Health Care in
NOWHERELAND
improving services for undocumented migrants in the EU

Ursula Karl-Trummer
Sonja Novak-Zezula

Health Care in NowHereLand
Improving Services for Undocumented Migrants in the EU

Draft Book Manuscript
Vienna, December 2010

Acknowledgements

Project group

Network partners

Models from assessments

Models in data base

Interview partners

DG Sanco/EU funding agency

National funding agencies

Structure

1. Three Forewords from different perspectives

Policies: Christa Peinhaupt (Policy) Fonds Gesundes Österreich, tbc
Practices: Michael Chalupka (NGO), Diakonie Österreich, tbc
Research: David Ingleby, Utrecht University

2. Executive Summary

3. Introduction

The project "Health Care in NowHereland: Improving services for Undocumented Migrants in the EU"	Explain word play Aims Approach (Policies / Practices / People) Project group Definition UDM	
	Introduction of structure (PPP, contextualisation, theoretical framework)	

4. Policies

Landscapes of NowHereland: Entitlements to health care for undocumented migrants in the EU, Norway and Switzerland	Different perspectives: Human rights, Public health, Economy, Different clustering / categories regulations	Description Explanation why two landscapes Intrduction of policy groups Malmö/Vienna
Policy frameworks for health care	Policy as contextual element for practice	Interpretation, intro to theoretical framework

Theoretical framework: NowHereland is paradox or the art of interpretation	Human rights versus state control Rigidity of regulations Invisible clients	
Management of three challenges Paradox Uncertainty Invisibility of clients	Concept/Challenges described on practical level, core strategies	

5. Practices

	How is policy linked to practice	
Practices of health care provision	Services providing health care for undocumented migrants in Europe and Switzerland: overview on organisations, their services, their personnel and their clients Data base	Description
	The heterogeneity of UDM as challenge for practices	
The role of NGOs		Interpretation
Contextualised models of good practice	model descriptions and assessments against the background of policies and client's needs	Austria Germany Italy Netherlands Spain
"Special Issues" Gender perspectives in Nowhereland Health promotion in NowHereland – you're talking crazy now?		

Undocumented migrant's health care needs and strategies	from the perspective of NGOs and civil society	Picum reports

6. People

UDM: who are they?	Evidence from HUMA/Picum + Heterogeneous group Work/health/behaviour Man/women strategies to survive: Fall nicht auf Bleib gesund	Results from sample Italy Database info Info in-depth assessments
XX ways to live in NowHereland: experiences of undocumented migrants in the EU and Switzerland	Life stories	

7. Perspectives from non EU states

The Swiss perspective: Switzerland as "little Europe"	Policy context Practices People Connection to EU perspectives	Interview with BAG (tbc)
The Norwegian perspective		Interview with NAKMI, Bergen (tbc)

8. Discussion: Equity in health and the boarder line of solidarity

Equity in health and the border line of solidarity	The equity (in health) debate	
	Costs and benefits of inclusion/exclusion	
	Informal labour markets	
	Who benefits from undocumented migration, drivers for	
	Role of NGOs: bridging the gap/maintaining the gap	
	Solidarity of EU member states	
	Desired outcomes of policies	

9. Recommendations

10. Research Notes / Reflections

Methodological Challenges	research in "Vulnerable space"	
	Working on a data base of practice models: the struggles to collect the untold	
	Intimate distance and distant intimacy © varela	How did I feel How did I manage What would I make different the next time

11. “Bastelanleitung” and material: NowHereland in and out

Framing	Getting the strain out of it to open minds and get sensible for creative and innovative approaches Learning by playing, not by suffering	
material	Make your privat nowhereland	
Description	“Spieleanleitung” • Roles • Rules • Cards, dice, board and Meanings	

12. Annex

Sources	Literature Initiatives, Projects	

Executive Summary

The issue of undocumented migrants (UDM) in the EU has been gaining increasing attention. Estimated at between 1.9 to 3.8 million people in the EU in 2008 (representing 7-13 % of the foreign population), this is a vulnerable group, exposed to high levels of health risks. Although all EU member states have ratified the human right to health care, heterogeneous national public health policies have different frameworks for health care provision which in many cases severely restrict UDM access to health care. Accordingly, practice models how to ensure the human right to health follow different logics.

The European project entitled "Health Care in NowHereland" has produced the first-ever compilation of the policies and regulations in force in the EU 27[1], a database of practice models in 11 EU member states and Switzerland, and has made in-depth assessments of selected practice models and provides insights into the 'daily lives' of UDM and their struggle to access healthcare services.

Policies and regulations in force in EU 27

A European landscape of policies can be drawn from two perspectives:

- According to Article 13.2 of Council of Europe Resolution 1509, where provision of emergency care is defined as the minimum for meeting the human right to health care, and the general comment Nr.14 from the UN Committee on Economic, Social and Cultural Rights (CESCR 2000, see Article 12 b), countries can be grouped into those that grant rights, minimum right, or no rights to health care. In this case, five countries (ES, FR, IT, NL, PT) grant rights, 13 countries (AT, BE, CY, DE, DK, EE, EL, HU, LT, PL, SK, SI, UK) grant minimum rights, which in most cases are limited to emergency care, and 9

[1] In addition, policies and regulations in Norway and Switzerland were collected and can be accessed at http://www.nowhreland.info/?i_ca_id=151

countries (BG, CZ, FI, IE, LU, LV, MT, RO, SE) provide no rights, which means the right to healthcare is restricted to an extent that makes even emergency care inaccessible.

- From a public health approach, it can be assumed that access to emergency care alone is an inefficient way of providing health care, leading to high costs, poor outcomes, and increased public health risks through uncontrolled infectious diseases. Therefore, access to emergency care only cannot be defined as access to health care. Seen from this perspective, the landscape changes into countries that provide full access, partial access, and no access, with countries granting only emergency care now being included in the "no access" group. Under this definition, four countries (ES, FR, NL, PT) allow full access, three countries (BE, IT, UK) partial access, and 20 countries no access (AT, BG, CY, CZ, DE, DK, EE, EL, FI, HU, IE, LT, LU, LV, MT, PL, RO, SE, SK, SI).

Practices

Collecting date about health care practices has been a challenge. In many cases, practices prefer to stay as invisible as their clients: sometimes because they already attract many people and are close to capacity in terms of space and resources, and often because their official target group is different (e.g. homeless people, people with no health insurance, etc.) and they fear loss of funding if they speak openly about the fact that they also serve UDM. The outcome of one year of intensive research using a number of different channels such as international experts, hospitals and NGO networks, is a collection of 71 practice models from 12 countries (AT, BE, FR, GE, EL, HU, IT, NL, PT, ES, SE and CH) representing the logic of no access, partial access and full access in terms of levels of entitlement to health care, including 24 governmental organisations (GOs) and 47 non-governmental organisations (NGOs).

A comparative analysis of these practices shows that:

- Health care services providers, whether they are governmental or NGOs, find that mental health care and infectious diseases care are the most common health care needs of their UDM clients. A third big issue is sexual health, where governmental organisations focusing on sexually transmitted diseases and HIV, and NGOs observing the need for reproductive health, followed by work-related health problems.

- The main services provided by both governmental organisations and NGOs are general care and diagnostic services, and emergency care in the case of governmental organisations and care for women and children in the case of NGOs. Mental health care, including psychiatric care and psychological support, is provided by about three quarters of these organisations, including both NGOs and governmental organisations.

- 50% of GOs report increasing numbers of UDM clients, 37% stable and 13% decreasing numbers. 71% of NGOs report an increase in the numbers of UDM clients, 29% stable and 0% decreasing numbers. This difference between GOs and NGOs may be because NGOs are easier to access: only 13% of NGOs request documents compared to 62% of the GOs.

- When it comes to support services, GOs provide more structures for facilitating communication. Although translated information material is available equally from GOs and NGOs (67% vs. 66%, respectively), GOs provide a higher level of interpreting services and cultural mediation than NGOs.

People: 'daily lives' of UDM and their struggle to access healthcare services

In most cases, UDM live in conditions of extreme hardship. Health is usually not their main concern, because they are busy using all of their energies to simple survive. At the same time, good health is their main resource for survival. They need to be healthy to be able to work and to find a place to sleep (since sleeping space is often shared, a compromised immune system can jeopardize their chances of being allowed to share those sleeping places).

Even in countries that grant access to health care services beyond emergency and urgent care, UDM mainly seek out health care services only when they are severely ill. They often fear discovery of their irregular status and thus consequent deportation, lack information about their entitlements to health care, they find it difficult to find their way around the health care system, and to meet the administrative requirements to get access.

UDM are a heterogeneous group. That becomes obvious when we take a closer look at practice models from the in-depth assessments made in Austria, Germany, Italy, The Netherlands, and Spain. For example. the Italian model report huge differences between their three main UDM client groups - from China, Eastern Europe (Georgia, Moldova, Ukraine) and Africa (Egypt, Morocco, Nigeria, Tunisia) in terms of concepts of health and illness as well as concerning living situations.

Introduction

The project "Health Care in NowHereland: Improving services for Undocumented Migrants in the EU"	Explain word play Aims Approach (Policies / Practices / People) Project group Definition UDM	
	Introduction of structure (PPP, contextualisation, theoretical framework)	

The EU Project, “Health Care in NowHereland”, works on the issue of improving healthcare services for undocumented migrants. Experts within research and the field identify and assess contextualised models of good practice within healthcare for undocumented migrants. This builds upon

- compilations of policies in the EU 27 at national level
- practices of healthcare for undocumented migrants at regional and local level
- experiences from NGOs and other advocacy groups from their work with undocumented migrants

As per its title, the project introduces the image of an invisible territory of NowHereland which is part of the European presence, “here and now”. How healthcare is organised in NowHereland, which policy frameworks influence healthcare provision and who the people are that live and act in this NowHereland are the central questions raised.

Inhabitants of NowHereland: Definitions

The Glossary of Migration defines irregular migrants as “Someone who, owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country’s admission rules and any other person not authorized to remain in the host country (also called clandestine/ illegal/undocumented migrant or migrant in an irregular situation).” (IOM 2004: 34).

Other sources define undocumented migrants as “foreign citizens present on the territory of a state, in violation of the regulations on entry and residence, having crossed the border illicitly or at an unauthorized point: those whose immigration/migration status is not regular, and can also include those who have overstayed their visa or work permit, those who are working in violation of some or all of the conditions attached to their immigration status: and failed asylum seekers or

immigrants who have no further right to appeal and have not left the country." (UWT 2008: 19).

With regard to stocks of residents the CLANDESTINO Methodological Report defines five groups of irregular migrants:

1. Illegal working EU-citizens
2. Persons with seemingly legal temporary residence status (e.g. "working tourists")
3. Persons with forged papers, or persons who have assumed false identities with real papers (they may live a regular life unless the falsification is discovered)
4. Persons with pending immigration status (e.g. application for regularisation is pending and application papers prevent expulsion, third country nationals who have submitted an asylum claim, persons who have failed a request for status prolongation but still wait for a decision by the time that their limited residence permit runs out)
5. Persons who are without residence status in the country, but with knowledge and toleration of the authorities (toleration does not legalize or change the unlawful presence of the tolerated alien)

(see Jandl et al. 2008: 6f)

Reports on specific policies on irregular migrants in five Council of Europe member states (Armenia, Germany, Greece, Italy and the Russian Federation) draw the conclusion "that the main cause of irregular migration may be over-restrictive procedures for regulated migration and a flexible, "tolerated" concealed labour economy" (Zanfrini & Kluth 2008: 22).

Ways to enter NowHereland and become undocumented are defined as endogenous – with a legal entry into a country and a fall out of the legal status e.g. from overstaying or not leaving when ordered – and exogenous – e.g. when crossing borders undetected (SOPEMI 1989). It is estimated that more then half of undocumented migrants are endogenous (Levinson 2005: 2).

There are also ways to get out of NowHereland, e.g. through regularisation programmes, which are defined as “any state procedure by which third country nationals who are illegally residing, or who are otherwise in breach of national immigration rules, in their current country of residence are granted a legal status.” (Baldwin-Edwards & Kraler 2009a: 7).

In the recent past the great majority of EU member states have already conducted regularisation measures. According to the REGINE report there are two distinct logics that regularisation follows: 1.) a “humanitarian and rights based logic”, that addresses policy (e.g. failures in the asylum system) and where regularisation is often used as an alternative to removal; and 2.) a “non-humanitarian, regulatory and labour market oriented logic” where regularisation is a mean to tackle irregular migration and the informal economy. (Baldwin-Edwards & Kraler 2009a; ICMPD 2009). “However, in the short term and in particular in countries with large irregular migrant stocks, regularisation is often a necessary and unavoidable option to address the presence of irregular migrants, which reforms of admission procedures [for legal migration] cannot directly address.” (ICMPD 2009: 5).

Apap, de Bruycker and Schmitter (2000) distinguish in their report the following five types of regularisation:

1. Permanent or one-off: Permanent regularisations are programmes on an on-going basis and have no time limits. A successful application is often determined by the criterion how long a migrant has been residing (illegally) in the country. One-off regularisations refer to programmes that occur one-time and are often restricted to a limited number of migrants.
2. Fait accompli or for protection: Fait accompli regularisations are often based on geographic or economic criteria and refer to migrants who have been residing in a country irregularly since a specific date. Protective regularisations mainly include humanitarian, medical or family grounds.

3. Individual or collective: In the event of an individual regularisation authorities make their decision on the individual merit of the case. Collective regularisation refers to the regularisation of a larger number of migrants by using objective criteria.
4. Expedience or obligation: The degree to which a state is forced to regularise a certain number of migrants because of constitutional and national human rights laws or international law.
5. Organized or informal: This category refers to the degree a formalised regularisation procedure exists. Informal regularisations refer to cases where, due to a lack of clear criteria, individual migrants petition to immigration authorities to get regularised.

In practice a regularisation programme rather is a combination than solely one of these categories (Apap et al. in Levinson 2005: 4; Baldwin-Edwards & Kraler 2009a: 19f)

It has to be kept in mind that “Regularisation programmes are usually undertaken only when internal and external migration controls have failed. The OECD (2000) cites three reasons why countries are opposed to amnesties or general regularisation programmes, including: the possibility that they will attract more undocumented immigration; that not all immigrants in an irregular situation will be able to take advantage of the programme (not being able to "wipe the state clean"); and having to implicitly acknowledge that existing controls were ineffective. Thus, countries undertake regularisation programmes with reluctance, and usually in conjunction with other methods of combating undocumented migration. In addition to regularisation, Baker (1997) identifies two other primary methods countries use to control immigration: wholesale deportation, and efforts at the border and internally to interdict and discourage new flows.” (Levinson 2005: 5f).

