pancreas, but she didn't give it to me. All she said was: 'There is nothing wrong with you, you all simply like taking medicine.'"* (29-year old female asylum seeker from Georgia)

Polish law states that asylum seekers are entitled to the same medical services as insured people. But some **services are excluded from the system coordinated by the Central Clinic Hospital of Ministry of Internal Affairs and the Office's authorisation is required, which hinders access**.[239] This is true for the refunding of the costs of prostheses, glasses and rehabilitation. Asylum seekers may decide to pay for a medical service in order not to have to wait too long, if they have the means.

> *"Things are worst when it comes to access to rehabilitation [for a daughter]. We have to wait for a very long time. I ask our doctor at the centre to send us to rehabilitation, but he says that the waiting period is very long, that there is no available financial support for my child because we are in the asylum procedure and we don't have a PESEL number[240]. So far we have been to two rounds of rehabilitation. The last was one year ago. For one year I have been waiting for someone to call us and let us know that there is a place for us, but I've heard nothing. (...) If I had the same access to rehabilitation that Polish parents have, my daughter would be sitting by now, maybe she would be even walking, but as it is, she progresses very slowly. Rehabilitation is very expensive (...) I am not able to pay for this. Recently I had some money, so I went somewhere to*

[238] The Central Hospital of the Ministry of Internal Affairs and Administration in Warsaw
[239] International Humanitarian Initiative Foundation (2009), *op.cit*., pp. 27. 40.
[240] See footnote number 143.

*the outskirts of the city, what a nightmare! I paid 90 PLN [i.e. approximately 20 euro], they only showed me one exercise and that was it."* (33-year old female asylum seeker from Russia/Dagestan)

**UNDOCUMENTED MIGRANTS**

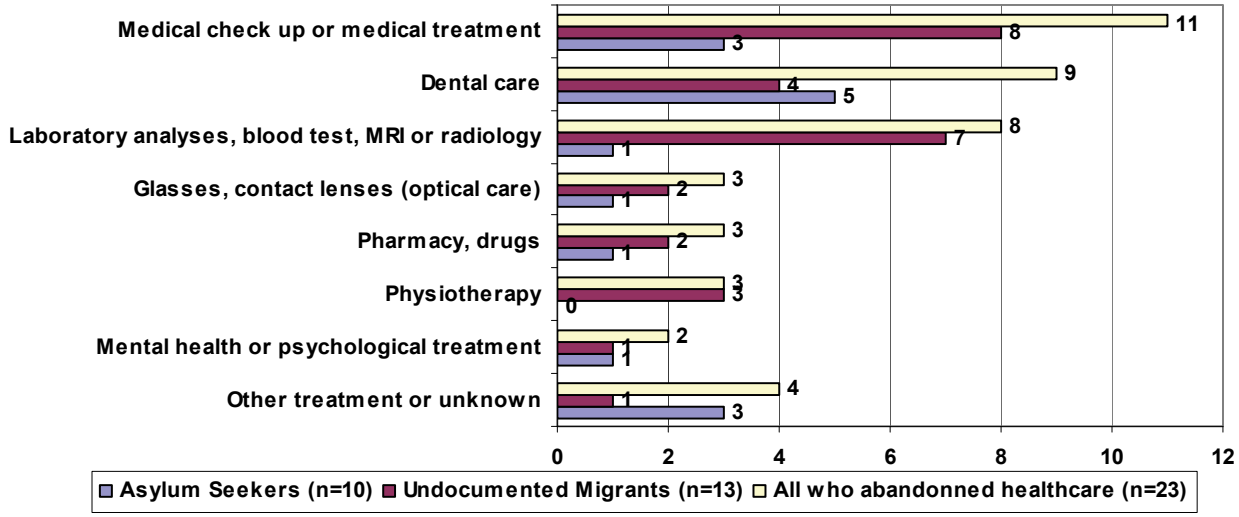
**Similarly, 22% (11 people) of the undocumented respondents said that health professionals had refused them access to healthcare at least once during the previous year**. Valid identity documents are often required for registration, which may explain such a high rate of refusal. And here, refusals may also refer to patients who were refused access to free healthcare to which they are entitled to only in the event of an emergency. In some outpatient clinics contracted with the National Health Fund for the provision of paid medical services, one can get access to healthcare without needing to show an identification card and so benefitting from such services is related only to payment.

## ■ Abandoning healthcare

**Given the difficulties and barriers faced by the respondents when attempting to access healthcare, 17% of asylum seekers (n=10) and more than 25% of undocumented migrants (n=13) said they had abandoned at some point their attempts to access healthcare.** All respondents who had given up on healthcare had encountered difficulties in accessing healthcare in the previous year.

Furthermore, **a significant link can be established between having been refused access to healthcare and having abandoned it**. Indeed, 9 out of 14 of asylum seekers and 9 out of 11 of undocumented migrants who had been refused access gave up on healthcare, whereas this was the case for respectively 14% and 12% of those who had not been refused.

28. Types of healthcare abandoned among those who gave up on healthcare (n=23) (%)*




* Cumulated percentages exceed 100% because it was a multiple-choice question; among the respondents who abandoned healthcare (n=23), 10 are asylum seekers and 13 undocumented migrants

**Ten of the respondents who stated they had abandoned healthcare said they gave up on several types of healthcare.**

All in all, **eleven respondents abandoned medical check-ups or medical treatment, in particular the undocumented respondents. Nine respondents abandoned dental care. Dental care is the main type of care abandoned by asylum seekers** (cited by half of those who abandoned healthcare), although all asylum seekers are entitled to free dental treatment. However,

to do so, they require a referral to dentists at specific medical facilities[241] and referrals to dentists may be limited[242].

# V. ACCESS TO HEALTHCARE FOR PREGNANT WOMEN AND FOR CHILDREN

## 1. PREGNANT WOMEN: ACCESS TO ANTE / POSTNATAL AND DELIVERY CARE

This analysis based on a few testimonies of female asylum seekers and undocumented women as regards their access to prenatal and delivery care **is intended to help raise awareness and pose the questions on the difficulties that undocumented and asylum seeker pregnant women face in Poland. Indeed, under Polish law pregnant women are not considered as belonging to a specific group** (contrary to, for example, unaccompanied minors, people with special needs or victims of violence, etc.), **but are considered to be vulnerable and, as such, a group with potential specific needs.**[243] **Also, pregnant women who do not have health insurance are recognised under Polish law which grants them access free of charge to healthcare.**[244]

Of the 59 women interviewed, the analysis focused on the **sixteen women who were pregnant or had been pregnant since their arrival in Poland.**

**Among them, eleven were female asylum seekers:** four were pregnant at the time of the interview (three under 10 weeks; one, 29 weeks) and eight women, one of whom was pregnant at the time of the interview, had been pregnant in Poland previously. All were asylum seekers during pregnancy. **Among the undocumented migrants, five respondents had been pregnant while undocumented.**

### ■ Housing conditions and health conditions of the pregnant women

Regarding the women who had been pregnant previously (n=12), six were from Chechnya, five from Vietnam, one from Dagestan and one from Ukraine. Nine of them were living with their spouse or partner at the time of the interview. No information was asked for on their living conditions or health at the time of their pregnancy. As a consequence, only the women who were pregnant at the time of the interview (n=4) are taken into consideration for the overview of the living conditions of the migrant women during their pregnancies.

**The four female asylum seekers who were pregnant at the time of the interview came from Chechnya**. All of them lived with their spouse or partner**.** Two of them lived at the asylum seeker centre, where they **were exposed to pest infestations and/or vermin, had no central heating, nor fully functioning toilets or washroom and suffered from a lack of privacy**. The two other women lived in a private accommodation. One said she **had no kitchen and shared an apartment with family members, which was overcrowded.** The other respondent who lived in a private accommodation said **there were pest infestations and vermin**. **Such dilapidated, insalubrious and overcrowded housing conditions are not appropriate for pregnant women.**

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[241] International Humanitarian Initiative Foundation (2009), *op.cit.*, pp. 92.

[242] Dental care (along with rehabilitation, etc.) is one of the services excluded from the system coordinated by the Ministry of Internal Affairs and is funded and controlled by the Office for Foreigners. These services may be restricted (for example number of visits to a specialist as well as proportion of funding).

[243] Council of the European Union (2003). *Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers*, Art. 17. Brussels, European Commission (specific requirement must be confirmed individually). Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:031:0018:0025:EN:PDF

[244] This only applies to Polish citizens domiciled in the country. See Art. 68 (3) of the Constitution of the Republic of Poland of 2 April 1997 (Journal of Rights No 78 of 1997, item 483 as amended).

**As regards their physical health, three of the four women felt their health was fair; one thought her health was poor. It was striking that all of the women judged their psychological health as poor or very poor**.

## ■ Access to antenatal care

**ASYLUM SEEKERS**

**Among the eleven female asylum seekers who were or had been previously pregnant in Poland at the time of the interview, two did not access to prenatal care**. **One of them said the medical facility was too far away. This may be a factor in discouraging the pregnant women from having prenatal care, when it becomes difficult for them to get around. The same respondent said that a medical professional denied her access to healthcare, which raises questions on female asylum seekers' access to antenatal care** (there is no information on the reason behind the refusal). The other asylum seeker respondent who said she was not getting access to antenatal care was only 9 weeks pregnant at the time of the interview and stated that the doctor at the asylum seeker centre had not referred her to a medical facility.

**Additionally, eight out of the nine women who had received access to antenatal care said they had difficulties in accessing it – most of them encountered several issues** (five respondents). **The difficulties experienced by the female asylum seekers were very similar to those the asylum seeker respondents said they faced when accessing healthcare in general: for most of the women**, the problems were **language-related** (mentioned by seven women). Three women also cited the lack of information, and some pointed out that little or no information regarding perinatal care was provided by the doctors at the asylum seeker centres. Three had trouble in getting to the medical facilities providing care to asylum seekers.

Also two women **felt unwelcome or discriminated against during their antenatal consultations**. One woman said that the cost of the antenatal care had been a problem for her. She was, in fact, **the only woman not to benefit from health coverage she was entitled to**.

**UNDOCUMENTED MIGRANTS**

**All five women respondents who were undocumented at the time of their pregnancies had access to prenatal care, but four of them had to pay**. All of the five women said they encountered difficulties when trying to access prenatal care. All **the women who had to pay for their antenatal consultations said that one of the difficulties was the price.** The language barrier, lack of information, and administrative issues were given as the main problems met when trying to access prenatal care (each problem was cited by 3 women).

## ■ Delivery care

The women who had been pregnant in Poland were asked about their access to delivery care. In our sample, seven female asylum seekers[245] and five undocumented women gave birth in Poland, all in a public facility.

29. Access to health coverage for delivery care, by administrative status

| | Asylum seekers (n=7)* | Undocumented Migrants (n=5) | All respondents |
|---|---|---|---|
| **Access to delivery care free of charge** | 6 | 1 | **7** |
| **Paid access to delivery care** | **1** | **4** | **5** |

**Six of the seven female asylum seekers who answered the question on delivery care did not have to pay for delivery care. Not having to pay did not mean, however, not having problems**.

> *"During the first visit [to Poland] I warned the doctor that due to an operation I am missing two ribs, I have a damaged spine and [that] I cannot give birth myself, but I must have a Caesarean*

[245] One woman had a miscarriage.

*section. The doctors here were aggressive; (...) they were angry that we could not pay anything extra during the childbirth. If you are a foreign woman – that's the end. You feel that you are treated differently to Polish women, that you are not welcome here. During the delivery (...) they didn't agree to a Caesarean section. I couldn't give birth. They took the child out with tongs and injured its head. My child is in need of constant rehabilitation and the constant care of many specialists."* (33-year old female asylum seeker from Russia/Chechnya)

Similar to antenatal care, one of the female asylum seekers said she had to pay for delivery care, although she gave birth in a public medical facility.[246] **On the contrary, four out of the five undocumented women interviewed paid for their delivery care**.

**Undocumented and asylum seeker alike suffered greatly from the language barrier and lack of interpretation during delivery at the medical facility** (mentioned by seven of the twelve respondents).

Another difficulty to affect asylum seekers and undocumented migrants alike was caused by **the distance of the medical facility** (mentioned by three asylum seeker respondents and one undocumented migrant). This is a huge issue, particularly for delivery care. It is also consistent with the general problem of the distance of medical facilities mentioned by asylum seekers. It may be partly due to the location of asylum seeker centres as they are often in remote places. For **two undocumented women, having to pay for their delivery care was one of the main difficulties**. Also two undocumented respondents mentioned administrative difficulties.

Additionally, 2 asylum seeker women cited the doctors' lack of attention. One respondent complained that there was no access to a female doctor and another that she had been refused healthcare by a medical professional (however she had been able to finally deliver in a medical facility.

**Generally speaking, it is important to underline that all the women, asylum seekers and undocumented migrants alike, suffered from major difficulties during their deliveries**. **When asked about their delivery care, eleven of the twelve said they faced several problems**. At the same time, it must be noted that, despite the problems, both groups of respondents could access to a medically-assisted delivery in a public hospital but five women had to cover themselves the charges.

## ■ Access to vaccination for newborns

The women who gave birth in Poland were asked about access to vaccination for their babies.

30. Access to vaccination for newborns, by administrative status (n=11*)

| AdministrativeSituation / VaccinationNewBorn | Asylum seekers | Undocumented migrants | TOTAL |
|---|---|---|---|
| **The child was vaccinated in the hospital after delivery** | 2 | 0 | **2** |
| **The child was vaccinated after delivery and in an out-patient clinic** | 4 | 4 | **8** |
| **No** | 1 | 0 | **1** |
| **TOTAL** | **7** | **4** | **11** |

* 12 women who gave birth in Poland, but one woman did not answer the question (n=11).

**Ten out of the eleven newborns of the women respondents were vaccinated either at the hospital immediately after the delivery, or at an out-patient clinic. One asylum seeker's newborn was not vaccinated at all even though there should have been access to health coverage which included vaccination. Three out of four undocumented mothers had to pay for their newborn to be vaccinated.**

[246] The woman who did not get access to health coverage for her delivery care did get it for her antenatal care. She is not the woman who did not get access free of charge to antenatal care.

## 2. CHILDREN OF ASYLUM SEEKERS AND UNDOCUMENTED MIGRANTS: THE DIFFICULTIES AND BARRIERS ENCOUNTERED TRYING TO ACCESS HEALTHCARE FOR THE CHILDREN

**Thirty-nine respondents lived with their children in Poland at the time of the interview: twenty eight of the asylum seekers and eleven of the undocumented migrants.**

In the case of nine respondents, the administrative status of their child was different to that of the parent who participated in the survey. The child's status may depend on the other parent's administrative status.

In the case of asylum seekers, two respondents' children were in a different administrative situation than the parent interviewed: one child had no document attesting to his presence in Poland, while the other one had Polish citizenship. As for the children of undocumented parents, four parents said that their children had Polish citizenship (probably as the child of a parent with Polish citizenship), and therefore in theory had access to health coverage. Another 3 said their children had a residence permit.

### ■ Socio-economic situation

Five out of thirty-nine parents said they were raising their children in Poland as single parents. The other thirty-four respondents lived with their spouse or partner and their children.

**The economic situation of these asylum seekers appeared to be fairly precarious: 64% (n=18) lived solely on financial support provided by the state, with no additional income. It is to be noted that all of the five respondents who had five or more dependent children had no other income than the financial support from the Polish state.**

**The housing conditions in which the respondents and their children lived were viewed as precarious by over 90%** (n=36).

Among the most cited problems were **overcrowding and the lack of privacy** (cited by 34 respondents, i.e., 61%) It is a proven fact that overcrowding can affect a child's and an adolescent's development because of the lack of privacy and a quiet place to do homework, etc. There is also the issue of separate areas for adults and the child/children.

In addition, **most parents described their living conditions as insalubrious and lacking basic facilities**; 16 said they had pest infestations and vermin in the accommodation they shared with their children, and 3 considered that it was degraded. 8 did not have access to a fully functioning toilet or washroom and over 10 of them did not have heating or ventilation. These conditions are clearly unsuitable for children to grow up in.

> *"During winter, it is very cold at the centre. At night, in order to safe money, they turn off the heating and make sure that we do not use heating ourselves, because it uses too much electricity, It is extremely cold in the corridors, all the children are constantly sick."* (29-year old female asylum seeker from Georgia)

### ■ Difficulties and barriers encountered by children in accessing healthcare

**Thirty six parents tried to access healthcare for their children (25 asylum seekers and 11 undocumented migrants), and ten were unable to see a doctor when they tried (7 asylum seekers and 3 undocumented migrants).**

## CHILDREN OF ASYLUM SEEKERS

Among the asylum seekers who lived with some or all of their children and had tried to access healthcare for at least one of their children during the previous year (n=25), **only five parents had no problems in accessing healthcare for their children (22%).**

It is important to emphasize that **seven respondents did not manage to access healthcare for their children when they tried** (almost 30% of respondents living with some or all of their children and who tried to access healthcare for them during the previous year), **and two were never able to have their children seen by a doctor.** These statements are particularly **alarming as the access to healthcare is crucial during the first years of life.** This was explained by the fact that they faced numerous barriers.

### Barriers faced by asylum seekers **who did not manage** to have their children seen by a doctor

The respondents were asked to describe the obstacles that had prevented them from accessing healthcare for their children. Out of seven asylum seekers, who did not manage to have their children seen by a doctor, **five parents cited a lack of information,** i.e. they did not have sufficient knowledge of their children's entitlements to healthcare or on the medical facilities they could go to.

> *"Sometimes they refer us to clinics which we do not know and they do not always explain how we can get there. Recently, I did not take my child to get his vaccinations because I only got a referral with an address, but no one told me where the site was, how to get there by bus and I didn't have money to pay the driver."* (29-year old female asylum seeker from Georgia)

**Also five respondents expressed their distrust of the medical professionals** at the centres or the ones they had been referred to. Difficulty with actually getting to consultations was also widely cited: four respondents said that the medical facility was too far away. This can even be detrimental to a child's health, as the mother of a girl who required rehabilitation said in a testimony:

> *"In general, the hospitals and clinics here are very far away. I always have to travel a minimum of an hour and half to get there. If it's cold, my daughter immediately gets sick. There should be more sites opened in Warsaw, because it is really very difficult to get to these places when travelling with children."* (33-year old female asylum seeker from Russia/Chechnya)

**It is very important to note that two respondents said that their child was refused healthcare,** one child was refused by the administration, and the other one by a health professional.

### Difficulties faced by asylum seekers **who managed** to have their children seen by a doctor

**When they were able to access healthcare for their children, most parents still did encounter difficulties**. Among these difficulties, they cited the problem of getting to the medical facility (9 parents) or the time to wait to get an appointment for a consultation (8 parents). Additionally, the language barrier and a lack of translation posed problems (5 parents) as they prevented them from understanding the diagnosis and treatment, which can increase the fear of a medical examination and treatment.

Due to these obstacles and other difficulties, **five respondents gave up on seeking healthcare for their children at some point for one or several types of treatment**. Two parents abandoned several types of care for their children; two respondents abandoned medical check-ups or treatment, one dental care, one optical care and one vaccination.

One parent said that his child was suffering from serious mental health problems, and needed major care. The child was in an asylum seeker centre and the parent explained that they were unable to get access to mental healthcare there for his child.

Another issue to be taken into consideration is the quality of medical care.

> *"In the winter my younger son had a severe cold, he was coughing, the doctor examined him and said that it was nothing, that I should give him onions and sugar, she didn't give us any medicine. The state of his health kept getting worse. Only when things got very bad did she give us a referral to the hospital, where he stayed for 5 days; it turned out that he had bronchitis and pneumonia of one lung. Obviously this could have been prevented."* (29-year old female asylum seeker from Georgia)

## CHILDREN OF UNDOCUMENTED MIGRANTS

Regarding undocumented migrants living with their child(ren) in Poland, **ten parents had tried to access healthcare for their children during the previous year. Three of them did not manage to have their child(ren) seen by a doctor every time they tried,** even though two of them had children with Polish citizenship. 1 respondent never succeeded.

### Barriers faced by undocumented migrants **who did not** manage to have their children seen by a doctor

The **three respondents who faced obstacles that hindered them from accessing healthcare for their children** at some point during the previous year were Vietnamese. **Administrative difficulties, not having the right documents for the child, and the language barrier**, were the reasons cited for being unable to access healthcare. Even when the children were Polish citizens, the parents faced major difficulties in understanding and dealing with the Polish health system.

### Difficulties faced by undocumented migrants **who managed** to have their children seen by a doctor

Nine out of the ten undocumented parents had problems on at least one occasion when they did manage to have their child seen by a doctor.

Among the Vietnamese parents (n=6), 5 were hampered by the **language barrier** and 3 encountered **administrative difficulties**. Although the sample is too small to draw any conclusions, this data raises awareness about the needs and the lack of sufficient help for the Vietnamese community in accessing healthcare for their children.

However, less Ukrainian parents (n=4) interviewed mentioned difficulties: only one parent said that his problem was to have to shoulder the costs for his children's treatment.

# CONCLUSIONS – POLAND

## ACCESSING HEALTHCARE IS PROBLEMATIC FOR ASYLUM SEEKERS

### ■ Access to healthcare for asylum seekers is not guaranteed

- **By law, asylum seekers** are not eligible for the statutory health insurance but they can still **access free of charge "health services" in specific medical facilities**. While there is no formal interpretation of this provision, it is generally understood to include all health services available to the insured.

- **In practice, the large majority of the asylum seekers (81%) interviewed who consulted a medical professional the last time they felt ill said they did benefit from free medical assistance.**

- However, **one-third of the asylum seekers interviewed pointed out that they had not always managed to see a medical professional when they tried, and close to one-fourth had already been refused access to healthcare in Poland, whether by a healthcare facility's administration or by health professionals. This is one the highest rate observed among the four European countries in this survey.**

- **81% of the asylum seeker respondents declared they faced one or several barriers and difficulties when they tried to access healthcare**. **The main barrier they faced was a lack of information on their entitlements and/or about how to get to the medical facility they were referred to**. This is worrying, given that access to healthcare free of charge for asylum seekers is restricted by a number of conditions and prerequisites. Asylum seekers must first see a doctor at an asylum seekers centre and, if necessary, are given a referral to medical services but only at contracted outpatient clinics. Medical consultations and treatment outside the centres are provided to asylum seekers at a limited number of outpatient clinics.

### ■ The referral system involving long distance to medical facilities

- **Asylum seekers cannot choose their primary care physician**, as they can only to consult the doctor working at the centre for refugees. This means that those living outside centres, sometimes quite some distance away, have to travel far for a medical examination, a prescription or a referral to a specialist, even when seriously unwell. Additionally, **referrals are made only to contracted outpatient clinics and hospitals**, and therefore often require some means of transport as the medical establishment often some distance away[247].

- **The long distance to medical facilities was one of the problems most commonly cited, as 38% of the asylum seeker respondents** regarding access to healthcare. This was confirmed by the testimonies. This may pose a particular challenge to **asylum seekers suffering from medical disorder and pregnant women**.

### ■ Language barrier

**- The language barrier was another major problem** cited by 36% of the asylum seekers interviewed as an obstacle to accessing healthcare. Asylum seekers are not guaranteed any translation assistance apart from that provided by NGO volunteers, who cannot cover all the needs. In the case of medical instructions and procedures, this could present a risk.

[247] This information is based on the experiences of the NGO SIP, as well as on the report: International Humanitarian Initiative Foundation (2009). *The Access to Medical and Psychological Assistance of Pregnant Women, Mothers, Children & the Victims of Torture & War Trauma in the Centres for Aliens Applying for Refugee Status or Asylum in Poland. The monitoring report* (in Polish).

### ■ Lack of psychological support and access to mental healthcare

- **The Office for Foreigners has only very few employed psychologists** who have patients in 14 refugee centres located all over Poland. This is insufficient. In fact, in most cases, adequate and long-term psychological treatment is rarely possible[248].

- In the survey, **almost half of the asylum seeker respondents felt they were in poor or very poor psychological health**. Taking into consideration the specific experiences and issues faced by asylum seekers, it is particularly disquieting that only a small percentage of those who felt in poor or very poor psychological health were able to benefit from emotional support.

- According to NGOs SIP and IHI, there is a **serious lack of psychologists specialising in Post Traumatic Stress Disorder therapy and trained to work in an intercultural context**. Furthermore, mental health professionals with different specialties, in particular **child psychologists**, are rarely available to asylum seekers.

**- The benefits and consequences of psychological treatment are several,** as not only does it have a significant impact on the person receiving the care but there is also the social dimension. Additionally, professional psychological assistance has an important role to play in identifying victims of violence who are entitled to specific treatment[249].

### ■ Poor housing conditions

- Despite the fact that asylum seekers are provided with shelter, **the asylum seeker respondents reported** poor **housing conditions.** Some of the problems encountered at the asylum seeker centres cited by respondents were no access to fully functioning toilets and washrooms, lack of ventilation and central heating and insalubrious conditions. **Poor housing can lead to premature deterioration in physical and mental health.**

## LACK OF ACCESS TO HEALTHCARE FOR UNDOCUMENTED MIGRANTS

### ■ Access to healthcare for undocumented migrants is jeopardised, causing a delayed recourse to healthcare

- **By law, undocumented migrants are highly discriminated against in Poland to the extent that the only care they are able to access free of charge is that provided by rescue teams outside hospitals in an emergency, and the treatment of infectious diseases requiring mandatory treatment**. Given the obligation imposed on healthcare providers to never refuse assistance when health or life are in danger, **undocumented migrants can be treated in emergency units but they must bear the full cost of the care**.

- **In the survey, only 57% of undocumented respondents had seen a health professional the last time they had a health problem requiring a medical consultation**. The majority of those undocumented respondents who had consulted a health professional referred to private healthcare facilities. The tendency to consult private medical facilities is partly related to the **fear of being reported or arrested in public facilities**. This fear was said to be a barrier to accessing healthcare by 1 out of 4 undocumented respondents.

### ■ Various difficulties and barriers in accessing healthcare

- **More than half of the undocumented respondents said that the cost of medical care was the biggest obstacle they faced when trying to access healthcare**. The lack of health coverage and the lack of medical centres offering free of charge heath services to the uninsured, including

[248] International Humanitarian Initiative Foundation (2009). *op. cit.* p. 8.
[249] According to the Act of 13 June 2003 on granting protection to aliens within the territory of the Republic of Poland (art. 68), people who are victims of violence, or whose psychophysical state allows to presume that they have been victims of violence and foreigners with disabilities and whose condition is attested by a specialist, are entitled to specific treatment. For example, asylum claim proceedings must be conducted in the presence of a psychologist or a doctor.

undocumented migrants, results in a situation where undocumented migrants appear to turn to healthcare only as a last resort - a decision which may impact their health.

- **20% of the undocumented respondents stated that they had already been refused access to healthcare**. In Poland, this refusal is legal unless the migrant's health problem constitutes a threat to his/her life. Anybody without insurance can meet with a refusal if they do not need emergency care, which must be provided unconditionally.

### ■ Working conditions as a factor of danger

**- The majority of undocumented, working migrant respondents thought their jobs could cause health problems or expose them to work accidents**. This is partly because of long working hours with **half of the undocumented respondents working more than 10 hours, 5 days a week or more, in sectors of activities that could expose them to work accidents (in particular construction work)**. The above, coupled with the fact that they do not have health insurance, could endanger their health.

### ■ No guaranteed access to healthcare for pregnant women and children

- **Access free of charge to perinatal care for undocumented migrants is not a legal requirement in Poland.** Undocumented women have to pay the full cost of their prenatal and delivery care; care associated with labour cannot be refused. In the survey, **all the undocumented women** respondents **who had given birth in Poland** did so in public facilities and all **had to pay**.

- By law, **children of undocumented migrants currently have access to free healthcare, but only those in education** and up to 18. In the survey, 9 out of the 10 undocumented parents interviewed who had tried to access healthcare for their children had encountered difficulties.

- **This situation contravenes the Convention on the Rights of the Child, which clearly states that (as does the Polish constitution) access to healthcare for all pregnant women and children should be provided.** According to the act on public health services, free healthcare is provided with our without insurance to children under 18 and pregnant women, but only to those with Polish citizenship. This restriction is in breach of both the Convention on the Rights of the Child and the Polish Constitution.

## NEED FOR FURTHER RESEARCH

**The subject of effective access to healthcare for asylum seekers and undocumented migrants in Poland needs to be further investigated**. The results of the study presented above are to be considered a valuable step forward. The survey was exploratory, and the results prompt us to further investigations, wider in scope, into the access to healthcare for asylum seekers and undocumented migrants. These would be examined separately. It would be interesting to look at effective access to healthcare in places other than Warsaw, which is somewhat unique as it is the location of the main administrative departments, including those that coordinate asylum seeker policy.

# RECOMMENDATIONS - POLAND

## ■ Regarding asylum seekers

- **We ask that health professionals and social workers in the centres for asylum seekers provide asylum seekers with all the necessary information on access to healthcare:**

  **1. On the health system for asylum seekers in Poland, including entitlements to healthcare free of charge, the procedure for getting a medical consultation, the referral system, etc.**

  **2. On the medical facilities providing healthcare to asylum seekers**

- **The information provided should be clear and understandable to all, and interpretation services in the native language should be provided.**
- **We recommend that the outpatient departments at asylum seekers centres be equipped with the instruments required for gynaecological examinations** (USG for example) and either employ a female gynaecologist or contract to a gynaecology department in the vicinity.
- **We recommend that the outpatient departments at asylum seekers centres provide paediatric care at the centres or in the vicinity.**
- **We recommend that interpreting and mediation services should be available** at the medical facilities providing healthcare to asylum seekers. These services, currently dependent on the goodwill of a few NGOs, **need to be funded** by the Ministry of Internal Affairs. Once funding has been obtained, given that the NGOs already have experience in interpreting, they could help with setting up the services.
- **In the event of emergency, the services of a telephone interpreter should be provided as a minimum service for asylum seekers requiring translation**.
- **We urge that special attention should be paid to the provision of mental healthcare for asylum seekers. Access to mental health professionals should be guaranteed to all and appropriate to different needs** (long-term therapy, PTSD therapy, child therapy, etc.). **Mental health professionals should therefore receive training on how to treat patients from different cultures**.
- **An independent mental health centre dedicated to treating trauma victims should be set up.**
- **Regarding lodging: acceptable standards of housing should be guaranteed to all asylum seekers and more particularly to families with children.**

## ■ Regarding undocumented migrants

- **We recommend that access to healthcare should be guaranteed to all, regardless of administrative status, as a right attached to the person. Reform of the healthcare system should take undocumented migrants into account.**
- **Providing primary and preventive care free of charge, rather than just simply emergency care free of charge, is not only crucial but appears to be more cost effective.** Moreover, an undocumented patient unable to pay the cost of emergency care becomes indebted to the medical facility.
- **We recommend that access to healthcare free of charge should be granted to all pregnant women and to all children, regardless of their administrative status.**

# ROMANIA

## ARCA - ROMANIAN FORUM FOR REFUGEES AND MIGRANTS

ARCA is member of the HUMA network since 2010 and implemented the researches for this report in Romania.

