



# Migration and the Right to Health in Europe

International Organization for Migration (IOM)

## Background Paper

*Developed within the framework of the IOM project  
"Assisting Migrants and Communities (AMAC): Analysis of  
Social Determinants of Health and Health Inequalities"  
Co-funded by the European Commission DG Health and Consumers' Health Programme,  
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## Executive Summary

The objective of this paper is to give an overview of the European legal framework governing migration and health.<sup>1</sup> At the outset, it must be noted that there is a large percentage of European migration that is, in fact, intra-European migration.<sup>2</sup> For EU nationals residing outside of their countries of origin there are numerous challenges that must be overcome in order to realize the right to health. While there is a substantial legal framework in place in the EU to address these challenges, it will not be the focus of this paper.

Instead, this paper will concentrate on migration of third country nationals into the EU.<sup>3</sup> They are the heterogeneous group of people involved in the migration process. They include: migrants,<sup>4</sup> be they in a regular or an irregular situation including those smuggled,<sup>5</sup> or intending a long or short term stay; victims of trafficking in persons;<sup>6</sup> asylum

seekers<sup>7</sup> and refugees<sup>8</sup>. Collectively, all these categories of individuals are referred to, in this paper, as migrating persons.

First, the paper will lay out some of the health problems confronted by these migrating persons. Second, the substance of the right to health will be briefly explained. Third, the paper will describe the current legal framework for migration and health within Europe and the ways in which this framework responds to the problems discussed in the first section. This section will focus exclusively on international and regional law; national law will not be considered. Finally, the paper will conclude by highlighting issues that need more attention within the current legal system and recommending measures that can be taken to ensure that they receive sufficient recognition.



## 1. Health for Migrating Persons in Europe

Migration in and of itself is not a risk factor to health. However, individually and collectively, the process of migration can result in vulnerability to physical, social and mental health problems, depending on the migration conditions.<sup>9</sup>

All phases of the migration process can affect communicable and infectious diseases in migrating persons. On the other hand, non-infectious diseases and illnesses may be inequitably distributed among migrants. Prior to migration, access to medical services may have been limited or unavailable, which makes certain conditions that are easily managed in high-income countries more advanced or less effectively treated in migrating persons. At the same time, for several conditions and illnesses, migrants display better health indicators than local or host populations, a phenomenon known as the healthy migrant effect. Longitudinal studies<sup>10</sup> in some major immigrant-receiving countries suggest that over time these positive advantages decrease and migrants begin to assume the characteristics of the host populations.<sup>11</sup>

Mental and psychosocial illness is a health concern for many migrating persons in Europe which may include high rates of alcohol and drug abuse, depression, and anxiety. Traumatic experiences prior to departure or during the migration process, such as armed conflict, hunger and physical or sexual abuse, can be a heavy burden on a migrant's mental well-being. Upon arrival, a variety of factors may increase psychosocial vulnerability and hinder successful integration, such as cultural differences, language barriers, racism and unemployment.<sup>12</sup> The Amsterdam Declaration<sup>13</sup> highlights that persons involved in migration are more vulnerable due to their lower socio-economic status, and sometimes due to their traumatic migration experiences and a lack of adequate social support. Migrants in an irregular situation, some of them living in detention and risking deportation, live in a state of uncertainty about their fate and often have limited access to services.

Gender-specific challenges also confront migrating persons. Maternal and child health, reproductive health and sexual health represent important challenges for some migrating persons. Accessing prenatal care for migrants, especially migrants in an irregular situation, is a major public health issue. Ensuring that migrating persons have early access to reproductive health services, preventive health services and health promotion, screening and diagnostic care, as well as prenatal and obstetrical services, will reduce the risks of adverse outcomes. Special attention should be paid to women and girls who have been trafficked and/or have been displaced, as they have often been subjected to gender-based violence.<sup>14</sup>

Cultural and ethnic reproductive and sexual health practices and norms of behaviour among certain migrant groups, such as female genital mutilation<sup>15</sup> and the use of contraception, may challenge or conflict with those in the host community. Recognition and management of reproductive and sexual health issues requires cultural competence in health care providers. Such cultural competence, however, may not be part of current medical education programmes in Europe.<sup>16</sup>

Migrants are often placed at increased risk of work- or occupation-related illness, injury and even death.<sup>17</sup>

The process of migration can pose particularly severe health risks for certain groups of migrating persons. Irregular migrants, for example, are those persons who have not been granted permission to enter or stay in a given country. They are among the most vulnerable groups of migrants, and because of their lack of legal status, they are often marginalized. As the Council of Europe has recognized, irregular migrants often fall "outside the scope of existing health and social services".<sup>18</sup>

Victims of trafficking in persons are another group of people that are especially vulnerable to health risks. Trafficking is an abusive form of migration involving the exploitation of victims in order to generate illegal profits for traffickers. People trafficked for sexual exploitation, for labor, for begging and delinquency, for adoption or for any other form of exploitation often suffer from a multitude of physical and psychological problems<sup>19</sup> and may exhibit symptoms associated with survivors of trauma and torture.<sup>20</sup> Trafficked women and girls are particularly susceptible to reproductive and gender-specific health problems due to trafficking associated physical and sexual abuse. Sexually exploited trafficked women suffer an increased risk of sexually transmitted infections, including HIV/AIDS, and unwanted pregnancies. Other reported problems are insensitive approaches by health practitioners, service providers and law enforcement towards trafficked persons due to lack of awareness, and fear of stigmatization.