What becomes visible through the definitions of stocks and flows regarding NowHereland is the heterogeneity of undocumented migrants and also the difficulty to find a common terminology. The Platform for International Cooperation on Undocumented Migrants, PICUM, recommends to use the term “undocumented

migrants", as the use of the term "illegal" has a connotation with criminality (see PICUM 2007a).

In NowHereland, the following definition is used:

"Undocumented Migrants are third-country nationals without a required permit authorising them to regularly stay in Europe.
There are many routes to becoming undocumented, the category includes those who have been unsuccessful in the asylum procedure or violated terms of their visa. The group does not include EU Citizens from new member states or migrants who are within the asylum seeking process (unless they have exhausted their asylum process and are thus considered rejected asylum seekers but are not returned to their country of origin)."

Policies

Landscapes of NowHereland: Entitlements to health care for undocumented migrants in the EU, Norway and Switzerland	Different perspectives: Human rights, Public health, Economy, Different clustering / categories regulations	description
Policy frameworks for health care: From ignorance to acceptance		Interpretation, intro to theoretical framework

Theoretical framework: NowHereland is paradox	Human rights versus state control Rigidity of regulations Invisible clients	

The European project "Health Care in NowHereland: Improving Services for Undocumented Migrants in the EU" is the first study that provides a compilation of national regulations concerning the access to health care for UDM of 27 EU member states plus Norway and Switzerland.

Two models were developed to make this compilation and to allow a comparison of policies by grouping countries into different categories in two sub-groups, one working at Malmö University, and one at the Center for Health and Migration, Vienna. While the Malmö group worked on in-depth country reports and a summary report, the Vienna Group worked on the compilation of regulations in a so called "policy matrix".

Methods

For the comparison of public health policies for EU 27, Norway and Switzerland, data collection on legal entitlements to health care and decisive context information concerning migration policies and migration logics was conducted.

Data collection was organised in the following process:

The definition of relevant indicators for the analysis was done in the framework of an expert meeting in Malmö, in May 2009. Chosen indicators were grouped in three main dimensions: 1) migration numbers and context: total population, foreign population in total numbers, percentage of foreigners and percentage of non-EU nationals as share of total population, net migration and net migration rate, main types of immigration (e.g., work or family related, humanitarian migration), rejected asylum applications, estimates on UDM; 2) healthcare financing system: tax/fiscal, state driven insurance and/or private insurance with share of financial contributions; and 3) entitlements to health care and social aspects recognised as social determinants on health for UDM.

It was then decided to build the two policy teams (Malmö: Country reports and summary report, Vienna: policy matrix) who applied the following data collection methods:

Malmö Group:

"key elements of the applied methodology were triangulation of obtained information and coherence testing. "Desk research" was conducted, involving various sources, including literature, research reports and grey literature, such as official reports and reports from nongovernmental organisations. Sources covering health systems and/or special focus on undocumented migrants, as well as of relevance to migration at EU and country level have been chosen in line with the developed indicators. Statistical information was obtained from official websites and from secondary sources. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was identified experts in the member states who have, in some cases, provided new contacts. They were identified due to membership in a research network or project or through established contacts, and were especially important during the process of coherence testing. As regards interviews, the chosen form was a questionnaire consisting of five sections, being welfare, healthcare system in general, policies regarding undocumented migrants, healthcare for undocumented migrants and migration, with both closed and open questions, and space was provided to allow for further remarks" (Björngren Cuadra & Cattacin 2010: 8ff).

Vienna Group:

Desk research, searching the following data bases and sources: Eurostat data and the UNHCR population database for statistics on general population, migration and asylum; the OECD continuous reporting system on migration and the EMN annual reports on asylum and migration statistics for information on the main types of immigration within a country; the Hamburg Institute of International Economic (HWWI) database on irregular migration that was created in the context of the project Clandestino was the source for estimates on UDM; the WHO European observatory on health systems and policies served for data regarding national health care financing systems; data regarding entitlements to health care and social determinants on health for UDM was mainly retrieved from HUMA network, PICUM, policy country reports from the NowHereland project and EMN country reports. In the search, particular attention was taken to collect the most recent data available as well as to the comparability of data. Thus, sources covering several countries, like comparative studies or statistics, were favoured. Single country studies were used to fill in gaps or to provide necessary background information on the collected data.

Expert consultation in case of missing data and/or unclear information. The collected data was sent to the members of the COST Action IS0603 - HOME network for verification and feedback. The COST HOME network brings together international experts of 29 countries to further the development of research and good practice concerning migrant health[2.]

Notification and request to the counsellors for health at the EU permanent representations of the Member States to confirm about the accurateness of the information compiled. In the request it was stated that in case no objections are raised within a given timeframe, it will be assumed that the information given is correct. Seven of the 27 EU permanent representations gave feedback regarding minor modification of the data, mainly updates of statistical information.

The process of data collection started in December 2009 and lasted until June 2010.

[2] For further information on the 'COST Action IS0603 – Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME)' go to http://www.cost.esf.org/domains_actions/isch/Actions/HOME

The collected data was compiled in a so called "policy matrix" and in reference guides for each country that contain the sources used and some additional information[3].

Legal entitlements to health care for UDM in the EU 27, Norway and Switzerland: first landscapes of NowHereland

Clustering of EU countries has been done according to the legal regulations governing UDMs' access to health care on a national level, from a human rights approach, and from a public health perspective.

The Art of Uncertainty on Policy Level

In many cases, legal regulations are formulated in a way that leaves a lot of room for interpretation. For example, the part of the German "Asylbewerberleistungsgesetz" dealing with health care has been interpreted as including or excluding undocumented migrants, depending on the expert providing the opinion. A human rights perspective requires the necessary range of health care services to be assured, while a public health viewpoint includes an exploration of broader public health issues, such as the implications of infectious diseases, and the effectiveness and efficiency of services. This opens up different possibilities for grouping countries according to different interpretations and perspectives.

The NowHereland project presents two landscapes with two underlying rationales for grouping countries.

Rationale 1 was developed by the Malmö Policy Group. It refers to a human rights perspective and is based on Article 13.2 of Council of Europe Resolution 1509 (2006)

[3] (available on http://www.nowhereland.info/?i_ca_id=368)

“Human Rights of Irregular Migrants”, where emergency health care is named as the minimum health care provision for UDM.

“In order to identify clusters, a typology has been used based on two aspects outlined in the respective report, namely 1) the right to healthcare and 2) the system of financing healthcare. In the intersection of these two aspects, six clusters have been identified. The typology leans on the Council of Europe Resolution 1509 (2006) on Human Rights of Irregular Migrants, Article 13.1, where it is stated that emergency care should be available and that states should seek to provide more holistic care, taking into account, in particular, the needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly. Emergency care is referred to as a minimum right.” (Björngren Cuadra & Cattacin 2010: 9)

It groups countries into those that grant rights / minimum rights / no rights:

“No rights: the right to healthcare is restricted to an extent that makes emergency care inaccessible. This level also involves policies implying that, from the patient’s perspective, access to care is not predictable (i.e. arbitrariness is involved) if a person seeks emergency care. In this level, member states which do not provide emergency care to a patient without asking for payment in advance or which charge the patient in a manner that can give rise to a considerate dept are also included. Collectively, nine member states can be found to be applying this level of rights.

Minimum rights: the right to healthcare involves emergency care (or care referred to as immediate, urgent or similar) and is provided without discrimination, including to an undocumented migrant. Whether or not there is a moderate fee to pay is not at stake, but rather that the provision of care is predictable from the patient’s perspective, and that in terms of legislation applicable to undocumented migrants, there is no discretionary rights for healthcare staff regarding the provision of healthcare. Included in this level are also the member states where care at a more extensive level might be accessible under certain but not always predictable circumstances (such as in return for payment of the full cost or where there is a professional discretion). Collectively, thirteen member states can be found to be applying this level of rights.

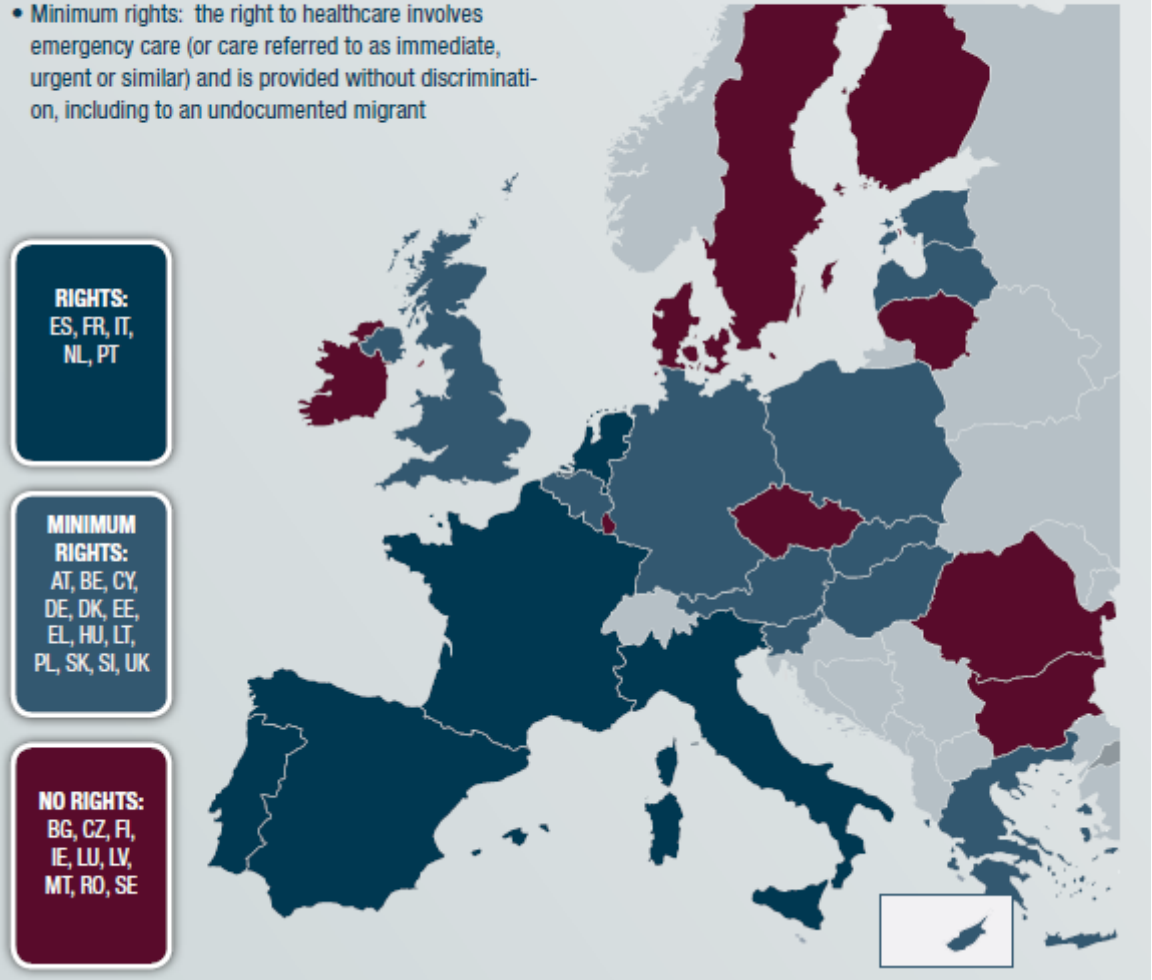
Rights: the access to care involves services beyond emergency care, such as primary and secondary care. In addition, the payment of moderate fees is not relevant, with the relevant provisions laid down in legislation which is applicable to undocumented migrants. It is an empirical fact that this level of rights is associated with administrative procedures which might impair access to healthcare in practice. As mentioned, such hindrances are not considered. Collectively, five member states can be found to be applying this level of rights." (Ibid, 10f)

Rationale 2 is based on a public health perspective and assumes that access to emergency care alone is an inefficient way of providing health care, leading to high costs, poor outcomes, and increased public health risks through uncontrolled infectious diseases. In addition, emergency care provision in general does not refer to any kind of legal status but to life threatening physical conditions.

Seen from this perspective, providing emergency care only is not a satisfactory approach. Accordingly, countries are grouped into full access / partial access / no access, with countries granting emergency care only included in the "no access" group.

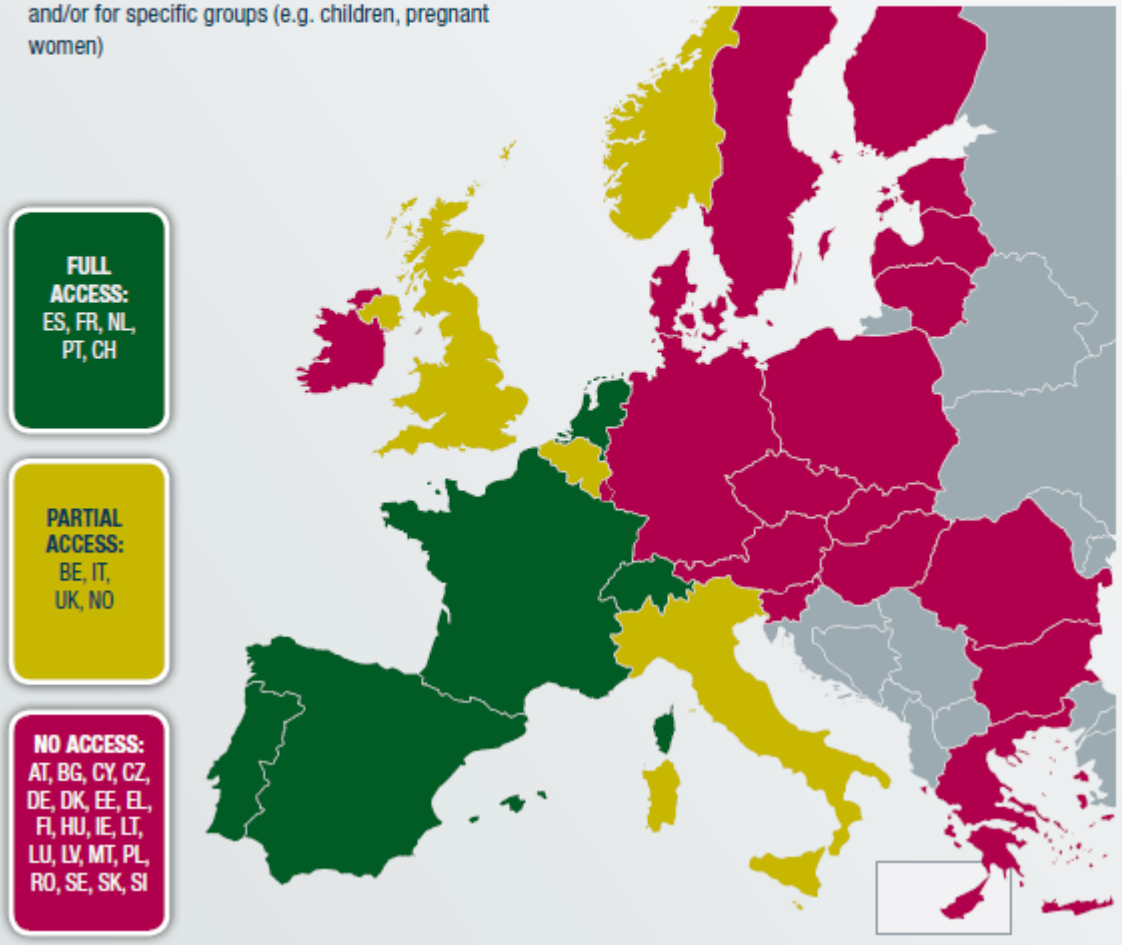
LANDSCAPE 1:
EMERGENCY CARE ONLY IS THE MINIMUM HEALTH CARE LEVEL TO ENSURE HUMAN RIGHTS ...