ARCA, the Romanian Forum for Refugees and Migrants, is a non-governmental, apolitical and non-confessional humanitarian organisation, established in 1998. ARCA aims at defending and promoting the universal human rights, especially the rights of refugees, of persons granted subsidiary protection and other migrants. ARCA works on the monitoring integration of refugees and advocates for improving legislation and practice in the migration field. The organisation also provides social services, legal assistance and assistance on citizenship procedure. ARCA also aims at developing a network of organizations and institutions working to answer adequately to refugees' needs.

## INTRODUCTION – CONTEXT IN ROMANIA

**Romania is one of the EU countries with the lowest percentage of immigrants**. According to an annual report by the Romanian Immigration Office, in August 2008 there were 53,164 aliens with legal residency in the country (or **0.25% of the population**). Indeed, **until recently, Romania was mostly an emigrant nation**, and many Romanians continue to emigrate. **The country's location on the Eastern border of the European Union has made it a migration transit country, in particular since the middle of 2000s. Since joining the European Union in 2007, however, Romania has also started to become a destination country for economic migrants and asylum seekers.**

**The foreigners living in Romania come mostly from other European countries - either from the EU or from neighboring Eastern countries, in particular Moldova or Ukraine - but also from Asian countries.** Some foreigners arrive with work permits obtained via specific bilateral agreements.

**The number of asylum seekers in Romania is quite low, with 1,180 in 2008,** most of them accommodated in one of the country's five open centres. **The asylum recognition rate in 2008 was 13.8%**[250].

**The policies and institutions managing migration issues in the country are quite recent. Since 1992, Romania has moved forward regarding asylum issues**: national legislations have evolved and governmental bodies responsible for asylum seeker and refugee issues have been established. NGOs are also active in providing support and assistance to refugees and asylum-seekers. Furthermore, in order to meet EU entry criteria, a National Migration Strategy was established in 2004, with the aim of, on the one hand, controlling and managing migration inflows,

[250] As exposed in Eurostat database: http://appsso.eurostat.ec.europa.eu/

preventing and combatting "*illegal immigration*", and on the other hand, improving protection for vulnerable migrants and assisting the social integration of alien residents**.**

**A single national level authority, the Romanian Immigration Office (hereafter referred to as RIO), was put in charge of Romania's migration and asylum policies.** Its recent achievements include the implementation of a program for refugee integration and the opening of five new reception centres for asylum seekers close to border areas (Timisoara, Galati, Radauti and Somcuta Mare). In 2010, changes were made to legislation and policy documents, including in December an amendment to Asylum Law no. 122[251]. Amendments to the Aliens law are also bound to be made in the future as a result of the obligation to implement the EU's "Returns Directive" and Romania's forthcoming entry into the Schengen area (expected in 2011).

**The Romanian legislation has also established a "tolerance**": it is a "*permission to remain on Romanian territory*" for objective reasons that prevent the persons' *expulsion from Romania*", creating a category of people who cannot be expelled from the country[252]. This **permission only protects against expulsion, with no social or economic rights attached**. Asylum seekers and holders of a tolerance are in permanent contact with the authorities[253] and with NGOs working in the fields of migration or integration. **Undocumented migrants, however, (those without a tolerance) remain quite invisible**: their number is very uncertain with neither the authorities nor NGOs able to make accurate estimates[254], and **nothing is known about these people's living circumstances**.

Despite noticeable improvements in macro-economic trends between 2004 and 2008, Romania's overall economic[255], political and social situation remains difficult and was severely affected by the global economic crisis. **Economic hardship has also had a negative impact on the country's healthcare system**[256].

The healthcare system has gone through a series of rapid changes since 1989. A mandatory health insurance scheme covers the whole population, except certain categories who are exempted from paying contributions[257]. However, **the level of healthcare expenditure per capita is much lower than in most other EU countries** (€200 euros per capita per annum or 7.9% of the State budget is devoted to health), **and thus access to healthcare is problematic for a significant proportion of the Romanian population. 2.6 million people are uninsured and there is a lack of adequate care and treatment even for those with insurance. The system is also undermined by widespread corruption**[258]. Consequently, **the access to healthcare of the country's whole population is problematic, and the general health situation in Romania remains poor compared with other European countri**es, with, for example, one of the highest infant mortality rates in Europe. **In this already difficult context, migrants often encounter major problems in accessing healthcare**.

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[251] Amendment by presidential decree no. 1270.

[252] With regard to tolerance, see Article 104 of the General Emergency Ordinance 194/2002.

[253] Tolerance holders have to go to the RIO office of their city of "residence" every month, in order to get a "monthly visa" (i.e. a stamp on their tolerated card). Their tolerated stay is re-evaluated every six months and can be confirmed as long as the person can not be removed.

[254] Although this does not provide a clear picture of the number of undocumented migrants in Romania, in 2007, RIO issued 4,470 "measures of return" for aliens identified as having no authorisation to remain or who no longer complied with the conditions of temporary leave to remain. Among the aliens removed from the territory, most of them were from Turkey (1,337; i.e. 30% of the total), other were from Moldova (1,304, 29% of the total) and China (431, 10% of the total). However, those undocumented migrants identified and issued with measures of return represent only a part of those living in Romania.

[255] 33% of Romanian nationals living below poverty line, according to Eurostat

[256] Including reductions in funding for hospitals, salary cuts for doctors and late or no reimbursement of the costs of medical care for acute or chronic diseases.

[257] Basically, except for emergencies, insured persons contribute towards visits to the family doctor or the specialist, inpatient care, blood tests etc. However, Ministry of Health estimates show that a total of 8,006,507 persons are exempted from co-payment (retirees who earn less than 700 lei, children up to 18, young people from 18 to 26 years old with no income, patients included in national health programs - if they have no income from work). The level of co-payment is considered too high, especially for poor people.

[258] See UNCHR (2005). *Report submitted by the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Paul Hunt. Mission to Romania.* UN Ref: E/CN.4/2005/51/Add.4. Available at: http://www2.ohchr.org/english/bodies/chr/sessions/61/lisdocs.htm

# PART 1: LEGAL ANALYSIS

## HEALTH SYSTEM

Romania has a national social health insurance system "based on solidarity, subsidiarity and transparency", mostly financed through contributions. In order to benefit from the majority of the services offered by the public healthcare system, people must be insured (either compulsory or facultative insurance). People without insurance can, however, benefit from a minimum package of services free-of-charge.

There is only one public insurance fund[259], operated by the National Department of Health Insurance[260]. The National Department manages the health system at national level and has branch offices in all forty-two counties. There are other schemes for special categories of persons, such as Ministry of Transport employees, the army and public defence, police and justice personnel, but these special departments come under the remit of the National Department of Health Insurance.

The public system coexists with a number of private service providers, but private insurance is rare, as its high cost makes it too expensive for most of the population.

The health system is currently being reformed, and constant amendments make it difficult to understand for both patients and healthcare providers alike[261]. Other major problems include insufficient budget and additional funds, the high number of uninsured peope, as well as an ever-growing dissatisfaction among patients, medical professionals and other service providers. Furthermore, the fact that hospitals are entirely self-funded [262] means they can refuse to provide services free of charge to entitled patients if they do not have sufficient funds to cover the costs.

## LEGAL ENTITLEMENTS TO HEALTHCARE

Romanian Constitution provides a very general framework with regard to health, referring only to "the right to the protection of health". It also states that "citizens have the right to medical care in health centres".[263]

**Nationals** with permanent residence in Romania and **authorised residents**[264] with a valid temporary or permanent permit are eligible for statutory social health insurance[265]. For them, insurance is compulsory. Romanians who do not permanently reside in the country and foreigners holding a visa can sign a "facultative insurance agreement", granting them the same rights and basic services.

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[259] *Fondul Unic de Asigurari Sociale de Sanatate*
[260] *Casa Nationala de Asigurari Sociale de Sanatate*
[261] The *Legea nr. 95/2006 privind reforma in domeniul sanatatii* of 2006 (the National Health Reform Law) is the main piece of legislation on healthcare and medical services. It has been amended through Government Ordinances and other laws more than 25 times in the past 4 years.
[262] See Article 118 of the *Legea nr. 95/2006*
[263] See Articles 34 and 47 of the Romanian Constitution of 1991, as amended in 2003.
[264] According to Article 3(4) of Government Emergency Ordinance 194/2002 concerning the rights of third country nationals, they "may benefit from social protection measures in the same conditions as Romanian citizens" if they are entitled to legally reside (permanently or temporarily) in Romania.
[265] Article 211 of the *Legea nr. 95/2006*

There is also a large number of people without insurance, either because they are not able to pay the contributions or because they are not willing to declare their income. They can still access emergency care, ante- and postnatal care, treatment of listed infectious diseases and family planning services free of charge[266].

When registering with the Local Health Insurance Department and the family doctor, nationals must provide their ID, which contains a personal identification code. Once registered with their family doctor, they no longer have to provide this ID at every visit. As a general rule, insured people pay a monthly contribution. Contributions for employed people amounts to 5.5% of gross income (the rest is paid by employers). The unemployed (even if they have no source of income) have to pay a monthly contribution of 5.5% of the annual national minimum wage[267] and six months of contributions in advance. Certain categories of people are insured without the obligation to pay contributions. These include children under 18; young people aged 18-26 who are studying or come from child protection and have no income; persons persecuted by the communist regime; persons with disabilities[268] with no financial means; persons with chronic diseases who cannot work; women in need of ante- and postnatal care if their income is below the national minimum wage, and retired persons whose income is under the taxable limit.[269]

The basic package covers a wide range of preventive and curative healthcare services, as well as some medical health supplies, medical devices[270] and rehabilitation services. These include emergency care, primary care (mostly provided by family doctors), some outpatient and inpatient secondary care (that can either be free of charge or copaid[271]), some dental care and prophylactic check-ups. Certain secondary care services such as those provided for occupational illnesses, certain high-performance services and organ transplants, cosmetic surgery, *in vitro* fertilization and most dental care are not included in this package. Similarly, devices for the correction of hearing and visual impairments (such as glasses) and certain physiotherapy and rehabilitation procedures are also excluded[272].

Certificates issued by the Department of Health Insurance (*adeverinta* or *carnet de asigurat*) or employers are the main means of proving healthcare entitlements, as electronic health cards are only just beginning to be introduced in the country. This certificate also contains the personal identification code needed to access all public services in Romania.

**Asylum seekers** are eligible for social health insurance if they are employed[273], otherwise they can still sign the "facultative insurance agreement" and in theory enjoy the same rights and basic services. However, in practice, this is rarely the case due to difficulties in paying the contributions. Fortunately, the Asylum legislation also entitles them to benefit free of charge from "primary medical care and emergency inpatient care, as well as from medical assistance and treatment in the case of acute or chronic diseases creating an imminent danger to their life". It also mentions that those with special needs will receive "adequate medical assistance".[274] Asylum seekers residing in one of the five regional reception and accommodation centres may access primary care in the centre. In theory, in the centres, access is provided by a general practitioner, but in practice they are usually only staffed by a nurse. People living outside the reception centres generally access primary care in the centre where they were registered.

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[266] See Article 210(e) of the *Legea nr. 95/2006* (which refers to the minimum package of services) and the Annual Agreement 2010 regarding the framework for medical and healthcare activities of 2010 (*Contractul-Cadru 2010*). See also Article 98(7) of the *Legea nr. 95/2006*, according to which "qualified first aid and emergency care is given without any discrimination related to, but not limited to, income, gender, age, ethnicity, religion, nationality or political opinion, whether or not the patient is insured".

[267] This amount is less than 10 EUR in 2010.

[268] They must hold an official disability certificate.

[269] See Article 213 of the *Legea nr. 95/2006.*

[270] Glasses and hearing devices are not included, for example.

[271] The government is currently considering the possibility of extending the co-payment, although still excluding certain categories of persons.

[272] See Art. 237 of the *Legea nr. 95/2006.* The list of services for which copayment is required and the fees are established every year by the Annual Agreement on the framework for medical and healthcare activities. Preventive dental care is only covered for children and for some categories of young people.

[273] They are entitled to work one year after submitting the application for asylum.

[274] See Articles 17(1)(m) and (n) of the *Legea azilului nr. 122/2006* of 2006 (Asylum Law).

People who have filed a formal application receive a document identifying them as an asylum seeker. To access healthcare, they must show this document as proof of entitlements. In practice however, there is a huge gap in the information offered by service providers, making effective access extremely difficult.

Although the asylum seekers' identification document should be sufficient to access healthcare, the absence of a personal identification code on this document can create administrative problems, as healthcare providers who are not informed may not accept the asylum seekers' identification document as proof of entitlements. In this respect, a recent amendment to the Asylum Law states that: "In order for asylum seekers to benefit from the rights mentioned in paragraphs m) and p) of art.17[275], the Romanian Immigration Office may – upon request – grant them a personal identification code that will be inscribed on the temporary ID document".[276] Before this amendment, a personal identification code was occasionally issued to asylum seekers and migrants holders of a "tolerance" who applied for it; it has now become an entitlement for asylum seekers.

Although the law makes no specific reference to the children of asylum seekers, it does state that unaccompanied minors will benefit from the "same protection offered to national children in vulnerable situations"[277]. They are normally accommodated in reception centres for asylum seekers or centres for minors, depending on whether they were under or over sixteen when they arrived in the country. They are entitled to stay in these centres until the age of eighteen.

There are no specific legal provisions as regards access to healthcare for **undocumented migrants** in Romania, so general provisions apply. As for any other uninsured person, they are theoretically entitled to care for medical and surgical emergencies, potential epidemic diseases, ante- and postnatal care and family planning[278]. Other healthcare services are only available to them on a full payment basis. In practice, however, effective access to healthcare services by undocumented migrants, whether free or at full cost, is extremely problematic in Romania.

Only undocumented migrants confined in detention centres are entitled to access "adequate medical assistance, medicines and health supplies"[279] free of charge.

The persons **granted a "tolerance"** *(see definition in the introduction on Romania)* do not have any rights or social protection attached to it. Therefore, are in the same situation as undocumented migrants as regards their access to healthcare and benefit from the same minimal entitlements as them (see above). In the tables their entitlements are presented with the entitlements of the undocumented migrants.

According to applicable legislation, all children under eighteen have the right to access all healthcare (beyond the basic package) free of charge in Romania[280]. In practice, most doctors will offer equal treatment to all children, including accompanied or unaccompanied children with no regular status[281]. However, there are exceptions, and some doctors refuse to provide services free

[275] Paragraph m**)** refers to" *the right to receive (free of charge) primary care and treatment, emergency care, as well as free medical care and treatment in the case of acute or chronic illnesses (...)*". Paragraph p) refers to access to education for minor children, in the same conditions as for Romanian children.

[276] Asylum Law no. 122/2006 was amended in December 2010, through Law no. 280/2010, published in the Official Journal of Romania no. 888 of December 30th, 2010.

[277] Article 17(4) of the *Legea azilului*.

[278] See Article 210(e) of the *Legea nr. 95/2006.* According to Article 86(e) of the same law, a medical emergency is an accident or acute illness which requires qualified first aid or urgent medical assistance. Emergencies may be life-threatening (where more levels of healthcare and several interventions are required and provided) or not posing an immediate danger to life (in this case, services may be provided in a hospital or other health centre).

[279] See Article 99(2) of Government Emergency Ordinance 194/2002 ("foreigners who find themselves in detention centre have the right to counsel, medical care and social assistance", and Article 100 ("foreigners taken into custody are entitled to public healthcare, free medicines and health materials"; "medical services are granted by the medical service in the detention centre or by the hospitals funded by the Ministry of Administration and Interior/or Public Health Ministry").

[280] Article 213 of the *Legea nr. 95/2006*.

[281] Unaccompanied migrant children are accommodated in a child protection facility and benefit from all services on an equal basis with Romanian citizens, until they are reunited with their family. If reunification is not possible, they are granted a permit to temporarily stay in Romania. See Article 131 of the General Emergency Ordinance 194/2002

of charge to children of undocumented migrants and persons holding a “tolerance”, as they have no personal identification code.

Reform to the legislation on third country nationals is currently underway, although as yet there is no formal legislative proposal. Among the aspects under discussion are the right to work for persons with a “tolerance” (after holding it for a certain period) and the need to grant further protection to certain vulnerable persons, such as children and pregnant women. If the right to work for holders of a “tolerance” is approved, this would make them eligible for social health insurance -provided they are able to pay the contributions.

# ADULTS CARE

## EMERGENCY CARE

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:** Access free of charge. |
| | **Conditions:** No particular conditions, but proof of identity required once the patient’s situation has stablised |
| **Asylum seekers** | **Entitlements:** Same as nationals. |
| | **Conditions:** Same as nationals. |
| **Undocumented migrants/ Tolerance holders** | **Entitlements:** Same as nationals. |
| | **Conditions:** Same as nationals. |

## PRIMARY AND SECONDARY (OUTPATIENT) HEALTHCARE

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br><br>**Primary care:** Access free of charge.<br><br>**Secondary care:** Access free of charge, co-paid or on a full payment basis, depending on services. |
| | **Conditions:**<br><br>**Primary care:**<br>➤ Membership of the national (statutory) social health insurance system (i.e. payment of contributions). Exceptions: children under 18; young people between 18 and 26 who are studying or from child protection and have no income; persons persecuted by the communist regime; persons with disabilities and no income; persons with chronic diseases who cannot work; women in need of ante- and postnatal care, if income below the national minimum wage limit; and retired persons with income under the taxable limit.<br>➤ Register with a family doctor (upon registration, ID with personal identification code required, but once registered proof of entitlements no longer necessary at every medical visit)<br><br>**Secondary care:**<br>a) If care is in the standard package:<br>➤ Membership of the national (statutory) social health insurance system (i.e. payment of contributions). Exceptions: as for primary care<br>➤ Prior authorisation by family doctor.<br>➤ Show certificate issued by the Health Insurance Department, or special certificate (for those exempted from contributions). |

| | |
|---|---|
| | ➢ Payment of part of the cost of the service (only for certain categories of care)[282].<br><br>b) If care is not in the standard package:<br>➢ Prior authorisation by family doctor.<br>➢ Payment of full cost. |
| **Asylum seekers**[283] | **Entitlements:**<br><br>**Primary care:** Access free of charge.<br><br>**Secondary care:** Payment of full cost. |
| | **Conditions:**<br><br>**Primary care:**<br>➢ Show asylum seeker identification document.<br>➢ Primary care is provided ONLY by the general practitioner of the reception centre[284].<br><br>**Secondary care:**<br>➢ Show asylum seeker identification document.<br>➢ Prior authorisation by the general practitioner of the reception centre.<br>➢ Payment of full cost. |
| **Undocumented migrants/ Tolerance holders** | **Entitlements:**<br>Payment of full cost. |

# HOSPITALISATION (INPATIENT CARE)

| | |
|---|---|
| **Nationals/ Authorised residents** | **Entitlements:**<br>Access free of charge, co-paid or on a full payment basis, depending on services |
| | **Conditions:**<br>a) If care is in the standard package:<br>➢ Membership in the national social (statutory) health insurance system (thus paying the contributions). Exceptions: children under 18; young people between 18 and 26 going to school or from child protection and with no income; persons prosecuted by the communism regime; persons with disabilities and no means; persons with chronic diseases who cannot work; women in need of ante and post natal care if income under the national minimum wage limit; and retired persons with income under the taxable limit.<br>➢ Previous authorisation by family doctor.<br>➢ Show certificate issued by the Health Insurance Department or special certificate (for those exempted from contributions).<br>➢ Payment of part of the cost (only for certain categories of care).<br><br>b) If care is not in the standard package:<br>➢ Prior authorisation by family doctor.<br>➢ Payment of full cost. |
| **Asylum seekers** | **Entitlements:**<br>Payment of full cost, except in emergency situations. |
| **Undocumented migrants/ Tolerance holders** | **Entitlements:**<br>Payment of full cost, except in emergency situations. |

[282] Fees and the list of services for which copayment is required are established every year by the Annual Agreement on medical and healthcare activities.
[283] Asylum seekers in Romania are also entitled to social health insurance if they are working (one year after submitting the asylum application) or if they have signed the "facultative insurance agreement". This possibility has not been included in this table given its rare applicability in practice (difficulties paying the contributions).
[284] "Regional Centre for Asylum Seekers". Persons living outside these centres usually access primary care in the centre where they were registered.

## ANTE- AND POSTNATAL CARE

| | |
|---|---|
| **Nationals/Authorised residents** | **Entitlements:**<br>Access free of charge[285].<br>**Conditions:**<br>a) If insured:<br>➤ Membership in the national (statutory) social health insurance system (i.e. payment of contributions).<br>➤ Show medical certificate proving pregnancy, or the baby's birth certificate.<br><br>b) If uninsured:<br>➤ Prove income below the minimum wage limit to obtain a certificate from the financial administration, or sworn statement.<br>➤ Show medical certificate proving pregnancy, or the baby's birth certificate. |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge.<br>**Conditions:**<br>➤ Show asylum seeker identification document.<br>➤ Prior authorisation by the general practitioner of the reception centre.<br>➤ Show medical certificate proving pregnancy, or the baby's birth certificate. |
| **Undocumented migrants/ Tolerance holders** | **Entitlements:**<br>Access free of charge. (In practice, however, there is a noticeable information gap on these entitlements, especially among health professionals[286]).<br>**Conditions:**<br>No conditions foreseen by law. |

# ADULTS TREATMENT

## MEDICINES

| | |
|---|---|
| **Nationals/Authorised residents** | **Entitlements:**<br>Access free of charge, co-paid (10% or 50%) or on full payment basis depending on the category of medicines.<br>**Conditions:**<br>➤ Membership in the national social (statutory) health insurance system (thus paying the contributions). Exceptions: children under 18; young people between 18 and 26 going to school or from child protection and with no income; persons prosecuted by the communism regime; persons with disabilities and no means; persons with chronic diseases who cannot work; women in need of ante and post natal care if income under the national minimum wage limit; and retired persons with income under the taxable limit.<br>➤ Show the prescription.<br>➤ Payment of full or part of the cost (10% or 50%), depending on the category of medicine. (In practice, family doctors issue prescriptions for fully or partially reimbursed medicines to chronically ill persons and persons with acute diseases only[287]). |

[285] See Article 223(2) of the *Legea nr. 95/2006*.
[286] Information about practice provided by the organisation ARCA.
[287] The list of medicines for chronic and acute illnesses are included in a list approved annually by decision of the President of the National Heath Insurances Department.

| | |
|---|---|
| **Asylum seekers** | **Entitlements:**<br>Payment of full cost, except emergency situations. |
| | **Conditions:**<br>➤ Show asylum seeker identification document.<br>➤ Show prescription. |
| **Undocumented migrants/ Tolerance holders** | **Entitlements**<br>Payment of full cost, unless admitted to hospital in an emergency situation. |

## HIV SCREENING

| | |
|---|---|
| **Nationals/Authorised residents** | **Entitlements:**<br>Access free of charge and anonymous[288]. |
| | **Conditions:**<br>No particular conditions required. |
| **Asylum seekers** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>Same as nationals. |
| **Undocumented migrants/ Tolerance holders** | **Entitlements:**<br>Same as nationals. |
| | **Entitlements:**<br>Same as nationals. |

## HIV TREATMENT

| | |
|---|---|
| **Nationals/Authorised residents** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>➤ Membership in the national social (statutory) health insurance system (thus paying the contributions). Exceptions: children under 18; young people between 18 and 26 going to school or from child protection and with no income; persons prosecuted by the communism regime; persons with disabilities and no means; persons with chronic diseases who cannot work; women in need of ante and post natal care if income under the national minimum wage limit; and retired persons with income under the taxable limit.<br>➤ Prior authorisation by family doctor.<br>➤ Show certificate issued by the Health Insurance Department or special certificate (for those exempted from contributions). |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge. |
| | **Conditions:**<br>➤ Prior authorisation by the general practitioner of the reception centre. |
| **Undocumented migrants/ Tolerance holders** | **Entitlements:**<br>Payment of full cost, except in emergency situations. |

[288] Screening possible in public facilities (including the “Infectious Diseases Centre”) and NGO-run centres

## TREATMENT OF OTHER INFECTIOUS DISEASES

| | |
|---|---|
| **Nationals/Authorised residents** | **Entitlements:**<br>Access free of charge to listed diseases (including TB and STDs). |
| | **Conditions:**<br>➤ Membership in the national social (statutory) health insurance system (thus paying the contributions). Exceptions: children under 18; young people between 18 and 26 going to school or from child protection and with no income; persons prosecuted by the communism regime; persons with disabilities and no means; persons with chronic diseases who cannot work; women in need of ante and post natal care if income under the national minimum wage limit; and retired persons with income under the taxable limit.<br>➤ Prior authorisation by family doctor.<br>➤ Show certificate issued by the Health Insurance Department or special certificate (for those exempted from contributions) . |
| **Asylum seekers** | **Entitlements:**<br>Access free of charge "in case of acute or chronic diseases causing an imminent danger to life". |
| | **Conditions:**<br>➤ Prior authorisation by the general practitioner of the reception centre. |
| **Undocumented migrants/ Tolerance holders** | **Entitlements:**<br>NO access free of charge (payment of full cost), except in emergency situations. |

# CHILDREN

| | |
|---|---|
| **Nationals/Authorised residents** | **Entitlements:**<br>Access free of charge to all types of care (beyond standard package) |
| | **Conditions:**<br>➤ Membership of the national (public) social health insurance system (exempted from contributions).<br>➤ Show ID or birth certificate when registering with family doctor. |
| **Asylum seekers' children** | **Entitlements:**<br>Same as nationals. |
| | **Conditions:**<br>➤ Show asylum seeker identification document.<br>➤ Prior authorisation by the general practitioner of the reception centre to access secondary care. |
| **Unaccompanied (asylum seeking) children** | **Entitlements:**<br>Same as nationals |
| | **Conditions:**<br>➤ Show asylum seeker identification document.<br>➤ Prior authorisation by the general practitioner of the reception centre to access secondary care (if the child is over sixteen) or the general practitioner of the centre for minors (if the child is under sixteen). |
| **Children of undocumented migrants / Unaccompanied (migrant) children** | **Entitlements:**<br>Same as nationals |
| | **Conditions:**<br>No particular conditions. |

# DETENTION CENTRES

| | |
|---|---|
| **Adults** | Access free of charge to "medical assistance, medicines and health supplies" in Public Custody Centres (detention centres).<br><br>These services are provided by the health professionals working in centres or public facilities depending on the Ministry of Interior or the Ministry of Public Health. The cost is paid by the Ministry of Interior. |
| **Children** | Access to healthcare on same conditions as adults.<br><br>Children of undocumented migrants can be confined in detention centres as there are no legal provisions preventing this. Unaccompanied children below 18 are however accommodated in centres for minors if they arrived in the country aged 16 or under. |

# TRANSFER OF OR ACCESS TO INFORMATION BY THE AUTHORITIES

**Transfer of or access to information about administrative status**: Healthcare professionals are under a duty of confidentiality[289] concerning the situation, treatment, diagnosis and personal data of the patient. However, the law also says that "confidential information may be divulged only if the patient explicitly consents to it, or if the law strictly requires it"[290]. One of the situations in which the law requires that such information be disclosed is when it is considered to facilitate the illegal stay of undocumented migrants' in Romania, "in any shape or form"[291].

Very recently, at the request of the NGO ARCA, the Romanian immigration authorities clarified this provision, stipulating that both healthcare providers and administrations are under an obligation to report undocumented migrants. In a formal letter[292] addressed to ARCA, they specify that "healthcare providers must ask to see documents proving that the person requesting medical assistance is the holder of insurance. Doctors, medical personnel or hospital administrations should report undocumented migrants to the Romanian Immigration Office". Consequently, doctors and hospitals' administrations may be held to account for "facilitating an illegal stay" if they do not report the patient to the authorities. By not doing so, they risk a fine of up to €700 [293].

So far, there are no known cases of health professional being fined for not reporting undocumented migrants. However, ARCA believes that the denunciation of undocumented migrants in heath care facilities could well be practiced as providers interviewed in an informal survey declared that they would report an undocumented migrant patient as soon as his or her situation stabilised[294].

[289] See Article 39 of *Legea nr. 95/2006.*
[290] See Article 22 of the *Legea drepturilor pacientului* nr. 46/2003 (on patients' rights).
[291] See Article 134(16) of the General Emergency Ordinance 194/2002.
[292] Letter dated of 25 May 2010.
[293] See Article 135(c) of the General Emergency Ordinance 194/2002. The fine can range from €100 to €700.
[294] ARCA has recently conducted an informal survey to assess the risk of denunciation among health professionals working in some of Bucharest's hospitals. Representatives of more than 10 hospitals, as well as several health professionals were asked what they would do if an undocumented migrant came to them for treatment. A large majority of respondents declared that they would report the patient to the immigration authorities, in order to avoid subsequent problems. Health professionals did show some reluctance about the practice of denunciation, but most of them stated they would not take the risk of not denouncing for fear of the consequences.

# NON EXPULSION ON MEDICAL GROUNDS

## NO RECOURSE TO EXPULSION, OR SUSPENSION OF EXPULSION ORDERS ON MEDICAL GROUNDS: THE "TOLERANCE"

Legislation prohibits the removal of a person if there is a justified fear that his/her life may be put at risk or that he/she will be subjected to torture, inhumane or degrading treatment in the country to which he/she will be sent[295]. However, this provision is vague and does not specifically aim to protect seriously-ill undocumented migrants against expulsion.

As all other migrants who for objective reasons cannot be removed from Romanian territory, undocumented migrants who are severely ill can also apply for a "tolerance". This status does not constitute a residence permit, however, and does not afford to the holder any rights[296].

⇒ **WHO?**
Undocumented migrants who cannot be removed from Romanian territory for objectives reasons, including seriously ill undocumented migrants[297]

⇒ **CONDITIONS:**

- Objective reasons, independent of the applicants' will, must prevent them from leaving the country.
- Be a rejected asylum seeker or not hold a residence permit for other reasons.
- Submit application to the Romanian Immigration Office.

⇒ **DURATION:**
Six months, with the possibility of renewal for further periods of up to six months, for as long as the reasons to grant it still exist[298].

⇒ **ACCESS TO HEALTHCARE:**
Access free of charge to emergency care, ante- and postnatal care, treatment of listed infectious diseases and family planning services only, according to the same conditions as any other undocumented migrant living in Romania

## RESIDENCE PERMITS FOR MEDICAL REASONS

No residence permits are granted to protect seriously-ill undocumented migrants against deportation. Civil society organisations are trying to promote changes in the legislation that include the introduction of either a residence permit for medical reasons, or at least a formal legal provision expressly ensuring that all seriously-ill undocumented migrants will be granted tolerated status.

[295] Article 2(e) of the General Emergency Ordinance 194/2002.
[296] A serious problem regarding their situation is that, unless otherwise authorised, their freedom of movement is restricted to the territory of the regional authority (RIO) which granted them tolerated status. See Article 104(7) of the General Emergency Ordinance 194/2002
[297] The wording of the law does not specifically mention health reasons.
[298] Article 104(1) of the General Emergency Ordinance 194/2002

# PART 2: FIELD STUDY IN ROMANIA

## METHODOLOGY AND SAMPLING

The field survey in Romania took place between August 15th – October 15th 2010 and targeted asylum seekers, undocumented migrants and holders of a "tolerance". It was decided to focus on migrants living outside centres administered by the RIO (centres for asylum seekers and detention centres), as very little information is available on the living conditions of asylum seekers accommodated outside of these centres or on undocumented migrants in general. The field survey was coordinated by Ms. Carolina Marin (ARCA), and the team comprised 4 interviewers with different professional backgrounds (one doctor, one social worker, one sociologist, one legal adviser), all trained to use the same methodology in this field investigation.