Asylum seekers and refugees are also susceptible to increased health risks. These groups of migrating persons are particularly vulnerable due to possible pre-migration risk factors such as torture or other trauma, which may result in physical or mental problems. Documented physical problems have included tuberculosis, HIV/AIDS, hepatitis A and B, parasitic diseases and non-specific body pains, while mental health problems include depression related to the traumatic experiences incurred prior to and during the journey. Moreover, asylum seekers often come from conflict areas, with no or little access to adequate health services. Post-migration factors such as detention and length of asylum procedure also have an impact on health.

## 2. The Right to Health

According to the Committee on Economic, Social and Cultural Rights (CESCR), the right to health is the right to the underlying preconditions for health, such as an adequate supply of safe food, nutrition and housing, and the right to health care. The States Parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR),<sup>21</sup> whose implementation is monitored by the aforementioned Committee, are under the specific obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including migrating persons, to preventative, curative and palliative health care; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs.<sup>22</sup>

Specifically, States must ensure that the following four elements are present throughout all health facilities, goods and services: availability, accessibility, acceptability and quality. Availability refers to the quantity of sufficient health facilities, goods and services, as well as programmes available throughout the State. Accessibility refers to the ability of people within the State to actually utilize these health facilities, goods and services. The concept of accessibility has four

components: (1) non-discrimination —health facilities, goods and services must be available to everyone within the jurisdiction of the State; (2) physical accessibility —health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups; (3) economic accessibility —health facilities, goods and services must be affordable for all; and (4) information accessibility —everyone has the right to seek, receive and impart information concerning health issues. Acceptability refers to the degree to which health facilities, goods and services are respectful of medical ethics and culturally sensitive to the needs of all patients. Quality refers to the skill of medical personnel as well as the scientific and medical appropriateness of health facilities, goods and services.<sup>23</sup>

In order to ensure that migrating persons throughout Europe realize their right to the highest attainable standard of health, a legal framework must be in place that addresses all four of these elements as they relate to migrating persons in general and particularly vulnerable groups within the migrant population. In addition, social and economic determinants of health must be taken into account.



### 3. The Legal Framework

#### A. International Instruments

The International Covenant on Economic, Social and Cultural Rights (ICESCR), which has been ratified by all of the EU Member States, recognizes that everyone has the right to the “highest attainable standard of physical and mental health”. The right to health is also recognized in several other instruments, to which several EU Member States are party, including: the International Convention on the Elimination of All Forms of Racial Discrimination (Article 5),<sup>24</sup> the Convention on the Elimination of All Forms of Discrimination against Women (Article 12),<sup>25</sup> the Convention on the Rights of the Child (Article 24),<sup>26</sup> and the Convention on the Rights of Persons with Disabilities (Article 25).<sup>27</sup> All of these instruments provide for the right to health without any discrimination based on nationality or legal status.

The ICESCR imposes an obligation on each State Party to “take steps. . . to the maximum of its available resources, with a view toward achieving the full realization of the rights recognized in the Covenant”. Under the ICESCR’s interpretation of the right to health discussed above, the ICESCR thus obliges States Parties to take steps to the maximum of their available resources to ensure that all persons within their jurisdiction have not only the right to receive preventative, curative and palliative health care, but also the right to the underlying preconditions for health.

The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW)<sup>28</sup> also recognizes the right to health. It provides for the right to equal treatment regarding access to social and health services for regular migrant workers<sup>29</sup> and members of their family<sup>30</sup> and nationals. Article 28 guarantees the right to necessary emergency medical treatment for all migrant workers and members of their family regardless of the regularity of their stay or employment. Article 81(1) stipulates, however, that nothing in the Convention shall affect more favourable rights or freedoms granted to migrant workers and members of their families by virtue of the law or practice of a State Party; or any bilateral or multilateral treaty<sup>31</sup> in force for the State Party concerned. The ICRMW however, is only binding on those countries that have ratified or acceded to it, and as of yet, no EU Member State has done so.<sup>32</sup>

The decision of the UN to draft and adopt some 20 years ago this Convention was a strong statement of international consensus concerning the need for greater protection of the rights of migrants. Now, that decision must be implemented through national ratification and legislation. The 20th anniversary campaign has been recently launched by the International Steering Committee for the Campaign for Rati-

fication of the Migrants Rights Convention, a unique network of UN agencies, international organizations, including IOM, and global civil society organizations.<sup>33</sup>

Strengthening the measures aimed at promoting respect for the right to health and related rights of migrating persons as well as to prevent their violation is paramount.

Accountability mechanisms and remedies to redress violations exist at the international level. For example, some of the United Nations Treaty Monitoring Bodies<sup>34</sup> address right to health accountability of governments. The Treaty Monitoring Bodies’ concluding observations on States’ reports cover the topic of non nationals’ access to health services. They also argue for application of relevant treaty provisions to irregular migrants in European countries.<sup>35</sup> In addition, several Treaty Monitoring Bodies have the competence to consider individual communications that concern issues related to the right to health of individuals and groups.<sup>36</sup>

Under the recently adopted Optional Protocol to the ICESCR, individuals, after having exhausted domestic remedies, will be able to complain to an independent human rights body at the international level about violations of rights enshrined in the ICESCR such as the right to health. This will be possible upon the treaty’s entry into force. However, its application will be subject to ratification of or accession to the treaty by the State which had jurisdiction over the victim at the moment of and acceptance of the Protocol’s individual complaints procedure. Important is also the role played by the special procedures that are mechanisms established by the Commission on Human Rights and assumed by the Human Rights Council to address, for example, thematic issues like the right to health or the human rights of migrants.<sup>37</sup>

Finally, a resolution on the health of migrants<sup>38</sup> was adopted at the 61st World Health Assembly in May 2008. It asks WHO Member States for migrant sensitive health policies and practices and requests WHO to promote migrant health, in collaboration with other relevant organizations and encouraging interregional and international cooperation. IOM and WHO are organizing a global consultation where the actions taken by WHO Member States in all regions will be presented.