- No rights: the right to healthcare is restricted to an extent that makes emergency care inaccessible
- Minimum rights: the right to healthcare involves emergency care (or care referred to as immediate, urgent or similar) and is provided without discrimination, including to an undocumented migrant
- Rights: the access to care involves services beyond emergency care, such as primary care



LANDSCAPE 2:
... BUT IS THE MOST INEFFICIENT WAY OF PROVIDING HEALTH CARE

- No access: includes countries which grant access to emergency care only
- Partial access: countries with explicit entitlements for specific services (e.g. primary care, maternity care), and/or for specific groups (e.g. children, pregnant women)
- Full access: countries where UDM are entitled to access the same range of services as nationals of that country as long as they meet certain pre-conditions (e.g. can provide proof of identity/residence, etc.)



Entitlements for Undocumented Migrants to Access Health Care

Countries are divided into three categories, according to the range of entitlements they offer to UDM in terms of access to health care: no access, partial access and full access.

Countries where UDM have no access to health care:

This category includes countries which provide access to emergency care, because
a) emergency care is usually not linked to any kind of status
b) from a public health and economic perspective providing access to emergency care only is an inefficient way of providing health care leading to high costs, poor outcomes, and increased public health risks through uncontrolled infectious diseases.

In Austria, Cyprus, Denmark, Estonia, Germany, Greece, Hungary, Lithuania, Poland, Slovak Republic and Slovenia access to health care is limited to emergency care only.

In Bulgaria, Czech Republic, Finland, Ireland, Latvia, Luxembourg, Malta, Romania and Sweden, UDM are charged for emergency care.

Countries where UDM have partial access to health care:

These are countries with explicit entitlements for specific services (e.g. primary care, maternity care), and/or for specific groups (e.g. children, pregnant women).

Belgium: UDM may apply to the social welfare centres (CPAS/OCMW) for urgent medical assistance (AMU – Aide Médicale Urgente) free of charge. A broad range of medical services fall within this category, albeit with some (minor) exceptions, as in the case of some prosthetics and medications. Compulsory health insurance can be obtained for some specific groups of UDM (e.g., unaccompanied minors).

Italy: UDM may be granted a so-called “STP code” (Straniero Temporaneamente Presente), an anonymous health card which is free of charge, valid for six months (renewable), which provides access to a wide range of health services. The form of healthcare provided under the STP code is defined as urgent and essential care. The card is issued by the local health unit (ASL - Azienda Sanitaria Locale). Services are provided free of charge if the UDM can show a self-certified ‘application for indigence status’. It should be noted that although the basic logic of access and provision of health care is the same all over Italy, regions deal with this common logic in different ways.

United Kingdom: accident and emergency (A&E) departments provide necessary emergency treatment free of charge, whereas charges are made for secondary care (for in-patient care, ante- and postnatal care, medicines, etc.). Since general practitioners (GPs) involved in primary care have the right to choose to register any person on the NHS patient list regardless of their status, UDM accepted by a GP have access to primary care services free of charge.

Norway: UDM are entitled to emergency care and necessary health care provided by local health services. Furthermore, children up to the age of 18 and pregnant women are entitled to the same range of health services as nationals.

Countries where UDM have full access to health care:

These are countries where UDM are legally entitled to access the same range of services as nationals of that country. For full access, UDM must be able to prove that they fulfil certain preconditions (e.g. by providing proof of identity/residence/indigence/minimum duration of stay).

France: a parallel administrative system, the AME (Aide Médicale d’Etat), enables UDM to have cost-free access to the same health care services as nationals. To be treated under the AME, UDM must provide documentation indicating that they have been living in France for at least three months, proof of identity and evidence of their

lack of financial means. UDM who are not eligible for the AME are entitled to emergency care free of charge, as well as to screening for sexually transmitted diseases and HIV/AIDS and screening for and treatment of tuberculosis, as well as vaccinations, and family planning services

The Netherlands: In January 2009, a special government fund was set up to provide for reimbursement of medical care costs for UDM. This new scheme differentiates between directly-accessible care (GPs, midwives, dentists, and hospital emergency departments) and care which is not accessible directly (in contracted hospitals). While UDM may theoretically go to any provider available for directly-accessible care, for care that is not directly accessible, only a limited number of hospitals (25 – one hospital per district) have a contract with the Health Insurance Board (CVZ - College voor Zorgverzekeringen) and are thus able to claim reimbursement. Depending on the kind of service, between 80% and 100% of care costs can be reimbursed to the service provider. In order to apply for reimbursement of these health care costs, service providers must prove that they have taken certain steps to claim the expenses of treatment from the UDM patient directly.

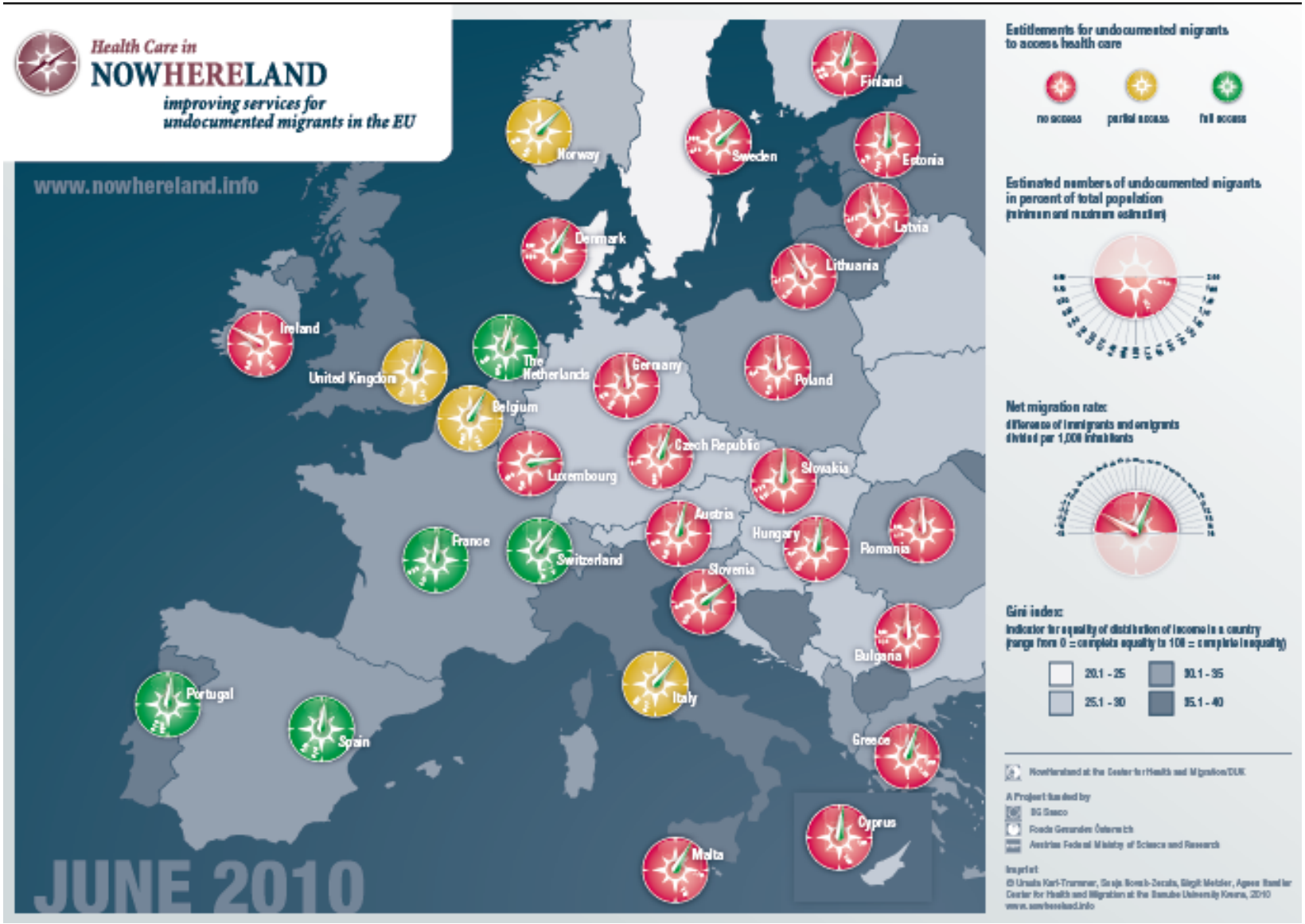
Portugal: Full access for UDM is dependent on provision by the UDM of proof of residence in Portugal for more than 90 days and entitles them to temporary registration at a health centre. If UDM have been residing in Portugal for less than 90 days or fail to provide proof of residence, free access is possible only for a limited range of services (treatment of contagious diseases, maternity care, vaccinations and family planning); the full cost must be paid for other health care services. UDM may be charged for emergency care as well, although this type of care cannot be refused if the patient is unable to pay.

Spain: To have full access, UDM need to register at the local civil registry with a valid passport, proof of residence and declaration of indigence. Undocumented children under the age of 18 and pregnant women are entitled to full health care treatment under the same conditions as nationals even if they are not registered. For certain diseases (e.g. HIV and diabetes), some regions permit UDM to access essential

treatments through a specific health care document (DAS – Documento de asistencia sanitaria) that does not require a valid passport.

Switzerland: Any person living in Switzerland for longer than three months has both the right and the obligation to sign up for statutory health insurance. The Public Health Insurance Law obliges insurance companies offering compulsory health insurance to accept all applicants for the basic health insurance, irrespective of individual risk related to e.g. gender, solvency, or residence status and thus also accept UDM. The basic package of benefits covers services provided in the event of sickness or accident, as well as maternity care. However, statutory health insurance is costly: the average total monthly cost of basic health insurance in 2009 was 262 CHF (185 EUR). Emergency care is free of charge.

A coloured landscape of NowHereland, showing results of this data collection (estimates on UDM, net migration rates, Gini index as measure of inequality of income distribution) is provided as a download at http://www.nowhereland.info/?i_ca_id=368.


Health Care in
NOWHERELAND
improving services for undocumented migrants in the EU
www.nowhereland.info
Norway
Sweden
Finland
Estonia
Latvia
Lithuania
Denmark
Ireland
United Kingdom
The Netherlands
Germany
Poland
Belgium
Czech Republic
Slovakia
Luxembourg
Austria
Hungary
Romania
France
Switzerland
Slovenia
Bulgaria
Portugal
Spain
Italy
Greece
Cyprus
Malta
JUNE 2010
Entitlements for undocumented migrants to access health care
no access
partial access
full access
Estimated numbers of undocumented migrants in percent of total population (minimum and maximum estimation)
Net migration rate:
difference of immigrants and emigrants divided per 1,000 inhabitants
Gini index:
indicator for equality of distribution of income in a country (range from 0 = complete equality to 100 = complete inequality)
20.1 - 25
25.1 - 30
30.1 - 35
35.1 - 40

Policy frameworks for health care: NowHereland is paradox / From ignorance to acceptance

When looking at a European landscape of NowHereland, it gets visible that a majority of EU member states does not provide any entitlements for UDM to access mainstream health care services except in case of emergency, which by definition implies a life threatening condition. For UDM this means that, in most EU countries, their only possibility to legally access health services is to get in real trouble concerning their health status. This picture confirms the findings from other studies (Chauvin et al. 2009, HUMA network 2009, PICUM 2007b) that access to health care, defined as a fundamental human right for UDM is severely restricted.

With the analysis starting on the policy level, one fact becomes evident that is pointed out already in previous studies (Zanfrini and Kluth 2008, Karl-Trummer et al. 2009a): the dilemma between national regulations that control national borders, define citizenship and different entitlements to social security systems within a country on one hand and the universal approach of human rights on the other.

Health care in NowHereland: a management of paradox?

Conflicting demands of the fundamental right to health care on one side and restriction of access to health care on national rights level create a paradox situation, where inclusion and exclusion is stipulated at the same time. Seven out of the 27 EU member states and Switzerland have legal frameworks in place that try to regulate access to health care for UDM to a certain extent, while in 20 member states the question of how to handle the paradox - simultaneous consideration of inclusion and exclusion - remains neglected.

In practical terms, this creates a framework of uncertainty for the practice of health care organisations and their personnel: if they provide care, they may act against legal

and financial regulations; if they do not provide care, they violate human rights and exclude the most vulnerable.

This uncertainty comes with the need to refer to a NOW HERE and to a NOWHERE at the same time. It is opened up on policy level and influences practices as well as people’s behaviour.

	NOW HERE	NO WHERE
Policy	HUMAN RIGHTS*	NATIONAL STATE
Practice	Access to health care should be assured	No or strictly limited access should be provided
People	Get care and stay UDM	Remain healthy and invisible or get severely ill (illness clause#)

Beside the paradox opening up through conflicting demands, two more elements characterise the contextual framework of service provision. It's the rigidity of regulations in place and the very nature of UDM as an Invisible target group.

The art of uncertainty coming to practice level

Empirical studies on practices of health care provision in European countries show that also in countries that do not provide any official access to health care it is possible to get good care, while the other way round in countries that provide full access it may be impossible for an individual UDM to get any access (HUMA network 2009, PICUM 2007b, Karl-Trummer et al. 2009b). Somehow policies seem to be disconnected from practice and vice versa.
But taking a closer look at the practice level, it becomes apparent that practices sound / swing with policies.