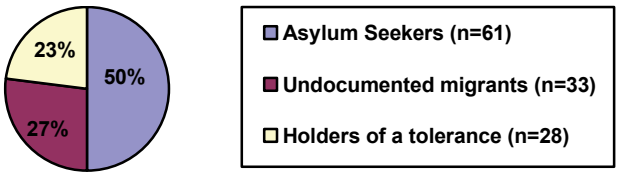
**The field activities and meetings with the respondents took place[299]:**

- At ARCA's head office, mostly among ARCA's beneficiaries. The doctor involved in the survey invited some of the asylum-seeking patients being seen at the ICAR medical facility[300] to come to ARCA and take part in the survey. Participants were also asked to inform any friends or community members who they knew had encountered healthcare related problems and invite them to ARCA to take part in the survey (80 people interviewed);
- At the Jesuit Refugee Service's shelter with the holders of a "tolerance" accommodated there (20 people interviewed);
- The involvement and support of Iraqi and Chinese community associations in Bucharest allowed to reach other interviewees (11 people interviewed)
- Although most of the interviews were held in Bucharest, 11 undocumented migrants and asylum seekers were interviewed in Somcuta Mare. The meetings there were organised by ARCA's community worker in Somcuta Mare.

Most of the participants were selected from among ARCA's regular beneficiaries. After attending social or legal counselling sessions, they were all informed about the survey and invited to participate. The interviews for the survey always took place in a separate room (whether in ARCA or in the other locations) to ensure privacy and enable free discussion with the surveyor.

**All in all, 122 interviews were held with 61 asylum seekers, 33 undocumented migrants and 28 tolerance holders**.

1. Administrative status of the migrants interviewed (%)



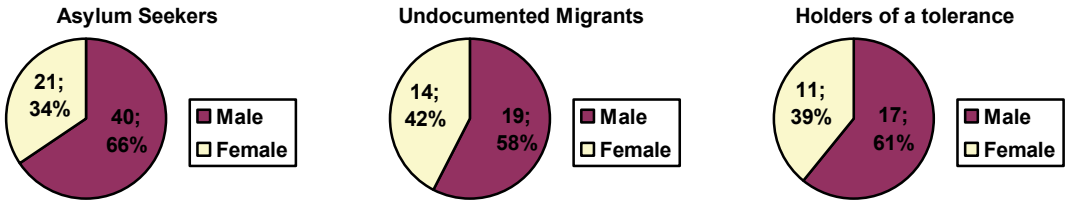

**Thirteen 'testimony-gathering interviews' were also held**, mainly among ARCA's beneficiaries and at ARCA's head office: 7 asylum seekers, 4 undocumented migrants and 2 holders of a tolerance were asked to describe some of their experiences with the healthcare system.

[299] For a more precise view of the on-going of the field activities, see table 10 in Appendix 2 in the part dedicated to Romania.
[300] ICAR is a NGO providing health services to persons excluded from or having difficulties in accessing the health system in Romania (especially asylum seekers, refugees and Romanians victims of the communist regime)

# I. DEMOGRAPHIC CHARACTERISTICS

## 1. SEX AND AGE

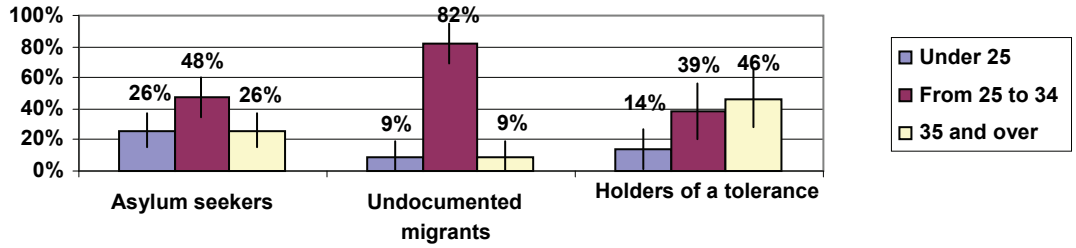
2. Distribution by sex, by administrative status (nb; %)




**Our sample included more men than women**: 66% of the asylum seekers interviewed were men, 58% of the undocumented migrants and 61% of the tolerance holders interviewed.

Among the asylum seekers, women were in fact slightly overrepresented in this study (due to the decision to have a clearer focus on women in this study). According to Eurostat, in the first quarter of 2010, only around 15% of asylum seekers in Romania were women.

3. Age groups of the respondents, by administrative status (%)




There were significant differences in the distribution per age group of asylum seekers, undocumented migrants and tolerance holders.

Most of the asylum seekers in our sample were under 35 (84%). This corresponds to Eurostat statistics which state that, in the first quarter of 2010, almost 80% of adult asylum seekers in Romania were under 35. No significant differences existed between men and women nor depending on the regions of origin of the respondents.

Undocumented migrants were widely represented among the 25 to 34 year-olds (82% of the undocumented migrants interviewed), whereas most of the tolerance holders were over 35 (46%). Most of these tolerance holders over 35 were, however, under 40 years of age.

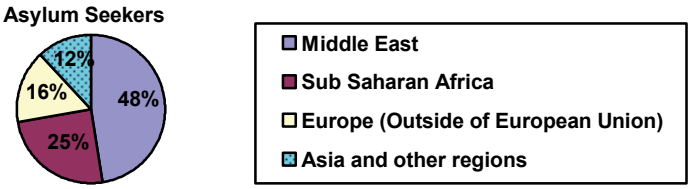
Among both undocumented migrants and tolerance holders, women were, on average, slightly younger than men, with an average age of 28.5 years old.

**With an average age of 30, and an age range between 18 and 53, the population interviewed was quite young, regardless of administrative status.**

## 2. REGION OF ORIGIN AND NATIONALITY

### ASYLUM SEEKERS

4. Regions of origin of the asylum seekers interviewed (%)




**The asylum seekers interviewed came from four main regions: Middle East (48%), Sub-Saharan Africa (25%), non-EU European countries (16%), and Asia (9%)**. One respondent was from Venezuela.

**Middle East (n=29)**: Among the respondents from Middle Eastern countries, more than half were Afghans. This was the most common nationality among the asylum seekers in our sample, representing one-quarter of respondents. Eurostat confirms that Afghans were indeed the biggest group of asylum seekers in Romania in the first quarter of 2010. In our sample, asylum seekers also included Iraqis (10%), Iranians (8%), Pakistanis (two respondents) and one respondent from Lebanon.[301]

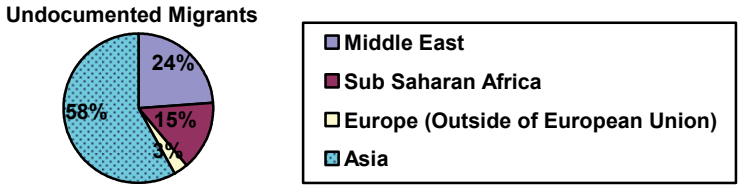
**Sub-Saharan Africa (n=15)**: In the group of Sub-Saharan Africans, eight nationalities were represented. The most common nationality was Ethiopian, with six respondents (10% of the asylum seekers). The others were from different regions of Africa that had also been affected by political and economic instability and/or war: Somalia, Nigeria, Sudan, Rwanda, Sierra Leone, Liberia and Kenya.

**Europe (n=10)**: Mainly Eastern European countries were represented, most of them sharing borders with Romania and former USSR countries. Ukrainians were the biggest nationality group among European nationals seeking asylum (five respondents, 8% of asylum seekers). The remaining asylum seekers came from four other European countries: two from Georgia, one from Moldavia, one from Armenia and one from Turkey.

**Asia and other regions (n=7)**: This group is essentially made up of asylum seekers from Asian countries: two respondents were from Bangladesh, two others were from China, one from India, and one from Sri Lanka. One other asylum seeker came from Venezuela.

### UNDOCUMENTED MIGRANTS (N=33)

5. Regions of origin of the undocumented migrants interviewed (%)




A comparison between the regions of origin of the asylum seekers and those of the undocumented migrants interviewed revealed significant differences[302].

**Asia (n=19)**: **The main region of origin of the undocumented migrants interviewed was Asia** (n=19; 58% of the undocumented migrants). Most were **Chinese** (39% of the undocumented

[301] For a more precise view of the nationalities represented among asylum seekers, see table 11 in appendix 2 in the part dedicated to Romania.
[302] For a more precise view of the nationalities represented among undocumented migrants, see table 12 in appendix 2 in the part dedicated to Romania

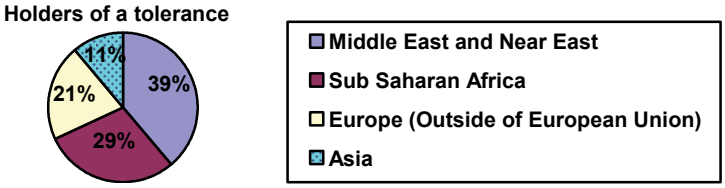
migrants interviewed; six men, and seven women). The other Asian countries represented were Bangladesh (two respondents), Taiwan (two respondents), India and the Philippines (one respondent from each country).

**Middle East (n=8):** Almost one-quarter of the undocumented migrants came from the Middle East, all of them from **Iraq**. Iraqis are the second biggest nationality group in the sample of undocumented migrants, after the Chinese. Only one Iraqi woman was interviewed.

**Sub-Saharan Africa and other (n=5)**: Five undocumented migrants from Sub-Saharan Africa came from Cameroon (two respondents), and Nigeria, Sierra Leone and Somalia (one respondent of each nationality). These nationalities are also represented among asylum seekers. Again, only one respondent was a woman. Finally, one male respondent was a Kurd with Turkish citizenship.

#### HOLDERS OF A TOLERANCE (N=28)

6. Regions of origin of the tolerance holders interviewed (%)



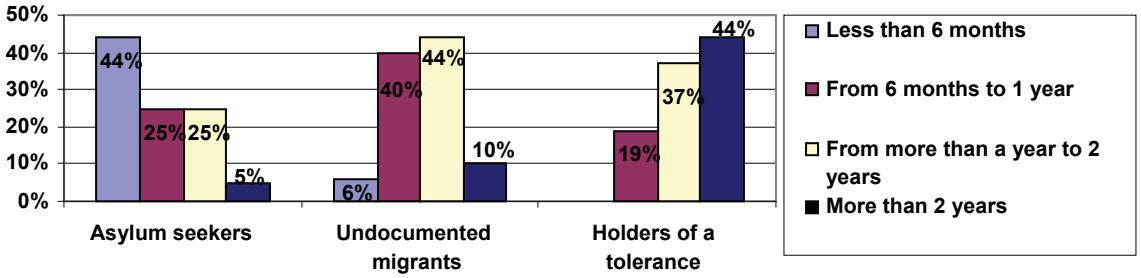

**Distribution by regions of origin for tolerance holders was similar to that observed for the asylum seekers interviewed, as holders of a tolerance were, for most, rejected denied asylum seekers**[303]. Indeed, Middle Eastern nationals were the most commonly represented (n=11; 39% of tolerance holders), the second most common region of origin was Sub-Saharan Africa (n=8; 29%), then European countries (n=6; 21%) and finally Asian countries (n=3; 11%).

Among the Middle Eastern nationals, most of the respondents came from Iraq (eight respondents) and two were from Iran. For the other regions, the distribution is very similar to that for asylum seekers.

# II. MIGRATION EXPERIENCE

## 1. TIME PERIOD SINCE ARRIVAL

7. Time period since migration, by administrative status (%)




**The asylum seekers interviewed had been living in Romania for 9 months on average** (including all journeys), but the range stretched from 1 month to 8 years. 44% of them arrived in Romania less than 6 months prior to the survey, and 70% one year prior or less.

[303] For a more precise view of the nationalities represented among respondents granted a tolerance, see table 13 in appendix 2 in the part dedicated to Romania

The asylum seekers respondents who had spent the longest time in Romania on average were the European and Asian nationals. The Middle Eastern and Sub-Saharan Africans had arrived on average respectively less than 7 months and less than 6 months prior to the survey.

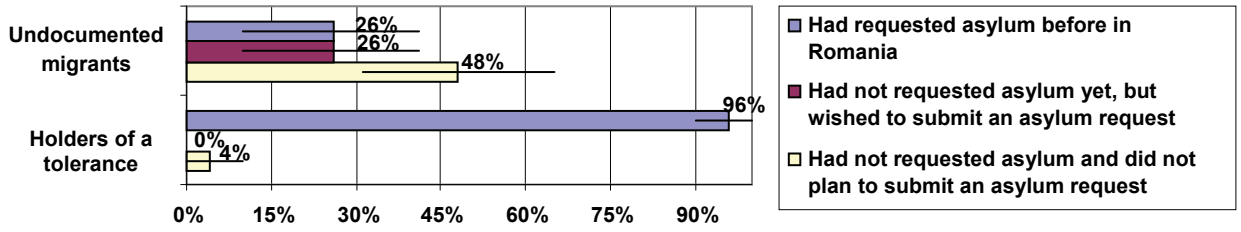
**On average, the undocumented migrants had been living in Romania for a little more than a year** (1.3 years), with no significant difference noted between regions of origin, sex or age. 84% of the undocumented migrants interviewed arrived in Romania six months to two years prior to the survey.

**Respondents with a tolerance** were naturally those who had been living in Romania the longest, as **all but one were in fact former asylum seekers** and therefore had been through the asylum procedure, been denied asylum, had applied for a tolerance and been issued it. **On average the tolerance holders interviewed had lived in Romania for almost three years** (range: one to seven years). 80% of the tolerance holders had been in Romania for more than a year.

**Whatever the administrative status, the respondents who had spent the longest time in Romania on average were the European and Asian nationals, which corresponds to the history of migration inflows in Romania.** The Middle Eastern and Sub-Saharan Africans had arrived more recently on average, as immigration to Romania from these regions is a more recent phenomenon.

## 2. FORMER ASYLUM SEEKERS

8. Asylum claim engaged or planned by the undocumented migrants and migrants with a tolerance (%)

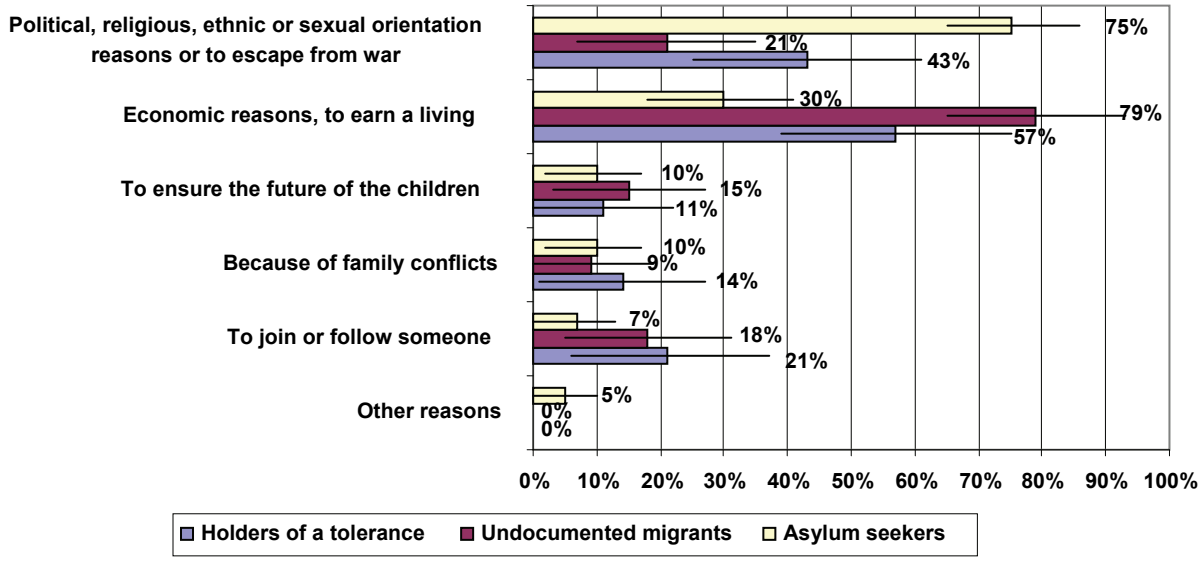



**All but one tolerance holders and 9 undocumented migrants interviewed were rejected asylum seekers**. **9 other undocumented migrants were planning to apply for asylum.**

Among the undocumented migrants interviewed, there is a link between the tendency to have had applied or to plan to apply for asylum and the region of origin and the reasons given for migrating linked to the general context in their country. Almost 40% of the respondents from Iraq had requested and been denied asylum, and one-quarter wanted to submit an asylum request. A large majority of respondents from Sub Saharan African countries (60%) had been through the asylum procedure but have been denied any form of protection. Respondents from Asia mostly replied that they had never made a claim for asylum and did not wish to do so (58%).

## 3. REASONS FOR MIGRATION

9. Reasons given for migration, by administrative status (%)




* The percentages exceed 100% because this was a multiple choice question.

**Three-quarters of the asylum seekers interviewed explained that they had migrated to escape persecution for political or religious reasons or for reasons of ethnic origin, or sexual orientation, or to escape from war**.

The other main reason cited was economic or the need to earn a living, given by 30% of the respondents. For most of them, however, this reason came in addition to other reasons (i.e. for 73% it was not the only reason cited): they also explained that they had fled their country to escape persecution for political or religious reasons or reasons of ethnic origin or sexual orientation, or to escape from war; or because they wanted to ensure a decent future for their children.

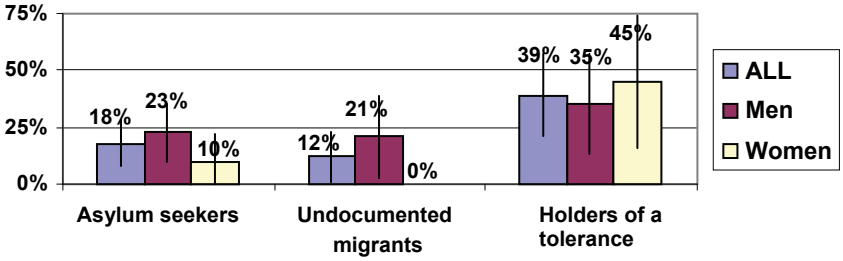
Another 10% explained they had fled family conflicts. 7% joined or followed someone else. None of these reasons were given as the sole reason for leaving their countries**. It is of particular interest that none of the respondents claimed to have migrated for health reasons.**

**Most of the undocumented migrants interviewed explained that they had migrated for economic reasons, or to be able to earn a living** (79%). **A further 21% of the respondents explained they that they had migrated to escape persecution for political or religious reasons or reasons of ethnic origin or sexual orientation, or to escape from war**, and all of them came from Iraq.

The **respondents with a tolerance** were more likely to say that they had **fled political or religious persecution or persecution due to their ethnic origin or sexual orientation, or to escape from war** (43%, both men and women). **Migration for economic reasons was again the most common response**, given by 57% of the respondents. However, as in the case of the asylum seekers interviewed, this particular reason was usually not the only reason given. All regions of origin considered, 21% of the holder of a tolerance explained that they came, among other reasons, to join or follow someone else (this may refer to family reunion). And 14% claimed they had left their countries because of a family conflict: this concerned slightly more women (18%) than men (12%).

## 4. EXPERIENCE OF DETENTION AND FEAR

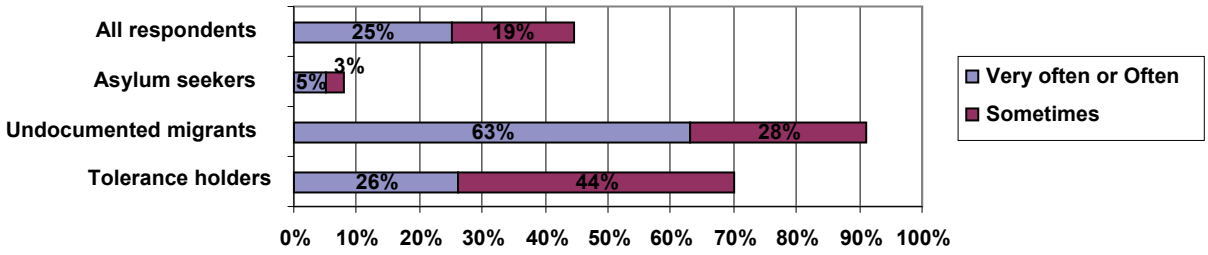
10. Percentage of the respondents who had been held in a detention centre in Romania, by administrative status (%)




**18% of the asylum seekers, 12% of the undocumented migrants and almost 40% of tolerance holders had been held in detention in Romania**. The biggest group to have been held in detention was migrants with a tolerance. It was also notable that, generally speaking, Sub-Saharan African nationals were proportionally the most likely to have been held in detention, regardless of their administrative status.

The asylum seekers and former asylum seekers concerned might have spent only short periods of time in detention[304]: migrants, when put in detention, have 48 hours in which to file a claim for asylum. Those who do so are freed once the procedure is underway[305].

11. Tendency to limit activities for fear of the authorities, by administrative status (%)




**Almost half of the respondents stated that they limited their activities at least sometimes for fear of the authorities**. This tendency was clearly linked to administrative status: **undocumented migrants were far more likely to limit their activities**, 63% claimed to limit their activities frequently or very frequently. Sub-Saharan Africa nationals were the most likely to limit their activities.

**Overall, 70% of the tolerance holders and more than 90% of the undocumented migrants interviewed limited their activities at least sometimes**. A particularly alarming aspect of this finding is that the tendency to limit activities did not diminish the longer a person spent in Romania. For tolerance holders who are protected against expulsion by their status, there are probably two main reasons why such a very high percentage limited activities: fear of being caught working (as they are not authorised to work) and of losing their job. Tolerance holders are not authorised to leave a given territorial area without permission from the RIO, and thus, are limited in their activities and movements[306].

As for asylum seekers, 8% of the respondents limited their activities at least sometimes, in spite of the fact that they should feel protected by their status.

[304] No information was asked about the length of time spent in detention.
[305] According to RIO statistics published in the 2010 Annual Program of the European Refugee Fund, out of the 774 applications for asylum that were submitted from January to October 2010, 156 were submitted in the 2 detention centre of Arad and Otopeni, and 469 of the applicants were undocumented migrants.
[306] Tolerance is granted for a certain territorial area, hence the obligation of holders to inform and get permission from the RIO before travelling to another location. For instance, if a tolerance is for Bucharest, in order to travel elsewhere or have an activity in another city, permission must be obtained from the RIO in Bucharest.

**Such limitations on everyday life has are bound to have consequences on psychological health**, and **may lead to people avoiding public facilities, including health facilities**. This implies **delaying recourse to healthcare** in case of illness, and consulting a medical professional only as a last resort. The testimony of a young Chinese undocumented woman is quite revealing in this respect:

> *"I live in fear of being caught and removed from Romanian territory, every day (…) I feel very lonely and awful not being able to go to a doctor when I need to, without being so afraid…"*

# III. LIVING CONDITIONS IN ROMANIA

## 1. FAMILY AND SOCIAL NETWORKS

### ■ Family situation

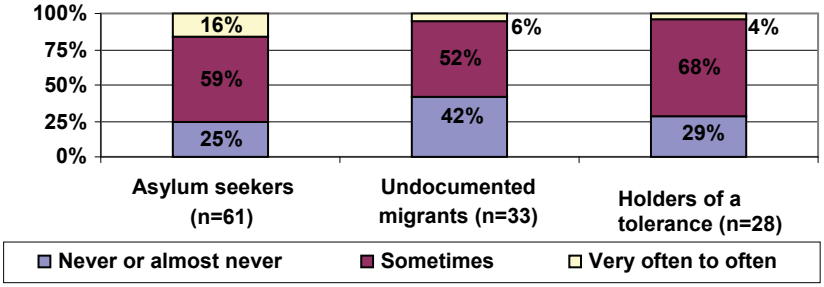
In our sample, a total of 40 respondents had children: 15 asylum seekers, 9 undocumented migrants, and 16 tolerance holders interviewed.

However, **more than half of the respondents lived apart from their children in Romania.** Whatever their administrative status, men were more likely to live apart from their children than women as it concerned the three-quarters of 20 fathers. No statistically significant differences can be established between the different administrative statuses, although in our sample, undocumented migrants were the most likely to live apart from their children (70% of those undocumented migrants who were parents).

It should be emphasized that whatever the status of the respondents, the tendency to live (and thus, for some parents, to have migrated with their children) can be linked to the context in the country of origin and/or to the reasons for migration. The vast majority of our respondents from Middle Eastern countries came with their children: they usually came to escape from war and persecution; all but one of the parents from African countries were living apart from their children, and the same is true for the parents from Asian countries[307]. **Separation from the family, especially from children, can be a factor seriously affecting a person's psychological and may lead to social isolation**.

### ■ Access to emotional support

12. Frequency of emotional support when needed, by administrative status (%)



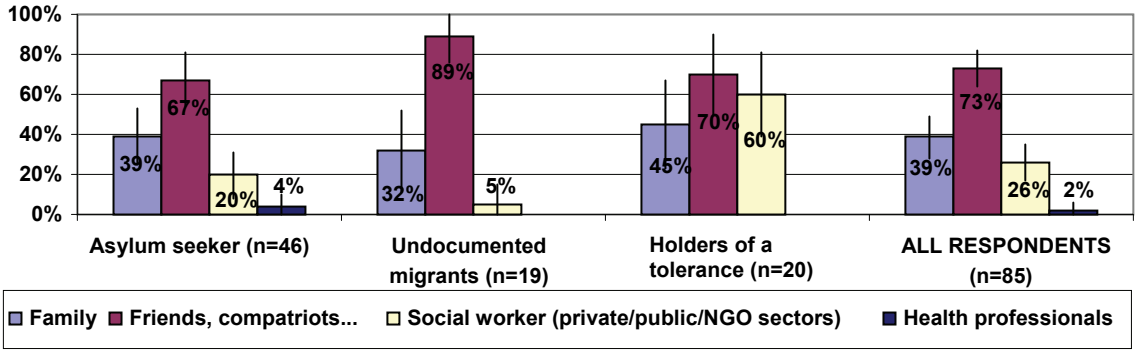

**A large proportion of our respondents** – a quarter of the asylum seekers, almost 30% of the tolerance holders and up to 42% of the undocumented migrants – **stated that in Romania they could never, or almost never, count on emotional support.** The **undocumented migrants** interviewed were more likely to suffer from this social isolation. This is no doubt at least partly due to

[307] However, the limited number of respondents per region of origin does not allow to come to significant conclusion (14 parents respondent from Middle Eastern countries; 10 for Sub-Saharan African countries; 9 from European countries and 7 from Asian countries)

the tendency to limit their activities for fear of the authorities, as this probably contributes towards keeping their social network and social interactions down to a minimum. Furthermore, **there is a clear link between the fact of migrating with family and children and suffering from social isolation: not only is the family often the main provider of emotional support, but the presence of children also helps people to develop social networks.** The fact of living longer in Romania does not seem to lead to more access to emotional support.

**A clear correlation exists between social isolation and a higher risk of disease** (not only on mental health conditions). We also know that social isolation, weak networks and poor social support are factors in people's estrangement from the health system and in their limited access to health services.[308]

13. Type of person providing emotional support when needed among the respondents who declared they could count on such support, by administrative status (%)*




*The percentages exceed 100% because this was a multiple choice question.

Friends, compatriots and family are the most commonly mentioned providers of emotional support. Help from family members is more likely to be provided very often or often than help provided by friends or compatriots.

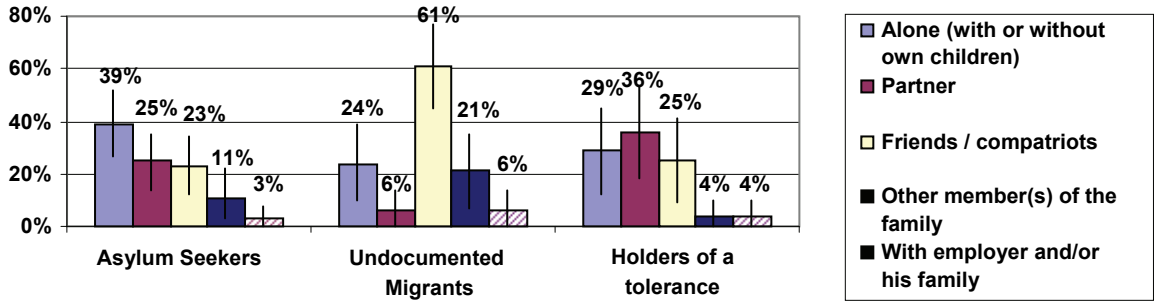
**20% of the asylum seekers said they could confide in social workers for emotional help** (but only sometimes). 60% of the tolerance holders interviewed also said they confided in social workers. This very high percentage may be due to the fact that a large proportion of the tolerance holders interviewed were living in a shelter run by the NGO JRS where they had access to social workers. Recourse to social workers was very limited for undocumented migrants (only 5%). They may be less informed of the possibility of obtaining such help and/or more afraid and reluctant to confide in social workers.

**Recourse to healthcare professionals, including mental health professionals, for emotional support seems to have been very marginal**. Only two asylum seekers claimed to have had recourse to this kind of help, and not on a regular basis.

[308] On this subject see the recent study carried out among undocumented migrants in Milan; Devillanova C. (2008), *op. cit.*

## 2. HOUSING CONDITIONS

14. Sharing accommodation, by administrative status (%)*

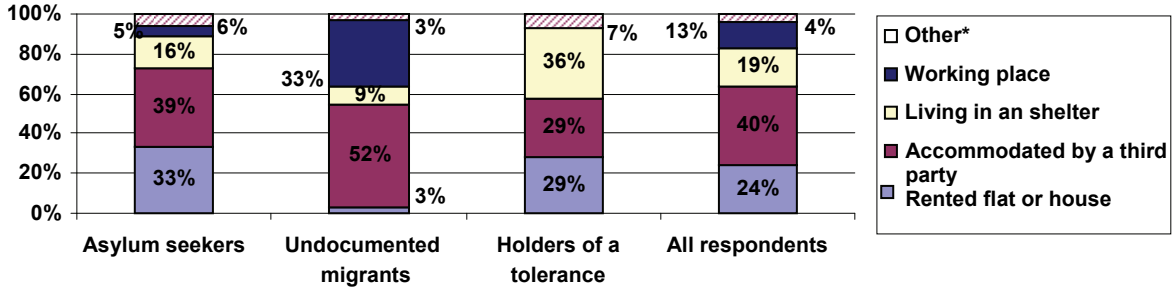



*The percentages exceed 100% because this was a multiple choice question.
* For holders of a tolerance, the category 'other' refers to living with other holders of a tolerance in a shelter accommodating tolerance holders run by JRS

**The most common situation for the asylum seekers and tolerance holders interviewed was either to be living alone or with their nuclear family** (partner and children): more than half of them were concerned. Men were more likely to live alone or with their children (i.e without a partner), whereas female respondents were more likely to live with their partner and children, if they had children. Sharing accommodation with friends and compatriots, with other family members, or in the case of tolerance holders with fellow tolerance holders, was also very common.

**The most common situation for undocumented migrants was to share their accommodation with friends or compatriots** (61%), and/or with members of their extended family (21%). Only 6% lived with a partner and only 24% (n=8; 7 men) lived alone.