#### B. European Instruments

The competence of the EU in the field of health is based on Article 168 of the consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union.<sup>39</sup> Such competence

is based on and limited by the subsidiarity principle. This principle is intended to ensure that all decisions are taken as close as possible to nationals, and that constant checks are made as to whether action at the Community level is justified in light of the possibilities available at the national, regional or local levels. Consequently, competence to act in the field of public health and health care services is still primarily a national matter. Further, the responsibility for ensuring access to quality health care in the EU lies within the Member States, in line with the principle of territoriality. Nevertheless, direct EU influence is increasing in this area.

The European community has shown some commitment to ensuring the right to health for third country nationals residing within Europe. In 1999, the European Council, in its special summit in Tampere, stated that the European Union should ensure fair treatment of third-country nationals who reside legally in the territory of its Member States, grant them rights and obligations comparable to those of EU nationals, enhance non-discrimination in economic, social and cultural life and approximate their legal status to that of EU nationals. Furthermore, in its Resolution of 27 October 1999,<sup>40</sup> the European Parliament urges the rapid realisation of promises of fair treatment of third-country nationals who reside legally in Member States and the definition of their legal status with uniform rights as near as possible to those enjoyed by EU nationals.

In response to these calls for action, Council Regulation (EC) No 859/2003<sup>41</sup> was adopted to extend the scope of the rules coordinating national social security schemes to third-country nationals, as well as to members of their families and to their survivors, provided they are legally residing in the territory of a Member State and are in a situation that involves more than a single Member State. Council Directive 2003/109/EC,<sup>42</sup> moreover, requires that third-country nationals who are long-term residents enjoy equal treatment with nationals as regards "social security, social assistance and social protection as defined by national law".

The need for achieving the objectives defined by Tampere was reaffirmed by the Hague Programme of November 2004.

The "Health and Migration in the EU: Better Health for All in an Inclusive Society" Conference, held in Lisbon in September 2007, outlined the key emerging issues for EU Member States in this field. The Conference aimed to identify the main health problems that affect migrants in the EU, together with the determinants of their health status and ways to respond to their health needs. Underscoring the Conference proceedings were the ideas that access to health care by everyone must be seen as: a prerequisite to public health in the EU; an essential element of its social, economic and political development; and central to the protection of human rights. In September 2009, a second conference supported by the Portuguese Government, organ-

ised by IOM, the "EU-Level Consultation on Migration Health - Better Health for All", further promoted the goal of adequately addressing migrant health priority issues in Europe and fighting health inequalities.

The Council of Europe Convention on Human Rights and Biomedicine<sup>43</sup> aims to "ensure equitable access to health care of appropriate quality in accordance with the person's medical needs" and imposes a duty on states to use their best efforts to reach this goal.

Two important instruments, namely the European Convention on Social and Medical Assistance of 1953<sup>44</sup> and the European Social Charter of 1991 (revised in 1996),<sup>45</sup> whose Article 11 recognizes the right to protection of health, explicitly require that nationals of one State Party lawfully present on the territory of another be afforded medical assistance on terms equal to those of nationals of the second State Party.

Despite this focus on lawful presence, however, the European Committee of Social Rights whose task is to monitor the application of the European Social Charter, found that "legislation or practice that denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter".

The European Convention for the Protection of Human Rights and Fundamental Freedoms,<sup>46</sup> adopted by the Council of Europe in 1950, has been interpreted as having a health dimension by the regional judicial accountability mechanism that is the European Court of Human Rights (ECHR). The Convention applies to everyone within the jurisdiction of a State Party, including non-nationals, be they migrants, asylum seekers, rejected asylum seekers or refugees. Its Article 3 recognizes the right to be free from torture and degrading and inhuman treatment. The case law of the ECHR outlined that the denial of health care to migrants in an irregular situation may also amount to an infringement of this right. Article 3 has also been invoked to prevent migrants who are ill from being deported to countries of origin or third countries with inadequate health care facilities, as in the case of *D. vs. the United Kingdom* (1997)<sup>47</sup> and the case of *B.B. vs. France* (1998).<sup>48</sup> Additionally, the case of *Bensaid vs. the United Kingdom* expanded Article 3 protection to encompass mental illness as well.<sup>49</sup>

However, the recent decisions in the cases of *N vs. the United Kingdom* (2008), and *Henao vs. the Netherlands* (2003) provide examples where the ECHR ruled that expulsion would not give rise to an Article 3 violation.<sup>50</sup> In *N vs. the United Kingdom*, the Court held by a majority that the deportation of an Ugandan woman with advanced stages of AIDS would not give rise to a violation of Article 3 because the disease "alleged future harm would emanate not from intentional acts or omissions of public authorities. . . but from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiv-



ing country”.<sup>51</sup> Similarly, in *Henao vs. the Netherlands*, inadmissibility was based on the early stage of illness and accessibility to medical care in the petitioner’s country of origin.<sup>52</sup>

Additionally, according to the case law of the ECHR, a State’s failure to provide effective access to health care for migrants in an irregular situation could also potentially result in a violation of Articles 2 (right to life) and/or Article 8 (right to respect for private and family life).