According to the three main elements in the art of uncertainty, three management approaches can be identified:

- The management of paradox in case of no access countries
- The management of uncertainty and rigidity of regulations
- The management of invisible target group

So far, little is known about these practices in relation to the different legal frameworks they have to consider. In the NowHereland project, a first database with practice models of health care provision for UDM under different regulative contexts has been set up and can be accessed on the internet (http://www.nowhereland.info/?i_ca_id=370). These attempts to get better evidence about public health policies and practices of health care provision hope to stimulate further research and practice developments, as further studies are needed to improve the knowledge base for appropriate public health action.

Practices of Health Care Provision

	How is policy linked to practice	
Practices of health care provision	Services providing health care for undocumented migrants in Europe and Switzerland: overview on organisations, their services, their personnel and their clients Data base	Description
	The heterogeneity of UDM as challenge for practices	
The role of NGOs		Interpretation
Contextualised models of good practice	model descriptions and assessments against the background of policies and client's needs	Austria Germany Italy Netherlands Spain
"Special Issues" Gender perspectives in Nowhereland Health promotion in NowHereland – you're talking crazy now?		

Practices of health care provision for UDM can be characterised by three main contextual elements:

- Conflicting demands between human rights and national regulations: The contradiction between a ratified fundamental right to health care irrespective of legal status on the one hand, and rights linked to citizenship and/or health insurance systems on the other means that health care providers face a paradoxical situation. This is most often the case for health providers in countries which have no legal entitlement to access in place.
- The grade of rigidity of regulations: For example, a national regulation might restrict access to health care for UDM to "emergency and urgent care". Whereas the definition of emergency care is rigid, since it is provided only in life-threatening situations, the definition of urgent care is open to broader interpretation. The more space for interpretation, the more uncertainty there is, putting a strain on service providers, yet at the same time allowing for more flexible decision-making.
- The special nature of their clients: for UDM, to stay invisible is a central strategy for survival. Their health literacy is limited and expectations are influenced by their experiences with systems in their country of origin, and conditions of their everyday life are a major threat to their health.

Collecting data about health care practices has been a challenge. In many cases, practices prefer to stay as invisible as their clients: sometimes because they already attract many people and are close to capacity in terms of space and resources, and often because their official target group is different (e.g. homeless people, people with no health insurance, etc.) and they fear loss of funding if they speak openly about the fact that they also serve UDM.

For data collection two plans were developed and applied:

- **Plan A** (04/09-09/09): Identification of focal persons through international expert networks (HOPE, HPH, TF MFCCH, COST HOME, PICUM) as channel for dissemination of the template to hospitals and NGOs.

    - As defined in a successful proposal, but without success in practice
- **Plan B** (09/09-04/10): Contacting identified organisations directly and personally
    - Selective, expensive, with limited success – practices don't have questionnaires high on their priority lists
    - Practices from contexts of no access for UDM don't want to get known, as one factor of success is being an undocumented practice

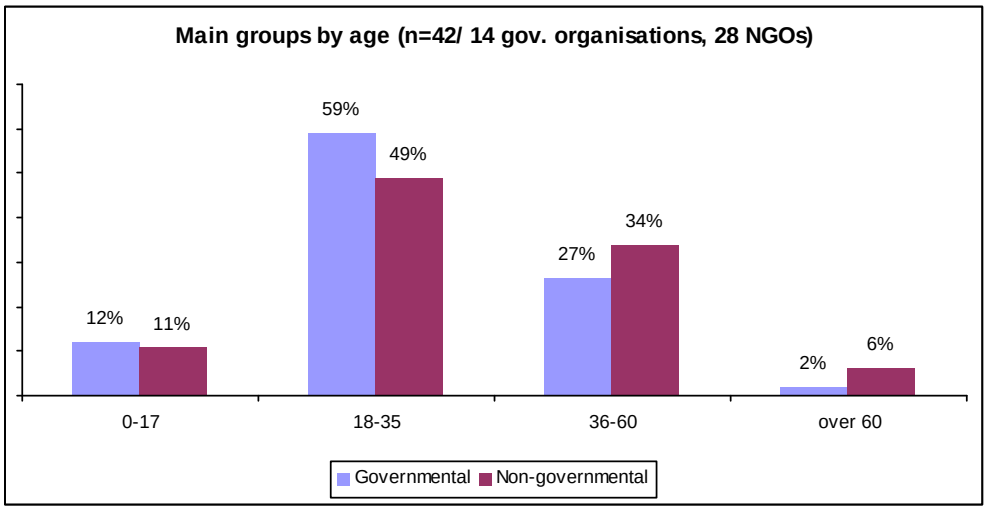
The outcome of one year of intensive research using a number of different channels such as international experts, hospitals and NGO networks, is a collection of 71 practice models from 12 countries (AT, BE, FR, GE, EL, HU, IT, NL, PT, ES, SE and CH) representing the logic of no access, partial access and full access in terms of levels of entitlement to health care, including 24 governmental organisations (GOs) and 47 non-governmental organisations (NGOs).

Table 1: Numbers of services per country and type of organisation

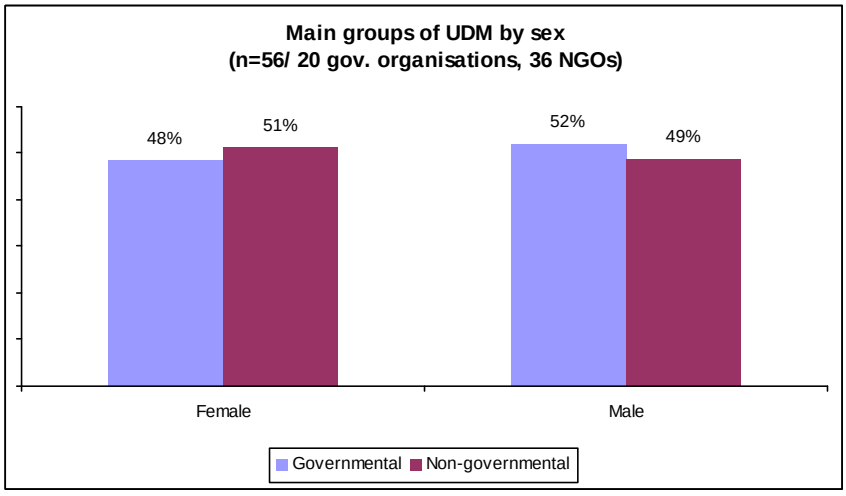
Country	**Governmental organisations**	**NGOs**	**total**
AT	0	9	9
BE	0	2	2
FR	1	0	1
GE	2	11	13
EL	1	1	2
HU	0	1	1
IT	10	5	15
NL	2	3	5
PT	0	1	1
ES	3	2	5
SE	0	2	2
CH	5	9	14
Total	**24**	**47**	**71**

UDM clients by age and sex

The majority of UDM clients is in an age group between 18 and 35 years. UDM clients of GOs on average are younger than clients of NGOs: 12% of GOs´ clients are minors under 18, 59% are between 18 and 35 years old, 27% are between 36 and 60, and 2% are over 60. In NGOs, 11% of UDM clients are under 18 years of age, 49% between 18 and 35, 34% between 36 and 60% and 6% over 60 years old.

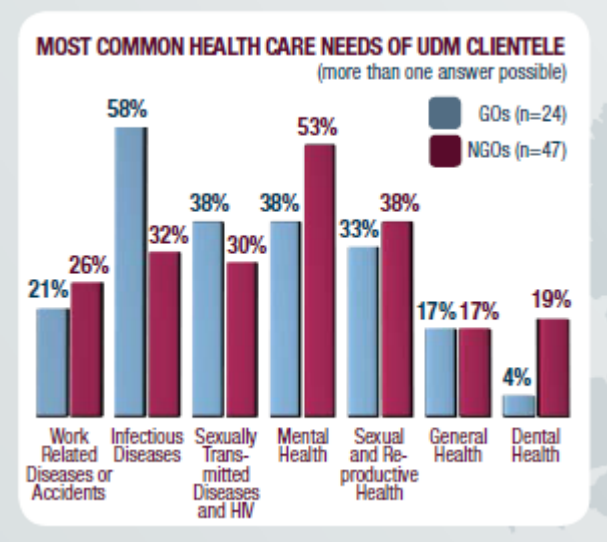


Concerning sex, the shares of males and females are rather similar with only marginal differences between GOs (48% female, 52% male) and NGOs (51% female, 49% male).



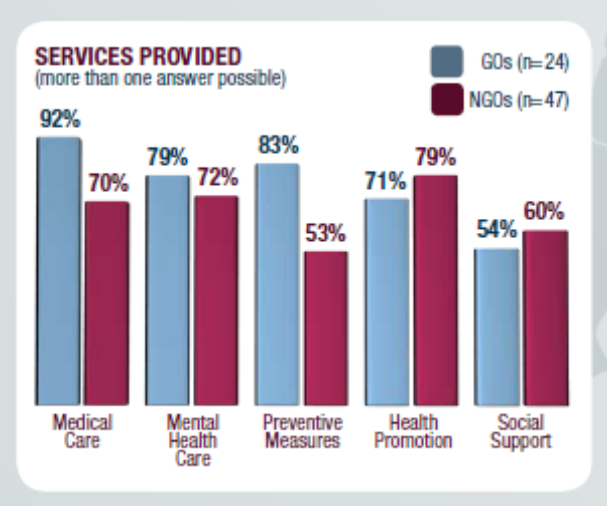
Health needs of UDM clients from viewpoint of providers

Health care services providers, whether GOs or NGOs, find that mental health care and infectious diseases care are the most common health care needs of their UDM clients. A third big issue is sexual health, with GOs focusing on sexually transmitted diseases and HIV, and NGOs observing the need for reproductive health care, followed by work-related health problems.

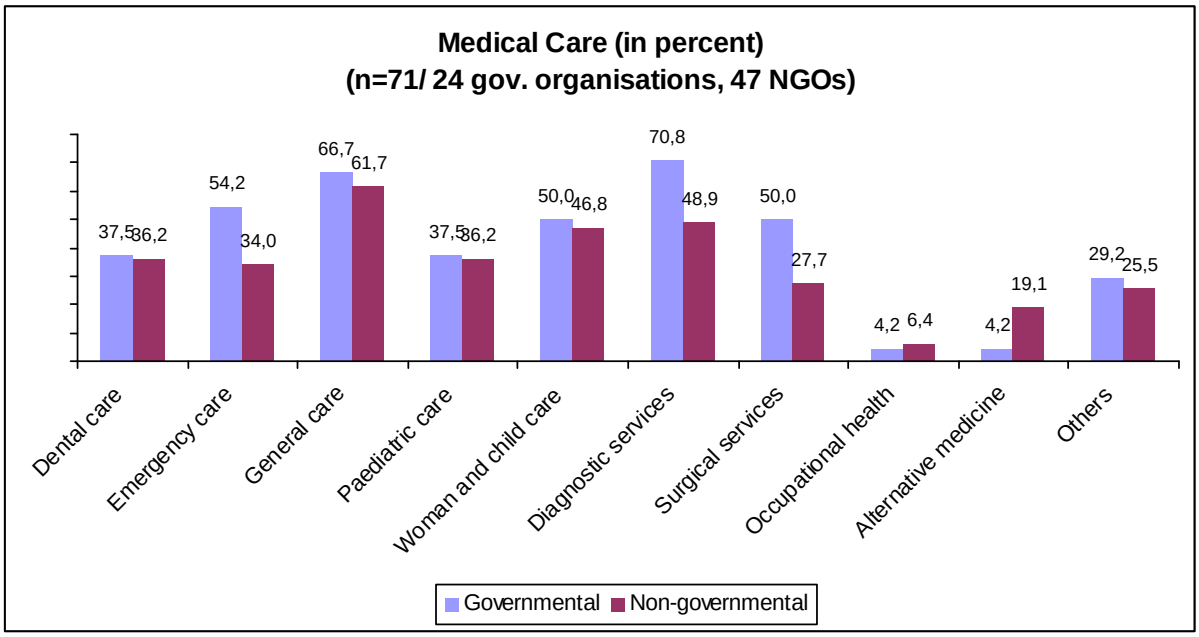


Services provided

The main services provided by GOs are medical care, preventive measures as vaccinations and screening, and mental health care. NGOs mainly provide health promotion measures, mental health care and medical care.

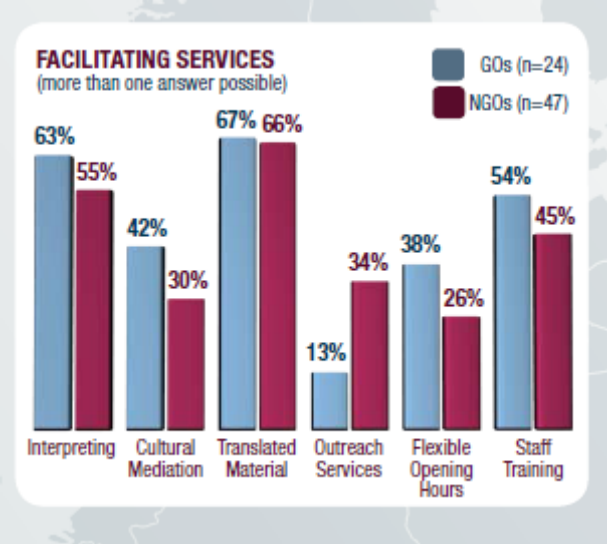


Medical care services mainly comprise general care and diagnostic services for both GOs and NGOs, and emergency care in the case of GOs and care for women and children in the case of NGOs. Mental health care, including psychiatric care and psychological support, is provided by about three quarters of these organisations, including both NGOs and GOs.