15. Type of accommodation, by administrative status (%)



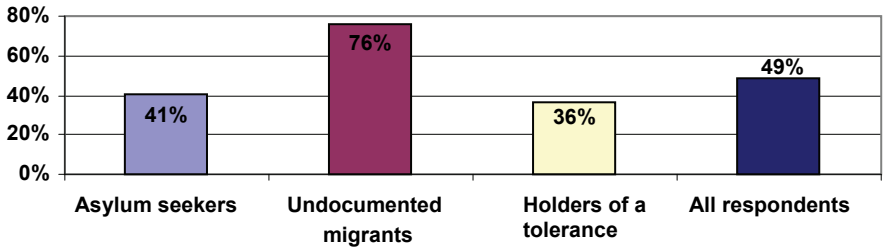

* Among 'Other': 3 respondents were sleeping in very difficult conditions (sleeping rough or in squat)

With regard to the type of accommodation occupied, the most **common situation was for respondents to be lodged by a third party, such as a friend or a family member** (40%). The situation was slightly different for holders of a tolerance as a proportion of them were offered a place in the JRS shelter (36%).

While around 30% of asylum seekers and tolerance holders lived in a rented flat or house, this situation was very rare among undocumented migrants (3%). Those undocumented migrants who were not lodged by a friend or family were most often accommodated by their employer. This was the case of most of the women domestic workers and for men working as construction workers, who were housed in shelters provided by the employer.

It should also be noted that **three male respondents were living in extremely harsh conditions**: two were living in abandoned premises and one asylum seeker was sleeping rough. In general, male respondents were significantly more likely to live in insecure accommodation than women: 26% lived in a shelter or a hotel, 12% were accommodated by their employer near their construction sites or at the farm they worked in. Among the women, 7% were also living in an organisation, a shelter or a squat.

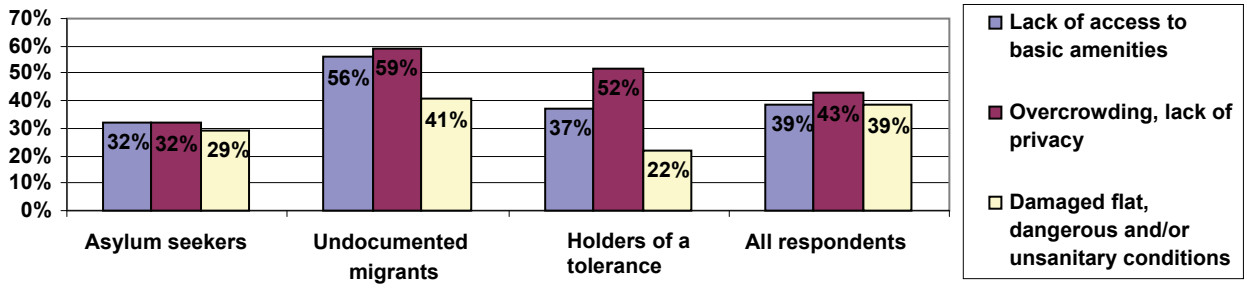
16. Proportion of respondents who felt their accommodation status was insecure, by administrative status (%)




In total, **almost half of the respondents felt their current accommodation was only a short term and insecure solution.** Undocumented migrants were the most affected, but a high percentage of the asylum seekers interviewed also said they felt insecure about their accommodation. In their case, this feeling might also be linked to uncertainty about their status, i.e. they felt insecure about their accommodation because they were waiting the outcome of their asylum application. Those who were accommodated with family, living in shelters or hotels, in squats or sleeping rough were most likely to consider their accommodation status to be insecure. However, a further quarter of the respondents renting their accommodation still felt that their situation was insecure.

The status of accommodation was seen to be remarkably poor: **97% of the respondents said they had at least one problem with their accommodation that could potentially affect their health.**

17. Types of problems encountered with accommodation, by administrative status(%)




The numerous problems cited have been arranged into 3 categories to make their analysis easier: overcrowding and lack of privacy; lack of access to basic amenities (water, electricity, central heating, etc.); and insanitary and dangerous conditions. Most of the respondents cited several problems in the same category, but the problems were only counted once if they referred to a same category.

**The respondents all described disgraceful housing conditions**, whatever their administrative status and whatever the type of accommodation:

**- Problems of overcrowding and lack of privacy** were the most frequently cited: affecting 43% of the respondents.

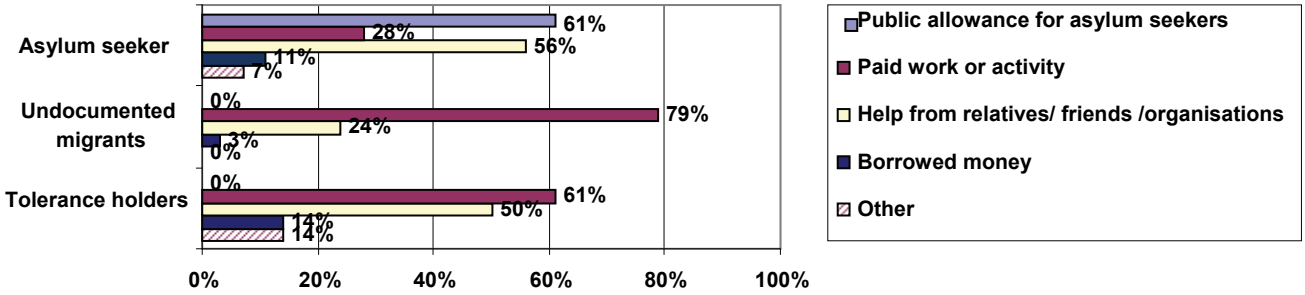
**- Almost 40% of the respondents said they suffered from the absence of basic amenities**, especially undocumented migrants (56%), but also 37% of tolerance holders and 32% of the asylum seekers interviewed. 21% of all the respondents had no central heating and suffered from the cold; 11% had no access to functioning toilets or a washroom; 7% declared their accommodation was not properly ventilated; 6% had no windows and 3% had no access to running water. Accommodation provided by employers, mostly undocumented migrants, was seen to be indecent, with little or no access to basic amenities.

- Also, almost **40% of the respondents described serious degradation of their accommodation and unsanitary and/or dangerous conditions**: 22% explained their accommodation was damp and degraded; 14% felt they lived in a dangerous environment due to faulty electrical fittings, and 3% said their accommodation was infested with pests and vermin.

# 3. SOURCES OF INCOME AND WORKING CONDITIONS

## ■ Sources of income

18. Sources of income, by administrative status (%)*




* The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of respondents.

**Asylum seekers** are legally entitled to receive social benefits**. The amount of these welfare payments has not exceeded 108 leï per person and per month since 2004, i.e. approximately €25**, **and thus is extremely difficult to live on**, in particular for people living outside of a reception centre. Among the interviewees, **61% of the asylum seekers interviewed were dependant on this public allowance**, although most of them (90%) had an additional source of income, generally help from friends, relatives or organisations. 28% of the asylum seekers worked, and for most of them, their salary was their only source of income. By law, asylum seekers are allowed to work one year after their application.

**Almost 80% of the undocumented migrants and 61% of the tolerance holders worked** to earn a living. The tendency to work increased the longer they had been in Romania: for example on average, working undocumented migrants had been living in the country for almost a 1 ½ years (against less than a year for those who depended on another source of income). Both men and women worked, with no significant differences. Altogether, half of the respondents with a tolerance depended on the help of relatives, friends or organisations to obtain a minimum income, against one-quarter of the undocumented migrants interviewed. Neither undocumented migrants nor holders of a tolerance are allowed to work in Romania, and thus are forced to work illegally to earn a living.

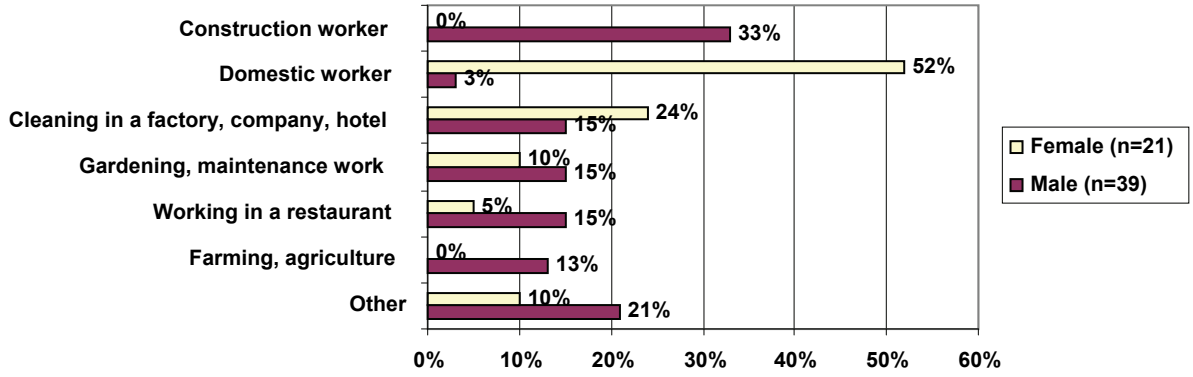
## ■ Sector of activities

**In total, 60 respondents were working at the time of the interview**: 17 asylum seekers, 26 undocumented migrants and 17 tolerance holders. The analysis in this section covers all working respondents, and no distinction was made between the different administrative statuses, unless specifically relevant.

**The migrants interviewed all worked in low-skilled sectors of activity**, both men and women and regardless of their administrative status. **Most did not have the right to work and so had to work illegally and were unable to benefit from social protection or medical insurance**.

The sectors of activities in which the respondents worked differed according to their sex.

19. Sectors of activity in which the respondents were working (n=60), by sex (%)*




*The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of workers.

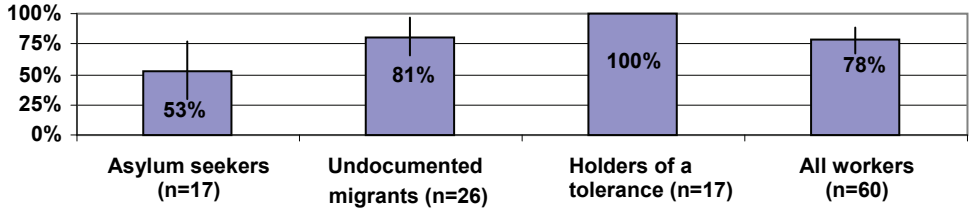
**Whatever their status, women worked mainly as domestic workers in private households (52%) or were cleaners in factories (24%).**

**Men were mostly employed as construction workers** (33%). They also worked as cleaners in companies (15%), did maintenance work and gardening (15%) or worked in restaurants (15%). 13% worked in farming and agriculture. The fact that most of this latter group was made up of asylum seekers could be due to the fact that some interviews with asylum seekers were held in a rural region where most of the demand for labour is seasonal farm work.

Some of the respondents worked in informal sectors of activity ('other' category), selling goods in the streets or in a market place (12%), begging in the street (one respondent), or as sex workers (one respondent).

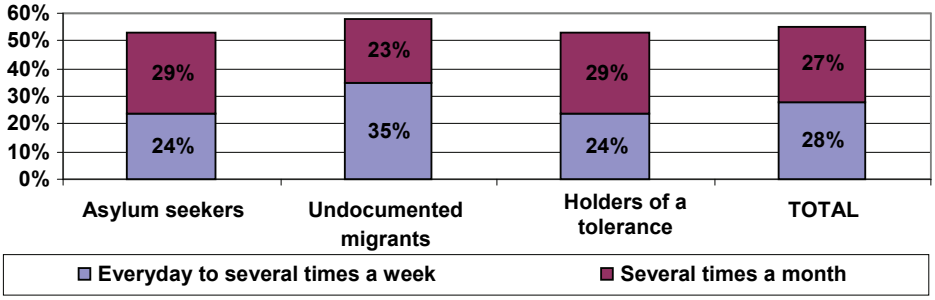
## ■ Working conditions

20. Proportion of working respondents in an unstable work situation (n=60), by administrative status (%)




**78% of respondents worked in unstable jobs and said they didn't have work all the time, leaving them in precarious situations**. This situation concerned 53% of the working asylum seekers, increased to 81% for undocumented migrants and affected all the tolerance holders interviewed. This phenomenon concerned all the sectors of activities in which the respondents worked and thus affected both men and women. It should be noted that those respondents who had been in Romania the longest did not benefit from a more stable work situation.

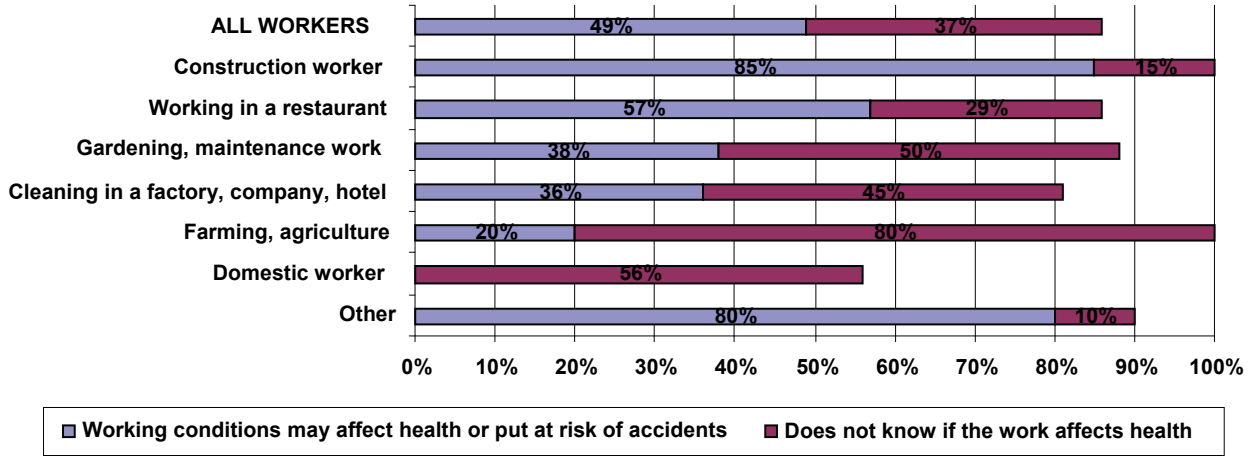
21. Proportion of the workers (n=60) working more than 10 hours daily on a regular basis, by administrative status (%)



**The working conditions described by the respondents were quite worrying**: 55% claimed to be working more then 10 hours a day on a regular basis. **Almost one in three workers in our sample stated that they worked 10 hours a day everyday to several times a week**. Undocumented migrants were the most affected by long working hours.

Construction workers were the worst affected by these difficult working conditions: 92% of them said they worked more than 10 hours a day at least several times a month, and half of them said they worked more than 10 hours a day everyday to several times a week. Similar proportions were noted among those working in restaurants. **These extreme working conditions can lead to a potential increase in accidents at work, and in exposure to occupational diseases**, **and have serious consequences on health,** particularly in sectors of activity with dangerous working conditions, such as construction (exposure to chemicals, manipulation of dangerous machinery, etc…).

22. Proportion of the workers who felt their work could affect their health or put them at risk of work accidents, by sectors of activity (%)




Respondents working in sectors of activities with difficult working conditions were the most likely to consider that their work could adversely affect their health or put them at risk of work accidents: 85% of construction workers said their work was dangerous. The analysis also revealed a statistically significant link between the fact of working long hours and considering work potentially dangerous for health and safety.

Altogether, **almost half of working respondents considered that their work may affect or have affected their health and put them at risk of work accidents**. Such a high proportion reveals the vulnerability of the migrants interviewed, who do not benefit from any protection against exploitative working conditions. Exposure to such conditions over a long period of time and as people get older is sure to increase the potential consequences on health.

# IV. PERCEIVED HEALTH AND ACCESS TO HEALTHCARE

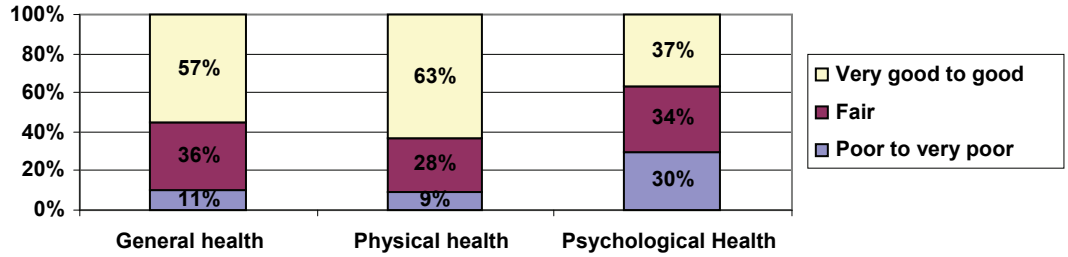
## 1. PERCEIVED HEALTH STATUS

The perceived health of a population is a subjective indicator, but most studies show a clear correlation (although not necessarily at individual level) between this indicator and medical indicators of health.[309]

### ■ Self perceived general, physical and psychological state of health

The perceived general and physical health conditions of the migrants interviewed did not vary significantly according to administrative status, thus the respondents are not considered separately in the following graphic.

23. Self-rated general, physical and psychological health statuses among respondents (%)




The majority of the respondents considered their general health to be good to very good (from 55% to 57% depending on their status). However, **a further 11% said they were in a poor to very poor state of general health**. The proportion of respondents who rated their general health negatively was **larger than for the general Romanian population in the age groups represented in our sample**: in 2008, less than 2% of Romanians under 45 considered their general health to be poor or very poor (and almost 90% rated their general health as good or very good)[310].

The way the respondents rated their physical health was close to the way they rated their general health. **There is a clear correlation between the way the respondents rated their physical health and how they perceived their housing and living conditions**. Indeed, those who felt their living conditions and accommodation status were good or very good also considered their health to be good or very good (in 94% of cases), and vice-versa.[311]

24. Self-rated physical health in relation to the perceived consequences of working conditions on health and safety, for working respondents (%)

| Physical Health / Working conditions | Very good to good | Fair | Poor to very poor | TOTAL |
|---|---|---|---|---|
| **Safety or health is not at risk** | 78% (7) | 22% ( 2) | 0% (0) | **100% (9)** |
| **Safety or health at risk** | 29% (8) | 54% (15) | 18% (5) | **100% (28)** |
| **Does not know** | **70% (14)** | **25% ( 5)** | **5% ( 1)** | **100% (20)** |

**We also observed a link between working conditions and self-rated health**: only 29% of working respondents who stated they considered their health was or could be at risk because of their working conditions said they were in a good or very good state of general health, against 78%

[309] Kaplan G.A, Goldberg D.E., Everson S.A et al. (1996), *op. cit.* ,25: 259-65; DeSalvo K.B, Bloser N., Reynolds K., He J., Muntner P. (2005), *op. cit.*
[310] For the perceived general health status of the Romanian population, see http://appsso.eurostat.ec.europa.eu/
[311] Refer to the table 14 in the appendix 2 in the part dedicated to Romania

of those who considered their working conditions to be safe. The same conclusions can be drawn when perceived physical health is measured against the more "objective" indicator of working hours: those who frequently work more than 10 hours a day are indeed more likely to feel to be in a poor or very poor state of physical health.

### ■ An alarming state of psychological health

**Respondents' rating of their psychological health is very alarming: respectively 26%, 39% and 23% of the asylum seekers, undocumented migrants and tolerance holders interviewed considered their emotional and psychological state of health to be poor or very poor**. Overall, only 37% of the respondents rated their psychological and emotional state of health as good or very good.

For some, the traumatic events experienced in their countries of origin or during migration (war, violence, being deprived of their rights, freedom or unable to satisfy their basic needs) may be a factor affecting mental health.

Life consequences related to the condition of migrant are also to be taken into consideration: being separated from family, and particularly from children, uncertainty about the future linked to their administrative status, and the lack of security and protection of their basics rights in Romania are also clear factors of this low self perception of psychological health. Precarious economic, housing and working conditions, as well as social isolation, also help explain the poor self-perception of psychological health.

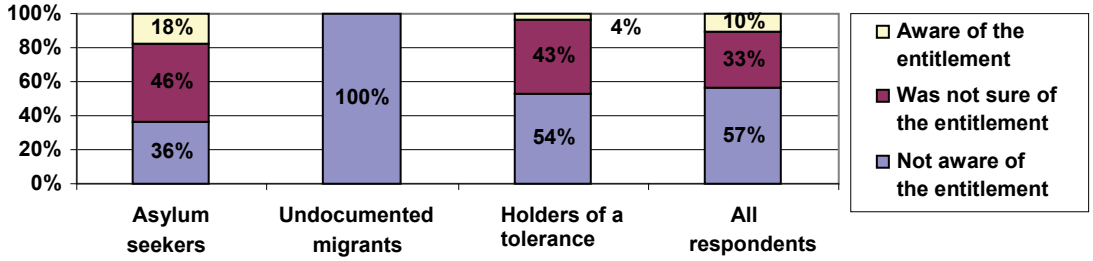
**There is a significant correlation between little or no emotional support and the poor self-perceived state of psychological health:** 36% of those in a poor state of psychological health claimed they could not count on anyone for emotional support in Romania. It is to be reminded the poor access to health professionals pointed out above in the results.

The low perceived state of psychological health can be a factor to lower the way the respondents rated their general health: it has been demonstrated that a correlation exist between the psychological condition and the general health condition.

## 2. ENTITLEMENTS TO HEALTH COVERAGE

### ■ Knowledge of rights to health coverage

25. Level of knowledge of the entitlement to health coverage, by administrative status (%)




**Only a very low proportion (10%) of the respondents was aware of their entitlements to health coverage in Romania**.

For all of them, the lack of information was a serious issue. **More than one asylum seeker in three did not know that they could access healthcare free of charge if they depended on welfare or had very low income**. These results tend to show that, although guaranteed by law, effective access to health coverage, and thus to healthcare for all asylum seekers, is not ensured.

> *"They did not explain our rights to us when we arrived in Romania, I am lucky I can read, I am educated. But what does somebody do who can't read or speak Romanian or English and has no money, nothing?"* 40 year-old asylum seeker from Ukraine, living on welfare benefits

**All undocumented migrants and almost all holders of a tolerance (except one) were unaware that they were entitled to healthcare free of charge in case of emergency.**

**Furthermore, according to the respondents, there was a serious lack of knowledge on the part of the health professionals about their entitlements to health coverage**. Some respondents claimed that they had been asked to pay for their medical consultations even in case of serious health problems.

> *"They did not tell us anything about our rights to healthcare. I told them I had a medical problem, I've had it since the bombings in Iraq. I suffer from the effects of an explosion which causes me severe headaches and makes me faint. (…) We went to a hospital near where we lived. We did not know any words in Romanian, we tried English and I think they understood what the problem was, that we wanted a consultation. They looked strangely at our documents and they called what we think was a superior, or the administrator. They said we would have to pay for my consultation", 18 year-old* asylum Seeker, living on welfare benefits.

These results show that migrants can have lived in Romania for several years without getting access to information about their (relatively limited) rights to access healthcare.

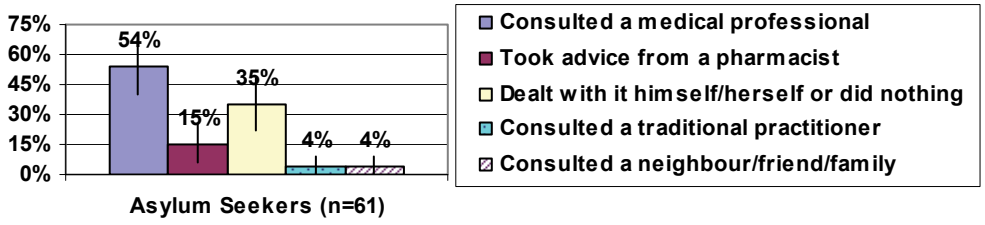
## 3. RECOURSE TO HEALTHCARE: THE ACTION TAKEN DURING THE MOST RECENT HEALTH PROBLEM

**This part of the report is a case study that focuses on respondents' experience the last time they were ill in Romania (no time limit).** In the following sections, some tendencies are linked to administrative status and therefore the findings are analysed in relation to status.

### ASYLUM SEEKERS

In our sample, nine asylum seekers (15%) stated that they had not suffered from any health problem that had merited a consultation since arriving in Romania. They have been excluded from the sample in this section, which only focuses on those asylum seekers who declared having a health problem (n= 52)

26. Action taken the last time the asylum seekers interviewed were ill (n=52) (%)*

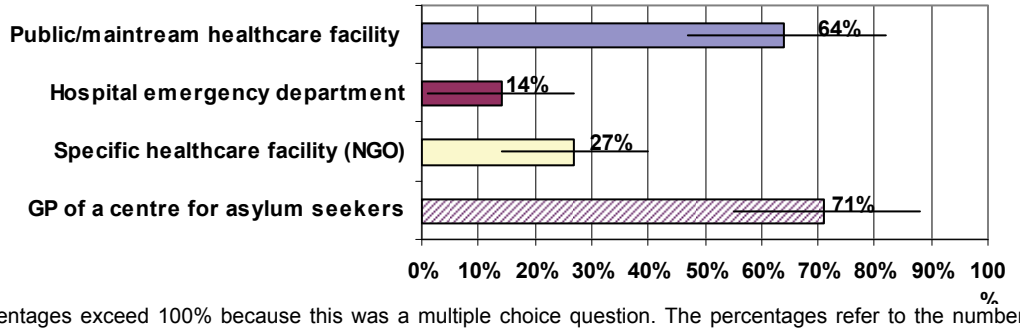



*The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of asylum seekers who declared they had a health problem that had merited a consultation since arriving in Romania.

**Although access to healthcare should be ensured for asylum seekers, only 54% of the asylum seekers interviewed actually consulted a health professional the last time they had a health problem**. The tendency to consult a doctor was slightly higher among women (67% against 47% for men).

The most common action taken by respondents who did not consult a medical professional the last time they were ill was to deal with the illness themselves (35%).

27. Medical facilities attended by the asylum seekers interviewed the last time they were ill in Romania (n=28), (%)*




*The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of asylum seekers who consulted a health professional.

**Most of the respondents consulted both a general practitioner from the centre for asylum seekers and a mainstream public facility, as asylum seekers need for a referral from the centre's doctor in order to gain access to mainstream facilities**. Almost 80% of those who first consulted the doctor from the centre then also consulted another facility.

28. Access to health coverage for the last medical consultation of asylum seekers who consulted a medical professional the last time they were ill (n=28), (%)

| Access to heath coverage | Nb. cit. |
|---|---|
| Paid for the medical consultation | 5 |
| Obtained access to health coverage | 23 |
| All asylum seekers | 28 |

Among those who consulted a medical professional, **5 asylum seekers did not obtain access to the health coverage they were entitled to and had to pay for their consultation**. In the end, 20% of the asylum seekers who consulted at a public healthcare facility were asked to pay for their consultation.

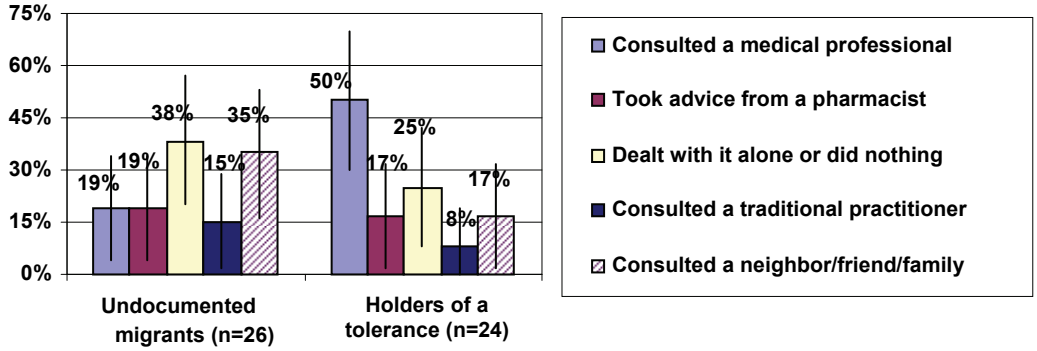
The fact that some asylum seekers did not consult a medical professional can indeed, partly and among other reasons, be linked to asylum seekers' lack of knowledge of their entitlements to access healthcare free of charge in the public health system, as well as to the fact that health professionals may ask them to pay for consultations:

> *"Of course I had medical problems, who doesn't? When I did, I did not go to the doctor. Why go? I do not have money for a consultation or for a little attention. I know it's dangerous, but I took care of myself searching the internet and getting medicines. When I have the money I will go to get a complete examination but for now, I do not have money and I treat myself. "40 year-old* asylum seeker from Ukraine, living in Romania for 3 years and dependent on welfare benefits.

## UNDOCUMENTED MIGRANTS AND TOLERANCE HOLDERS

Only those who declared they had had a health problem that they considered merited a medical consultation since arriving in Romania were taken into account in this section, i.e. 26 undocumented migrants and 24 tolerance holders.

29. Actions taken the last time the undocumented migrants and holders of a tolerance interviewed were ill (n=50), by administrative status (%)*




*The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of undocumented migrants and tolerance holders who consulted a health professional.

## Undocumented Migrants

**Less than 20% of the undocumented migrants in our sample consulted a medical professional the last time they were ill, which appears particularly worrying.** The most common reaction was to deal with the situation themselves without consulting anyone (38% of them) or to consult a neighbor or a friend (35% of them).

**This analysis reveals the existence of major barriers preventing undocumented migrants from accessing healthcare**. Part of the explanation for this can be found in the fact that, in Romania**, health professionals and healthcare facilities' administrative services are legally required to report undocumented migrants when it is considered they are facilitating their stay, or they may be charged with facilitating their stay**. The consequences of this dangerous legal obligation for undocumented migrants' access to healthcare and for the practices of health professional can be seen in the findings of this study. Some testimonies show that **the health professionals consulted by undocumented migrants could face a dilemma: whether to treat the person according to their medical ethics and human values, or to deny them a consultation (to avoid taking risks with the law), or to report them (according to the law)**.

> *"Last month, I felt so sick after a heavy cold, and eventually I gathered the strength to go to the doctor. (…) While she was checking me, she started asking all these questions, and I realized she suspected my being illegal. She said she believed my condition to be pneumonia, thus the treatment was going to be rather expensive, I had to stay indoors, in bed, I was not allowed to work". [The doctor also suggested that the patient go see a specialist and possibly call an ambulance and stay in hospital for a few days if the situation became worse. The patient explained she could not afford expensive treatment, or to get insurance and go to the hospital.]. "She looked at me and I understood she knew my situation. She asked if I gave her assistant my ID for a copy; when I said no, she told me she should normally call the police if I don't have the right to stay in Romania, otherwise she could be in trouble. I started crying (…).Then she went out for a few seconds and talked to the assistant in reception. That young lady went out and came back in 5 minutes, with a bag of medicines (…)". [The respondent said that those were the longest 5 minutes in her life; because she was sure the police would be arriving at any minute to arrest and deport her. She could only think that she would never see her daughter again.] "The doctor was nice and I was lucky. She paid for the medicines herself, but as I was leaving the office, she told me to not come to her again because I would get her in trouble",* 32 year-old undocumented migrant from the Philippines, living in Romania for 3 years.

The testimony above describes an emergency situation in which the doctor chose to treat the person free of charge, and asked him not to come back. Among the five respondents who consulted a medical professional, two others did not have to pay for their consultation, which might also have been the doctor's personal decision.