Moreover, in the Recommendation on health services in a multicultural society,<sup>53</sup> “The Committee of Ministers (...) recommends that the governments of Member States: (...) promote an intersectoral and multidisciplinary approach to health problems and health care delivery in multicultural societies, taking into consideration the rights of multicultural populations; (...) embed health issues of multicultural populations in the legal framework as an integral part of the general health system”.

During the Eighth Conference of European Health Ministers, in 2007, health ministers of the 47 Council of Europe Member States signed the Bratislava Declaration. This declaration states that “someone’s health should not be a ground for any exception to the principles and standards embodied in international migration law”.

Thus far, almost all the instruments that have been mentioned affect all third country nationals residing within Europe. Additionally, there are a number of European instruments that are particularly relevant for the various groups of migrating people that are highly vulnerable to health risks —i.e. irregular migrants, victims of trafficking in persons, asylum seekers and refugees.

### a) Irregular Migrants

The European Commission has noted “illegal immigrants are protected by universal human rights standards and should enjoy some basic rights i.e. emergency health care and school education for their children”.<sup>54</sup> The term “irregular” migrant is preferable to “illegal” as the latter carries a criminal connotation and is seen as denying migrants’ humanity. Irregular migrant is therefore not only more neutral, but it also accords with the right of everyone to recognition everywhere as a person before the law.<sup>55</sup>

Romero-Ortuño has addressed the question of whether irregular migrants should be granted full access to publicly funded health care, taking into consideration also the issue of the affordability of meeting irregular migrants’ health care needs. He acknowledges the importance of containing public expenditure in the field of public health, and the fact that many countries —including EU Member States— seek to prevent collectively funded health care systems from being used by “free riders” —people who, if allowed, would benefit from

the services at zero cost (i.e. without having paid taxes or other social contributions). This “free rider” concept, however, does not entirely apply to irregular migrants because they are indirect tax payers; this could have significant entitlement implications in those cases in which the public health service receives a significant proportion of its funding from this kind of revenue.

Romero-Ortuño concludes that only host States are accountable for the consequences of the irregular presence of people within their borders; therefore, they have to create the legal conditions for the fulfillment of their duty to provide comprehensive health care coverage to irregular migrants,<sup>56</sup> in line with the right to the highest attainable standard of health recognized as a basic human right by various international instruments that the Member States have ratified.

The issue has been recognized in a number of Council of Europe’s Recommendations and Resolutions. Recommendation No R (2000) 3 of the Committee of Ministers to Member States on the right to the satisfaction of basic material needs of persons in situations of extreme hardship, for example, urges Member States to provide for the basic material needs of any person in a situation of extreme hardship, which is defined to include basic medical care of “any person in a situation of extreme hardship”.<sup>57</sup> Recommendation 1618 (2003) of the Parliamentary Assembly of migrants in irregular employment in the agricultural sector of Southern European countries calls on States to grant seasonal or temporary migrant workers the right to receive social services.<sup>58</sup> Furthermore, Resolution 1509 (2006) of the Parliamentary Assembly on human rights of irregular migrants recognizes that irregular migrants have the right to emergency healthcare that takes into account the needs of particular vulnerable groups such as children, disabled persons, pregnant women, and the elderly.<sup>59</sup>

With regard to the enjoyment of the right to health of migrants in an irregular situation, the abovementioned Bratislava Declaration highlights that: “The Member States will ensure that irregular migrants are able to access health care services in accordance with international treaties as may be in force at the time and national laws and policies” and that the Member States “encourage host countries to consider the invitation of the Parliamentary Assembly in the Resolution 1509 (2006) to eliminate any requirement on health service providers and school authorities to report the presence of irregular migrants to the authorities.”

### b) Victims of Trafficking

In 2004, the European Union adopted a Council Directive that requires all EU Member States, by 6 August 2006, to provide a reflection period and residence permit to victims of trafficking under limited circumstances. According to the Directive, a reflection period, whose length can be determined under national law, should be provided to all vic-

tims of trafficking. During the reflection period and while awaiting the decision of the competent authorities, the third-country nationals concerned who do not have sufficient resources should be granted standards of living capable of ensuring their subsistence and access to emergency medical treatment. Further, EU Member States shall attend to the special needs of the most vulnerable, including, where appropriate and if provided by national law, psychological assistance. Thereafter, EU Member States should grant a residence permit depending upon criteria developed by the country, which could include the opportunity for the victim to assist in investigative and judicial proceedings, whether the victim has shown a clear intent to cooperate, and whether the victim has severed all ties with her exploiter/s.

Moreover, Article 4 of the Directive states that Member States may adopt or maintain more favorable provisions for trafficked persons; therefore, victims of trafficking can be granted a residence permit solely based upon the danger they would face if they were deported to their home country.

Finally, the Council of Europe, under the Convention on Action Against Trafficking in Human Beings,<sup>60</sup> requires Member States that ratify the treaty to provide a reflection period of at least 30 days to victims of trafficking, and, thereafter, to issue a renewable residence permit to victims of trafficking if “the competent authority considers that their stay is necessary owing to their personal situation” or “the competent authority considers that their stay is necessary for the purpose of their co-operation with the competent authorities in investigation or criminal proceedings”. Assistance to the victims in their physical, psychological and social recovery is also contemplated by this treaty.

### c) Asylum Seekers

On 27 January 2003, the EU Council of Ministers adopted a Directive laying down minimum standards for the reception of asylum applicants in Member States, requiring transposition in all Member States by 6 February 2005.<sup>61</sup> The Directive deals also with health care, and lays down rules for persons with special needs, minors, unaccompanied children and victims of torture. In the context of medical screening, the Directive states that “Member States may require medical screening for applicants on public health grounds”; regarding

access to health care, it states that “Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illness”.