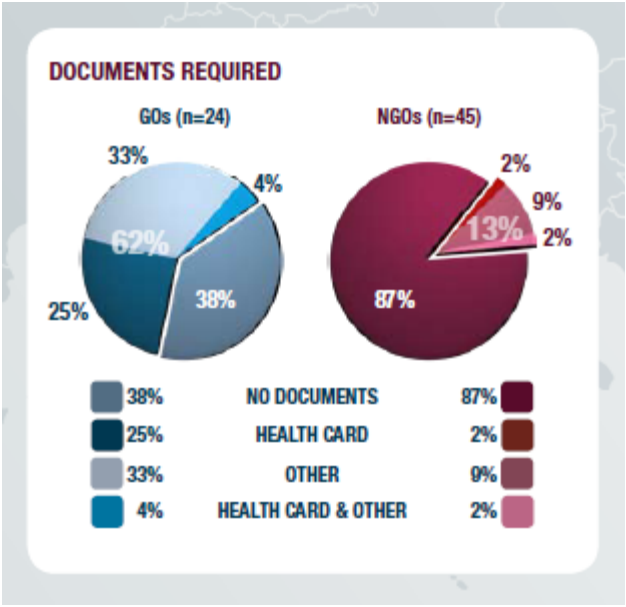
Services to facilitate health care provision

When it comes to support health care services, GOs provide more structures for facilitating communication. Although translated information is available equally from GOs and NGOs (67% and 66%, respectively), GOs provide a higher level of interpreting services and cultural mediation than NGOs.



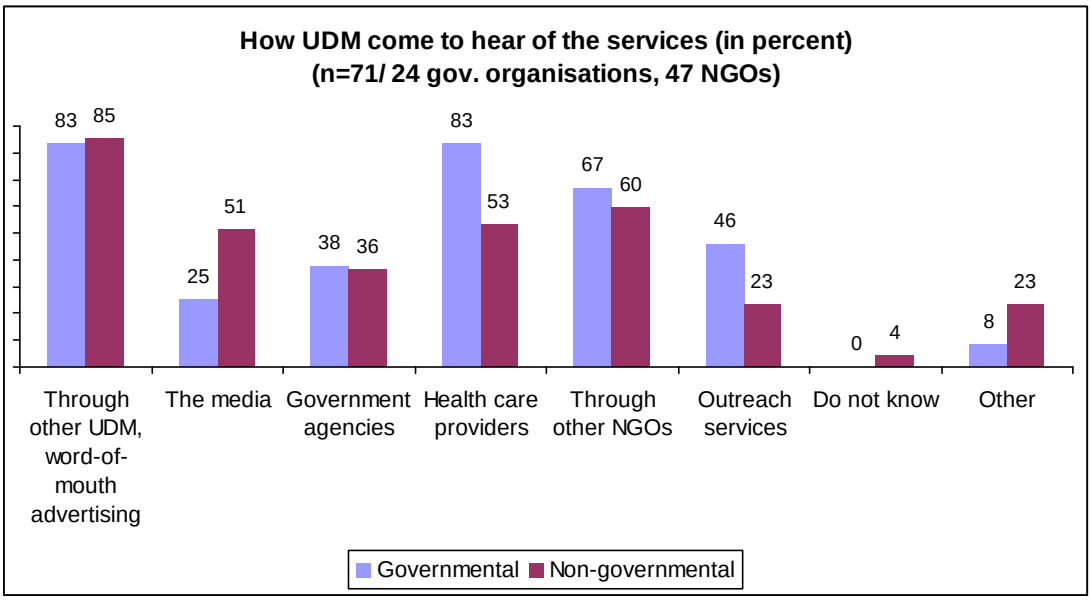
Tendencies of service utilization and information channels

Overall, about 55% of total organizations report increasing numbers of UDM clients. Decreasing tendencies are reported by 13% of GOs but no NGOs. This may be because NGOs are easier to access: only 13% of NGOs ask to see documents compared to 62% of the GOs.



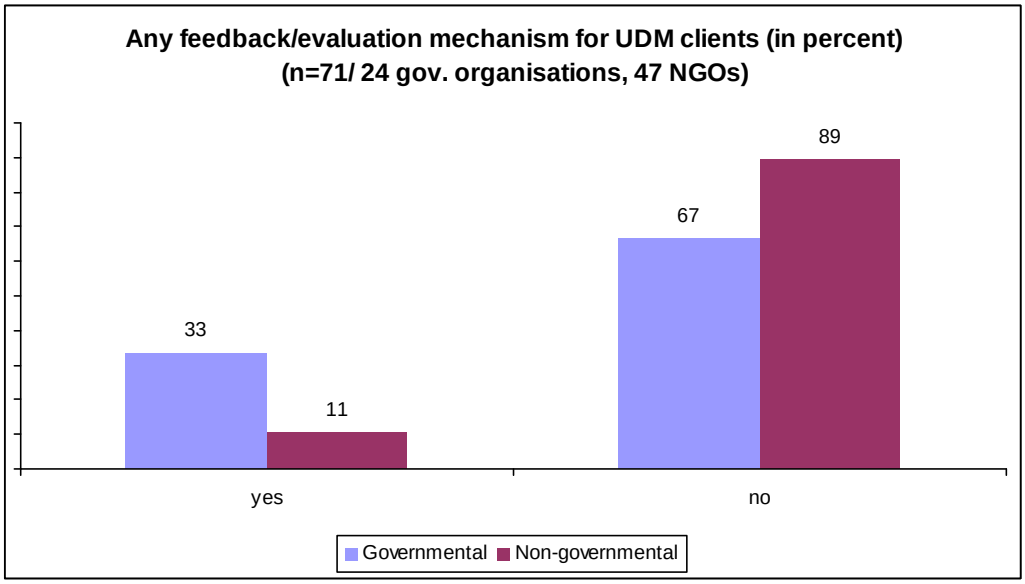
UDM get informed about the services through different channels. In both cases, GOs and NGOs, word-of-mouth advertising within the communities is of utmost importance, followed by information through other health care providers and NGOs.

More than half of NGOs report that their clients learned about their service from media.



Evaluation of services from clients

Mechanisms for collecting feedback and evaluation from UDM clients on services provided are in place in 33% of GOs and 11% of NGOs.



A comparative analysis of these practices shows that:

- Health care services providers, whether they are governmental or NGOs, find that mental health care and infectious diseases care are the most common health care needs of their UDM clients. A third big issue is sexual health, where governmental organisations focusing on sexually transmitted diseases and HIV, and NGOs observing the need for reproductive health, followed by work-related health problems.
- The main services provided by both governmental organisations and NGOs are general care and diagnostic services, and emergency care in the case of governmental organisations and care for women and children in the case of NGOs. Mental health care, including psychiatric care and psychological support, is provided by about three quarters of these organisations, including both NGOs and governmental organisations.
- 50% of GOs report increasing numbers of UDM clients, 37% stable and 13% decreasing numbers. 71% of NGOs report an increase in the numbers of UDM clients, 29% stable and 0% decreasing numbers. This difference between GOs and NGOs may be because NGOs are easier to access: only 13% of NGOs request documents compared to 62% of the GOs.
- When it comes to support services, GOs provide more structures for facilitating communication. Although translated information material is available equally from GOs and NGOs (67% vs. 66%, respectively), GOs provide a higher level of interpreting services and cultural mediation than NGOs.

Contextualised practices

Austria

Undocumented Migrants in Austria

As for all European countries, for Austria only estimates on numbers of undocumented migrants are available. These estimates name numbers between 17.000 (e.g. IOM 2005) and 100.000 people staying in the country without an official entitlement (BMGF 2003). Recent debates criticise these numbers and clearly state that: “On the basis of the available evidence, no serious quantification of irregular migration in Austria is possible.” (Kraler et al. 2008: 2)

In Austria, the issue of undocumented migration is not high on the agenda of public debates, and relevant data and information is accordingly scarce. Reports state that there is no comprehensive policy approach to legalise or regularise irregular migrants. Procedures are based on selective and individual regulations, an explicit programme to regularise irregular staying migrants has never been implemented, (Kraler et al. 2008; Baldwin-Edwards & Kraler 2009b).

There are a few options for undocumented migrants to turn from an illegal to a legal status that have been significantly reduced with the last amendment to the law in 2005. E.g. before 2005 it was possible to receive a legal status through marriage with a citizen which constituted an important option. As now applications for family reunification have to be submitted from abroad it is no longer possible for irregular migrants to obtain a residence title in this way (Kraler et al. 2008).
One possibility for a way into legality is the asylum application as it is likely that a certain share of asylum applicants has been staying illegally in the country before the asylum claim was submitted (Kraler et al. 2008).

The main option to receive a legal status is the granting of the status of humanitarian stay that was first introduced in 1997 and is awarded by the Federal Ministry of

Interior. For illegally staying third country nationals this is the only way provided by the state to obtain a legal residence title (Kraler et al. 2008). The most important reason for granting a humanitarian residence title is non-refoulement. Other reasons are family reunification and facilitation of criminal prosecutions particularly meant for victims of trafficking (Baldwin-Edwards & Kraler 2009b). According to the IOM report on illegal immigration in Austria, humanitarian residence permits have also been granted for other reasons, e.g. to "long-term resident, paperless adolescents, who were brought into the country irregularly by their parents" or to "persons with severe health problems, who cannot receive adequate treatment in their country of origin (e.g. in cases of cancer, Aids or dialysis)" (IOM 2005:37).

Over the last years there has been a significant decline in the number of persons who were granted a humanitarian stay, from 1.500 in 2001 to 460 in 2007 (Kraler et al. 2008: 46). "The current practise of awarding humanitarian stay is deficient in several regards: to date, no right to apply for this status exists and the status is awarded on the discretion of the responsible authorities; in addition, decisions are not judicially scrutinized, nor are there clear criteria for awarding the status or a strong right to humanitarian stay for particularly vulnerable groups." (Kraler et al. 2008: 57).

Legal Regulations Concerning Health Care

Health care provision is primarily a public task in Austria, which is regulated by social law. Main legislative competencies are given to the Federal Ministry of Health, Family and Youth (BMGFJ 2008). Nine federal states are responsible for enactment of the legislation and implementation, as well as for financing and provision of inpatient care (BMGF 2005). Main funding source of the Austrian health care system are contributions to the social health insurance, through which approx. half of the total health expenditure is financed. The other half is financed one quarter each through tax subsidies from federal governments, communities and private households (BMGF 2005; Hofmarcher & Rack 2006).

In 2007 around 99% of the population was covered by the social health insurance (Hauptverband der österreichischen Sozialversicherungsträger 2008). This compulsory insurance under an obligatory scheme by law is financed through income-related

contributions and is based on occupation. The insured are entitled to a broad spectrum of benefits within a legally defined framework. Coverage is extended to co-insured affiliates. For specific groups who are not covered by the compulsory insurance (e.g. marginal employed workers) the possibility of a self-insurance is provided. Migrants who have a recognised status for humanitarian reasons like refugees and asylum seekers are entitled to get health care and their services are covered by health insurance. Registered persons without health insurance mostly comprise unemployed without entitlement to benefits or asylum seekers who are not accepted into the federal care system (e.g. in case of leaving Austrian territory or being arrested or judged for a criminal offence). A study of the Federal Ministry of Health and Women (BMGF 2003) noted that in 2003 around 160.000 people[4] aged 15 or older were living in Austria without any registered entitlement in case of illness.

If somebody without insurance makes use of medical treatment, in principle this works on a fee for service basis. In any case and despite the financial aspects, through the Austrian Federal Hospitals Act every hospital is committed to provide first aid in case of emergencies (KAKuG 2008). In cases where people are unable to pay or the identification of the patient is not possible, hospitals have to cover the expenses out of their own budget (IOM 2005).

Access to Health Care for Undocumented Migrants

Austrian legislation doesn't comprise a specific regulation for health care provision for undocumented migrants. It can be said that on regulatory level, undocumented migrants do not exist. In practice, undocumented migrants belong to a small group of people without health and social insurance, and with a high likelihood, are unable to pay expensive treatment costs.

In general, opportunities to receive medical treatment without being insured or able to pay directly are highly limited. Offered services mostly depend on sporadic agreements with doctors who offer medical treatment at lower-cost, or organisations

[4] The description of the concerned groups doesn't say if the data also covers an estimated number of undocumented migrants.

who offer specific services (e.g. gynaecological examinations, child birth) free of charge. But there are also some established organisations that provide services for people that have fallen out of the health and social insurance system. (see also PICUM 2007b)

Services/Organisations to Provide Health Care for Undocumented Migrants in Austria

Two main actors in the field of health care provision for this marginalised group can be distinguished: Hospitals and NGOs.

Hospitals

Hospitals are the lowest threshold provider of the public health system in Austria. As there is no gatekeeper system like e.g. in the Netherlands, everybody can directly access the outpatient units at any time.

As mentioned, in case of emergency providing treatment is mandatory.

Starting from this obligation, a window of opportunity opens for undocumented migrants to get treatment beyond an actual case of emergency. E.g., medical professionals can 'turn a blind eye' by applying a wider definition of emergency, providing services knowing that they will not be paid and/or accepting false identities. Professionals also mention the possibility that if cases are "interesting", people receive treatment with the argument of scientific and/or educational benefits (Karl-Trummer & Metzler 2007).

Some specific hospitals with a confessional background offer treatment free of charge for people without insurance. The most prominent example in Austria is the private order hospital of the Barmherzigen Brüder ("brothers of mercy"), founded in 1614, which has become one of the most important contact points for undocumented migrants in Vienna (PICUM 2007b; Karl-Trummer & Metzler 2007). Every year around 20.000–30.000 patients without insurance get treatment there, of which 1.000–5.000 are hospitalised. With the guiding principle of the so-called 'new hospitality', the hospital admitted itself to grant every patient the best possible nursing and medical care. There are no restrictions on service provision, the whole range of outpatient and inpatient services is also offered for undocumented migrants. The hospital is DRG-

(Diagnosis-Related-Groups) funded by provincial health fund and additionally financed by donations (www.barmherzige-brueder.at, accessed 21.01.2009).

This organisation is both a public hospital and as such part of the regular health care system and at the same time a NGO acting as a private welfare institution.

This leads to the important role of NGOs for health care provision for undocumented migrants.

NGOs as Intermediaries and as Direct Providers

There is a number of NGOs that act as intermediaries who provide guidance and practical assistance how to access medical services.

A prominent example in Austria is the "Verein Ute Bock"[5] or "Asyl in Not"[6].
The "Verein Ute Bock" offers accommodation, legal advice, consultation – e.g. concerning access to health care –, the possibility to name the address of the association for registration and a postal address, as well as education and training for asylum seekers and refugees. The initiative is based on volunteer work and financed through donations.

"Asyl in Not" offers legal and social advice including health insurance issues in several languages.

Other NGOs provide direct medical care for people without insurance. The two largest organisations throughout Austria are AMBER-MED and the Marienambulanz (AMBER-MED 2008; Sprenger & Bruckner 2008; Ambulatorium Caritas Marienambulanz 2008).