**Holders of a tolerance**

The actions taken by **tolerance holders** were closer to those taken by the asylum seekers[312] **: only half of them consulted a medical professional the last time they felt ill (12 respondents)**.

**6 tolerance holders did nothing or dealt with the illness themselves the last time they were ill**, 3 consulted a pharmacist and 3 took advice from a non-health professional – a friend, a neighbour or family member.

Among the 12 tolerance holders who consulted a medical professional the last time they were ill, half consulted at least at two medical facilities. Most combined a consultation at a specific healthcare facility[313] for migrants with one at a public healthcare facility. This was either because they were advised to do so or because it was cheaper for them to consult at this type of facility. However, **11 of the 12 tolerance holders who consulted a medical professional had to pay for their consultation**.

**ALL RESPONDENTS**

**Whether for asylum seekers, undocumented migrants or tolerance holders, access to healthcare was clearly a highly problematic issue, as too few consulted a medical professional the last time they felt ill, whatever their administrative statuses**.

## 4. DIFFICULTIES AND BARRIERS IN ACCESSING HEALTHCARE AND THE REFUSALS

This section does not only concern the barriers faced by the respondents the last time they felt ill, but refers to all the experiences they may have had when trying to access healthcare in Romania in the past year or since they arrived (if they have been in the country for less than a year). Each respondent may have had several experiences. Consequently, the results of this section are not to be crossed with the results of the previous section (case study about the last time they were ill); they are intended to complement the findings already presented.

### ■ The difficulties and barriers in accessing healthcare

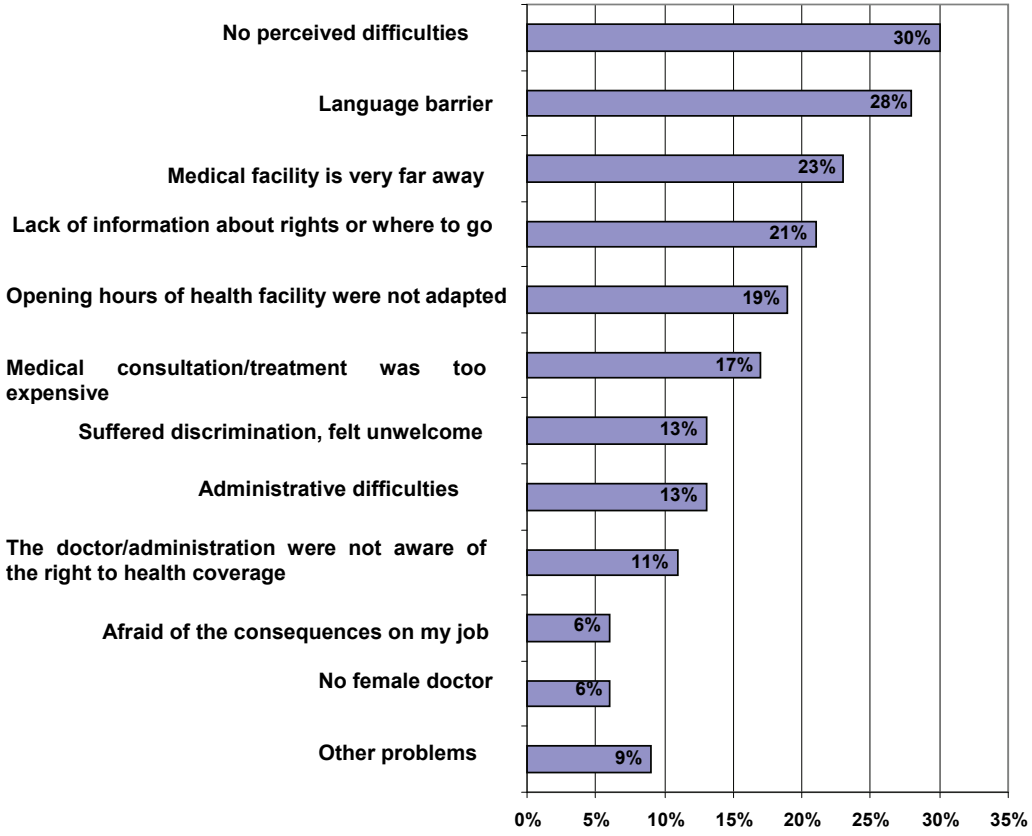
**ASYLUM SEEKERS**

Eight asylum seekers said that they had not tried to access healthcare in the past year (or since their arrival in Romania), and so were excluded from the sample in this section. The percentages given refer to 53 of the asylum seekers interviewed.

[312] NB: almost all of the tolerance holders are former asylum seekers, and some situations may refer to the time when these respondents were asylum seekers.

[313] The migrants who said they had consulted a specific healthcare facility were probably referring to the medical facility run by the NGO, ICAR. It should be borne in mind that one of the ways of targeting the respondents for this survey was through an interviewer who is also a volunteer at ICAR. The fact that a large proportion of tolerance holders consulted this facility might therefore be considered as resulting from a selection bias.

30. Difficulties encountered by the asylum seekers interviewed when trying to access healthcare in Romania in the past year or since arrival (n=53) (%)*




*The percentages exceed 100% because this was a multiple choice question.

**70% of the asylum seekers interviewed who had tried to access healthcare in the past year reported that they had faced at least one difficulty in attempting to do so**, and 53% said they had encountered several problems.

**The most frequently mentioned difficulty was the language barrier**. Almost three out of ten respondents (28%) encountered a problem here. The asylum seekers had a hard time being understood by the health professionals and/or understanding a diagnosis and the procedures to follow after a medical examination. Since, on average, the asylum seekers interviewed had not been living in Romania for very long, they probably had little knowledge of the language. **This analysis clearly reveals the need for translation and mediation services for asylum seekers when accessing healthcare**.

**21% of the asylum seekers, men and women, said they lacked sufficient information about their rights**. This particular problem was also highlighted previously in the section dealing with the actions taken by asylum seekers the last time they were ill. **Administrative difficulties and health professionals who were unaware of their entitlements to healthcare free of charge** were also quoted respectively by 13% and 11% of the respondents. 17% of the asylum seekers interviewed considered the cost of healthcare was a barrier preventing them from accessing healthcare, which can again be linked to a **lack of information on the part of all the protagonists, patients and health providers**. **And 13% also explained that they felt discriminated against** when they tried to access healthcare in Romania.

**Difficulty in getting to the medical facility was also a common problem**: 23% of the asylum seekers considered that the medical facility they were referred to was too far away. It should be borne in mind that the asylum seekers interviewed mostly lived outside of the centres for asylum seekers but still had to refer to the centre's doctor for healthcare or for a referral elsewhere. This difficulty was usually coupled with that of the impractical opening hours of the health facilities. This could be due to the fact that the doctors in reception centres are not full-time employees and only

work there for a few hours a day and on certain days of the week. It is also partly linked to a lack of information on where to go.

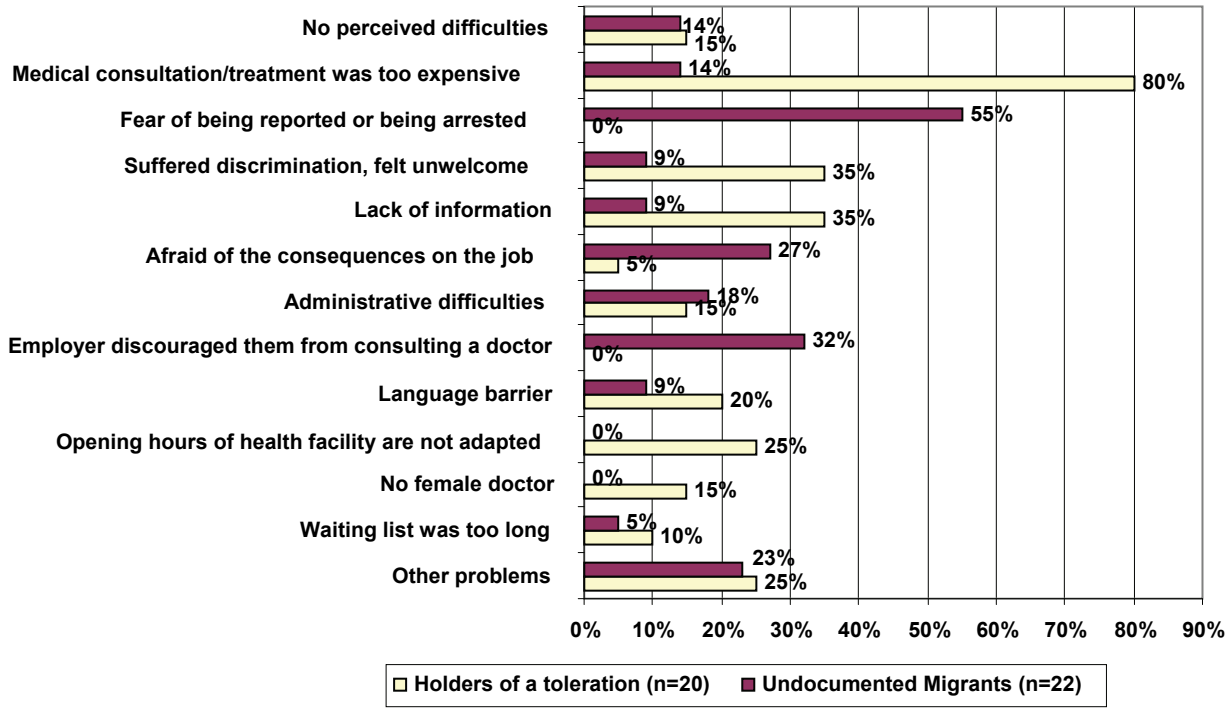
> *"There is no GP in the Centre, so you have to go all the way to Somcuta for nothing, then the nurse sends you back to Baia Mare to see a GP. For a sick person, it is difficult to travel all that way for nothing."* 22 year-old asylum seeker from Ukraine, living in Romania for 3 months

**Healthcare refusals:** It is quite noticeable and alarming that more than **7%, of the asylum seekers interviewed (n=4) claimed to have been refused access to healthcare when they tried**. This finding not only illustrates serious discrimination and questionable practices on the part of health professionals and/or the administrative services of healthcare facilities who refuse access to healthcare to patients, but it also proves, once again, that there is a serious lack of information among health professional with regard to asylum seekers's rights to access healthcare.

### UNDOCUMENTED MIGRANTS AND TOLERANCE HOLDERS

Eleven of the undocumented migrants and eight of the tolerance holders interviewed said they had not tried to access healthcare during the past year spent in Romania (or since arrival). They were therefore excluded from the following graph (n=22 for undocumented migrants and n=20 for tolerance holders).

31. Difficulties faced by undocumented migrants and tolerance holders in accessing healthcare in the past year (n=42) (%)*




*The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of undocumented migrants (22) and holders of a tolerance (20) interviewed.

**More than 85% of both undocumented migrants and tolerance holders who tried to access healthcare had encountered difficulties and barriers in the past year** (or since their arrival if the respondent had been in Romania for less than a year). Most mentioned several difficulties.

**The main and very significant barrier preventing undocumented migrants from accessing healthcare, was fear of being reported to the authorities or being arrested: it affected 55 % of the respondents**.

**The second most frequently mentioned difficulty was connected to work**: almost one-third of the respondents explained that their employers discouraged them from going to the doctor, and 27% said they were afraid to consult a doctor because of the consequences it might have on their job. These difficulties most probably prevented working respondents from accessing or having recourse to healthcare and confirms that they are denied the most basic rights as workers. **They are related to the lack of protection of undocumented migrants with regard to their working conditions**, as was highlighted earlier on in this report.

**Administrative difficulties at the health facility (4 respondents), discriminatory practices and behavior (2 respondents) and the language barrier (2 respondents) were also cited.** Surprisingly, the cost of care was cited by only 3 undocumented respondents. These findings lead us to the conclusion that **the difficulties encountered by undocumented migrants are barriers preventing them from attempting to access healthcare rather than difficulties encountered when actually accessing healthcare**.

**For holders of a tolerance**, **the cost of healthcare clearly stood out as the main and most widely-shared difficulty**: 80% of the respondents said that the costs of the medical consultation and treatment were too high for them, as they were not entitled to any health coverage.

7 tolerance holders also suffered from a **lack of proper information about their rights** and existing health facilities. Another 7 explained they encountered **discriminatory practices** and behavior. 4 encountered a language barrier and 2 encountered administrative difficulties.

**In conclusion, major barriers and difficulties exist for both undocumented migrants and tolerance holders. The situation of the undocumented migrants, as illustrated in these testimonies, is particularly worrying as the difficulties faced are clearly barriers that prevent them from even attempting to access healthcare.**

## ■ Abandoning healthcare and refusals

### UNDOCUMENTED MIGRANTS

Remarkably, almost **half (n=15) of all the undocumented migrants interviewed stated that they had given up on healthcare** because of their administrative status at least once since being in Romania One explained:

> *"When I had a visa, the main problem was the high cost of the treatment. Now, since I no longer have a permit to stay, I am mostly afraid of being deported, so I would not seek treatment in a public facility again."* 29 year-old undocumented woman from China, living in Romania for 2 years

32. Type of treatment given up on by those undocumented migrants who had given up on healthcare (%)*

| Kind of treatment given up on | Nb. cit. |
|---|---|
| Medical check up or medical treatment | 11 |
| Laboratory analyses, blood test, MRI or radiology | 8 |
| Dental care | 5 |
| Vaccinations | 2 |
| Pharmacy, drugs | 2 |
| Mental health or psychological treatment | 1 |
| Other treatment or unknown | 1 |
| TOTAL OBS. | 15 |

*The percentages exceed 100% because this was a multiple choice question. The percentages refer to the number of undocumented migrants who said thet had given up on healthcare at some point in Romania.

Almost three-quarters of the undocumented migrants who had given up on healthcare had at least given up on medical check ups. Usually, respondents had in fact given up on a various types of medical care, including laboratory analyses, blood tests, MRI or radiology and dental care.

These results are even more worrying as **four of the undocumented migrants interviewed claimed that they had been refused access to healthcare in Romania by health professionals**

**and/or administrations**. If we only take into consideration those respondents in our sample who had tried to access healthcare (n=22), the proportion is **18% of the undocumented migrants**.

> *"Not only did the doctor refuse to receive me, although I told them I would pay, but I was also threatened with being reported when I tried to seek medical care." 30 year-old* undocumented man from China, living in Romania for more than a year

**HOLDERS OF A TOLERANCE**

**Four tolerance holders explained that they had given up on medical check ups, laboratory analyses and/or dental care (14%).**

**Five tolerance holders claimed they had been refused access to healthcare**. Although the sample is too small to draw significant conclusions, the fact remains that this was an extremely high proportion: **25% of the tolerance holders who tried to access healthcare (n=20) were denied care**.

**ALL RESPONDENTS**

**For all our respondents the experience of being denied access to healthcare discouraged them from seeking further access to healthcare. Indeed, those who had been refused access were significantly more likely to give up on healthcare**: almost half of those who had been refused access to healthcare gave up on seeking healthcare, whereas 83% of those who had never been refused access to healthcare never gave up on any type of healthcare.

# V. ACCESS TO HEALTHCARE FOR PREGNANT WOMEN AND CHILDREN

## 1. PREGNANT WOMEN: ACCESS TO ANTENATAL AND POSTNATAL CARE

**In Romania, all pregnant women are legally entitled to antenatal and postnatal care free of charge, irrespective of their status**. Consequently, differences in the administrative statuses of the women will be highlighted only when relevant.

Among the women interviewed, 16 were or had been pregnant in Romania at the time of the interview, whether as a tolerance holder, undocumented or as an asylum seeker[314]. Four of them reported that they did not carry their pregnancies to term and so were not asked about their experience with antenatal care. **Thus, in this section, 12 women gave testimony about their access to antenatal care and, for those who had given birth (n=6), to delivery care**: five women were asylum seekers (four were pregnant at the time of the interview and one had been pregnant); six were holding a tolerance (two were pregnant at the time of the interview and four had been pregnant); one woman had been undocumented during her pregnancy in Romania (had been pregnant before)

[314] Two other women interviewed also had been pregnant in Romania before, but they had a residence or working permit at the time of their pregnancies and so were excluded from the following analysis.

33. Number of women interviewed who were pregnant or had been pregnant in Romania, according to their administrative status at the time of their pregnancy (nb)

| | Pregnant at the time of the interview | Has been pregnant before in Romania |
|---|---|---|
| **Asylum seekers** | 4 | **1** |
| **Undocumented migrants** | / | **1** |
| **Holders of a tolerance** | **2** | **4** |

Of course, such a small sample does not allow any significant conclusions to be drawn, but it does provide **insight into some of the difficulties asylum seeking, undocumented and tolerated women face in Romania during pregnancy and at the time of their delivery**.

## ■ Socio-economic and health situation of the pregnant women interviewed

No questions were put to the women who were no longer pregnant about their living conditions at the time of their pregnancy. In this section, only the living conditions of the women who were pregnant at the time of the interview were taken into account (six women).

These six pregnant women all lived in rented apartments with their partners and any other children. Two also shared their accommodation with friends and compatriots**. All testified that they encountered various accommodation-related problems that could affect their pregnancies**: they all said their accommodation was damp and in a poor condition; two of them said the wiring was dangerous, three had no central heating and three were living in overcrowded conditions.

Although all these women were quite young – between 26 and 33 years old - **five out of the six said they were in only a fair state of physical health**. Just one rated her physical health as good. **Even more worrying was the state of their psychological health: four said they were in a poor state of psychological health, the other two said they were in a fair state of psychological health.**

> *"This was supposed to be a happy time for our family, but I couldn't stop worrying and asking myself what might happen if complications set in and we couldn't afford the cost of the medical treatment."* 29 year-old tolerance holder from Ukraine

**Similarly, both of the women who had been pregnant in Romania while undocumented emphasized that they had been in distress and in a poor psychological state of health at the time of their pregnancies**, partly because of their administrative status.

> *"When I found out I could be pregnant, instead of being happy, I felt even more scared and sad. I finally decided to go to a doctor, although all my former colleagues told me "No! It is too risky!"."* 28 year-old undocumented woman from China

## ■ Access to antenatal and delivery care

**One of the 12 women** asked about access to antenatal care at the time of her pregnancy **had not had access to any antenatal care**.

Out of the 11 women who had antenatal follow-up, **only four did not have to pay for their antenatal consultations, and so accessed successfully to their rights to antenatal care free of charge**. Similarly, among the six women who had given birth in Romania, five delivered in a medical facility[315] and **all of them had to pay for their delivery care**.

**The 11 women who accessed antenatal care encountered various difficulties in accessing antenatal care and/or delivery care**.

[315] The remaining one delivered at work: her harrowing testimony appears next

There was again clear evidence of a **lack of knowledge about entitlements to healthcare free of charge among health professionals and the women themselves**: **all the women who didn't obtain access to healthcare free of charge cited this specific difficulty**.

Some highlighted the fact that **the absence of a personal identification code** was often given as the reason why they had to pay full costs, as was explained by one woman who had been issued with a tolerance when she was seven months' pregnant, after her asylum application had been rejected:

> *"That's when the doctors started charging me for the care [when she changed status from asylum seeker to tolerance holder]. I believed them when they said i had to pay for all services… I knew insured people don't have to pay, but when I tried to get insurance I was told I couldn't do that without a personal identification code – and I didn't have one"*. 29 year-old tolerance holder from Ukraine

**In addition to the problem of cost and access to health coverage, most women suffered from discrimination and the feeling they were unwelcome**, as well as from not being treated by a woman doctor, and half of them also said that the medical facility they were referred to was too far away and that they had trouble getting there, which can be particularly problematic at the end of a pregnancy when mobility is reduced. The language barrier and a lack of attention on the part the doctor were also cited.

**The only undocumented woman who carried her pregnancy to term interviewed did not get access to either antenatal care or delivery care, despite a difficult pregnancy and complications.** She worked until the term of her pregnancy, and gave birth in the factory she was working in, assisted only by fellow worker, in unsanitary conditions that were a danger to herself and to her baby. **For fear of being reported by a health professional if she attempted to get antenatal and delivery care in a medical facility, for fear of the consequences on her job if she revealed her pregnancy and because she did not have the financial means, she chose not to seek recourse to antenatal and delivery care.** She explained that she felt desperate during her pregnancy, and that her psychological state of health and physical health quickly deteriorated. The testimony of the only undocumented woman interviewed who carried her pregnancy to term is disturbing, alarming and speaks for itself with regard to the difficulties she encountered:

> *"I quickly realized I was pregnant. I felt desperate because I had nobody to rely on, I worked for a few euros a day, and I did not know anything about medical services here. (…) I used to work for 10-12 hours a day and I barely had money for food, and rent. If I went to the public system, to a clinic, and was asked for my ID, they could report me, and then what would happen to me? I would have had to go back to poverty with another mouth to feed. (…) My pregnancy started to show, to be obvious and I had to hide it from my employers because nobody wants this. They wouldn't want a pregnant employee who could not work or could get them in trouble with the law. (…) My health started to deteriorate because I worked a lot and did not have vitamins supplements or anything, I got anemic and I would almost faint, get nausea and bleed from my nose. I was able to keep my pregnancy hidden but as time passed I felt very desperate. I had nobody besides the people from India whom I lived with. It was very hard for me, I fainted a couple of times in the last months of pregnancy, and I almost wanted to die and have my child survive, because I worried so much about how I would deliver the baby. (…) When the time came, the women from my workplace helped me deliver the baby, I was lucky she was an older woman, who had delivered babies in the past. I had a long labor, I could have died, and the baby could have died too. After cutting the umbilical cord I was very afraid for him. My baby needed proper care, and I am still very concerned about him. He needs vaccines and other medical care. I can feed him but I need so much more. Only time will tell."* 29 year-old undocumented woman from India

**This testimony provides clear evidence that the obligation to report undocumented migrants seeking healthcare, and the fear of this provision, can have dramatic consequences for undocumented patients.**

### ■ Vaccination of new borns

**All the new-born children of the women who delivered in a medical facility were vaccinated after the delivery, but some mothers had to pay for this basic preventive care**. The undocumented migrant who delivered outside of a medical facility did not have her child vaccinated as she didn't want to take the risk of going being reported. The example of this women brings light to one of the possible alarming consequences that the 'obligation to denounce undocumented migrants' can lead to. **Access to vaccination is crucial at personal level, as the absence of vaccination may lead to premature deterioration of health and have life long consequences, and at a collective level as ensuring vaccination to all is a public health measure to eradicate diseases.**

## 2. ACCESS TO HEALTHCARE FOR CHILDREN

**Twenty respondents were living with their children in Romania: ten were seeking asylum, three were undocumented and seven were holders of a tolerance**. Some of the respondents recounted their extremely difficult situation with children suffering from serious pathologies.

In this analysis, no difference is made between the children on the basis of their parents' administrative status of their parents: **in Romania, all children are legally entitled to healthcare free of charge (beyond package) until the age of 18**.

### ■ Living conditions of the children

The most common situation was for children to be living with both parents in a private flat considered to be a stable accommodation solution (12 respondents). A further five respondents were accommodated by a third party, two were accommodated by their employer, and one was living in a reception centre. All considered their accommodation status to be insecure.

**The accommodation of the respondents living with their children appeared to be inappropriate for children. Whatever their accommodation, all but one respondent said they encountered problems that could affect health:** 8 described **damp and degradation**, 7 said there were **dangerous installations such as faulty wiring**, exposing children to the **risk of domestic accidents** - an important cause of death and injury in young children.

7 also said their accommodation was too small and **overcrowded** and that they **lacked privacy** for themselves and their children, which is problematic for **children who have homework to do, as well as for the general well-being of children and teenagers**. Two also felt that they lived in an unsafe area and did not dare let their children go out. Two respondents had no central heating and **two had no access to functioning toilets or a washroom and therefore to the basic hygiene conditions essential to children**.

**Such precarious conditions can contribute to the deterioration of both psychological and physical health of children and expose them to the risk of domestic accidents, and are unsuitable for providing children with a healthy and safe environment in which to develop.**

> *For one of the asylum seekers interviewed, his current living conditions and any that he might hope to obtain in the future were a serious worry as one of his children is seriously ill. His 15 year-old son suffers from epilepsy and cerebral palsy and is in a wheelchair. They currently live in a reception centre for asylum seekers where none of the installations are adapted to accommodate asylum seekers with reduced mobility, or children with disabilities: there are no ramps for wheelchairs, the rooms are very small and there are no individual kitchens and bathrooms.* [316]

[316] The conditions in reception centres were perceived by asylum seekers as quite restrictive: the dormitories are shared, there are separate floors for women (with children) and for men, no private and properly functioning toilets and washroom, no facilities for disabled people, poor access to information or entertainment, no access to facilities such as washing machines, etc. As a result, asylum seekers who come to Romania with at least one other family member tend to prefer to live outside the centres – if they

## ■ Difficulties and barriers for children in accessing healthcare

**The respondents' general lack of information about their rights to healthcare free of charge extended to their children as well: none of the 20 parents were sure about their children's entitlements** – five had no idea at all.

**15 parents had tried to access healthcare for their children since arriving in Romania**. **Six (30% of them) did not manage to see a doctor for their children on every occasion that they attempted to do so**.

**Among these 15 parents, all but one said they had encountered other difficulties and obstacles when they did manage to see a doctor. For undocumented migrants, again, one of the main problems was the fear of being reported and separated from their children, leading them to seek healthcare only as last resort, even for their children**.

> *"My son started coughing, he got sick, was running a bit of a temperature; I hoped it was just a cold. I got some medicines from the pharmacy which made him a little bit better but it did not go away completely. I took the risk and went to the hospital but having no documents they did not want to treat him. They needed a personal numeric code, which I did not have, neither did he. I did not have anybody to ask, people are not forthcoming about these kinds of things. I did not have money to go to a private clinic either. (…) Somebody told me if I went to social workers they might report me and take the child away from me. I could not risk such a thing. I tried at another public clinic and they told me the same thing, they could not register or treat the child. I was desperate, I did not know where to go and I could not do anything for my child, which was a nightmare. I insisted and they threatened me asking me to leave or they would call security. I felt humiliated; I was very anxious and could not think clearly. I went home crying and holding my child and I could not sleep seeing him suffer with fever. My son was in pain and I could not treat him and nobody cared. [The second day she was advised to go to an NGO which could provide medical assistance. There, she was able to access a private clinic which was a partner of the NGO. ] They sent me to a private clinic and they deducted a part of the payment. My son had a severe cold with complications and it could have killed him, being so young. I wouldn't want anyone else to experience what I went though"* Undocumented women from Cameroon, 8 months in Romania

**In total, 11 respondents (or more than half) cited problems potentially leading to the impossibility of accessing health coverage**. Almost half of the respondents (n=9) reported that the medical professionals or the medical facility's administrative services were not aware of their children's right to healthcare free of charge, two also had problems with the complexity of the procedures / could not get health coverage (10%), two said the consultation and/or treatment was too expensive for them (10%).

Six respondents (30%) encountered a language barrier, five found the healthcare facility they were referred to was too far away and six had problems because the waiting lists were too long for the specialist care they needed for their children.

A mother recounted her experience of attempting to access healthcare for her 12 year old child with Down's syndrome. She said she received a lot of help from institutions for hygiene products. But her child needed more support and she was unable to get access to specialist care for her child. All she could get for him was medical check-ups. She felt that the barriers she had encountered were due to a lack of information about who to consult and where to go, and difficulties with the administration.

She explained:

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have the means to do so. At the time of our survey, according to the RIO, among the 400 or so asylum seekers in Bucharest, around 300 lived outside of the centre.

> *"I tried to get him checked by a medical commission but this had no effect. I had a difficult time trying to get him signed up. They did not recognize our identity codes and I had to explain to their superiors why we had different codes from Romanians. Then, a lot of time went by and we got no answer from them. I got back to them and they said to wait. I do not know why they are silently refusing us, maybe they do not want us to benefit from any form of social support."* Asylum seeking women from Iran, a year in Romania

Adversely, another person testified to his happy experience with health professionals willing to help his epileptic son suffering from cerebral palsy.

> *"People from different institutions helped us with Pampers, medicines, hygiene products for the boy and my family. I am thankful and happy to see that many people are interested in helping us. Someone offered to do physical therapy with my son and told me that this can improve his quality of life, I didn't know about it. For the first time, someone told me that my son could stand and walk on his own if he does physical therapy."* Asylum seeker from Afghanistan, 2 years in Romania

**It is striking that both of the undocumented parents were refused access to healthcare for their children at some point**. This experience led one mother to abandon seeking healthcare for her child: she gave up on checkups, but also on vaccinations and important laboratory analyses. **Such lack of access to the most basic preventive care exposes children to serious health risks**.

Finally, some parents had given up on going to health facilities even for their children because of the number of barriers they had to overcome:

> *"I hope my boy never needs to see a doctor again, not even for a cold. I don't believe he will ever get anything for free, even if the law says he should because he's a child. When you get to see a doctor and you have a health problem, you can't fight with him over what is said in the law… You just give him whatever he asks for and hope for the best, hope to get well. You don't bargain over that".* Young mother from Ukraine, tolerance holder

**Although these testimonies can not, of course, be considered as representative of the whole population of asylum seekers and undocumented migrants in Romania, the serious nature of the situations described and the distress caused are clear arguments for more prevention and for improving the effective access to healthcare of children, in particular for children of undocumented migrants who seem not to be protected at all and whose living conditions put them at considerable risk**.

# CONCLUSIONS - ROMANIA

In Romania, while asylum seekers and tolerance holders are clearly identified and not very numerous, there is little reliable information available on the situation of those living outside of centres for asylum seekers or shelters[317]. As for undocumented migrants, they are neither visible nor identified, and there are almost no actions or organisations addressing their needs.

This report is one of the first studies to compile data on the legal entitlements to healthcare and the real living circumstances of these populations and their children. **In a context where access to healthcare is an issue for all Romanians, it reveals that accessing healthcare is particularly problematic for asylum seekers, undocumented migrants and holders of a tolerance**. What is more, these migrant populations seem to be living in poor conditions that could potentially contribute towards the deterioration of their health.

## ■ Social determinants of health: inadequate living conditions

- We know that **adequate living conditions** – i.e. a secure accommodation status, sanitary housing conditions and basic amenities, as well as rights to protection at work, reasonable working hours and a decent economic situation, all **play a very significant role in general and mental health**.

- However, almost half the respondents to the study, regardless of their status, and even when they had children, considered their accommodation status to be insecure. It is even more striking that **97% of the respondents said they encountered at least one problem with their accommodation that could potentially affect their health** – whether linked to overcrowding and the lack of privacy, the lack of basic amenities, or to insanitary conditions and dangerous installations that put them at risk of domestic accidents.

- **Working conditions are also an issue of great concern**, and since all the categories of migrants interviewed work "on the black market" (apart from asylum seekers whose application process has been underway for more than 1 year), the lack of social security, frequently dangerous conditions and excessive working hours (more than 10 hours/day on regular basis), pose a serious threat to the health situation of these persons.

- Partly as a consequence of these poor living conditions, **11% of this quite young population rated their general health as poor to very poor** (compared to 2% of the Romanian population of a similar age).