Additionally, Council Directive 2001/55/EC provides minimum standards for giving temporary protection in the event of a mass influx of displaced persons.<sup>62</sup> The Directive provides, *inter alia*, that Member States “shall make provision for persons enjoying temporary protection to receive necessary assistance in terms of social welfare and means of subsistence, if they do not have sufficient resources, as well as for medical care”; and that “the assistance necessary for medical care shall include at least emergency care and essential treatment of illness”.

### d) Refugees

Article 23 of the 1951 Convention Relating to the Status of Refugees states that “The Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals”. This includes, *inter alia*, relief and assistance to persons in need due to illness, age, and physical or mental impairment. The 1951 Convention has been ratified by all of the EU Member States.

At the European level, the Appendix to the European Social Charter, entitled “Scope of the Social Charter in terms of Persons Protected”, imposes on Contracting States the obligation to grant refugees at least the same standards of treatment as those required by the 1951 Convention. This Appendix allows refugees to take advantage of the Charter’s supervisory mechanisms in order to enforce these rights.

Article 29 of Council Directive 2004/83/EC requires that Member States “ensure that beneficiaries of refugee or subsidiary protection status have access to health care under the same eligibility conditions as nationals of the Member State that has granted such statuses”. Indeed, in EU Member States, recognized refugees are entitled to full access to national health systems on the same basis as nationals, mostly by virtue of the fact that they are granted permanent residence status and the rights that accompany this, or are granted the same rights as nationals under the asylum law of the country in question.



## 4. Challenges in Realizing the Right to Health for Migrating Persons

As mentioned in Section 2, the right to health includes the right to the underlying preconditions of health as well as the right to health care. The right to health also contemplates health facilities, goods and services that are available, accessible, acceptable and of good quality. The current European legal framework governing the right to health for migrating people fails to address all of these facets of the right to health. While concentrating on ensuring that migrating people are de jure entitled to health care, the legal framework fails to create provisions designed to alleviate de facto barriers that inhibit the ability of migrating people to receive health care.

Migrating people in Europe confront substantial barriers in realizing their right to health. There are language barriers, particularly related to inadequate availability of competent interpreters. There are cultural barriers, including different ways of viewing illness and the “health care provider–patient relationship”.<sup>63</sup> Finally, there is a lack of awareness of available services due to the absence of information about the health care system in host countries, including a lack of awareness and training on the part of health workforce regarding migration health issues, a lack of understanding of their specific needs and expectations together with a lack of trust on the part of persons involved in migration.<sup>64</sup>

These barriers are often particularly limiting for irregular migrants. Romero-Ortuño considers the issue from both the demand-side (irregular migrants) and the supply-side (health care providers).<sup>65</sup> On

the demand side, he notes that a lack of information on the laws concerning the provision of medical care to foreigners make irregular migrants afraid of using public care services, and by the time they decide to seek medical treatment, a disease or illness may have developed to an advanced stage. Even when irregular migrants are aware of their rights, the process for obtaining regular access to health care can be prohibitively long and complicated. Illiteracy, language problems and lack of time can discourage irregular migrants from starting or completing the process of seeking regular access to health services.

On the supply-side, Romero-Ortuño observes that health care managers and providers are also often unaware of the current legislation concerning access to health care for irregular migrants, or are faced with ambiguously or imprecisely defined entitlements, subject to incoherent and conflicting interpretations. Thus, health care managers are often reluctant to provide irregular migrants with the services to which they are entitled. Social issues related to racism and bias in the healthcare system, as well as institutional structures ill-equipped to handle migrating persons from different places in the world hinder the realization in practice of the right to health for migrating persons.

The current legal framework in the EU focuses on giving migrating people legal entitlement to health care, but it does not adequately address the determinant of health. Additionally, various are the barriers that significantly infringe upon migrating peoples’ right to health and that have to be urgently addressed.

## 5. Conclusions

Recognizing that:

- the specific vulnerability to physical, mental and social health problems of migrating persons depends on the risk factors surrounding the migration process, including pre-migration circumstances, travel conditions, arrival or transit phase, as well as return phase;
- the health condition or legal status of an individual is not a ground for any exception to the principles and standards embodied in international migration law;
- migrating persons face barriers in terms of access to health services and equal care arising, inter alia, from their legal and socio economic status, lack of awareness and understanding of available services as well as lack of migration related knowledge and training on the part of health care professionals, compounded in both instances by communication difficulties and linguistic and cultural barriers.

### Recommendations

It is recommended that EU Member States take the following measures:

#### a) Regarding persons involved in migration generally,

- ensure that the right to health is formally recognized in national laws, that entitlements are clearly stated and that implementation measures and sufficient funding are ensured;
- make sure that the obstacles to the enjoyment of the right to health by all migrating persons, including migrants in an irregular situation, be eliminated;
- overcome barriers to the realization of the right to health for migrating persons, through training for health providers, policy makers, health management planners and health educators as well as other professions concerned with health services delivery, on how to address health care issues associated with population mobility and disparities of health services between geographical locations; Such training should include modules on the right to health and how it applies at the national level to migrants, regular and irregular alike, victims of trafficking, asylum seekers, refugees, and other

persons in need of international protection;

- assist migrating persons in gaining awareness of and confidence in the health care systems of Member States as well as in realizing the importance of preventive health care;
- develop integration and prevention strategies to decrease stigmatization, discrimination and vulnerability of migrating persons (e.g. improve communication by language, culture and gender sensitive services) and to facilitate ethnic community participation in health services delivery, policy design, programme planning and evaluation;