[5] (www.fraubock.at, accessed 21.01.2009)
[6] (www.asyl-in-not.org, accessed 21.01.2009)

AMBER-MED

Since 2004, AMBER-MED, a joint project of the refugee service of Diakonie Austria and the Austrian Red Cross, provides outpatient treatment, social counselling and medication for people without insurance coverage in Vienna. The services offered are free of charge and anonymous and include among others general medicine, gynaecological examinations, paediatric care and diabetes care. In 2007, 889 patients, by the majority asylum seekers, refugees and homeless people, made use of AMBER-MEDs services – the tendency is increasing. The existence of this organisation is mainly made possible due to the volunteering of doctors, nurses and interpreters – the team consists of 3 employees and 31 volunteers – as well as through the support of a large network of medical specialists and institutes. Until 2006 AMBER-MED had been financed exclusively through donations. In 2007 the organisation for the first time received subsidies from the Federal Ministry of Health and the Fund for Social Affairs in Vienna (Fonds Soziales Wien), since 2008 also from the Vienna Health Insurance (Wiener Gebietskrankenkasse) (see AMBER-MED 2008, Diakonie Flüchtlingsdienst 2008).

Marienambulanz

Since 1999 the Marienambulanz in Graz, Styria, provides primary health care for people without insurance coverage and for other marginalised groups. Responsible body is the Caritas Austria. An outpatient department offers general medicine care as well as target group oriented care (e.g. diabetes, hypertension, psychiatric disorders). A mobile unit visits different places in the city once a week to provide medical and psycho-social care and counselling. The team consists of 5 employees and 31 voluntary workers who are covering a wide range of disciplines, cultural backgrounds and languages. In 2007 there were 7.954 documented contacts and 1.250 patients from 72 nations were treated and counselled in the outpatient department. About half of the patients was without insurance coverage. The Marienambulanz has a close co-operation with health authorities and institutions and established itself in the health care system as an expert for medical treatment of socially marginalised groups. Financing is supplied by the Federal Ministry for Health, Family and Youth, the “Land Steiermark - Gesundheitsfonds Steiermark und Sozialressort”, the Municipal Health

Authority Graz and the Caritas. Since 2006 the service has a contract with the Styrian Health Insurance Company. In 2007 the Styrian Health Platform as the responsible public body nominated the Marienambulanz unanimously as a measure that disburdens hospitals, which opened the possibility for further funding (Sprenger & Bruckner 2008; Marienambulanz 2008).

Germany

“I´m not an enemy of the immigration authorities”
Malteser Migranten Medizin (MMM),
Berlin
Country: Germany
Policy context: Minimum Rights / No Access
Type of organisation: NGO

MMM was founded by Malteser Germany, a Catholic charitable organization, in 2001 and provides primary health care for people without medical insurance, including UDM. Services include basic care, gynecological, pediatric, dental, orthopedic and neurological care, psychological treatment and physical therapy. A total of 15 staff members (7 health care professionals and 8 administrative staff) work at the MMM on a volunteer basis. In 2009 MMM treated about 5.600 patients, 69% of which were UDM. Health care in general is provided free of charge; in case of expensive treatments patients are asked for financial contribution.

Italy

Public-private partnership
Centro per la Famiglia Straniera (CSFS)
& their partner Caritas,

Reggio Emilia

Country: Italy

Policy context: Rights / Partial Access

Type of organisation: Dedicated Public Health Service and NGO

The CSFS is run by the local health authority (Azienda Unità Sanitaria Locale - AUSL) of Reggio Emilia, providing outpatient care and medical treatment, including gynaecological examinations and counselling, prenatal care, pediatric care, a TBC surgery and cultural mediation services. Services for specific target groups are offered on a project basis, e.g., psychosocial support and health care for prostitutes or badanti. The centre keeps precise statistics on its patients, which is made possible through the STP code, which permits the identification of patients and the keeping of patient records, while at the same time preserving patients' anonymity. The CSFS shares its database with the Caritas's "Querce di Mamre" medical practice which offers specialist care in 11 areas: dental care, general care, woman and child care, surgical services, neurology, urology, cardiology, ophthalmology, orthopaedics, ear-nose and throat specialist, dermatology.

Undocumented Migrants in Italy

From a historical perspective, Italy represents a traditional source country of emigration that has become a receiving country, "with little experience of managing the high number of incoming flows" (Zanfrini & Kluth 2008: 13). Documented immigrants currently represent a 5.7% of the total population and "contribute for about 70% of the growth of the population residing in Italy, and their babies born in Italy are about one tenth of the newborns." (Fasani 2008: 9).

According to estimates, a high proportion of the regular immigrant population currently residing in Italy passed from an undocumented status to a legal one. This was enabled by five mass-regularisation laws that came into force in 1986, 1990, 1995, 1998 and 2002 and which have jointly regularised almost 1.5 million irregular migrants who were already residing in the country. Nearly 700.000 of them got their

legal status through the regularisation in 2002 (Fasani 2008:13; Zanfrini & Kluth 2008: 30).

It is suggested that Italy is a prominent receiving country for undocumented migration especially for economic reasons: “Italy attracts illegal immigration more than other countries due to the importance of its informal economy, which enables a flexible expansion of private care and domestic services as well as a proliferation of small enterprises where unregistered labour can more easily be hidden” (Zincone 2001: 1).

“There is a widespread consensus among experts and commentators that the lack of adequate possibilities of legally accessing the Italian labour market (…) has played a major role in increasing undocumented stocks and flows.” (Fasani 2008: 16)

According to the Clandestino country report, the latest estimates on the stock of undocumented migrants in Italy amount up to approximately 541.000 in 2005, 650.000 in 2006 and 349.000 in 2007 (Fasani 2008:31). The decline in the estimates from 2007 is mainly explained due to the effect of the so-called “Flow-decree” in 2006, a quota system established by the government every year to manage the legal inflows of migrant workers. The “Flow-decree” allows employees to apply for hiring immigrant workers until the quota number is filled. It does not allow an application for immigrant workers who are already residing in the country. “…if they [undocumented migrants] find a job and an employer who wants to legalize their situation and working contract, they wait for the “Flow decree”, apply for a place (In recent years applications have to be submitted to any Post Office and with the last Decree (2007) one could apply through internet: the application can be made by the migrants on behalf of their employers), and, finally, if the application is accepted, they move back to their origin countries and then return to Italy, entering officially and pretending not to have been in Italy before. Basically, migrants undergo an indeterminate probation period as undocumented ones, and if the working relationship consolidates they may obtain the legal status and emerge form the underground economy.” (Fasani 2008: 37)

In 2007 the Italian Ministry of Interior published estimates on the main types of undocumented migration. According to these, the majority of the group of undocumented workers are overstayers (60-75%). Another significant part entered Italy at the Northern borders by avoiding the border controls and at international ports and airports. Only a small proportion is landing along the Southern shores (Fasani 2008: 13).

With respect to the undocumented migrants' country of origin, it is reported that in 2005 the largest group (more than the half) were from Eastern European countries (Albania, Romania, Ukraine and Poland), nearly one sixth was from Northern Africa (mainly Morocco and Tunesia), around one tenth were each from Asia and Oceania, Sub-Saharan Africa and Latin America (ISMU estimates in Fasani 2008: 50f). A comparison between documented and undocumented migrants shows that there are no big differences concerning the composition of nationality.

Legal Regulations Concerning Health Care

The Italian National Health Service (Servizio Sanitario Nazionale) was established in 1978 and introduced universal coverage to all citizens with the aim to guarantee "equal access to uniform levels of health care, irrespective of income or geographical location" to everyone. This universal system replaced an insurance based system that had been set up after the Second World War. The aim of the 1978 reform was to implement a fully tax-based public health care system with only marginal private contributions (Donatini et.al. 2001:14f). Although universal coverage has been realized, health care and health expenditure between the regions show great differences, with a clear north-south divide.

The responsibility for health care is organised on national, regional and local level. The state is in charge of defining the basic benefit package (Livelli Essenziali di Assistenza – LEA) which must be supplied equally throughout the country and has to ensure the general objectives and principles of the national health care system. Task on regional level is the organisation and administration of the health care system through regional health departments where the local health authorities have the responsibility

for the health care service delivery (Große-Tebbe & Figueras 2004: 41; Donatini et.al. 2001:19).

The system is financed by regional- and general taxation. In addition, local health units receive co-payments of patients through a system of prescription fees - so-called "tickets". Private health care services and over-the-counter drugs also have to be paid out-of-pocket. In 2004 around 15% of the population had complementary private health insurance (Große-Tebbe & Figueras 2004: 41f).

Access to Health Care for Undocumented Migrants

Since 1998 in Italy all migrants without a regular permit of stay have a right to urgent or primary hospital and outpatient treatment in case of sickness or accidents as well as for preventive treatments. Due to the Italian legislation on "health care for foreign nationals who are not registered with the National Healthcare System" (Legislative Decree no.286 dated 25th July 1998 Art. 35) access is specifically guaranteed to the following services:

- prenatal and maternity care
- health care for minors
- vaccinations
- preventive medicine programs
- prevention, diagnosis and treatment of infectious diseases.

Additionally there are three categories of undocumented patients, which are covered by law and can be also treated besides emergency/urgency: minors up to 18 years, pregnant women up to 6 month after birth and patients with diagnosed infectious diseases[7].

According to the regional law "Immigrant women shall be treated on equal terms to Italian women and shall enjoy social safeguard pursuant to the legislation on women

[7] This refers to Article 19, paragraph 2, letters a) and b) of the national law

clinics, promoting and supporting health and social services sensitive to cultural differences. The safeguard of minors under the age of eighteen is also guaranteed, in conformity with the principles established by the Convention on the Rights of Child, held in New York on 20th November 1989 and ratified with law no. 176 of 27th May 1991."[8]

As soon as the pregnancy of an undocumented woman is attested, she is entitled to get access to the family planning clinic of the national healthcare service, which is located in each ASL (Azienda di Sanità Locale = Local Health Authority) and where assistance is for free.

The Italian legislation prohibits the health services any form of reporting to the competent authorities the undocumented migrant's presence, except cases in which reporting is compulsory, due to equal treatment applied to Italian citizens (e.g. serious injuries as a result of a criminal offence, reporting in case of infectious or diffusive diseases). In such cases the healthcare facilities must record the personal data provided by the patient, even if ID documents are not available (see also Ministerial Circular no.5 dated 24th March 2000: Applicative provisions of Legislative Decree no. 286; Pace 2007:23f; PICUM 2007b: 51ff). This regulation safeguarding undocumented from detection, however, is under discussion (see MSF 2009; PICUM 2009c) and was changed in February 2009 (SIMM 2009; Turone 2009).

To access to public health and medical care services, undocumented migrants need to obtain the so-called regional "STP-Code" (Straniero Temporaneamento Presente - foreign national temporarily present). Undocumented migrants may get the STP-code from a hospital administration or the ASL any time and free of charge. It is valid for 6

[8] According to the national law: Unified Text of the provisions regarding immigration control and the norms on the condition of foreign nationals. Legislative Decree no. 286 dated 25th July 1998. Article 35, Paragraph 3.:
a)the social safeguard of pregnancies and the maternity condition, on equal terms to treatment to Italian women, pursuant to laws no. 405 of 29th July 1975 and no. 194 of 22nd May 1978 and the Decree by the Minister of Health of 6th March 1995 published on the Official Gazette no. 87 of 13th April 1995, and on equal terms of treatment to Italian citizens;
b)the safeguard of the minor's health in compliance with the Convention on the Rights of the Child dated 20th November 1989, ratified and enforced pursuant to law no. 176 of 27th May 1991;
c)vaccinations according to the applicable legislation and within the ambit of community prevention campaigns promoted by the Regional Authorities;

months and can be renewed (see also PICUM 2007b). This code is anonymous and consists of an STP-number, an ISTAT code (Italian National Statistics Institute) relating to the public health authority that first issued it, and the public health service where treatment is provided and a progressive number assigned at the date of issue. Regarding the provision of medical treatment, the code is used for accounting procedures, for compensation purposes and for the prescription of drugs. The code identifies the patient for all health care services he or she is entitled to and is recognised throughout Italy (Italian Presidential Decree no. 394 dated 31st August 1999 Art. 43).
The STP doesn't entitle the undocumented migrant to turn to a general practitioner. Instead, if a GP is needed, undocumented migrants go to dedicated services or NGOs, where general medical care is provided.

If undocumented migrants do not possess sufficient economic means for the medical treatment, they can apply for the "status of indigence" (Dichiarazione di Indigenza) which is certified by self-declaration. This usually happens at the time when the regional STP-code is assigned. The self-declaration document is also valid for six months and permits undocumented migrants to receive medical treatment free of charge in the framework of the abovementioned services. However, undocumented migrants have to pay the out-of-pocket contributions to the expense on equal terms to Italian citizens. Costs incurred from urgent or primary hospital treatment, even for a continued period, are covered by the Ministry of Interior. For refunding, the hospital in question informs the ASL which gets reimbursement from the Ministry of Interior. For this, the anonymous STP-code, the diagnosis, the type of treatment and the reimbursement amount have to be provided. The financing of the special services (prenatal and maternity care, health care for minors, vaccinations, preventive medicine programs, prevention, diagnosis and treatment of infectious diseases) follows a similar procedure and is covered by the National Healthcare Fund (see also Italian Presidential Decree no. 394 dated 31st August 1999 Art. 43; PICUM 2007b).

Services/Organisations to Provide Health Care for Undocumented Migrants in Italy – The Example Reggio Emilia

The following section gives an overview of services for undocumented migrants implemented in Reggio Emilia, Region Emilia Romagna. Reggio Emilia is a region that belongs to the "rich parts" of Italy and has a long leftwing oriented political tradition.

It is important to point out that, while the basic logic of access and provision of health care all over Italy is almost the same, regions are dealing with this common logic in different ways. This might be due to the richness of a region but also because of its political orientation.

PICUM states that there are remarkable differences in implementing the law - between regions as well as within regional health care centres and hospitals. They conclude that access to health care seems less guaranteed in areas with less immigrant population or with just low pressure of NGOs and state that the degree of awareness and information about access to public health care services for undocumented migrants varies among the relevant actors in the different cities and regions (PICUM 2007b: 53ff).

Information on policies and practices concerning health care for undocumented migrants was gathered in the framework of a Short Term Scientific Mission funded by the COST Initiative[9]. As stated, health care and health expenditure in Italy show great differences between regions. Findings on regional level therefore cannot be generalised for other regions.

In Reggio Emilia, three main actors providing health care for undocumented migrants could be identified, two of them public and one private:

- Hospitals, accessible in cases of emergency and/or urgency
- So called "dedicated services", tailored services for undocumented migrants, networking with NGO
- NGOs as specific services for the poor

[9] 'COST Action IS0603 – Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME) The authors would like to thank again the COST initiative for this opportunity.

