



Migrants' access to health care in Europe: A literature review

Document Information

Grant Agreement Number	Mig-HealthCare - 738186
Project full title	Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities.
Deliverable No and title	D4.2: Literature review report
Work Package No and title	WP4: Physical and mental health profile of vulnerable migrants/refugees in the EU including needs, expectations and capacities of service providers
Version	Final
Date	24/4/2018
Nature	Report
Dissemination Level	Public

Responsible partner	University of Uppsala
Contributing partners	PROLEPSIS, OXFAM ITALIA, EMZ, NCIPD, UoA, EHESP, CARDET, RSE, Kopin, KEDE, MoH Greece, VM, UVEG

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Description of deliverable	Literature review of migrant/refugee physical and mental health status, health care needs, and availability of health care and social services in the EU member states.
Key words	Migration, health care, refugees, asylum seekers, services, policy, intervention, health, care, vulnerable migrants, social care, obstacles, promising/best practices

The **Mig- HealthCare** consortium. This document is an output of a research project partially funded by the European Commission: Consumers, Health, Agriculture and Food Executive Agency. According to the Grant Agreement no 738186

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Abstract

There is an increasing number of migrants from outside the EU region in the different European countries. This review scoped 71 papers from ten European countries in English and their native languages in order to provide an overview concerning migrants' access to health care. More specifically the review aimed to identify what is known about the physical and mental health status of migrants and refugees in the EU member states; what is known about the health care needs of migrants and refugees in the EU member states and finally what health care and social services are available for migrants and refugees. The review shows that despite the aspiration to ensure equality in access and provision of health care, there is evidence of persistent inequalities between migrants and non-migrants in health and in access to health care services. Inequalities are the results of legal barriers in access to care for refugees and undocumented migrants, but they are also due to the economic situation of migrants who may lack the means to pay for health services or may lack the language and cultural competency to navigate the health care systems, or may be exposed to discrimination. It is of paramount importance to improve provision of care at the primary level, coordination between various agencies and to ensure that all groups of migrants get legal right to health care.

The MighealthCare project

The MigHealthCare is a three year project starting in May 2017 which aims to produce a roadmap to effective community-based care models to improve health care access of vulnerable migrants and refugees, based on a comprehensive methodology comprising a review of original research and piloting implementation. The roadmap will aim at improving access to health care including mental health care services and support the inclusion and participation of migrants and refugees in European communities. The project will explore the feasibility of implementing community – based care models in different contexts and countries through pilot testing and assessment focusing on health promotion and prevention with the aim of facilitating integration and reduction of health inequalities.

The countries

The Consortium, led by Astiki Mikerdoskopiki Etaireia Prolipsis (PROLEPSIS), is comprised of the following partners: Ethniko and Kapodistriako Panepistimio Athinon (UoA), Perifereia Stereas Elladas (RSE), Kentriki Enosi Dimon kai Koinotiton Ellados (KEDE) and Ministry of Health from Greece; Oxfam Italia Onlus (Oxfam Italia); Ethno-Medizinisches Zentrum Ev (EMZ) from Germany; National Center of Infectious and Parasitic Diseases (NCIPD) from Bulgaria; French School of Public Health - Ecole des Hautes Etudes en Sante Publique (EHESP) from France; Centre for the Advancement of Research & Development in Educational Technology (CARDET) from Cyprus; Koperazzjoni Internazzjonali-Malta Association (KOPIN) from Malta; Uppsala Universitet (UU) from Sweden; Verein Multikulturell (VM) from Austria and Universitat de Valencia (UVEG) from Spain.

Definitions

Migrant and *refugees* are terms that are often used interchangeably, but they are defined by the UN as follows (<https://refugeesmigrants.un.org/definitions>) :

Refugees are “persons who are outside their country of origin for reasons of feared persecution, conflict, generalized violence, or other circumstances that have seriously disturbed public order and, as a result, require international protection. The refugee definition can be found in the 1951 Convention and regional refugee instruments, as well as UNHCR’s Statute”.

Migrants “While there is no formal legal definition of an international migrant, most experts agree that an international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status. Generally, a distinction is made between short-term or temporary migration, covering movements with a duration between three and 12 months, and long-term or permanent migration, referring to a change of country of residence for a duration of one year or more”.

Best practice is “a relevant policy or intervention implemented in a real life setting and which has been favorably assessed in terms of adequacy (ethics and evidence) and equity as well as effectiveness and efficiency related to process and outcomes. Other criteria are important for a successful transferability of the practice such as a clear definition of the context, sustainability, intersectorality and participation of stakeholders”. (Criteria to select best practices in health promotion and chronic disease prevention and management in Europe https://ec.europa.eu/health/sites/health/files/major_chronic_diseases/docs/sgpp_bestpracticescriteria_en.pdf)

“Community Health refers to the health status of a defined group of people and the actions and conditions, both private and public (governmental), to promote, protect, and preserve their health” ([McKenzie et al., 2005](#)).