#### b) Regarding migrants in an irregular situation,

- eliminate any requirement on health service providers to report the presence of irregular migrants to the authorities;
- guarantee a holistic, equal and publicly financed health care for irregular migrants, and avoid the establishment of parallel structures for healthcare;

#### c) Regarding victims of trafficking,

- provide a longer reflection period which gives a victim the opportunity to recover and to make an informed decision whether to cooperate with law enforcement authorities;
- guarantee health promotion, information, education and care services to victims of trafficking regardless of their willingness to cooperate in criminal proceedings against traffickers;
- guarantee health care appropriate to the needs and circumstances of individual victims with the understanding that “different stages of intervention call for different priorities in terms of health care that is offered to victims”;<sup>66</sup>

#### d) Regarding asylum seekers, refugees and persons in need of international protection,

- ensure that host communities provide full and non discriminatory access to health care to asylum seekers, refugees and other persons in need of international protection on the same basis as nationals; host communities should also be aware of possible pre-migratory experiences or experiences during flight and the potential consequent need for specialized health services;
- address disruption of continuity and quality of care due to change of geographic location.



## Note about the Authors

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Since 2005, Paola Pace works as a Research Officer for the International Migration Law and Legal Affairs Department of IOM in Geneva, Switzerland. She has written two IOM publications on migration and the right to health. She also coauthored a peer-reviewed chapter on migrant health, which was commissioned to IOM by WHO for Resolution EUR/RC52/R7 case studies: how European health systems are addressing the health of socioeconomically disadvantaged groups [TBC]. Copenhagen, WHO Regional Office for Europe, 2008. She researches and advises departments at headquarters, field offices and external counterparts on International Migration Law (IML); trains IOM staff, government officials, diplomats and civil society organizations and lectures in IML in international fora; she designs, raises funds and manages projects and provides legal advice to the IOM offices in commercial matters.

Previous to her work with IOM, Paola Pace was the research assistant of a member of the United Nations International Law Commission in Geneva. She has also worked for an international law firm in Padua, Italy, and a Belgian Law Firm in Brussels as well as for an NGO in Ghent, Belgium. She has a Master Degree in Law for Padua University, Italy and she is completing a Postgraduate Diploma in Public Health from the London School of Hygiene and Tropical Medicine, United Kingdom.