These main actors are described in the following through three health care organisations which were visited in the framework of the Short Term Scientific Mission.

Hospital: City Hospital Santa Maria Nuova

As in Austria, emergency units in Hospitals are the lowest threshold provider. In Reggio Emilia, the emergency unit at the City Hospital Santa Maria Nuova offers health care provision for undocumented migrants in cases of emergency and/or urgency. Main cases of treatments are related to workplace accidents, violence, and trauma.

It also serves as a contact point for other health care providers that give services to undocumented migrants. The hospital provides undocumented migrants with leaflets and information about these services.

As the legislation foresees that in case of pregnancy undocumented women shall be treated on equal terms to Italian women, undocumented women also have access to the gynaecological department.

In the hospital there is no monitoring of undocumented migrants. For the gynaecological department it is estimated that within the whole group of migrant patients of about 30% of the total, there are around 5% undocumented (Karl-Trummer & Metzler 2008). The department provides cultural mediators for Arabic and Chinese.

Dedicated Service: Centro per la salute della famiglia straniera

The health care centre Centro per la salute della famiglia straniera is providing outpatient care and medical treatment for undocumented migrants and for foreign nationals without registration in the National Health System. It is located within the Local Health Authority of Reggio Emilia as responsible body and has a close cooperation with the Caritas. The centre employs health care professionals (general practitioner, midwife, paediatrician, gynaecologist, and nursing staff) and social worker who are available twice a month. The provided services include gynaecological

examinations and counselling, prenatal care, paediatric care and one time per month a TBC surgery. Services for specific target groups are offered on a project basis. In the framework of such projects, psychosocial support and health care for prostitutes and "Badanti" – elderly Eastern European women working irregularly as caregivers in private households – is offered. To facilitate communication and interaction, cultural mediators for Chinese, Arabic, Albanian, Russian, Indo-Pakistani and Nigerian are working at the centre.

The health care centre keeps precise statistics on its patients. This is made possible through the STP code. The statistical database is shared with the Caritas surgery "Querce di Mamre" (see section below) which among others enables both services to make appointments for patients in the respective centre. Both organisations also provide shared information material for patients.

According to the patient statistics of 2007, the centre had a total of 3.189 patients. 53,7 % of these were there for the first time. The largest communities represented are Asian (33,9%), Eastern European (33,2%) and North African (21,6%). In cases of urgency, the centre refers undocumented migrants to the emergency unit of the hospital and calls the responsible doctor there in advance. For special services (e.g. blood screening) the patients have to go to the territorial health care service (see also Manghi 2005, AUSL di Reggio Emilia 2008b, Regione Emilia Romana 2008, Karl-Trummer & Metzler 2008).

Continuity of care is an important factor of these services, especially during pregnancy. Staff members therefore try to fix all appointments and steps through pregnancy in advance to assure the continuity of care. Through legislation pregnant undocumented women are on equal terms to Italian women concerning health care. They can access the general health care system and do not need to go to the dedicated service. Nevertheless it is reported that most pregnant women prefer to receive treatment at the dedicated centre. Reasons for this are the trustful relationship and the continuous availability of a cultural mediator (Karl-Trummer & Metzler 2008).

NGO: Caritas Surgery "Querce di Mamre"

Querce di Mamre is an outpatient clinic run by the Caritas in cooperation with the Local Health Authority of Reggio Emilia (AUSL). The AUSL provides the NGO with pharmaceuticals, dental materials, and covers costs for cultural mediators. Costs for electricity, heating, cleaning and waste disposal are also covered by the AUSL. The NGO has 2 surgeries for general medicine, 1 gynaecological surgery, a dental surgery and a surgery with tools and drugs for emergency use. It is well equipped with various instruments like ultrasound, electrocardiograph and has a well-stocked pharmacy. It is supported by a network of several medical surgeries that offer assistance directly at their private sites.

The team of Querce di Mamre consists of 60 volunteering doctors (GPs and specialists) and 15 volunteering nurses. The large number of staff makes it possible to cover nearly all medical fields. Among others these are general medicine, internal medicine, general surgery, obstetrics and gynaecology, paediatrics, otorhinolaryngology, ophthalmology, psychiatry, and dental care. Additionally there are 2 chemists, 1 psychologist and 5 informatics assistants. Communication and information is supported by mediators and written information material.

Target group of the centre are undocumented migrants without access to the NHS and people with a declared status of indigence. To get services for free, patients need to declare the status of indigence immediately before they access the health care service in the so-called "listening centre" (Centro d'Ascolto) which is in the same block of buildings. In the last 5 years there was a steady increase of numbers of total visits from 437 in 2003 to 1411 in 2008. More than half of the patients are aged between 20 and 40. In 2008 the 3 largest groups were represented by Chinese (approx. 20%), Morocco (approx. 16%) and Moldavia (approx. 12%). (Pisi 2008; Caritas Diocesana di Reggio Emilia 2008; AUSL di Reggio Emilia 2008a).

The Netherlands

Maria!
Maria van den Muijsenbergh,
Nijmegen
Country: The Netherlands
Policy context: Rights / Full Access
Type of organisation: General Practitioner

Maria van den Muijsenbergh has been running her medical practice since 1994. As general practitioner (GP) she provides general care including vaccinations, health screening, infectious diseases control, emergency care, paediatric care, mother and child care, diagnostic services und surgeries. In addition, Dr. van den Muijsenbergh advises her patients on health promotion, psychiatric care and psychological support. Although GPs are guaranteed reimbursement of at least 80% of the UDM treatment costs, Dr. van den Muijsenbergh is the only GP in Nijmegen who serves UDM.

Spain

Help in Navigating One's Way around the System
Salud y familia,
Barcelona
Country: Spain
Policy context: Rights / Full Access
Type of organisation: NGO

Salud y familia is a private, non-profit association which works together with public authorities and other NGOs. Salud y familia does not provide health care as such, but rather, it facilitates access to mainstream health care and helps clients to navigate their way around the system, and informs health care organisations about regulations in place.

People

UDM: who are they?	Evidence from HUMA/Picum + Heterogeneous group Work/health/behaviour Man/women strategies to survive: Fall nicht auf Bleib gesund	Results from sample Italy Database info Info in-depth assessments
XX ways to live in NowHereland: experiences of undocumented migrants in the EU and Switzerland	Life stories	

Life stories of UDM in Europe and Switzerland

XX ways to live in NowHereland: Adam

Adam, 30, has spent the past 13 years in m/m[10]. He cites multiple countries of origin, including Uganda, Gambia, and Mauritania. The strategy helps him confuse authorities. The Ministry of Interior has even contracted speakers of different African languages and dialects to interact with Adam, with the intention of ultimately discerning his true ethnicity. However, Adam's knack for cultural subtleties has confused even native speakers. The trickery avoids him deportation.

For Adam, m/m is an enjoyable, small city, in which everyone knows one another. Nevertheless, he recognizes that he needs to "know the ropes" to avoid hassles. He knows where to find good, free food, where to find a place to sleep, where to access health care, and especially how to interact with authorities. He knows m/m well, and knows which locations are regularly monitored by the police. The police often find Adam. He has been living in m/m for a long time, so he knows the guards and how to bargain with them. If "everything is ok," they release him. Occasionally, they find Adam carrying a small amount of drugs, and thus charge him a penalty fee. Adam has

[10] Abbreviation: m/m stands for the municipality where the UDM stays

the means to pay the fee, however he prefers to be sent to prison. In this case, he doesn't have to name his place of residence and he likes c/c[11] prisons, especially those who require inmates to work in an agricultural setting (Adam was originally a farmer). At these camps, food and accommodation is good.

Adam describes his living situation as "very mobile". Sometimes he sleeps in the streets, but mostly he stays with various friends. His social network consists of "many very open-minded people," who provide him with a place to sleep, money, and whatever else he needs.

He works odd jobs, predominantly in the informal sector (custodial, moving, farming, or small drug dealing). Adam rates his health status as excellent, noting that he needs dental care. He visits o/o[12], because "they are cool and I'm sure they do everything super".

Adam sees no reason to change his lifestyle. He plans to stay in m/m with friends, both old and new.

XX ways to live in NowHereland: Ariana, Garip and their baby

Garip and Ariana are both about 25 years old. Originally from Kosovo, they seek asylum in c/c. Their families are enemies and have threatened the couple. As a result, their application was refused by the c/c authorities. ("Romeo and Juliette stories" are not legally considered persecutory) Adriana's pregnancy was followed by severe post-natal depression. Both are obstacles to deportation. As long as they report to the police every three months, the family may continue to live in c/c.
The family currently lives in a shelter for women and families. The shelter is characterized by poverty and conflicts, thus they would prefer to live in their own flat.

[11] Abbreviation: c/c stands for the country in which the UDM stays

[12] Abbreviation: o/o stands for the regarding health care organisation

However, finances are tight and m/m is expensive. They are barred from working and must survive on very little.

A nurse at the shelter referred the couple to o/o (responsible for asylum seekers in m/m). They visit o/o only when health problems arise. Their baby has health insurance, and therefore can be treated at the hospital. However, Ariana and Garip are treated at o/o.

Ariana and Garip suffer from mental disorders. Ariana hears voices that say she will be killed by her family. She thinks of suicide. Both receive psychological care once a week.

The young family's only contacts are the staff at o/o. They are completely isolated and rely only on each other. They do not speak to their families, friends, and have no contacts in m/m.

With regard to their future, they have no ideas, no plans, and no prospects.

XX ways to live in NowHereland: Michael

Michael is a 35-year-old man from Nigeria. He lived in Greece for "some time". There, he requested asylum and obtained the necessary documents to stay in Europe during the application process.
Michael describes the living and working situation in Greece as "insecure and uncertain": the political and the economic crises led him to c/c, a country he had always known as rich, safe and clean. Assuming that c/c was an EU member state, he thought his Greek documents would be accepted by c/c authorities. While job searching in m/m Michael learned of his illegal status. Nevertheless, he does not fear the police. His documents, he says, are in Greek (unintelligible to c/c authorities), and appear official.

He has lived in m/m for two months. Life in c/c turned out to be difficult. As an undocumented male without German-language skills, Michael cannot find a job. His unclear and uncertain living situation is aggravated by his lack of income. He lives on the streets, occasionally he spends the night with a friend. He has a loose network of acquaintances, and few stable relationships with relatives and friends. Recently, he lost contact with his family in Nigeria. The family expects remittances, which Michael cannot send.

This instability has affected Michael's physical and mental health. He suffers from high blood pressure and a sleeping disorder. He has only been able to obtain care at o/o, which is affiliated with the Red Cross. Michael was drawn to o/o because of the reputation of the Red Cross. He finds the staff to be friendly and knowledgeable. Their work is "life-saving", as they offer first aid, diagnoses and therapy (medication.) He also says that they are good listeners.

Concerning his future, Michael finds himself at a crossroads: Will he stay in c/c, and adopt criminality (the only source of income for someone in his situation)? Will he return to Greece, where living conditions are poor? Will he travel to another EU member state, where conditions might be better? He prefers the last alternative, so he is currently researching the conditions in other parts of Europe, as well as finding ways to finance his relocation..

XX ways to live in NowHereland: Mohamed

Mohamed, born in Mauritania, is 32 years old. He has lived in m/m for six years.

He sees m/m as a quiet, clean, and safe city. People are friendly and public transportation is efficient.

Some years ago, the c/c police detained Mohamed and he had to stay in detention awaiting deportation for 6 months. However, neither the c/c nor the Mauritanian

authorities could confirm Mohamed's Mauritanian citizenship. Though he is no longer in detention, Mohamed avoids sites that are frequented by the c/c authorities (e.g. places where drug dealing takes place). His strategy to avoid police encounters, he says, includes following public laws, frequenting locations "where the good people are," and putting forth a relaxed imaged.

Mohamed's social network consists of migrants and c/c nationals; however he has no contact with his family. These friends provide him with homes, which he changes periodically. His poor health prevents him from working; however he previously worked in the informal sector as a custodian, kitchen assistant, and translator.

To care for his health, Mohamed often visits o/o. He avoids discussing his health publicly, and thus appreciates the discretion of the o/o staff. They care for all of his health needs, do not ask his name, and are very helpful.

For Mohamed, the key to integration is linguistics. He learned German independently, in order to speak with authorities and physicians without an interpreter. He refuses to trust third parties. His speaks with a German accent, thus c/c authorities have attempted to deport him to Germany. However, authorities are unable to certify that Mohamed ever lived in Germany.
In c/c, Mohamed feels partially integrated: He has a close network of friends and perfect command of the local language. Nevertheless, he knows he must obtain legal status and the necessary documents to feel wholly integrated into c/c society. So, his next project is to obtain documentation.

XX ways to live in NowHereland: Nathalie

Nathalie, 30, is from Tanzania and has been living in c/c for 8 years. She has spent her time in different cities. Five years ago her application for asylum was rejected; and since then Nathalie has been living without papers and without a valid residence permit. She fled Tanzania because her mother wanted her to be circumcised, and she

was frightened and ran away. This was rejected as a reason for seeking asylum, on the grounds that female circumcision was not common practice in Tanzania. She is currently without a job. Some time ago, she worked in a private household as a cleaner for an elderly couple, and she constantly is in search of work to get some money for a living. This of course is difficult because she has no papers and no legal status. At the time of the interview, Nathalie was living with her "friend" who gives her a place to sleep and money. She says it is important to have a friend, because this means that you have a place to sleep. Without a friend, you have to move around and find shelter where you can, sometimes sneaking into an asylum-seeker camp for a couple of days, managing to avoid the security patrols by hiding in the toilet, sometimes with friends for a few days at a time. Quite often, these "friends" short-change her, she says: she has to clean and cook for them and always be cautious not to disturb them. To be in good health is important, she says: when you're sick, nobody wants to take you in – they're frightened of catching whatever you have.

She says it is important to have a boyfriend, because it's exhausting to stay with friends: you start to feel uncomfortable because you know that they feel uncomfortable if you stay too long and of course, they always want something in return. The relation to her boyfriend is questioned by herself: "One day I went out to a club and was late, and he would not let me in – I did not know what to do. I don't know if I would be with him if I weren't in need for accommodation."
She always asks herself the same question: would I stay with this guy if I had more freedom to choose?" Sometimes I ask myself: Am I a prostitute?" she says.