- Their **self-perceived psychological health is particularly alarming**: respectively 26%, 39% and 23% of the asylum seekers, undocumented migrants and tolerance holders rated their psychological state of health as poor to very poor. **The experience of migration and, for some, of violence in their countries of origin, added to the insecurity of their status, social isolation and poor living conditions, have obvious adverse effects on psychological health**[318].

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[317] On the other hand, reliable data on their situation are accessible through regular UNHCR-coordinated surveys carried out at the reception centres, such as UNHCR, Being a refugee, how refugees and asylum seekers experience life in Central Europe – 2008 report, Budapest, 2009.

[318] According to the report of the Special Rapporteur on the human rights of migrants, Jorge Bustamante, that covers the activities carried out by the Special Rapporteur from January 2009 to December 2009, it is stated that "*The mental health of migrants is also an issue of concern, as factors such as social isolation caused by separation from family and social networks, job insecurity, difficult living conditions and exploitative treatment can have adverse affects*". Also, one of the recommendations states the following: "*In view of the fact that migratory processes in host States may have negative effects on their mental health, States should ensure that migrants' access to healthcare includes mental healthcare. In this regard, States should pay particular attention to improving the mental well-being of migrants by creating services that are integrated and appropriate to their needs. Further studies into the mental health needs of migrants, which recognize the crucial interrelationship between social circumstances and mental health and help provide an insight into relevant mental healthcare and assistance, in particular to migrant women, migrant children and migrants in detention, are required*".

## ■ Access to healthcare for asylum seekers: a gap between rights and entitlements and effective access to healthcare

- **Asylum seekers are protected by enforceable legal entitlements, which provide them with access to certain limited types of healthcare free of charge** (e.g.: primary care, treatment of acute or chronic diseases etc. covered by the Ministry of Administration and Internal Affairs). On the other hand, they have to pay for their medicines, hospitalisation or for secondary care. **The main problem is the gap between their rights in theory and how these rights can be exercised in practice**.

- **Due to a lack of information among asylum seekers on the one hand and healthcare providers or the administrative services of medical facilities on the other, effective access free of charge to the health services supposedly included in health coverage is hindered**.

- **82% did not know or were not sure whether they were entitled to access to healthcare free of charge**.

- From an administrative point of view, **the biggest problem identified by asylum seekers was the refusal by some doctors to provide healthcare free of charge, possibly due to the absence of a *personal identification code* that would facilitate access to healthcare and health coverage**. **A recent amendment to the Asylum Law[319]** foresees that: "*In order for asylum seekers to benefit from the rights mentioned in paragraphs m) and p) of art.17[320], **the Romanian Immigration Office may – upon request – grant them a personal identification code that will be inscribed on the temporary identification document***"[321]**. This new ruling may help fill the gap between theoretical and effective access to healthcare.**

## ■ Access to healthcare for undocumented migrants dependant on the practices of health professionals

- By law, **access to medical care for undocumented migrants in Romania is at risk and extremely limited**: they are not entitled to any health coverage and can only access only emergency care free of charge. Moreover**, the national legislation imposes a duty to denounce undocumented migrants on health professionals, although the precise circumstances in which they are required to do so are unclear**. Ironically enough, the only category of undocumented migrants to benefit from healthcare free of charge are those in detention centres.

- **In some instances, doctors may face the dilemma of having to choose between obeying the law and reporting a person, or heeding their professional ethics and providing care to undocumented migrants**. This survey has revealed certain cases in which the choice made by individual doctors was to assume their ethical and moral responsibilities by providing medical care to particularly vulnerable people, sometimes at their own expense. **However, 18% of those who tried to access healthcare were refused care by the administration services of health facilities or by health professionals**. Furthermore, the obligation to report irregular migrants was quite well-known within hospitals administrations, and in some cases put into practice.

- **Undocumented migrants, even those unaware of the existence of this provision, were usually reluctant to ask for medical care because of fear** of being arrested or deported: **more than half of the undocumented migrants interviewed confirmed that fear was a major factor affecting their access to healthcare in Romania, and the study has shown that a large proportion had abandoned attempts to access healthcare.** Half of undocumented respondents stated they had given up on healthcare at some point in Romania.

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[319] Asylum Law no. 122/2006 was amended in December 2010, through Law no. 280/2010, published in the Official Journal; of Romania no. 888 of December 30th, 2010. For further info in Romanian, see link: http://www.dreptonline.ro/legislatie/legea_280_2010_modificarea_legii_122_2006_azilul_romania.php

[320] Paraghraph m**)** refers to the right to receive (free of charge) primary care and treatment, emergency care, as well as free medical care and treatment in the case of acute or chronic illnesses (...)". Paragraph p) refers to access to education for minor children, under the same conditions as for Romanian children.

[321] The issuance of a PIC was a practice before, but now it is mentioned officially in the legislation.

**- Very often, undocumented migrants encountered difficulties that seem to have kept them from even attempting to access healthcare, even when vulnerable**: one undocumented women interviewed tried to hide her pregnancy because she was afraid of the consequences on her job and feared being deported She had no access to healthcare despite a difficult pregnancy and gave birth in her workplace in unacceptable conditions.

## ■ Tolerance holders: a serious lack of rights hindering access to healthcare

- The situations faced by **tolerance holders** are also an issue of great concern to us, as their general circumstances are extremely difficult. With only a "temporary permission to remain on Romanian territory", they do not have any real status or social and economic rights. **By law, they are only entitled to emergency care free of charge and are required to pay full costs for any other care. In practice, tolerance holders may, in special cases, apply to the Romanian Immigration Office for a *personal identification code*** to access health coverage for restricted types of care.

- **Few of the tolerance holders interviewed were aware of the fact that they had a legal right** to **benefit from emergency healthcare free of charge**, or that they could apply for *a personal identification code*. A lack of information about their rights was in fact the second biggest difficulty cited by the tolerance holders interviewed (in 35% of cases).

- Due to a lack of entitlements to health coverage, **the cost of medical treatment and healthcare was a serious problem for tolerance holders,** cited by 80% of the respondents. This situation is particularly problematic for holders of a tolerance as they are caught up in a vicious circle: they are not entitled to work for a living or receive any social benefits, such as welfare – and yet are expected to pay for their healthcare.

## ■ A need for more migrant-friendly facilities

Two major issues highlighted by the survey are the refusals met when trying to access healthcare and the tendency to give up on healthcare:

- **The fact that even some asylum seekers were refused access to healthcare highlights the existence of discriminatory and questionable practices**. Indeed, discriminatory practices were mentioned by 13% of asylum seekers, 9% undocumented migrants and 35% of the tolerance holders in our survey. It also reveals a serious lack of information among health professionals or the administration services of healthcare facilities about the rights of asylum seekers to access healthcare.

- **The study has revealed a link between the experience of being refused access to healthcare and abandoning attempts to seek medical assistance, which can have serious consequences for vulnerable people**. Other barriers, such as the language barrier for example, reflects the need for more migrant-friendly facilities.

## ■ Despite legal provision, access to healthcare is hindered even for pregnant women and children

- Legally, **children as well as pregnant women with no income – regardless of their status – should benefit from medical care free of charge**.

- **In practice, they are not always able to access their rights to this care** because of administrative barriers, a lack of knowledge of their entitlements by health professionals and administrations and other impeding practices. All these practices should be addressed and eliminated in the near future.

# RECOMMENDATIONS - ROMANIA

In light of the findings from the field study and the analysis of relevant legislation, we conclude that action needs to be taken in five main directions to ensure tangible improvements in general access to healthcare for vulnerable migrants:

- **The relevant public authorities (with the help of the NGOs they support) should systematically provide information on migrants' entitlements to healthcare to both healthcare professionals and to the migrants themselves and promote good practices in this regard, in particular with respect to the laws regarding**
    - the entitlements of asylum seekers,
    - unrestricted access to emergency care for all,
    - unrestricted access to healthcare for pregnant women and children.

- **The regime of tolerance holders is supposed to change slightly following the revision of the Aliens' law in 2010-2011: the draft law amending the regime of Aliens provided for some social-economic rights for tolerance holders, although this law has yet to be passed. These new rights and obligations for tolerance holders should be voted in order to ensure compliance with international standards on Human Rights protection; the Romanian Immigration Office should then implement the law as soon as possible.**
- **Representatives of NGOs, healthcare professionals and civil society should lobby and advocate for improvements in general access to healthcare for vulnerable categories of patients, including asylum seekers, tolerance holders and undocumented migrants.**
- **Public authorities should urgently lift the obligation to report undocumented migrants. Such an obligation, especially when imposed upon health professionals and other social services providers, not only criminalizes assistance to undocumented migrants, but also hinders access to fundamental human rights of a extremely vulnerable categories of persons[322] (by preventing directly their access to healthcare and indirectly by reducing their tendency to seek healthcare). The obligation to report undocumented migrants is in clear contradiction with the professional codes of ethics of healthcare professionals which ask them to provide healthcare to anyone in need, without discrimination.**
- **Health professionals have a responsibility in defending and promoting the respect of their professional codes of ethics. In more concrete terms, they have to promote regulations and practices to improve access to healthcare for these categories of migrants. Consequently, their own access to information and their practices should be improved; similarly, healthcare professionals should refuse the requirement to report undocumented migrants, as being contrary to their professional ethics.**

[322] Interestingly, one of the recommendations in the fifth report submitted to the Human Rights Council by the Special Rapporteur on the human rights of migrants, Jorge Bustamante, was that "As a matter of fundamental principle, States should fulfill the "minimum core obligation" to ensure the satisfaction of minimum essential levels of primary healthcare as well as basic shelter and housing for all individuals within their jurisdiction, regardless of their citizenship, nationality or immigration status, including migrants, migrants in irregular situations, migrant children and women" (para. 71).

# GENERAL CONCLUSION

The HUMA network and its members, namely the NGO KISA in Cyprus, the NGO platform SKOP in Malta, the Association for Legal Intervention SIP in Poland, and ARCA in Romania all work to promote the rights of migrants in their countries and throughout Europe.

**As Cyprus, Malta, Poland and Romania are all recent members of the European Union and situated on its borders, there is considerable concern about immigration issues in these countries by the European Union institutions**. There (as elsewhere in Europe), immigration policies are focused on the control of immigration and leave aside or even hinder human rights.

**The HUMA network reminds that fundamental rights should be the first concern. Therefore HUMA brings awareness on the living conditions and the access to healthcare of migrants, of those particularly endangered by these EU policies, namely asylum seekers and migrants who become undocumented.**

In the countries studied, these critical areas of concern were still poorly documented. This report provides new data from the field and clearer insight into **the social determinants of health such as the living conditions and into access to healthcare, by right and in practice, of asylum seekers and undocumented migrants**. **A special focus was placed on those living outside of detention or reception centres and on the most vulnerable among them, i.e. undocumented and asylum seeking pregnant women and the children of asylum seekers and undocumented migrants.**

**In addition to the legal analysis, field surveys were conducted in the four countries**. **Interviews were held with 434 people, 203 asylum seekers, 203 undocumented migrants, and 28 tolerance holders (in Romania), who had fled from a difficult context in their countries of origin, mostly for economic reasons or because they faced and/or feared persecutions.**

## SOCIAL DETERMINANTS OF HEALTH: PATHOGENIC LIVING CONDITIONS

**Living conditions, including economic issues, housing and working conditions are crucial health determinants,** as highlighted by the Commission on Social Determinants of Health of the World Health Organization: "***the social determinants of health*** **[as]** ***the conditions in which people are born, grow, live, work and age, including the health system,*** *(…) are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries*."[323]

### ■ Unstable socio-economic means

**Most of the asylum seekers and the undocumented migrants interviewed in our field surveys lived in precarious and unstable socio-economical conditions.** 56% of the asylum seekers interviewed depended on a low state welfare and 17% of all respondents (asylum seekers and undocumented migrants) were entirely dependent on help from friends and borrowed money.

**It seems particularly absurd that some migrants are granted with a status or a permission which does not entitle them to work,** but provides them only with a very low public allowance or with no allowance at all. They are therefore obviously forced to work illegally to earn a living. This is the case most of the time for asylum seekers in the countries studied. This is also the case for the

[323] CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization. Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

holders of a tolerance in Romania: this tolerance only provides with a permission to remain on the territory but holders are neither entitled to any social benefits nor have a permission to work. Then the legal frame makes their life in Romania impossible.

Among asylum seekers and undocumented migrants who were working at the time of the interview, **81% were employed in temporary or short-term jobs and so could not ensure a constant and sustainable income for themselves and their family**.

### ■ Poor housing conditions

As a consequence to their low economic means, **59% of all the migrants interviewed saw their accommodation as a temporary solution**. Difficulties in finding a long-term solution affected asylum seekers and undocumented migrants alike, in all four of the countries investigated.

The issue of housing conditions is a major concern as "*not only is the provision of shelter essential, but the quality of the shelter and the services associated with it, such as water and sanitation, are also vital contributors to health*".[324]

The asylum seekers and undocumented migrants interviewed in each of the four countries described **living in poor housing conditions that could be potentially pathogenic**: **87% of the migrants interviewed said they had to deal with one or several problems with their accommodation that could affect health.** The most frequently cited problems were linked to **overcrowding, unsanitary conditions, dangerous installations and the lack of basic amenities** (such as heating, electricity, running water or functioning toilets).

### ■ Insecure working conditions

**We know that employment and working conditions also have powerful effects on health**.

- The instability of the working conditions of the working migrants interviewed raises serious concerns. **Studies indicate that mortality is significantly higher among temporary workers than among permanent workers[325] and that poor mental health outcomes are associated with unstable employment**[326].

- Most of the working respondents interviewed were employed in low-skilled jobs and studies show the adverse conditions exposing individuals to a range of health hazards tend to be concentrated in lower-status occupations.[327]

- Most worked in sectors of activity involving dangerous working conditions, such as construction (employing most of the male workers interviewed), and/or long working hours, such as domestic work (employing most of the female workers interviewed)**. The working conditions described by the respondents revealed indeed a lack of security at work and difficult working conditions: 48% of the working migrants interviewed considered their work could adversely affect their health or put them at risk of an accident at work, and 38% reported working more than 10 hours a day everyday or several times a week**. **These two indicators are commonly used as key health determinants linked to hard working conditions.** Indeed, studies have shown that workers who perceive their work situation as insecure experience significant adverse effects on their physical and mental health[328].

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[324] Shaw M. (2004). Housing and public health. *Annual Review of Public Health*, 25:397-418.

[325] Kivimäki M et al. (2003). Temporary employment and risk of overall and cause-specific mortality. *American Journal of Epidemiology*, 158:663-668.

[326] Kivimäki M et al. (2006). Work stress in the aetiology of coronary heart disease – a meta-analysis. *Scandinavian Journal of Work and Environmental Health*, 32:431-442.
And Artazcoz L et al. (2005). Social inequalities in the impact of flexible employment on different domains of psychosocial health. *Journal of Epidemiology and Community Health*, 59: 761-767.

[327] ILO (2005). *Decent work – safe work. Introductory report to the XVIIth World Congress on Safety and Health at Work*. Geneva, International Labour Organization. Available at: www.ilo.org/public/english/protection/safework/wdcongrs17/intrep.pdf

[328] Ferrie JE et al. (2002). Effects of chronic job insecurity and change of job security on self-reported health, minor psychiatry morbidity, psychological measures, and health related behaviours in British civil servants: the Whitehall II study. *Journal of Epidemiology and Community Health*, 56:450-454.

- Most of the working interviewees were certainly forced to work illegally (probably even for asylum seekers, not entitled to work), they are particularly vulnerable to work exploitation and cannot benefit from any kind of protection to ensure decent and safe working conditions.

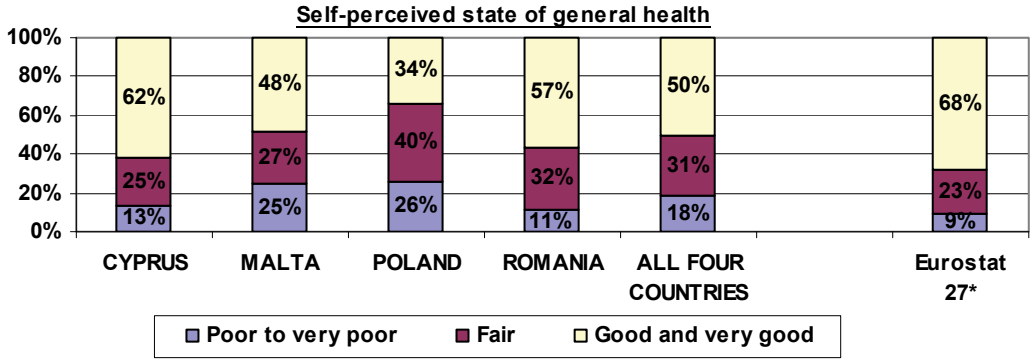
## SELF PERCEIVED STATE OF HEALTH: A VULNERABLE POPULATION

**In these conditions, the asylum seekers and undocumented migrants interviewed are clearly vulnerable**. The self-perceived state of general and psychological health of the asylum seekers and undocumented migrants interviewed revealed their deteriorated state of health, in all four countries.

### ■ The self-perceived state of general health

**The self-perceived state of general health of the asylum seekers and the undocumented migrants interviewed was significantly poorer than that observed for the general population in the European Union**: 18% of the migrants interviewed felt in a poor or very poor state of general health, compared to 9% within the EU's general population in 2008. The difference observed is even greater when compared to a section of the EU's general population with demographic characteristics closer to those observed in the sample of the survey.[329]

1. Self-perceived state of general health of the migrants interviewed, by country investigated and compared to the results of the population in the European Union (%)



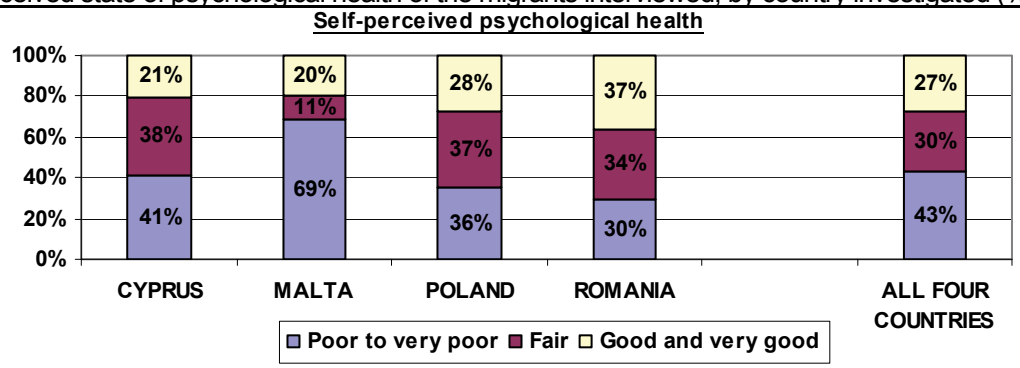

**These findings are worrying considering that the population interviewed was still quite young. They demonstrate to some extent a premature deterioration in the state of general health of these migrant populations that can be partly attributed to poor living conditions and poor access to preventive and primary healthcare in their host countries.**

### ■ A self-perceived psychological state of health that should be addressed

**The self-perceived state of psychological health of the asylum seekers and undocumented migrants interviewed was particularly alarming in each of the 4 countries.**

[329] No more than 2.3% of the 25 to 34 years olds and 3.9% of the 35 to 44 year olds felt in a poor or very poor state of general health in the European Union in 2008. These data are a more valuable element of comparison than the data for the general population as most of the asylum seekers and undocumented migrants interviewed were in these age groups. Data available in Eurostat dynamic statistics database, http://epp.eurostat.ec.europa.eu

2. Self-perceived state of psychological health of the migrants interviewed, by country investigated (%)




**43% of respondents felt they were in a poor or very poor self-perceived state of psychological health, affecting both undocumented migrants and asylum seekers in all four countries.** The most worrying rates were in Malta, where close to 70% of the asylum seekers and undocumented migrants (all former asylum seekers) claimed to be in a poor psychological health condition. In Cyprus, Poland and Romania, asylum seekers were a bit more likely to rate their psychological health as poor or very poor than undocumented migrants.

**The mental health of migrants is now known to be affected by many factors that stem from their pre-migratory experiences and are also due to the difficulties involved in adapting to life in the host country.** The migrants interviewed may have lived difficult, violent and possibly traumatizing experiences before, during and after migration. Moreover, the living conditions in the 'host countries' (described above) also affect mental health, as does the fact that some respondents **lived in fear of being arrested**, or the fact some felt discriminated against and, for asylum seekers, the fact to live with apprehension about the outcome of their asylum application.

**The survey has revealed the poor access to and support by medical services in general, which would imply that undocumented migrants or asylum seekers in need of mental care would not be able to obtain proper medical assistance**. Up to now, the acute public health issue of psychological health and access to mental healthcare for migrant populations, in particular for asylum seekers and refugees, have not been sufficiently addressed in the countries studied. **The survey reveals these specific needs, which call for specific measures to address them.**

## ■ The myth of health tourism

The main reasons for migrating given by the respondents in all four countries were very much connected to the political and/or economic context in the respondents' countries of origin. The percentage of respondents giving health reasons among the motives for fleeing their country was very low or zero, depending on the countries. In total, for all four countries, **only 3% of the respondents cited health among their reasons for migrating**. **This survey does not, therefore, confirm healthcare to be the "pull factor" for migration to Europe that it is often given to be in political debate. Similar findings have been made in other studies conducted in Europe**.

**Furthermore, this survey demonstrates that the frequency with which personal health reasons were cited did not correlate with whether or not the legislation on access to healthcare was favorable to undocumented migrants and asylum seekers**. Indeed, in Malta where the conditions for accessing healthcare can be considered as among the most favorable for migrants in the four countries concerned, only 4% cited personal health problems as a reason for migration, whereas this reason was given by 8% of the migrants interviewed in Poland. These findings seem to confirm the conclusions of the Médecins du Monde European observatory survey[330].

[330] Médecins du Monde European observatory on access to healthcare, Chauvin, P., Parizot, I., Simonnot, N. (2009), *op. cit.,* p.51

# A DIFFICULT AND POORLY-ADAPTED ACCESS TO HEALTHCARE FOR ASYLUM SEEKERS

## ■ Limited legal entitlements

**Asylum seekers are protected by binding international, as well as EU instruments. Their legal status should be particularly protective – in view of their vulnerability.** But in the four countries studied, the law provides asylum seekers with relatively limited entitlements, and effective access to these entitlements is even more limited.

**In theory, Poland and, to a lesser extent, Cyprus provide asylum seekers a similar level of health coverage as for the rest of the national population**. But **even in Poland**, where they are theoretically entitled to access "health services" free of charge, **there is no formal interpretation of this provision.** It is generally understood to include all health services available to the insured. Moreover, **the system is quite complex** with a referral system that allows access to healthcare in specific medical facilities only. **In Cyprus**, only asylum seekers who manage to obtain the Medical card A, i.e. are living in a reception centre, receiving welfare benefits, can prove a lack of sufficient resources or belong to a vulnerable group, can actually benefit from these health services free of charge. The rest have to pay the full cost of services.

**As for Malta, asylum seekers are legally entitled to "state medical care and services", but there is a clear lack of applicability of this legislation.** The interpretation of this provision is generally quite broad, but practice shows that effective access to **healthcare and medicines by these populations depend to a large extent on discretionary decisions**.

**In Romania, the situation is critical: Romania has applied the EU directive on minimum reception standards for asylum seekers in a very narrow definition** by only guaranteeing free access to certain type of healthcare: primary care, emergency care, treatment of certain infectious diseases and ante- and postnatal care.

**Asylum seekers' right to access healthcare and health coverage should be protected by the law in the four countries:** in the actual situation, this is not sufficiently the case.

3. Access to healthcare and treatment for adult asylum seekers according to applicable legislation

| | ACCESS TO HEALTH CARE | | | | | ACCESS TO TREATMENT | | |
|---|---|---|---|---|---|---|---|---|
| | Primary | Secondary (outpatient) | Hospita-lisation (inpatient) | Emergency | Ante/ post natal | Medicines | HIV | Other infectious diseases |
| Cyprus | If living in a reception centre, receiving welfare benefits, able to prove a lack of sufficient resources or belonging to a vulnerable group.[331] | | | | | If living in a reception centre, receiving welfare benefits, able to prove a lack of sufficient resources or belonging to a vulnerable group. | | |
| Malta | One legal provision generally entitling them to "state medical care and services" and a non-legally binding policy document entitling them to "free state medical care and services", applying to asylum seekers and undocumented migrants in detention centres. | | | | | | | |
| Poland | | | | | | | | |
| Romania[332] | | | | | | | | If disease is causing imminent danger to life |

No access | Payment of full cost | Access free of charge

[331] Even if theoretically entitled to access free-of-charge, in practice they pay €2 as a nominal contribution, except for certain medical services and some serious chronic diseases, if treatment is necessary.

[332] Asylum seekers in Romania are entitled to social health insurance if they work (possible one year after submitting the asylum application) or if they have signed the "facultative insurance agreement". This possibility has not been reflected in this table given its remote applicability in practice (difficulties paying the contributions).

### ■ In practice, access to healthcare is difficult and poorly adapted to asylum seekers

Moreover the effective application of the law is commonly threatened. **In the survey**, **in practice, asylum seekers would seem to have been able to access healthcare. However, this access, although possible, was difficult**: 80% of the asylum seekers interviewed encountered one or several difficulties when attempting to access healthcare.

4. Main barriers encountered by the asylum seekers when trying to access healthcare (%)

| Barrier / Country | FIRST BARRIER | | SECOND BARRIER | | THIRD BARRIER | |
|---|---|---|---|---|---|---|
| | **Type of barrier** | % | **Type of barrier** | % | **Type of barrier** | % |
| **Cyprus (n=54)** | Long waiting list | 29% | Problem of cost | 27% | Lack of information: | 25% |
| **Malta (n=30)** | **Discrimination** | **57%** | Distance of the medical facility | **47%** | Language barrier | **43%** |
| **Poland (n=58)** | Lack of information | **41%** | Distance of the medical facility | **38%** | Language barrier | **36%** |
| **Romania (n=61)** | Language barrier | **28%** | Distance of the medical facility | **23%** | Lack of information: | **21%** |
| **4 countries (n=203)** | Language barrier | **30%** | Lack of information: | **29%** | Distance of the medical facility | **25%** |

**The language barrier** was cited by 30% of respondents, which highlights **the absence of or need for more translation and mediation services in medical facilities**. **The fact that 29% of the asylum seekers declared they lacked of information about access to healthcare and health procedures reveals serious shortfalls in the amount and quality of information provided to them** about their rights and entitlements **and the lack of a necessary assistance provided to them in the health system**. Finally, difficulties getting to the medical facilities (25%) doubtless reflects the inappropriateness of the requirement to seek healthcare only in specific health facilities or from specific healthcare providers to be able to benefit from health coverage (the general practitioner from the asylum seekers centres or specific medical facilities to which he/she refers them), as in Poland and Romania.

**Overall, the main difficulties cited by the asylum seekers interviewed were linked to the complex nature of health systems, poorly-adapted to migrants' specific needs, and to the lack of or insufficient assistance to asylum seekers in accessing healthcare. The specific conditions allowing asylum seekers to benefit from health coverage** – such as the possession of Medical card A in Cyprus or the referral system described above in Poland and in Romania – **hardly seem adapted to migrants newly arrived in the host countries** and **tend to act as further barriers to healthcare. This highlights the need for a more 'migrant friendly' health system.**

## UNDOCUMENTED MIGRANTS: ACCESS TO HEALTHCARE IN JEOPARDY

### ■ Insufficient or absence of legal provisions…

As far as legal entitlements are concerned, the situation of undocumented migrants is far worse than that of asylum seekers in these countries. **Legal provision for healthcare entitlements for this population is blatantly lacking**. In Malta, for example, only a non-legally binding policy document is in place for undocumented migrants and asylum seekers in detention centres, entitling them to "free state medical care and services". In the three other countries (Cyprus, Poland, and

Romania), only emergency care (which is not even systematic) and the treatment of certain infectious diseases are accessible free of charge. **Thus, generally-speaking, undocumented migrants have to meet the cost of their medical treatment, in spite of the deprived conditions in which their administrative situation forces them to live.**

**In addition to restrictions on legal entitlements, Romanian legislation includes a duty to denounce, and health facilities in Cyprus commonly report undocumented migrants to the authorities.**

5. Access to healthcare and treatment for adult undocumented migrants according to applicable legislation

| | ACCESS TO HEALTH CARE | | | | | ACCESS TO TREATMENT | | |
|---|---|---|---|---|---|---|---|---|
| | Primary | Secondary (outpatient) | Hospitalisation (inpatient) | Emergency | Ante/ post natal | Medicines | HIV | Other infectious diseases |
| Cyprus[333] | | | | If hospitalisation is not needed[334]. | | | | |
| Malta | No legal provisions, only a non legally-binding policy document applying to undocumented migrants and asylum seekers in detention centres and entitling them to "free state medical care and services". | | | | | | | |
| Poland | | | | Only for care provided by rescue teams out of hospitals[335]. | | | [336] | If in list of diseases that require mandatory treatment. |
| Romania* | The duty to denounce hinders access to healthcare. | | | The duty to denounce hinders access to healthcare. | | The duty to denounce hinders access to healthcare. | | If potential epidemic disease. |

* The holders of a tolerance, which is a "permission to remain on Romanian territory due to objective reasons that prevent the persons' removal / expulsion from Romania", are protected against expulsion although no social or economic rights are attached to their tolerance. They are not concerned by the duty to denounce.

| No access | Payment of full cost | Access free of charge | No legislation |
|---|---|---|---|

**The poor or total lack of entitlements to healthcare of the undocumented migrants in the countries investigated, as well as dissuasive provisions such as the duty to denounce undocumented migrants in Romania, have clearly had a limitative effect on the access to healthcare of the people interviewed.**

### ■ … Precluding undocumented migrants from accessing healthcare

**In practice, the undocumented migrants interviewed did not necessarily manage to access healthcare when they needed: the barriers they encountered seem to have precluded many of them from accessing healthcare.**

**In total, 79% of the undocumented migrants said they encountered barriers when attempting to access healthcare.** This proportion is higher than that observed for undocumented migrants in 11 other EU countries (68.4%)[337].