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## Footnotes

- <sup>1</sup> Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments, IOM, 2008.
- <sup>2</sup> Thirty per cent of migrants living in western and central European countries are originally from other western and central European countries (UN DESA, 2005). See *World Migration 2008: Managing Labour Mobility in the Evolving Global Economy*, IOM, 2008.
- <sup>3</sup> For data see the abovementioned IOM World Migration Report.
- <sup>4</sup> At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without intervention of an external compelling factor. This term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospects for themselves or their family. *Glossary on Migration*, International Migration Law Series, IOM, 2004.
- <sup>5</sup> Smuggled migrants are individuals who are victims of the crime of smuggling of migrants. For the definition of smuggling see Art. 3(a), UN Protocol against the Smuggling of Migrants by Land, Sea and Air, supplementing the United Nations Convention against Transnational Organized Crime, 2000.
- <sup>6</sup> Victims of trafficking are individuals who are victims of the crime of trafficking in persons. For the definition of trafficking see Art. 3(a), UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing United Nations Convention against Transnational Organized Crime, 2000.
- <sup>7</sup> Asylum seekers are persons who have left their country of origin seeking safety from persecution or serious harm, have applied for asylum in another country, and are awaiting a decision on their application. See *Glossary on Migration*, loc. cit. n. 4 and *Master Glossary of Terms*, UNHCR, June 2006.
- <sup>8</sup> A refugee is a person who meets the eligibility criteria under the applicable refugee definition, as provided for in international or regional refugee instruments, under UNHCR's mandate, and/or in national legislation.
- <sup>9</sup> *Migrant Health for the Benefit of All*, MC/INF/275, IOM, Geneva, 2004.
- <sup>10</sup> J. Hughes and J.-P. Foschia (eds.), *Migrant-Friendly Health Services and HIV/STI Prevention: A Handbook for Health Practitioners, Managers and Policy Planners*, published by the Veneto Regional Center for Health Promotion (CRRPS), Verona, Italy, with financial assistance from the European Commission (November 2004). "The Fruits of Hypocrisy: History of Who Makes the Agriculture... Hidden," Rome, Medici Senza Frontiere Onlus, 2005.
- <sup>11</sup> "Migration and health of migrants", IOM contribution to Resolution EUR/RC52/R7 case studies: how European health systems are addressing the health of socioeconomically disadvantaged groups [TBC]. Copenhagen, WHO Regional Office for Europe, 2008.
- <sup>12</sup> *Ibidem*.
- <sup>13</sup> The Migrant-Friendly Hospitals Project Group drew up the Amsterdam Declaration within the framework of the European Commission project "MFH - Migrant Friendly Hospitals, a European Initiative to Promote Health and Health Literacy for Migrants and Ethnic Minorities".
- <sup>14</sup> "Migration and health of migrants", loc. cit. n. 11.
- <sup>15</sup> IOM information sheet "Supporting the Abandonment of Female Genital Mutilation in the Context of Migration", available at: <http://www.iom.int/jahia/Jahia/about-iom/organizational-structure/iom-gender/activities-best-practices/fgm/>. See also: the Guidelines developed by Société Suisse de Gynécologie et Obstétrique in 2005 to support health professionals dealing with FGM victims, available in French and German at <http://www.iamaneh.ch/dokumente>; L. Catania, O. Abdulcadir, V. Puppo, J.B. Verde, J. Abdulcadir, D. Abdulcadir, "Pleasure and orgasm in women with Female Genital Mutilation/Cutting (FGM/C)" in *Journal of Sexual Medicine*, 4(6), November 2007, pp. 1666-78; Département des Institutions de Genève, *How to Put and End to the Practice of Female genital Mutilation (FGM)?*, Panel Discussion Report, IOM, IPU, IAC, February 2008, available at: <http://www.ipu.org/english/Surveys.htm>; Guidance Note on Refugee Claims relating to Female Genital Mutilation, UNHCR, Protection Policy and Legal Advice Section Division of International Protection Services, Geneva, May 2009.
- <sup>16</sup> "Migration and health of migrants", loc. cit. n. 11.
- <sup>17</sup> P. Bollini, H. Siem, "No Real Progress Towards Equity: Health of Migrants and Ethnic Minorities on the Eve of the year 2000", in *Social Science and Medicine*, 41(6), 1995, pp. 819-828. See also E. Q. Ahonen and F. G. Benavides, "Risk of Fatal and Non-Fatal Occupational Injury in Foreign Workers in Spain", in *Journal of Epidemiology and Community Health*, 60(5), 2006, pp. 424-426.
- <sup>18</sup> Council of Europe, Parliamentary Assembly (2000) Health conditions of migrants and refugees in Europe. See Doc. 8650, Report of the Committee on Migration, Refugees and Demography, Rapporteur: Lord Ponsonby, Strasbourg: Council of Europe, Committee on Migration, Refugees and Demography. See also Doc. 8878, Opinion of the Social, Health and Family Affairs Committee, Rapporteur: Mr Arnau, Strasbourg: Council of Europe, Social, Health and Family Affairs Committee.
- <sup>19</sup> R. Surtees, *Second Annual Report on Victims of Trafficking in South-Eastern Europe*, IOM, 2005.
- <sup>20</sup> M. Orhant, "Trafficking in Persons: Myths, Methods, and Human Rights" in *Trafficking in Migrants*, No. 23, IOM, April 2001. C. Zimmerman, M. Hossain, K. Yun, B. Roche, L. Morison, and C. Watts, *Stolen Smiles: a Summary Report on the Physical and Psychological Health Consequences of Women and Adolescents Trafficked in Europe*, London School of Hygiene & Tropical Medicine (LSHTM), London, 2006. *The Mental Health Aspects of Trafficking – Training Manual*, IOM, Budapest, 2004.
- <sup>21</sup> *International Covenant on Economic, Social and Cultural Rights* (U.N.G.A. Res. 2200 A (XXI), 993 U.N.T.S. 3).
- <sup>22</sup> UN Committee on Economic Social and Cultural Rights (CESCR), General Comment No. 14: the right to the highest attainable standard of health (Art. 12) (E/C.12/2000/4).
- <sup>23</sup> *Ibidem*.
- <sup>24</sup> *International Convention on the Elimination of All Forms of all Forms of Racial Discrimination* (U.N.G.A. Res. 2105 A (XX), 660 U.N.T.S. 195).
- <sup>25</sup> *Convention on the Elimination of All Forms of Discrimination against Women* (U.N.G.A. Res. 34/180, 1249 U.N.T.S. 13).
- <sup>26</sup> *Convention on the Rights of the Child* (U.N.G.A. Res. 44/25, 1577 U.N.T.S. 3).
- <sup>27</sup> *Convention on the Rights of Persons with Disabilities* (UN Doc. A/61/611, Annex I).
- <sup>28</sup> *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (U.N.G.A. Res. 45/158).
- <sup>29</sup> See Art. 43.
- <sup>30</sup> See Art. 45.
- <sup>31</sup> The ICESCR and the International Convention on the Elimination of All Forms of Racial Discrimination are among the multilateral treaties that recognize a more favourable right to health for all.
- <sup>32</sup> E. MacDonald and R. Cholewinski, *The Migrant Workers Convention in Europe: Obstacles to the Ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families: EU/EEA Perspectives* (UNESCO), 2007. See also *Guide on Ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*, International Steering Committee for the Campaign for Ratification of the Migrants Rights Convention, April 2009, available