Nathalie knows that she is an attractive woman, and she made the experience that this also helps to get out of difficult situations. She tells us about the experience of a police raid in a music club – "they locked the door and started to check people and ask for documents – I behaved like an average young girl and started to flirt with a policeman, I told him that I had been about to leave when they came in and that my friends were already outside, and he let me go."

She always has €20 on her for emergencies. “When I have 20 Euros in my pocket, I feel safe” she says. When her reserve dips below that “minimum safe level”, she uses one of two strategies to get money: either she tells her boyfriend that she needs money to get her nails done, or to buy a new dress, etc., and then pockets the money instead, or she looks for ‘casual work’, work paid “cash-in-hand” (no questions are asked, no contract is signed).

When asked about her plans and perspectives, she tells us that her dream was to study and to become a politician, to work for the UN or some other international organisations. Sometimes she asks herself – was it right to go away?

She has no direct contact with her family, but she has heard that her sister will not be forced to undergo female circumcision, because their mother is afraid of losing her sister, that she too will run away. That makes her feel better – at least it was good for something, she says. She would like to go back to Tanzania, but she sees no chance to do so.

Here in c/c she lives in fear of being discovered. “I only go out if I need to. If it’s a choice of fresh air or safety, I choose safety”. Her perspective? “Survive, and come around the next day, have a place to sleep and maybe a small job to get some money.”

Nathalie disappeared a few days after this interview.

Recommendations

Based on the evidence collected and experiences made within the framework of the NowHereland Project, preliminary recommendations can be formulated that address the policy frameworks and the practice level of health care provision itself as well as further research.

- Increased awareness on the issue of undocumented migration is required, so that policies are based more on evidence and less on emotions / myths. This requires a more systematic use of knowledge collected in various projects and initiatives, both on practical level and on level of research.

- UDM are the most flexible and exploitable work force and undocumented migration is closely connected to informal labour market demands. Policies to shape labour markets should be included into discussions concerning UDM issues.

- The debate on how to ensure the human right to health care is of undoubtedly highly relevant. Furthermore, economic conditions should be considered, which might show that the costs of excluding UDM from health care until they end up in emergency care are considerably higher than allowing (at least) partial access to main stream services.

- The development of partnerships between public health services and NGO initiatives has proven to be a factor for successful practice. GOs and NGOs should find a way to discuss and develop frameworks for joint service provision.

- UDM are a heterogeneous group, and there are vast differences between and within UDM communities. Differences are related to working and living situations as well as social networks. On practice level, this means that there is

standard, “one-size-fits-all” solution. Research and practice approaches have to be aware of the dangers of stereotyping.

- In most cased, UDM leave their countries of origin because they cannot have a “humane” life there. They are willing to work, to take care of their families and themselves in order to succeed in live, and they survive under extreme hardships. They could also be seen as a resource for Europe and not a threat. Maybe such a shift in perspective could open up new grounds for discussion.

Annexes

Related Projects and Initiatives

The EU-project 'AMAC - Assisting Migrants and Communities: Analysis of Social Determinants of Health and Health Inequalities'[13] reviews key health concerns of migrant populations in the context of social determinants of health. This project also serves as a platform for exchange for European projects concerned with migration and health.

'CLANDESTINO Undocumented Migration: Counting the Uncountable. Data and Trends across Europe'[14] is an EU-project that provides an inventory of data and estimates on undocumented migrants (stocks and flows) in selected EU countries. The project's aim is to improve knowledge, both in quantitative and in qualitative terms, of the undocumented migration phenomenon and to build up a reliable picture. A database on irregular migration which was built in the framework of the project is available at http://irregular-migration.hwwi.net

The EU-project REGINE - Regularisations in the European Union[15] provides a detailed picture of regularisation practices related to third country nationals illegally residing in the EU 27 with a comparison on regularisation practices in Switzerland and the US. Besides the investigation of regularisation practices in the different countries, the project also examines the relationship of regularisation policies to the overall policy framework and the political position and views of different stakeholders as well as options for regularisation policies on European level.

The HUMA Network (former 'Averroès Network) - Improving access to health care for asylum seekers and undocumented migrants in the EU'[16] aims to improve the health status of undocumented migrants and asylum seekers in the EU by encouraging

[13] (http://www.belgium.iom.int/page2.asp?Static_ID=10, accessed 07.02.2009)
[14] (http://ec.europa.eu/research/fp6/ssp/clandestino_en.htm, accessed 27.02.2009)
[15] (http://research.icmpd.org/1184.html#c2309#, accessed 27.02.2009)
[16] (http://www.mdm-international.org/spip.php?article103#, accessed 07.02.2009)

the elaboration and implementation of binding community regulations. For this purpose it created a NGO network covering 19 EU member states, which will carry out research, field surveys, and awareness raising activities at national and EU levels.

The 'COST Action IS0603 – Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME)'[17] brings together an international group of experts to further the development of research and good practice concerning migrant health. In three working groups on social and policy factors, migrant's state of health and its determinants and on health care for migrants and improvements in service delivery, the action consolidates and reviews work carried out so far, identifies blind spots and persistent problems and recommends ways forward to yield new insights into the causes of ill-health through a cross-national perspective.

[17] (http://www.cost.esf.org/domains_actions/isch/Actions/HOME, accessed 07.02.2009)

References

Baldwin-Edwards, Martin; Kraler, Albert (2009) REGINE Regularisations in Europe. Study on practices in the area of regularisation of illegally staying third-country nationals in the Member States of the EU, Final Report, Vienna: ICMPD. [http://ec.europa.eu/justice_home/doc_centre/immigration/studies/docs/regine_report_january_2009_en.pdf] access date 01.02.2009

Carrera, Sergio; Merlino, Massimo (eds.) (2009) Undocumented Immigrants and Rights in the EU. Addressing the Gap between Social Science Research and Policy-making in the Stockholm Programme? CEPS Liberty and Security in Europe Series, Centre for European Policy Studies, Brussels. [http://www.ceps.eu/book/undocumented-immigrants-and-rights-eu-addressing-gap-between-social-sciences-research-and-polic] access date 30.10.2010

Carrera, Sergio; Merlino, Massimo (eds.) (2010) Assessing EU Policy on Irregular Immigration under the Stockholm Programme. CEPS Liberty and Security in Europe Series, Centre for European Policy Studies, Brussels. [http://www.ceps.eu/book/assessing-eu-policy-irregular-immigration-under-stockholm-programme] access date 30.10.2010

Chauvin, Pierre; Isabelle Parizot; Nathalie Simonnot (2009) Access to healthcare for undocumented migrants in 11 European countries. 2008 Survey Report. Médecins du Monde European Observatory on Access to Healthcare. [http://www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf] access date 30.10.2010

Clandestino (2009) CLANDESTINO Project Final Report. CLANDESTINO research project [http://clandestino.eliamep.gr/wp-content/uploads/2010/03/clandestino-final-report_-november-2009.pdf] access date 30.10.2010

Council of Europe Parliamentary Assembly Resolution 1509 (2006) Human Rights of Irregular Migrants. [http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta06/eres1509.htm] access date 30.10.2010

Council of the European Union (2009) The Stockholm Programme: An open and secure Europe serving and protecting the Citizen, 16484/09, Brussels, 23 November 2009. [http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:115:0001:0038:EN:PDF] access date 30.10.2010

Dahinden, Janine; Denise Efionayi-Mäder (2009) Challenges and strategies in empirical fieldwork with asylum seekers and migrant sex workers. In: van Liempt, Ilse; Bilger, Veronika (Ed.) The Ethics of Migration Research Methodology. Dealing with Vulnerable Immigrants. Sussex Academic Press

Düvell, Franck (2009) Comparative Policy Brief - Pathways and Policies. Pathways into irregularity: The social construction of irregular migration. CLANDESTINO Research Project. Counting the Uncountable: Data and Trends across Europe.

ECHR/European Court of Human Rights (1950) Convention for the protection of human rights and fundamental freedoms, Rome: Council of Europe.

European Commission (2007) 'Towards a comprehensive European Migration Policy: Cracking down on employment of illegal immigrants and fostering circular migration and mobility partnerships' Press release, Brussels, 16 May. [http://europa.eu/rapid/pressReleasesAction.do?reference=IP/07/678] access date: 06.02.09.

Fernandes, Ana et al. (eds.) (2007) Challenges for health in the age of migration. Health and migration in the European Union, Lisbon: Portuguese EU Council Presidency.

Große-Tebbe, Susanne; Figueras, Josep (eds.) (2004) Snapshots of Health Systems. The state of affairs in 16 countries in summer 2004, Copenhagen: WHO Regional Office for Europe. [http://www.euro.who.int/document/e85400.pdf] access date 01.02.2009.

HUMA network (2009) Access to Health Care for Undocumented Migrants and Asylum Seekers in 10 EU countries. Law and Practice. HUMA Network, Paris [http://tinyurl.com/36rhzo5] access date 30.10.2010

IOM/International Organization for Migration (2004) International Migration Law, Glossary on Migration. Geneva: IOM.

IOM/International Organization for Migration (2005) Illegal immigration in Austria. A survey of recent Austrian migration research. Austrian contribution to the European Research Study Project II: 'Illegally Resident Third Country Nationals in the EU Member States: State Approaches Towards Them and Their Profile and Social Situation', Vienna: IOM.

Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit (2010) Access to healthcare for undocumented migrants in the EU: A first landscape of NowHereland. In: Eurohealth, Vol 16 No 1, 13-16

Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit; Handler, Agnes (2010) Gesundheitsförderung und mentale Gesundheit im Niemandsland undokumentierter Migration. Posterbeitrag im Rahmen des EUFEP Kongresses 2010 „Globale Evidenz für lokale Entscheidungen: Förderung mentaler Gesundheit - Prävention psychischer Erkrankungen“. 16.-18.06.2010 Baden, Österreich

Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit; Handler, Agnes (2010) Entitlements for Undocumented Migrants to Access Health Care. Poster developed

under the framework of the project “Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU” funded by DG SANCO. Center for Health and Migration at the Danube University Krems

Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit; Handler, Agnes (2010) Policy Matrix. Developed under the framework of the project “Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU” funded by DG SANCO. Center for Health and Migration at the Danube University Krems

Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit; Handler, Agnes (2010) Policy Matrix - Rationale. Developed under the framework of the project “Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU” funded by DG SANCO. Center for Health and Migration at the Danube University Krems

Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit; Handler, Agnes (2010) References Guides for the 27 EU Members States. Additional product for the Policy Matrix. Developed under the framework of the project “Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU” funded by DG SANCO. Center for Health and Migration at the Danube University Krems

Karl-Trummer, Ursula, Novak-Zezula, Sonja, Metzler, Birgit (2009) Gesundheitsservices im Niemandsland: Funktionale Ignoranz und informelle Solidarität. In: Rásky, Eva (Hg.): Gesundheit hat Bleiberecht. Migration und Gesundheit. Wien: Facultas Verlag

Karl-Trummer, Ursula; Metzler, Birgit; Novak-Zezula, Sonja (2009) Health Care for Undocumented Migrants in the EU: Concepts and Cases. Background Paper developed within the framework of the IOM project “Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities”. Brussels: IOM.

Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit (2009) Policy Brief: Health Care for Undocumented Migrants in the EU: Concepts and Cases. Developed within the framework of the IOM project “Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities”. Brussels: IOM.

Karl-Trummer, Ursula, Novak-Zezula, Sonja, Metzler, Birgit (2009) Managing a Paradox: Health Care for Undocumented Migrants in the EU. In: Finnish Journal of Ethnicity and Migration; 4, 2; 53-60

Karl-Trummer, Ursula (2009) Inklusion durch Exklusion: Paradoxienmanagement der Gesundheitsversorgung von Menschen ohne Papiere. In: Theda Borde, Matthias David, Ingrid Papies-Winkler (Hg.): Lebenslagen und Gesundheitliche Versorgung von Menschen ohne Papiere. Frankfurt am Main: Mabuse-Verlag

Kovacheva, Vesela (2010) Security challenges and the composition of irregular resident populations in Europe: overestimating the young men? Hamburg Institute of International Economics (HWWI) Working Paper No.8/2010

Levinson, Amanda (2005) The Regularisation of Unauthorized Migrants: Literature Survey and Country Case Studies, Oxford: Centre on Migration, Policy and Society, University of Oxford.

Mladovsky, Philipa (2007) Migration and health in the EU. Research note produced for the European Commission. London School of Economics. [http://mighealth.net/eu/images/3/3b/Mlad.pdf] access date 30.10.2010

OECD/SOPEMI (1989) Continuous Reporting System on Migration, Paris: OECD.

OECD/SOPEMI (2007) International Migration Outlook, Paris: OECD.

Pace, Paola (eds.) (2007) International Migration Law. Migration and the right to health: A review of European Community Law and Council of Europe instruments, Geneva: IOM.

Padilla, Beatriz; Pereira Miguel, José (2007) Health and Migration in the EU: Building a Shared Vision for Action. Background paper for the Portuguese EU Council Presidency 2007.

PICUM/Platform for International Cooperation on Undocumented Migrants (2007a) Undocumented migrants have rights! An overview of the International Human Rights Framework, Brussels: PICUM.

PICUM/Platform for International Cooperation on Undocumented Migrants (2007b) Access to Health Care for Undocumented Migrants in Europe. Brussels: PICUM.

Schierup, Carl-Ulrik; Hansen, Peo; Castles, Stephen (2006) Migration, citizenship, and the European welfare state: a European dilemma. Oxford University Press, Oxford

Simon, Fritz (2007) 'Paradoxiemanagement oder Genie und Wahnsinn der Organisation', in: Revue für postheroisches Management (1): 68–99.

UWT/Undocumented Worker Transitions (2008) Undocumented Migration Glossary. Work Package 5, EU Sixth Framework Programme Contract Number: 044272, prepared by the Roskilde University and Working Lives Research Institute, with contributions from all project partners, September 2008.

Vogel, Dita (2009) Comparative Policy Brief - Size of Irregular Migration. Size and development of irregular migration to the EU. CLANDESTINO Research Project. Counting the Uncountable: Data and Trends across Europe.

Vollmer, Bastian (2009) Comparative Policy Brief - Political Discourses. Political discourses on irregular migration in the EU. CLANDESTINO Research Project. Counting the Uncountable: Data and Trends across Europe.

Zanfrini, Laura; Kluth, Winfried (2008) Policies on irregular migrants. Volume I – Italy and Germany, Strasbourg: Council of Europe Publishing.

Zincone, Giovanna (2001) ITALY - Main features of Italian immigration flows. [http://www.mmo.gr/pdf/library/Italy/Main%20features%20of%20Italian%20immigration%20flows.pdf] access date 01.02.2009.