[333] There are no specific laws regarding access to healthcare for undocumented migrants but only some general provisions and a Circular from the Ministry of Health stating that "the Regulations should be implemented so as to allow access to emergency care free of charge for any person as far as they do not need hospitalisation".
[334] Only ministerial circulars refer to this.
[335] Healthcare providers are obliged to provide care in cases of immediate danger to life or health but undocumented migrants bear the cost of the services received in the emergency units of hospitals.
[336] They do, however, have free access to post-exposition anti-viral treatment.
[337] Results of Médecins du Monde European Observatory on access to healthcare in 2008, survey conducted in Belgium, Germany, Greece, Italy, Netherlands, Portugal, Spain, Sweden, Switzerland and the United Kingdom

6. Main barriers encountered by the undocumented migrants (and tolerance holders in Romania) when trying to access healthcare (%)

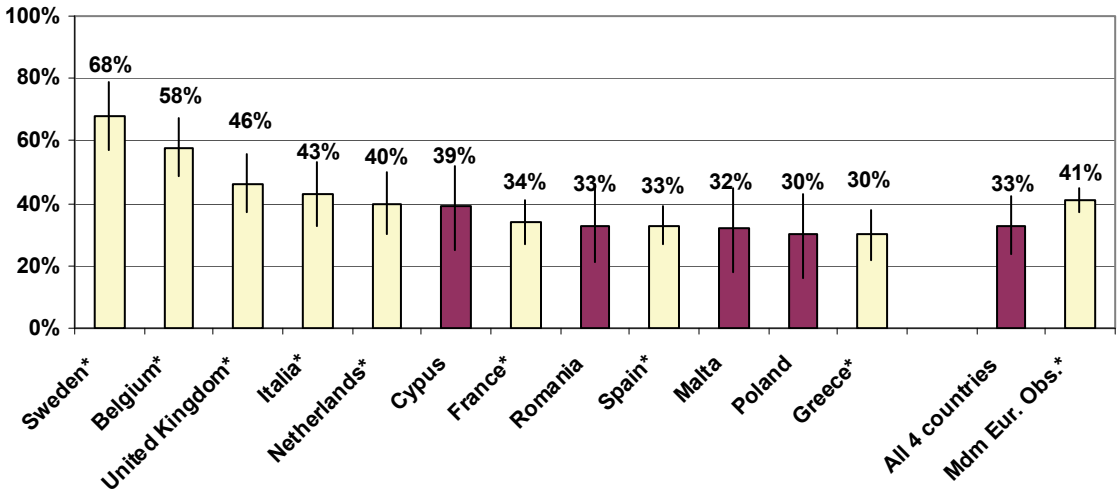
| Country \ Barrier | | FIRST BARRIER | | SECOND BARRIER | | THIRD BARRIER | |
|---|---|---|---|---|---|---|---|
| | | Type of barrier | % | Type of barrier | % | Type of barrier | % |
| Cyprus (n=49) | | Problem of costs | 62% | Fear | 45% | Administrative difficulties | 34% |
| Malta (n=70) | | Long waiting | 34% | Discrimination | 21% | Problem of costs | 16% |
| Poland (n=51) | | Problem of costs | 59% | Administrative difficulties | 31% | Lack of information | 29% |
| Romania | Und. migrants (n=33) | Fear | 55% | Job related barrier* | 36% | Administrative difficulties | 18% |
| | Tolerance holders (n=28) | Problem of costs | 80% | Discrimination | 35% | Lack of information | 35% |
| All 4 Countries (n=231) | | Problem of costs | 39% | Fear | 20% | Administrative difficulties | 19% |
| *MdM Eur.Obs.*** | | Administrative difficulties | *26%* | Problem of costs*** | *21%* | Complexity of the system | *21%* |

* This barrier compiles 2 difficulties cited, which were mostly cited together: "*Discouraged by the employer from going to the doctor*" and "*afraid of the consequences on the job*"
** Results of Médecins du Monde European Observatory on access to healthcare in 2009. The results refer to undocumented migrants only (1 125 adults)
*** This barrier refers to the costs of the medical consultation exclusively for the MdM European obsevatory.

The absence of health coverage led to almost 40% of respondents claiming that **medical examination and/or treatment were too expensive for them**. **Fear of being reported to the authorities** was the second most widely-cited difficulty (20%). **This particular barrier was very frequently cited in Romania and Cyprus – the countries most affected by denunciation in law and/or practice**. **Administrative difficulties** were the third biggest barrier.

When they did manage to access healthcare, **undocumented migrants tended to avoid public health facilities**, preferring to consult at private facilities, **mainly because they felt more secure**.

7. Proportion of undocumented migrants and tolerance holders (Romania) who abandoned seeking healthcare, by country (including results of Médecins du Monde European Observatory), (%)




* Results of Médecins du Monde European Observatory survey on access to healthcare in 2008, per country. The results refer only to undocumented migrants

**The barriers faced by the respondents led a significant proportion of them to abandon attempts to access healthcare. Taking all four countries as a whole, one undocumented respondent in three had given up on healthcare. This was the case for** 41% of the undocumented migrants interviewed in the Médecins du Monde European Observatory survey on access to healthcare (2009).

### ■ Tolerance holders: a 'quasi status' in breach with international Human Rights instruments

As highlighted by analysis of the situation in practice for tolerance holders in Romania, problems, of cost are very problematic, as well as discrimination or the lack of information. This has to do with the fact that they are only protected against expulsion and have no rights attached to their tolerance. Thus, tolerance in Romania is a "quasi-status", in breach with international Human Rights instruments[338].

## RECEPTION AND TREATMENT OF MIGRANTS BY HEALTH SERVICES

**We just presented that the legislation in place in the four countries studied in this survey barely entitles asylum seekers and undocumented migrants to appropriate and decent access to healthcare. In each country, there is a critical lack of respect for the fundamental rights and right to health of these vulnerable populations.**

**And in practice, these legal limitations are further aggravated by numerous other barriers and difficulties.** The difficulties cited by the respondents differed significantly according to their administrative situation, as they are linked to their legal entitlements. But a number of **common issues about the management of these migrant patients in the health system can be highlighted.**

### ■ The need for "migrant-friendly" access to healthcare

The situations faced by the undocumented migrants and asylum seekers are evidence that, in all four countries, the health systems lack services adapted to the special needs of migrant patients. **There is, therefore, a clear requirement for specific assistance to overcome language barriers, and improve the trust of the patients in the care provided.**

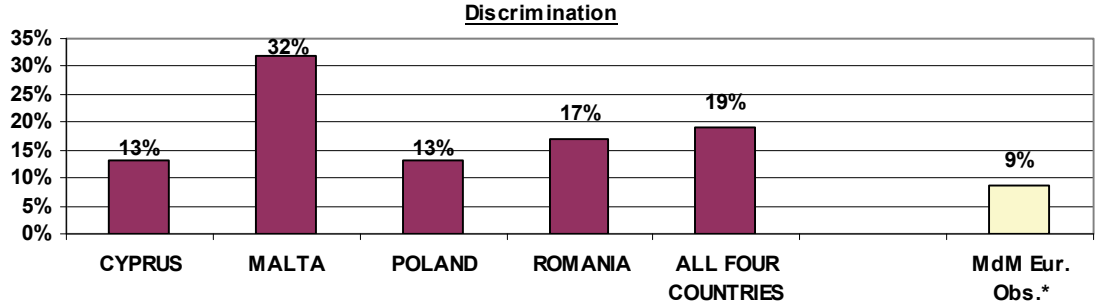
Furthermore, **both health professionals and administrative services seem unable to provide the necessary information to migrant patients about their rights** and about how the health system works. This seems to be essentially due to their ignorance of these rights. **Health professionals therefore need in-depth training in order to strengthen their capacity to provide healthcare to migrant patients and take their special needs into account, in keeping with the medical ethics that bind them.**

### ■ Medical ethics in question

**The study further revealed the existence of informal or discretionary practices among health professionals and in the administrative services of medical facilities. These practices are in breach of medical ethics, as they are counter to the principle of non-discrimination.**

338 See Directive 2004/83/EC of 29 April 2007 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted

8. Percentage of respondents claiming to have suffered discrimination while trying to access healthcare, by country and compared to the MdM European Observatory survey results (%)

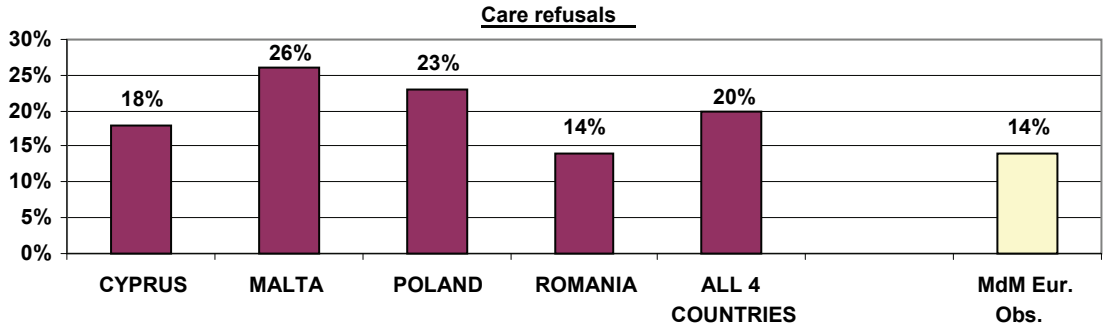



* Results of Médecins du Monde European Observatory survey on access to healthcare in 2008, per country. The results refer to undocumented migrants only.

Many respondents claimed to have suffered from discrimination and been made to feel unwelcome in the health system: in total, this was the case for 19% of the people interviewed.

**Furthermore, situations exist whereby the rights of the patients are ignored: in some cases, they are refused access to healthcare by health providers.**

9. Percentage of respondents who have been refused access to healthcare among the respondents who tried to access healthcare, by country and compared to the MdM European Observatory survey results (%)*




* Results of Médecins du Monde European Observatory survey on access to healthcare in 2008 (average for 8 countries). The results refer to undocumented migrants only.

**In total, 20% of the undocumented migrants and asylum seekers who tried to access healthcare were refused care** by health professionals or the administrative services of health facilities.

Even more serious, **the duty to denounce undocumented migrants in Romania is a clear breach of medical ethics**. **Health professionals are being obliged to choose between the law and the medical ethics they are bound by, i.e. that healthcare should be provided to all, confidentially and without discrimination. Such a situation is unacceptable.**

All these unethical provisions and practices serve to endanger the health of patients**.**

# THE RIGHTS OF PREGNANT WOMEN AND CHILDREN NOT RESPECTED

**The access to healthcare of pregnant women and children** was one of the focuses of this survey as these populations should receive special protection. Indeed existing studies highlight the **importance of appropriate access to healthcare during pregnancy and early childhood**: *"In the early years, the healthcare system has a pivotal role to play. **Mothers and children need a continuum of care from pre-pregnancy, through pregnancy and childbirth, to the early days and years of life**. (…) **[**Children**] need safe and healthy environments – good-quality housing, clean water and sanitation facilities, safe neighborhoods, and protection against violence."***[339]

## ■ The legal aspects: discriminatory laws

**In the four countries studied, the right to healthcare of the undocumented or asylum seeking pregnant women is not respected. The same is to be said about the children of undocumented migrants or asylum seekers**. Clear discrimination based on the administrative status exists, in particular against undocumented pregnant women and the children of undocumented migrants. Thus, these children cannot access health services on the same basis as the other children, and women encounter legal barriers in their access to antenatal and delivery care.

10. Level of discrimination of healthcare entitlements for foreign children and pregnant women according to applicable legislation

| | CHILDREN | | | | PREGNANT WOMEN | |
|---|---|---|---|---|---|---|
| | unaccompanied asylum seeking children | asylum seekers' children | unaccompanied migrant children | children of undocumented migrants | asylum seeking | undocumented |
| **Cyprus** | | If filed own asylum application: = entitlements ≠ conditions<br>If not: ≠ entitlements ≠ conditions | Access free of charge ONLY in case of emergency and infectious diseases, otherwise ONLY on full payment basis. | | | Access ONLY on full payment basis except in case of emergency and infectious diseases. |
| **Malta** | | | = entitlements ≠ conditions<br>There are NO legally-binding norms. | | | = entitlements ≠ conditions There are NO legally-binding norms. |
| **Poland** | = entitlements ≠ conditions | | Access free of charge ONLY very limited (at school), otherwise, access on full payment basis. | | = entitlements ≠ conditions | Access ONLY on full payment basis. |
| **Romania** | = entitlements ≠ conditions | | | | = entitlements ≠ conditions (referral system) | No particular conditions provided by law |

Color code

| |
|---|
| Not discriminated against when compared to national children/ pregnant women (i.e. same entitlements – usually free of charge access, and same conditions) |
| Discriminated against when compared to national children/ pregnant women (as regards the entitlements or the administrative conditions to access to them) |
| Highly discriminated against |

**This situation is in breach of the International Convention on the Rights of the Child** that states in its Article 24 that *"State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and*

[339] CSDH (2008). *op.cit.,* p.49.

*rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services; (...) shall take measures to ensure pre-natal and post-natal healthcare for mothers"*.

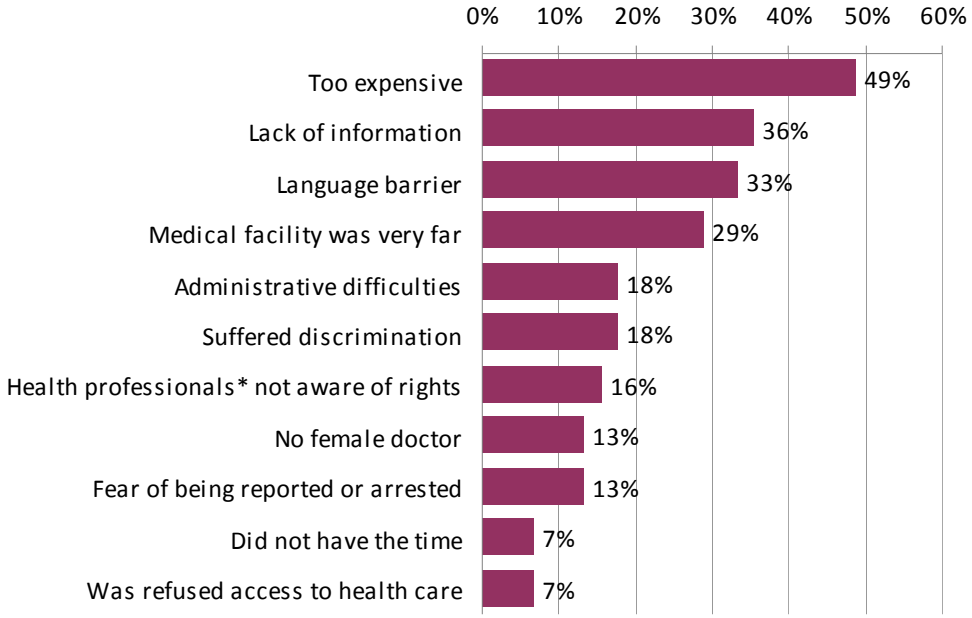
### ■ Pregnant women: in addition to restrictive laws, women faced numerous difficulties when accessing perinatal care

45 women interviewed in our survey testified to their experience of pregnancy in the 'host country'. The findings are worrying:

- **9% of these women were not able to access antenatal care during their pregnancy** (among those who were more than 3 month pregnant or who had already delivered), yet **the absence of follow-up during pregnancy increases potential problems during delivery and potential health conditions in the mother and new-born.**

- **55% of the women who benefited from antenatal consultations had to pay for them** (or at least for one of them), **and 69% of the women** (18 women out of 26) **had to pay for their delivery care**. **Consequently, cost was identified as the main problem or barrier faced by the women when accessing antenatal care.**

11. Main difficulties encountered when trying to access antenatal care by the women interviewed who were pregnant or had been pregnant in the host country (n=45) (%)**




* "Health professionals" include also health administrations
** The percentages exceed 100% because this was a multiple choice question.

- **Generally speaking, the women reported facing the same barriers during their pregnancy as those encountered by respondents in general. Apart from the costs of care, these also include a lack of information, the language barrier, the distance of the medical facility and discrimination or the fear of being reported**. Medical professionals or administrations were not aware of their rights in 16% of the cases. This implies that the treatment given to asylum seeking or undocumented pregnant women in health services is not significantly different from that given to asylum seekers or undocumented migrants in general.

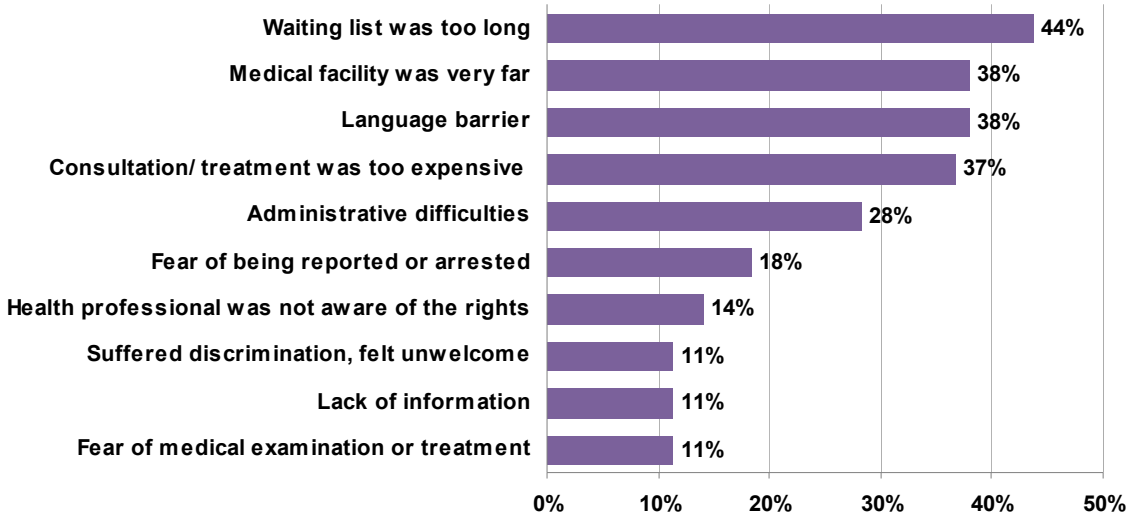
### ■ Children: alarming findings on living conditions and access to healthcare

In our sample, 71 respondents were living with their children in the country of residence. 56% of the parents interviewed were asylum seekers, 35% were undocumented migrants and 8% were tolerance holders. In 48% of cases, however, the child did not have the same administrative status as their parent.

**The living conditions described by the parents were critical and inadequate for children: 89% of them reported at least one problem with their accommodation that could adversely affect health**. Thus, insanitary conditions, including the presence of rats, cockroaches or other pests and vermin were cited by one third of the parents, overcrowding was cited by 24%, the lack of fully functioning toilets by 17% and dangerous electric fittings by 10%.

**With regard to access to healthcare, it was disturbing to note that as many as 27% of the parents interviewed reported that they had not managed to see a doctor for their children eon each occasion they had tried.**

12. Main barriers and difficulties faced by parents when trying to access healthcare for their children (n= 71) (%)*




*The percentages exceed 100% because this was a multiple choice question

Numerous barriers prevented or hindered children's access to healthcare: **87% of the parents encountered difficulties or obstacles when trying to access healthcare for their children**. In fact, the parents faced the same problems for their children as they did for themselves. In particular, 38% cited the language barrier, 37% said healthcare was too expensive for them and 28% encountered administrative difficulties. It is also worrying to note that **18% feared being reported** when they attempted to access healthcare for their child(ren). A further **7 % said they had already been refused healthcare for their children.**

The numerous barriers, including refusal of care, are factors in the high number of parents who abandon attempts to obtain healthcare for their children: **16% of the parents living with their children had given up on healthcare for them, even preventive care such as vaccinations, medical check-ups and dental care.**

**As a conclusion, the legal provisions and the effective access to healthcare for children and pregnant women, whether undocumented or asylum seekers, are very limited.** As a result, some pregnant women and children can remain with no access to healthcare, in spite of their needs. Their access to preventive care, including antenatal care or vaccinations, is also limited although preventive maternal and child healthcare is without doubt one of the most cost-effective public health measures. **To improve this situation and comply with their obligations with regard to the international Convention on the Rights of the Child, Cyprus, Malta, Poland and Romania should ensure effective access healthcare to all women and children, whatever their status, as Member States were urged to do by the Council of the European Union in its Conclusions of June 2010[340].** The Council called on all of them to "consider policies to ensure that citizens, and all children, young people and pregnant woman in particular, can make full use of their rights of universal access to health care, including health promotion and disease prevention services."

[340] Council of the European Union (2010). *Council conclusions on Equity and Health in All Policies: Solidarity in Health,* 3019th EPSCO meeting. Brussels. Available at: http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/114994.pdf

# GENERAL RECOMMENDATIONS

**The members of the HUMA network demand equitable[341] access to health care, treatment and prevention for all people living in Europe, without any discrimination on the basis of legal status or financial means.**

**The HUMA network calls for:**

- **Effective and equitable access to health care and prevention for undocumented migrants and asylum seekers (access on equal grounds as nationals with the same medical needs and level of resources);**
- **The specific needs of vulnerable groups (pregnant women, children and victims of torture) to be addressed, including providing them immediate access to prevention and care;**
- **The protection of seriously ill undocumented migrants from expulsion by granting them a permit to stay when they are unable to receive effective access to treatment in their country of origin;**
- **The respect of medical confidentiality; and an end to the duty to denounce undocumented migrants within the health system and an end to the penalisation of assistance to undocumented migrants;**
- **Effective access to health care for foreigners confined in detention centres and the monitoring of detention centres by independent bodies.**

The HUMA network and its members address specific **policy recommendations to the competent national authorities in Cyprus, Malta, Poland and Romania** in the Conclusions per country of this report.

You can also find the **HUMA policy recommendations to the European institutions** as well as to the competent national, regional and local authorities in the field of health and immigration in other countries in the 2009 HUMA report and at www.huma-network.org.

[341] Equitable access to health services is commonly described as "equal access to treatment for those in equal medical need, irrespective of other characteristics, such as income", EUPHIX - European Union Public Health Information System [website]. Health Inequalities - Inequalities in health service access, June 2009. Available at: www.euphix.org/object_document/o5679n29797.html

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## GENERAL CONCLUSION

# APPENDICES

# APPENDIX 1: HUMA SURVEY QUESTIONNAIRE

**Questionnaire number: _____**

**Country: _____ City/town: _____**

**Organisation/program/community attended by the interviewee: _____**

**Name of surveyor: _____**

**Date:…/…/… Time: …h…**

**Language used: _____**

**Interpreter present (apart from investigator)**

O Yes
O No

⇒ ***Before starting the interview, please make sure that the person interviewed is whether undocumented or an asylum seeker (or in the case of Romania, holder of a toleration)***

⇒ ***Make sure that the person that the person did not already pass the questionnaire before.***

⇒ ***Remember:***

- o ***Unique choice of answer***
- □ ***Multiple choice of answer***

⇒ ***In italic: guidelines to help the surveyor for the interview procedure. These are addressed to the surveyors and are not to be read to interviewee.***

**Presentation of the interview**

*My name is ….. I am from (*Name of organisation*), an organization promoting the rights of the migrants. We are doing a survey with a European organization; I would like to invite you to participate.*

*For this survey, I will not ask you your name or write any information about your identity. The information you want to give will stay secret and safe, and I will not share it.*

*The questionnaire concerns health, living conditions, and your experience with immigration. Whether you participate or not will not have any influence on the attention (*Name of organisation*) will offer you whenever you might need it.*

*Of course, you are totally free to choose whether to answer any question and you can stop the questionnaire at any time if you like.*

**To all**

**General**

**1. Gender**
- o 1. Male
- o 2. Female

**2. How old are you? :** … Or date of birth (mm/yy):

**3. What is your citizenship (including stateless person)? _____**

***If the person wants to include his/her nationality if different from citizenship: _____***

***For question 4 to 8: these questions must be adapted to each country context and legal provisions.***

**CYPRUS**

**4. Have you ever applied for asylum in Cyprus?**
- o 1. Yes
- o 3. Not yet, but wishes to submit an asylum request ➔ ***go to Q5***
- o 4. No, does not wish to submit an asylum request ➔ ***go to Q5***

**4.1 If yes, at what stage of the procedure are you?**
- o 1. The procedure is in process (including first appeal in administrative court)
- o 2. The procedure is in second appeal in Supreme Court ➔ ***in next question, tick "Appellant of asylum decisions in Court"***
- o 3. The status has been denied (did not appeal or status was denied in Supreme Court)

**5. What is your current administrative situation?**
- o 1. Asylum Seeker ➔ ***go to Q6***
- o 2. Appellant of asylum decisions in Court ➔ ***go to Q9***
- o 3. No permit to stay / undocumented ➔ ***go to Q9***
  **If the person answers "no residence permit", confirm if he/she is …**
- o 4. Released from detention centre (has no permit but can not be deported) ➔ ***go to Q9***
- o 5. Has an application pending for residence permit or citizenship / under labour dispute ➔ ***go to Q9***

***Question 6: For Asylum seekers only.***

**6. Have you got a medical card A?**
- o 1. Yes ➔ ***go to Q7***
- o 2. No ➔ ***go to the next question***

**6.1. If not, why?**
- □ 1. Does not know of this entitlement
- □ 2.Doesn't know the procedure/ whom to ask to
- □ 3. Isn't entitled to Medical card A
- □ 4. Lack of papers/ Unable to prove that didn't have sufficient resources
- □ 5. Awaiting renewal
- □ 6. Other reason, explain: _____

➔ ***go to question 9.***

***Question 7: For holders of medical card A only***

**7. Did you know that holders of medical card A are entitled to health care free of charge? *(condition for entitlement: showing medical card A)***
- o 1. Yes, I knew *(spontaneous)*
- o 2. Yes, but I was not sure
- o 3. No, I didn't know
  ➔ ***go to question 9.***

**8. Do not ask any question**

**MALTA**

**4. Have you ever applied for asylum in Malta?**
- o 1. Yes
- o 2. Not yet, but wishes to submit an asylum request
  ➔ ***go to Q5***
- o 3. No, does not wish to submit an asylum request
  ➔ ***go to Q5***

**4.1 If yes, at what stage of the procedure are you?**
- o 1. The procedure is in process (Including appeal)
- o 3. The status has been denied

**5. What is your current administrative situation?**
- o 1. Asylum Seeker
- o 2. No permit to stay / undocumented

**6. Do you have a Police Id Card in Malta? *(you get these documents when let out of the detention centres)***
- o 1. Yes
- o 2. No➔ ***go to Q9***

***Question 7: for Holder of an Id Card or a Police Number***

**7. Do you know that with your Id Card you are entitled to emergency care and basic medical care free of charge? *(condition: showing Id Card)***
- o 1. Yes, I knew (spontaneous)
- o 2. Yes, but I was not sure
- o 3. No ➔ ***Give further explanation: if the person shows his Police Id Card when he goes to the hospital, he is entitled to medical care free of charge (refer to p.22 of your guide)***

➔ ***go to question 9.***

**8. Do not ask any question**

**ROMANIA**

**4. Have you ever applied for asylum in Romania?**
- o 1. Yes
- o 2. Not yet, but wishes to submit an asylum request
  ➔ ***go Q5***
- o 3. No, does not wish to submit an asylum request
  ➔ ***go Q5***

**4.1 If yes, at what stage of the procedure are you?**
- o 1. The procedure is in process (including appeals)
- o 3. The status has been denied (did not appeal or status was denied in appeal)
- o 4. Obtained the tolerated status

**5. What is your current administrative situation?**
- o 1. Asylum Seeker ➔ ***go to Q7***
- o 2. No permit to stay / undocumented ➔ ***go to Q8***
- o 3. Tolerated ➔ ***go to Q8***

**6. Do not ask any question**

***Question 7: for Asylum seekers***

**7. Did you know that as an asylum seeker you are entitled to emergency care and basic medical care free of charge if you consult the doctor of a reception centre? *(condition: showing temporary identification certificate)***
- o 1. Yes, I knew (spontaneous)
- o 2. Yes, but I was not sure
- o 3. No
  ➔ ***go to Q9.***

***Question 8: for holders of a toleration only***

**8. Did you know that people in your situation are entitled to emergency care free of charge?**
- o 1. Yes, I knew (spontaneous)
- o 2. Yes, but I was not sure
- o 3. No
  ➔ ***go to Q9.***

**POLAND**

**4. Do not ask any question**

**5. What is your current administrative situation?**
- o 1. Asylum Seeker
- o 2. No permit to stay / undocumented

**6. Do you have a partner or a spouse in Poland?**
- o 1. Yes
- o 2. No

**7. Does your spouse or a partner live with you in Poland?**
- o 1. Yes
- o 2. No

**8. Choose the most relevant statement referring to the administrative status of your spouse or partner.**
- o 1. has the same administrative status as I
- o 2. has Polish citizenship
- o 3. has residence permit in Poland
- o 4. Other situation, specify……..