- at <http://www.migrantsrights.org/>.
- <sup>33</sup> See [http://www.migrantsrights.org/migrants\\_day\\_09.htm](http://www.migrantsrights.org/migrants_day_09.htm).
- <sup>34</sup> Such as the CESCR, the Committee on the Elimination of Racial Discrimination (CERD), the Committee on the Elimination of Discrimination Against Women (CEDAW) and the Committee on the Rights of the Child (CRC). See: Human Rights Fact Sheet No. 30, The United Nations Human Rights Treaty System, An introduction to the core human rights treaties and the treaty bodies, published by the Office of the United Nations High Commissioner for Human Rights, United Nations Office, Geneva; H. Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, University of Essex, funded by the Open Society Institute, 2008; and *Migration and the Right to Health: A Review of International Law*, International Migration Law Series No.19, IOM, 2009.
- <sup>35</sup> The UN Treaty Monitoring Bodies and Migrant Workers: a Samizdat, December 18 vzw, updated July 2007.
- <sup>36</sup> *Accountability and the Right to the Highest Attainable Standard of Health*, loc. cit. n. 34.
- <sup>37</sup> The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the Special Rapporteur on the human rights of migrants.
- <sup>38</sup> The term migrant in the WHA resolution covers the heterogeneous group of individuals who are referred to, in this paper, as migrating persons. See EB122/1 and EB122.R5.
- <sup>39</sup> Consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union, OJ 2008 C 115.
- <sup>40</sup> OJ 2000 C154, p. 65.
- <sup>41</sup> Council Regulation (EC) No 859/2003 of 14 May 2003 extending the provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 to nationals of third countries who are not already covered by those provisions solely on the ground of their nationality, OJ 2003 L124.
- <sup>42</sup> Council Directive 2003/109/EC of 25 November 2003 concerning the status of third-country nationals who are long-term residents, OJ 2004 L16.
- <sup>43</sup> Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Council of Europe, ETS No. 164, 1997).
- <sup>44</sup> Article 1.
- <sup>45</sup> Article 13.
- <sup>46</sup> Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocol No. 11 (ETS No. 5).
- <sup>47</sup> *D vs. the United Kingdom*, ECtHR judgement on 2 May 1997 (Case No: 146/1996/767/964).
- <sup>48</sup> *B.B vs. France* [1998] ECHR 84.
- <sup>49</sup> *Bensaid vs the United Kingdom*, ECtHR judgement on 6 February 2001 (Application No: 44599/98). Undocumented and Seriously Ill: Residence Permits for Medical Reasons in Europe, PICUM Report 2009, p. 12 available at <http://www.picum.org/data/Undocumented%20and%20Seriously%20Ill%20Report%20Picum.pdf>.
- <sup>50</sup> *Arcila Henao vs. The Netherlands*, Application N° 13669/03.
- <sup>51</sup> Undocumented and Seriously Ill: Residence Permits for Medical Reasons in Europe, loc. cit. n. 49, p. 13.
- <sup>52</sup> Undocumented and Seriously Ill: Residence Permits for Medical Reasons in Europe, loc. cit. n. 49, p. 12.
- <sup>53</sup> Recommendation Rec (2006)18 of the Committee of Ministers to Member States on health services in a multicultural society. Text available at: <http://www.coe.int/>.
- <sup>54</sup> European Commission (2003) Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on Immigration, Integration and Employment [COM (2003) 336 final of 3 June 2003].
- <sup>55</sup> Universal Declaration of Human Rights (UDHR), Art. 6; International Covenant on Civil and Political Rights (ICCPR), Art. 16.
- <sup>56</sup> Recognizing a mere right to emergency health care is too narrow for an adequate realization of the right to health. Moreover, although there is no common understanding as to what urgent or emergency health care entails, some Council of Europe countries reported that “a shift” can be noted “from a strict interpretation of urgent care (essential treatment, which can not reasonably be delayed) to a more flexible one of “necessary care” on the basis of which doctors consider regular follow-ups and vaccinations also to be part of “urgent treatment”. With regard to the treatment preventive care that has been undertaken to protect public health is also regularly being considered as falling under the notion of “urgent care”. The interpretation of what is emergency care is evolving and in common one understands that undocumented persons should be covered for the following: outpatient and hospital care which is urgent or otherwise essential even if continuous; medical programmes, which are preventive or which safeguard individual and collective health; maternity coverage; coverage of the health of minors; vaccinations foreseen by public health law; diagnosis, treatment, and prevention of infective diseases; activities of international prevention”. (Exploratory Report on the Access to Social Protection for Illegal Labour Migrants, P. Schoukens and D. Pieters, European Committee for Social Cohesion (CDCC), CDCC (2004)55, p. 12.) This is in line with a more integrated concept of health care and with the conclusions of the CESCR.
- <sup>57</sup> Text available at: <http://www.coe.int/>.
- <sup>58</sup> *Ibidem*.
- <sup>59</sup> *Ibidem*.
- <sup>60</sup> Council of Europe Convention on Action against Trafficking in Human Beings. Strasbourg, Council of Europe (European Treaty Series No. 197). See R Malpani, *Legal aspects of trafficking for forced labour purposes in Europe*, ILO, Geneva, 2006.
- <sup>61</sup> Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers, OJ 2003 L31, at p. 67.
- <sup>62</sup> Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (excerpt), OJ 2001 L212, p. 66.
- <sup>63</sup> Research carried out in the Netherlands has demonstrated that being able to speak the national language or having the assistance of a professional translator does not guarantee that all communication problems are solved. According to Richters and Van Vliet, different social and cultural perspectives can also cause communication problems. Miscommunication stems not only from language barriers, but also from differences in social and cultural familiarity and expectations. See A. Richters and K. Van Vliet (eds.), in Çinibulak L., 2002. See also Report on Mental Health in Europe Working Group, “Migration and Mental Health in Europe (the state of mental health in Europe Working Group: Appendix 1)” in *Clinical Practice and Epidemiology in Mental Health*, 1:13, 2005, p. 11.
- <sup>64</sup> Doudová highlights the following example: “a Chinese national studying at a grammar school in a European capital, who occasionally interprets for her compatriots during medical examinations, gave an account of her own experiences. In her opinion, a major problem for her community is the lack of necessary information, which is caused by language barriers. Apart from this, foreigners sometimes have problems finding a physician; the occasional interpreter even met a physician who refused to treat a patient. She also referred to cultural differences which can cause embarrassment to Chinese women, when being treated by a male doctor”. H. Doudová, *Debate on the Access of (Il)legal Migrants to Health Insurance (Report)*, Multicultural Center Prague, Prague, 2007.
- <sup>65</sup> R. Romero-Ortuño, “Access to Health Care for Illegal Immigrants in the EU: Should We Be Concerned?” in *European Journal of Health Law*, 11(3), 2004.
- <sup>66</sup> Budapest Declaration on Public Health and Trafficking in Human Beings, 2003.





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