**Living Conditions**

**9. Do you have any minor children (under 18)?**
- o 1. Yes (number of children – for Poland: …..)
- o 2. No ➔ ***go to Q11***

**10. Do you live with any of them?**
- o 1. Yes, all of them
- o 2. Yes, some of them (number of children – for Poland: …..)
- o 3. No

**11. With whom (else) do you currently live?**
- □ 1. Alone (with or without children)
- □ 2. Friends / compatriots
- □ 3. Partner
- □ 4. Other member of family
- □ 5. With employer and/or his family
- □ 6. Other, specify: _____

**12. Where do you currently live?**
- o 1. Own flat or house (rented or own property)
- o 2. Working place / at employer's flat or house
- o 4. Living in an organisation/charity/hotel/shelter
- o 5. Accommodated among family, friends, community for free
- o 6. Occupation of an accommodation without permission of the owner / In an abandoned or improvised place
- o 7. Sleeping rough (homeless, emergency accommodation)➔ ***go to Q16***
- o 8. Reception centre / a centre for asylum seekers
- o 9. Other, specify: _____

**13. Is-it a long-term situation or do you have to change accommodation often?**
- o 1. I often change accommodation: temporary-unstable accommodation
- o 2. It is a long term situation : stable accommodation

**14. How would you rate your housing conditions? *Propose the answers to the interviewee***
- o 1. Very good
- o 2. Good
- o 3. Fair/average
- o 4. Bad
- o 5. Very bad

**15. What problems do you have regarding your housing conditions?**
- □ 01. Too cold, no central heating
- □ 02. Too hot, no ventilation
- □ 03. No windows
- □ 04. No access to running water
- □ 05. No electricity
- □ 06. Bad electricity installations, dangerous
- □ 07. Damp walls, floors, foundation, etc.
- □ 08. No access to fully functioning toilets or washroom
- □ 09. Presence of rats, cockroach, vermin…
- □ 10. Overcrowded, too many people in same room
- □ 11. Lack of privacy
- □ 12. Other, specify: _____

**Working conditions, income**

**16. What is your source of income?**
- □ 1. Paid work or activity ➔ ***go to the next question***
- □ 2. Welfare or other governmental help
- □ 3. Help from relatives / friends / organization
- □ 4. Borrow money (from friends / relatives / community)

➔ ***go to Q22 if "paid work" is not ticked***

***If "Paid work or activity" figures at question 16*:**

**17. Is your main work stable or is it temporary? If you have more than one job, refer to the main one**
- o 1. Stable
- o 2. Temporary

**18. What is your work? If you have more than one job, refer to your two main jobs. *Tick up to two answers if the person has more than one activity)***
- □ 1. Domestic worker (cleaning, taking care of children and elderly for individuals …)
- □ 2. Cleaning in factory, company or hotel
- □ 3. Working in a restaurant
- □ 4. Selling objects in the streets
- □ 5. Construction worker
- □ 6. Farming, agriculture
- □ 7. Begging
- □ 8. Gardening, maintenance work
- □ 9. Other, state: _____

**CYPRUS, MALTA and ROMANIA**

**19. Do you ever work 10 hours or more a day?**
- o 1. Yes
- o 2. No ➔ ***go to Q22***

**20. How often do you work 10 hours a day or more?**
- o 1. Almost every day
- o 2. Several times a week
- o 3. Several times a month
- o 4. Rarely or never

**POLAND**

**19. How many hours a day do you work on average? Please take into account the last month.** .... Hours a day

**20. How many days a week do you work on average? Please take into account the last month.** …. Days a week or (*optionally*) …… Days a month

**ALL COUNTRIES**

**21. Do you think your work could lead to health problems or work accidents?**
- o 1. Yes
- o 2. No
- o 3. Doesn't know

**Perception of Health situation**

**22. How is your general health situation? Would you say it is …**
- o 1. Very good
- o 2. Good
- o 3. Fair
- o 4. Bad
- o 5. Very bad

**23. How is your physical health situation? Would you say it is …**
- o 1. Very good
- o 2. Good
- o 3. Fair
- o 4. Bad
- o 5. Very bad

**24. How is your psychological and emotional health situation? Would you say it is …**
- o 1. Very good
- o 2. Good
- o 3. Fair
- o 4. Bad
- o 5. Very bad

**25. In (*country*), can you rely on someone to support you emotionally and comfort you if you need it? *Propose the answers to the interviewee***
- o 1. Very often
- o 2. Often
- o 3. Sometimes
- o 4. Never or almost never ➔ ***go to Q27***

**26. If so, who can you rely on?**
- □ 1. Family
- □ 2. Friends, compatriots, members of community, neighbours
- □ 3. Social worker or advisor from private/public/NGO sectors
- □ 4. Health professionals: psychologist, doctor
- □ 5. Others, specify _____

**Migration Route**

**27. In total (including every time you have been here), how long have you lived in (*country*)?** … years / or … months

**27.1. *For Poland only:* How long is your current stay?**… years / or … months

**28. Why did you leave your country?**
- □ 1. For economic reasons, to earn a living
- □ 2. For political, religious, ethnic or sexual orientation reasons or to escape from war
- □ 3. Because of family conflicts
- □ 4. To ensure the future of your children
- □ 5. For own personal health reasons
- □ 6. To join or follow someone
- □ 7. To study
- □ 8. Other reasons, specify: _____

**Q29 AND Q30 ALL COUNTRIES EXCEPT POLAND**

**29. In (*country*), have you ever been held in a detention centre or detention place? *Ask which centre to verify if it is a detention centre.***
- o 1. Yes
- o 2. No

**30. Do you currently limit your activities and movements for fear of being arrested / of the authorities? *Propose the answers to the interviewee***
- o 1. Very often
- o 2. Often
- o 3. Sometimes
- o 4. Never

**The last health problem in (*country*)**

**31. In (*country*), how did you deal with your last health problem and who did you consult about this problem?**

- ☐ 1. Did not have any health problem since arrived in this country ➔***If the person is a woman: go to Q39 ➔ If the person is a man and has children in (country): to Q44 ➔ Otherwise, end the interview (orientation and information).***
- ☐ 2. Dealt with it himself/herself ➔ ***go to Q35***
- ☐ 3. Consulted a doctor or other healthcare professional ➔ ***go to the next question***
- ☐ 4. Took advice from a pharmacist ➔ ***go to Q35***
- ☐ 5. Consulted a traditional practitioner, folk medicine ➔ ***go to Q35***
- ☐ 6. Consulted a neighbour, friend, family member ➔ ***go to Q35***
- ☐ 7. Did nothing ➔ ***go to Q35***
- ☐ 8. Other, specify: _____ ➔ ***go to Q35***

**32. Did you have to pay for the medical consultation(s)?**

- ○ 1. Yes
- ○ 2. No

***Question 34: Only if the person consulted a health professional (Answer 3 at question 32)***

**33. Where did you go for medical care for this last health problem (refer to all the consultations made for this health problem)? *Multiple choice***

- ☐ 1. Hospital emergency department ➔ ***go to Q35***
- ☐ 2. Public healthcare facility – mainstream health services ➔ ***go to Q35***
- ☐ 3. Specific healthcare facility (used mostly by migrants, poor…) ➔ ***go to Q34.2***
- ☐ 4. Private health care facility ➔ ***go to Q34.1***
- ☐ *5.* The GP in a detention or accommodation centre ➔ ***go to Q35***

**34.1. Why did you go to a private facility?**

- ☐ 1. More secure: no fear of being reported
- ☐ 2. Cheaper than in the public facilities
- ☐ 3. Better medical attention
- ☐ 4. Takes less time than in the public system
- ☐ 4. The treatment wasn't available in the public facility
- ☐ 5. Was advised to go to this medical facility/doctor
- ☐ 6. Other, specify: _____

**34.2. If you went to a specific healthcare facility, why?**

- ☐ 1. More secure: no fear of being reported
- ☐ 2. Cheaper than in the public facilities
- ☐ 3. Better medical attention
- ☐ 4. Takes less time than in the public system
- ☐ 5. The treatment wasn't available in the public facility
- ☐ 6. Was advised to go to this medical facility/doctor
- ☐ 7. Other, specify: _____

**Difficulties and barriers in access to health care**

***- "in the past year" or if the person arrived in (country) less than a year ago, ask "since you arrived"***

**34. Generally speaking, what are the problems you have faced trying to access health services in the past year/since you arrived in (*country*)? *(Do not give out the choices of answers but prompt again, "did you face other problems?". Limit to 6 responses)***

- ☐ 01. No perceived difficulties
- ☐ 02. Medical consultation or/and treatment is too expensive
- ☐ 03. Medical facility is very far
- ☐ 04. Opening schedules of health services are not adapted
- ☐ 05. Does not have the time, has more important problems
- ☐ 06. Administrative difficulties: did not have the papers to get health coverage, complexity of the procedure…
- ☐ 07. Lack of information: does not know his/her rights, does not know where to go
- ☐ 08. Language barrier – no interpretation - did not understand the diagnosis or treatment prescribed
- ☐ 09. Was refused access to healthcare ➔ ***go to Q37***
- ☐ 10. Suffered discrimination, felt unwelcome
- ☐ 11. Fear of being reported or being arrested
- ☐ 12. Does not like going to the doctor, lack of trust in treatment
- ☐ 13. Waiting list was too long
- ☐ 14. Was reported to the authorities
- ☐ 15. No female doctor
- ☐ 16. Employer discouraged him/her of consulting a doctor
- ☐ 17. Afraid of the consequences on my job
- ☐ 18. Did not try to access healthcare ➔ ***go to Q37***
- ☐ 19. The medical professionals or administration were not aware of the rights to health coverage
- ☐ 20. Other reasons expressed : _____

**35. In the past year/since you arrived in (*country*), did any health professional - including administrative staff in a health facility- ever refuse to provide medical attention to you?**

- ○ 1. Yes
- ○ 2. No

**36. Did the difficulties lead you to give up seeking medical care or treatment for yourself?**

- ○ 1. Yes ➔ ***go to Q38***
- ○ 2. No ➔ ***end this part of the questionnaire***

***Question 38: Only if the person answered "yes" to the question 37 ("gave up seeking medical care")***

**37. What type of medical care or treatment did you give up seeking for yourself? *First do not quote any treatment, and then ask the question twice « Did you give up any other treatment? »***

- ☐ 1. Vaccinations
- ☐ 2. Dental care
- ☐ 3. Glasses, contact lenses (optical care)
- ☐ 4. Physiotherapy
- ☐ 5. Medical check up or medical treatment
- ☐ 6. Laboratory analyses, blood tests, MRI or radiology
- ☐ 7. Pharmacy, drugs
- ☐ 8. Mental health or psychological treatment
- ☐ 9. Other treatment or unknown, specify: ……..

***For a woman: go on with the interview***
***For a man with children: go to question 44***
***For a man with no children in (country): end the interview and give information and orientation about your organisation if needed***

***Time dedicated to interview:*** _____

**For Women**

**38. Are you pregnant or have you been pregnant since arrival in (*country*)?**

- ☐ 1. Currently pregnant: number of weeks of pregnancy ….
  ***➔ if the woman is more than 15 weeks pregnant, go to question 41***
  ***➔ if less than 15 weeks pregnant but has been pregnant in (country) before, go to quest. 40***
  ***➔ Otherwise, if she has children in (country) go to question 44; or end the interview***
- ☐ 2. Have been pregnant ***➔ go to the next question***
- ☐ 3. No ***➔ if the woman has children in Cyprus, go to question 44; or end the interview***

**39. What was your administrative situation when you last were pregnant in (*country*)?**

- o 1. Asylum Seeker
- o 2. Undocumented
- o 3. Appellant of asylum decisions in Court
- o 4. Released from detention centre (no permit but can not be deported)
- o 5. Has an application pending for residence permit or citizenship / under labour dispute
- o 6. Other, specify: _____

**40. Was your pregnancy completed?**

- o 1. Yes ***➔ go to question 44 if she lives with her child(ren) or end the interview.***
- o 2. No ***➔ go to question***

**Pre-natal care**

**41. For your last / current pregnancy in (*country*), did you get access to pre-natal care (monitoring, pregnancy follow-up)?**

- o 1. Yes
- o 2. No

**41.1. What difficulties were you confronted with?**

- ☐ 01. No perceived difficulties
- ☐ 02. Medical care was too expensive
- ☐ 03. Medical facility was very far
- ☐ 04. Opening schedules of health services are not adapted
- ☐ 05. Did not have the time, had more important problems
- ☐ 06. Administrative difficulties: did not have the papers to get health coverage, complexity of the procedure…
- ☐ 07. Lack of information: does not know his/her rights, does not know where to go
- ☐ 08. Language barrier – no interpretation
- ☐ 09. Was refused access to healthcare
- ☐ 10. Suffered discrimination, felt unwelcome
- ☐ 11. Fear of being reported or being arrested
- ☐ 12. Does not like going to the doctor, lack of trust in treatment
- ☐ 13. Was reported to the authorities
- ☐ 14. No female doctor
- ☐ 15. The medical professionals or administration were not aware of the rights to health coverage
- ☐ 16. Other reasons expressed : _____

***<u>Question 41.2: Only for the women who accessed prenatal care ("yes" at question 41)</u>***

**41.2. Were you asked to pay for the prenatal consultations?**

- o 1. Yes
- o 2. No

**Delivery care**

***This section about delivery care is dedicated to a woman who already gave birth in the country. Do not ask this part to a woman who is currently pregnant for the first time in (country) or did not complete her pregnancy.***

**42. When you had a baby in (*country*), where did you go to give birth? *If the person gave birth more than once in (country), refer to the last deliver.***

- ☐ 1. Hospital emergency department
- ☐ 2. Public healthcare facility – mainstream health services
- ☐ 3. Specific healthcare facility (used mostly by migrants)
- ☐ 4. Private health care facility
- ☐ 5. At home (with help of traditional practitioner / family) ***➔ go to question 42.2***
- ☐ 6. Other, specify: _____

**42.1 Did you face any problems with the administration or doctors at the health care facility?**

- o 1. Yes ***➔ go to the next question***
- o 2. No ***➔ go to question 42.2***

**42.1.1. <u>If yes</u>, what difficulties were you confronted with?**

- ☐ 01. Medical care was too expensive – unable to pay the costs
- ☐ 02. Medical facility was too far
- ☐ 03. Administrative difficulties: did not have the papers to get health coverage, complexity of the procedure…
- ☐ 04. Language barrier
- ☐ 05. Was refused access to health care
- ☐ 06. Suffered discrimination, felt unwelcome
- ☐ 07. Fear of being reported or being arrested
- ☐ 08. Was reported to the authorities
- ☐ 09. No female doctor
- ☐ 10. Lack of attention from doctor (during / after delivery)
- ☐ 11. The medical professionals or administration were not aware of the rights to health coverage
- ☐ 12. Other reasons expressed : _____

**42.2. Were you asked to pay for the delivery care?**

- o 1. Yes
- o 2. No

**Follow-up care of the baby**

**43. Has your baby been vaccinated?**

- o 1. Yes
- o 2. No, the baby is too young *(less than two months old)*
- o 3. No, no access to vaccination

***For a woman with children in (country): go on with the interview***
***For a woman with no children in (country) (pregnant but doesn't have any children here): End the interview and give information and orientation about your organisation if needed***

***Time dedicated to interview:*** _____

**For parents of children living in the country**

***- If the person is in (country) for more than a year, ask "in the past year"***
***- If the person arrived in (country) less than a year ago, ask "since you arrived"***

**44. Have you tried to see a doctor for any of your children since arrival / in the last year?**
- ○ 1. Yes
- ○ 2. No ➔ ***go to question 47***

**45. If so, did you manage to see a doctor every time you tried?**
- ○ 1. Yes ➔ ***go to the next question but do not ask q°45.2***
- ○ 2. No

**45.1. When you managed to see a doctor, what difficulties were you confronted with?**
- □ 01. No perceived difficulties
- □ 02. Medical consultation or/and treatment were very expensive
- □ 03. Medical facility was very far
- □ 04. Administrative difficulties: did not have the papers to get health coverage, complexity of the procedure…
- □ 05. Language barrier – no interpretation – Did not understand the diagnosis or treatment necessary
- □ 06. Suffered discrimination, felt unwelcome
- □ 07. Fear of being reported or being arrested
- □ 08. Does not like going to the doctor, lack of trust in treatment
- □ 09. Waiting list was too long
- □ 10. Was reported to the authorities
- □ 11. Never managed to see a doctor
- □ 12. The medical professionals or administration were not aware of the rights to health coverage
- □ 13. Other reasons expressed : _____

***Only if answered "No" at question 45***

**45.2. When you didn't manage to see a doctor, what were the obstacles you were confronted with?**
- □ 01. Medical consultation or/and treatment were too expensive
- □ 02. Medical facility was too far
- □ 03. Opening schedules of health services are not adapted
- □ 04. Does not have the time, has more important problems
- □ 05. Administrative difficulties: did not have the papers to get health coverage, complexity of the procedure…
- □ 06. Lack of information: does not know his/her rights, does not know where to go
- □ 07. Language barrier with administration of the health care facility
- □ 08. Was refused access to health care ➔ ***go to question 47***
- □ 09. Suffered discrimination
- □ 10. Fear of being reported or being arrested
- □ 11. Was reported to the authorities
- □ 12. Does not like going to the doctor, lack of trust in treatment
- □ 13. Waiting list was too long
- □ 14. The medical professionals or administration were not aware of the rights to health coverage
- □ 15. Other reasons expressed : _____

**46. In the past year/since arrival in (*country*), did any health professional - including administrative staff in a health facility- ever refuse to provide medical attention to your child(ren)?**
- ○ 1. Yes
- ○ 2. No

**47. Have you ever given up seeking medical care or treatment for your children in the past year / since you arrived?**
- ○ 1. Yes
- ○ 2. No ➔ ***If holder of medical card A, go to question 49; if not, end the questionnaire***

**48. If yes: What type of medical treatment did you give up seeking for your children in the past year / since you arrived? *Do not quote any treatments, then ask twice « Did you give up any other treatment? »***
- □ 1. Vaccinations
- □ 2. Dental care
- □ 3. Glasses, contact lenses (optical care)
- □ 4. Physiotherapy
- □ 5. Medical check up or medical treatment
- □ 6. Laboratory analyses, blood tests, MRI or radiology
- □ 7. Pharmacy, drugs
- □ 8. Mental health or psychological treatment
- □ 9. Other treatment or unknown, specify …….

**Q48 and Q50 are adapted to each country**

**CYPRUS**
**Holders of medical card A only**

**49. Do your children have the same administrative situation as your self?**
- ○ 1. Yes
- ○ 2. No

**50. Do you know that children of holders of medical card A are entitled to health care free of charge? (*condition: showing medical card A)***
- ○ 1. Yes, I knew (spontaneous)
- ○ 2. Yes, but I was not sure
- ○ 3. No, I didn't know

**MALTA**

**49. Do your children have the same administrative situation as your self?**
- ○ 1. Yes
- ○ 2. No

**For holder of an ID card only**

**50. Do you know that children of holders of Id cards are entitled to health care free of charge? (*condition: showing the ID card)***
- ○ 1. Yes, I knew (spontaneous)
- ○ 2. Yes, but I was not sure
- ○ 3. No

**ROMANIA**

**49. Do your children have the same administrative situation as your self?**
- ○ 1. Yes
- ○ 2. No

**To all: undocumented migrants and asylum seekers**

**50. Do you know that all children are entitled to health care free of charge?**
- ○ 1. Yes, I knew (spontaneous)
- ○ 2. Yes, but I was not sure
- ○ 3. No

**POLAND**

**49. Choose the most relevant statement referring to the administrative status of your child(ren). If your children are in different administrative situations, you can choose more than one answer.**
- □ 01. My child(ren) has(have) the same administrative status as I do
- □ 02. My child(ren) has(have) Polish citizenship
- □ 03. My child(ren) has(have) residence permit
- □ 04. Other situation, specify……..

***End the interview and give information and orientation about your organisation if needed***
***Time dedicated to interview:*** _____

# APPENDIX 2: COMPLEMENTARY GRAPHICS AND TABLES

## ▪ CYPRUS

1. Nationalities of the asylum seekers interviewed in Cyprus (nb;%)

| ASYLUM SEEKERS<br>Nationalities | Nb. cit. | % |
|---|---|---|
| **Sub Saharan Africa** | **19** | **35%** |
| Cameroun | 5 | 9% |
| Democratic Republic of Congo | 4 | 7% |
| Ghana | 3 | 6% |
| Somalia | 3 | 6% |
| Other nationalities | 4 | 8% |
| **Middle East and Near** | **14** | **26%** |
| Palestine | 4 | 7% |
| Afghanistan | 2 | 4% |
| Lebanon | 2 | 4% |
| Other nationalities | 6 | 12% |
| **Asia** | **14** | **26%** |
| Nepal | 5 | 9% |
| Sri Lanka | 4 | 7% |
| Bangladesh | 2 | 4% |
| Other nationalities | 3 | 6% |
| **Other nationalities** | **7** | **13%** |
| Stateless | 3 | 6% |
| Europe : Armenia, Georgia, Turkey | 3 | 6% |
| Morocco | 1 | 2% |
| **TOTAL** | **54** | **100%** |

2. Nationalities of the undocumented migrants interviewed in Cyprus (nb;%)

| UNDOCUMENTED MIGRANTS<br>Nationality | Nb.Cit | % |
|---|---|---|
| **Asia** | **29** | **59%** |
| Sri Lanka | 9 | 18% |
| Philippine | 7 | 14% |
| Bangladesh | 5 | 10% |
| Nepal | 4 | 8% |
| India | 3 | 6% |
| China | 1 | 2% |
| **Europe** | **12** | **24%** |
| Georgia | 6 | 12% |
| Serbia | 3 | 6% |
| Russia | 2 | 4% |
| Turkey - Kusdistan | 1 | 2% |
| **Middle-East and near** | **5** | **10%** |
| Syria - Kurdistan | 2 | 4% |
| Other nationalities | 3 | 6% |
| **Other nationalities** | 3 | **6%** |
| Sub Saharan Africa (Nigeria and Cameroon) | 2 | 4% |
| Stateless | 1 | 2% |
| **TOTAL** | **49** | **100%** |

3. Self-rated physical health reported to the self rated housing conditions, all respondents in Cyprus (%; nb)

| Physical Health / Housing conditions | Very good and good | Fair | Bad and Very Bad | TOTAL |
|---|---|---|---|---|
| **Very good and good** | 75% ( 27) | 17% ( 6) | 8% ( 3) | **100% ( 36)** |
| **Fair** | 68% ( 32) | 21% ( 10) | 11% ( 5) | **100% ( 47)** |
| **Bad and Very Bad** | 22% ( 4) | 33% ( 6) | 44% ( 8) | **100% ( 18)** |
| **TOTAL** | **61% ( 63)** | **23% ( 22)** | **16% ( 16)** | **100% (101)** |

Dependency is very significant; Chi²=19; 1-p => 99%

4. Services consulted by the asylum seekers in Cyprus during the last health problem referring to the entitlement to health coverage (%)

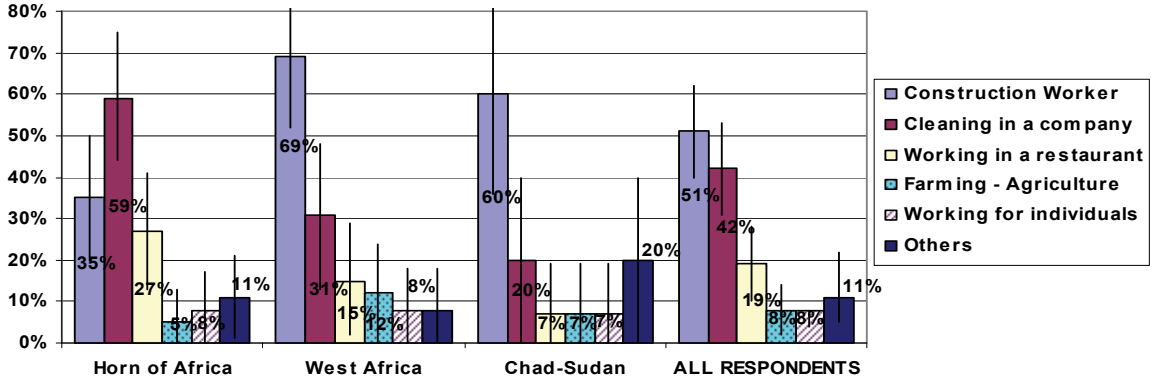
| Type of service / Respondent's access to health coverage | Hospital emergency department | Public healthcare facility | Specific healthcare facility | Private healthcare facility |
|---|---|---|---|---|
| **Asylum Seekers holding Medical Card A (n=18)** | 17% | 72% | 6% | **28%** |
| **Asylum Seekers not holding a Medical Card A (n=10)** | 20% | 10% | 10% | **60%** |

## ▪ MALTA

5. Regions of origin and nationalities of the respondents in Malta, by administrative situation (%)

| Administrative Status / Nationality | Undocumented Migrants | | Asylum Seekers | | All respondents |
|---|---|---|---|---|---|
| | Nb. | % | Nb | % | % |
| **Horn of Africa** | **37** | **53%** | **10** | **33%** | **47%** |
| **Ethiopia** | 21 | 30% | 4 | 13% | **25%** |
| **Eritrea** | 8 | 11,5% | 4 | 13% | **12%** |
| **Somalia** | 8 | 11,5% | 2 | 7% | **10%** |
| **West Africa** | **15** | **21%** | **15** | **50%** | **30%** |
| **Côte d'Ivoire** | 3 | 4% | 4 | 13% | **7%** |
| **Ghana** | 5 | 7% | / | / | **5%** |
| **Mali** | 1 | 1,5% | 4 | 13% | **5%** |
| **Guinea** | 1 | 1,5% | 3 | 10% | **4%** |
| **Gambia** | / | / | 2 | 7% | **2%** |
| **Niger** | 1 | 1% | 1 | 3% | **2%** |
| **Togo** | 2 | 3% | / | / | **2%** |
| **Others** | 2 | 3% | 1 | 4% | **3%** |
| **Sudan-Chad** | **18** | **26%** | **5** | **17%** | **23%** |
| **Sudan** | 14 | 20% | 5 | 17% | **19%** |
| **Chad** | 4 | 6% | / | / | **4%** |
| **TOTAL** | **70** | **100%** | **30** | **100%** | **100% (100)** |

6. Type of work of the working respondents (n=78) in Malta, by regions of origins (%)*




* The percentages are calculated on the 78 respondents: 37 came from countries of the Horn of Africa, 26 from West African countries and 15 from Chad or Sudan

## ▪ POLAND

7. Structure of the Sample in Poland – organisations in which the interviews through which the interviews were passed by administrative status of the interviewee (nb)

| Adm. Status / Org. of surveyor | Asylum seekers n=58 | Undocumented Migrants n=51 | All respondents n=109 |
|---|---|---|---|
| **SIP** | 51 | 13 | **64** |
| **Centrum Powitania** | 1 | 19 | **20** |
| **Association for Free Word** | 4 | 10 | **14** |
| **Other** | 2 | 9 | **11** |
| **TOTAL** | **58** | **51** | **109** |

8. Citizenship and declared nationalities of the asylum seekers interviewed in Poland (nb;%)

| Administrative Status / Nationality (Citizenship) | Asylum Seekers | |
|---|---|---|
| | **Nb** | **%** |
| **Eastern Europe – Former USSR** | **50** | **86%** |
| **Chechnya (Russia)** | 29 | 50% |
| **Ingushetia (Russia)** | 6 | 10% |
| **Kurdish (Georgia)** | 5 | 9% |
| **Dagestan (Russia)** | 4 | 7% |
| **Armenia (Russia)** | 4 | 7% |
| **Other** | 2 | 4% |
| **Africa** | **5** | **9%** |
| **Nigeria** | **2** | **3%** |
| **Other nationalities** | **3** | **6%** |
| **South-eastern Asia** | **3** | **5%** |
| **Vietnam** | 2 | 3% |
| **Nepal** | 1 | 2% |
| **TOTAL** | **58** | **100%** |

9. Citizenship of the undocumented migrants interviewed in Poland (nb; %)

| Administrative status / Nationality | Undocumented Migrants | |
|---|---|---|
| | **Nb.** | **%** |
| **Eastern Europe/Central Asia – Former USSR countries** | **28** | **55%** |
| **Ukraine** | 25 | 49% |
| **Other nationalities** | 3 | 6% |
| **South-Eastern Asia** | **10** | **20%** |
| **Vietnam** | 10 | 20% |
| **Africa** | **11** | **20%** |
| **Nigeria** | 4 | 8% |
| **Democratic Republic of Congo** | 2 | 4% |
| **Ghana** | 2 | 4% |
| **Other nationalities** | 4 | 8% |
| **MIDDLE EAST** | **2** | **6%** |
| **Pakistan** | 1 | 2% |
| **Iraq** | 1 | 2% |
| **TOTAL** | **51** | **100%** |

## ▪ ROMANIA

10. Location, targeted population and dates of field activities in Romania

| Field activity no. | Date(s) | Location | Targeted population group (and relation with ARCA) |
|---|---|---|---|
| **1** | 23.08.2010 | | Asylum seekers, undocumented migrants, tolerates – regular ARCA beneficiaries |
| **2** | 29.08.2010 | | Tolerates |
| **3** | 13-14.09.2010 | ARCA headquarters | Asylum seekers |
| **4** | 20.09.2010 | ARCA headquarters | Asylum seekers, undocumented migrants, tolerates – informed through their communities |
| **5** | 24.09.2010 | | Undocumented migrants - informed through their community |
| **6** | 25-26.09.2010 | | Asylum seekers, undocumented migrants, tolerates – informed through their community |
| **7** | 29.09.2010 | ARCA headquarters | Undocumented migrants, tolerates – informed through their communities |
| **8** | 30.09.2010 | ARCA headquarters | Undocumented migrants - regular ARCA beneficiaries |
| **9** | 1-3.10.2010 | Jesuit Refugee Service | Tolerates |
| **10** | 5-6-10-2010 | ARCA headquarters | Asylum seekers, undocumented migrants, tolerates – beneficiaries of a Muslim association, informed through their community |
| **11** | 13-14.10.2010 | Timisoara / Somcuta Mare / Galati | Asylum seekers, undocumented migrants, informed through a Community worker |

11. Nationalities of the asylum seekers interviewed in Romania (nb;%)

| **ASYLUM SEEKERS** **Nationalities** | **Nb. cit.** | **%** |
|---|---|---|
| **Middle East and Near** | **29** | **48%** |
| Afghanistan | 15 | 25% |
| Iraq | 6 | 10% |
| Iran | 5 | 8% |
| Pakistan | 2 | 3% |
| Lebanon | 1 | 2% |
| **Sub Saharan Africa** | **15** | **25%** |
| Ethiopia | 6 | 10% |
| Nigeria | 3 | 5% |
| Other countries | 6 | 10% |
| **Europe** | **10** | **16%** |
| Ukraine | 5 | 8% |
| Georgia | 2 | 3% |
| Other countries | 3 | 5% |
| **Other regions** | 7 | **12%** |
| Bangladesh | 2 | 3% |
| China | 2 | 3% |
| Other countries | 3 | 6% |
| **TOTAL** | **61** | **100%** |

12. Nationalities of the undocumented migrants interviewed in Romania (nb;%)

| UNDOCUMENTED MIGRANTS / Nationality | Nb.Cit | % |
|---|---|---|
| **Asia** | **19** | **58%** |
| China | 13 | 39% |
| Bangladesh | 2 | 6% |
| Taiwan | 2 | 6% |
| Other countries | 2 | 6% |
| **Middle East - Iraq** | **8** | **24%** |
| **Sub Saharan Africa** | **5** | **15%** |
| Cameroun | 2 | 6% |
| Other countries | 3 | 9% |
| **Other – Turkey (kurdistan)** | **1** | **3%** |
| **TOTAL** | **33** | **100%** |

13. Nationalities of the tolerated interviewed in Romania (nb;%)

| TOLERATED STATUS / Nationality | Nb.Cit | % |
|---|---|---|
| **Middle East** | **11** | **39%** |
| Iraq | 8 | 29%% |
| Iran (Kurdistan) | 2 | 7% |
| Iraq Kurdistan | 1 | 3% |
| **Sub-Saharan Africa** | **8** | **29%** |
| Somalia | 2 | 7% |
| Other countries | 6 | 18% |
| **Europe** | **6** | **21%** |
| Ukraine | 3 | 11% |
| Turkey (kurdistan) | 2 | 7% |
| Georgia | 1 | 3% |
| **Asia** | **3** | **11%** |
| **Sri Lanka** | **2** | **6%** |
| **China** | **1** | **3%** |
| **TOTAL** | **33** | **100%** |

14. Self-rated physical health reported to the perceived living conditions in the accommodation, all respondents in Romania (%; nb)

| Physical Health / Conditions in accommodation | Very good and good | Fair | Bad and very bad | TOTAL |
|---|---|---|---|---|
| **Very good and good** | 94% ( 47) | 2% ( 1) | 4% ( 2) | 100% ( 50) |
| **Fair** | 53% ( 26) | 39% ( 19) | 8% ( 4) | 100% ( 49) |
| **Bad and very bad** | 18% ( 4) | 59% ( 13) | 23% ( 5) | 100% ( 22) |

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## ABOUT THIS PUBLICATION

This report presents the results of multi-disciplinary research into access to healthcare for asylum seekers and undocumented migrants in Cyprus, Malta, Poland and Romania.

It reports on legal rights and entitlements as regards their access to healthcare and presents the findings of a quantitative survey with asylum seekers and undocumented migrants. The report reveals pathogenic living conditions and important legal and practical barriers in accessing healthcare for these populations.

The information and recommendations of this report are aimed at policy makers, health professionals, NGOs and the general public in the hope of bringing about an improvement in the health situation of asylum seekers and undocumented migrants by guaranteeing full protection of their right to access healthcare.

## THE HUMA NETWORK

The general objective of the HUMA network is to promote access to healthcare for undocumented migrants and asylum seekers on an equal basis with nationals within the European Union.

The HUMA network is an advocacy network that is active at both national and European level. It was set up by Médecins du Monde and is currently composed of 16 NGOs in 16 European countries, with a coordination team based in Paris, Brussels and Madrid.

The members of the HUMA network work in the field of health and migration, focusing on undocumented migrants and asylum seekers. Most members provide these population groups with primary healthcare. They also run advocacy programs and campaigns at national and European level and contribute to the network's expertise and data-collection.

HUMA network members in the countries of this report: in Cyprus, KISA (Action for equality, support, anti-racism); in Malta, SKOP; in Poland, the Association for Legal Intervention (SIP); in Romania, ARCA (Romanian forum for refugees and migrants).

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Epim
European Programme for Integration and Migration

Executive Agency for Health and Consumers

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