Community is defined as “a group of people, often living in a defined geographical area, who may share a common culture, values and norms, and are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them” ([Green and Ottoson, 1999](#)).

Community-based care / community-based services / programmes defined as “the blend of health and social services provided to an individual or family in his/her place of residence for the purpose of promoting, maintaining or restoring health or minimizing the effects of illness and disability. These services are usually designed to help older people remain independent and in their own homes. They can include senior centres, transportation, delivered meals or congregate meals sites, visiting

nurses or home health aides, adult day care and homemaker services”.(A glossary of terms for community health care and services for older persons (http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf)

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Summary

The problem

With the increased migration to Europe from non-European countries, it is important to look at the evidence available on provision and access to health care for this group.

Equal access and provision of health care needs to be ensured. A review of existing evidence on migrants' access to health care was conducted. The specific aims of the review are provided below.

Aim

The aim of this report is to provide an overview of evidence made available by academic articles and grey literature on the topic of health care and migration in the 10 European countries involved in the project. The specific research were:

- What is known about the physical and mental health status of migrants and refugees in the EU member states?
- What is known about the health care needs of migrants and refugees in the EU member states?
- What health care and social services are available for migrants and refugees?

Method

A scoping review was conducted with 71 papers from ten European countries as part of the MigHealthCare project funded by the European commission. A non-systematic review of the academic and grey literature in different European languages (English, Swedish, German, Italian, French, Spanish, Greek, and Maltese) was undertaken by the consortium partners. The evidence included documents from 2011 onwards.

Evidence to collect included:

- Academic articles and literature reviews (each country in its own language)
- Grey literature (think tanks, non-governmental organisation and government reports)
- Descriptions and evaluation of the legal and institutional framework (laws, policies, regulations, guidelines) governing health and migration in the different European countries (at least in the 9 countries that are part of the consortium)
- Existing EU projects

Results

Different countries tend to focus on different aspects of migrants' health, hence comparison and generalisation across countries is difficult. Most of the existing evidence is fragmented and scattered. However, it seems that there is an unmet need especially when it comes to mental and dental health. Legal barriers exist in equal access to health care, as well as language issues, discrimination, overuse of emergency services and underuse of primary health care.

Recommendations

- Guaranteeing equal legal entitlement as other residents of the country in accessing health care
- Fostering better living conditions for migrants in host countries
- Designing health policies that respond to migrants' needs
- Improving the role for primary health care services
- Improving the quality of European comparative work
- Improving mental and dental health care services for migrants
- Systematic inclusion of the determinant "migration background" in official health monitoring across European countries
- Increasing and improving the collaboration with various migrant groups

1. Introduction

1.1. Migration and Health Care in Europe

The European Union (EU) comprises a heterogeneous population, a growing share of which consists of migrants coming from non-European countries. According to Eurostat data, on 1st January 2014, there were 33.5 million people born outside the

EU, which represents 6.6% of the total EU population. Of these, 19.6 million were still citizens of countries outside the EU, while 14.3 million were citizens of one EU country, but living in another one (Eurostat, 2015). The arrival of migrants from different European and non-European countries implies new demands on public services in some countries, not least health care.

Ensuring access to health care for mobile and newly arrived people presents a significant challenge. The question of equality of access to health care services, both curative and preventative is an aspect of this challenge. The recent waves of migration, in 2015 and 2016, of refugees and asylum seekers have made the need to secure fair access to health care a matter of urgency. All the EU member states have recognised, at least formally, the right for each and every person to the highest attainable standard of physical and mental health. Despite this recognition, none of the European states have yet ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (MacDonald, 2007).

How health care can and should be provided for populations with high levels of immigration is a crucial issue, but one that is difficult to address with good quality data. Citizenship of legally recognised migrants captures part of the population of immigrants, but not naturalised migrants. Numbers of irregular or undocumented migrants are difficult to ascertain with any degree of certainty and definitions differ by member state within the Europe Union and across countries, making comparisons challenging. Publications on migration and health are often partial, with differential focus on different migrant populations such that results are incomplete. Some attempts have been made to fill these gaps and provide a more comprehensive overview of the topic of migration and health care in Europe, such as the Migration and Health in the European Union publication (Rechel, 2011).

The current report provides an overarching picture of the current state of knowledge of migration and health care in Europe, with a particular focus on the European countries that are part of the MigHealth consortium (see section 1.2. for aim and research questions). The MigHealth care consortium aims to produce a roadmap for effective community-based care models to improve health care access of vulnerable migrants and refugees, based on a comprehensive methodology comprising a review of original research and piloting implementation. The MigHealth care consortium includes 14 partners from 10 European countries including universities, Non-Governmental Organisations (NGOs) and national authorities with a composite range of expertise on health, migration, equality and integration issues. The current report provides an overview of the European literature on migration and health care, drawing on searches (see section 2.1. for search words) for published scholarly and grey literature conducted in different European languages as well as in English by the different partners of the project. The report is edited by Uppsala University and Prolepsis and based on the contribution of the countries participating in the consortium. According to the project's guidelines each country identified and reviewed the existing literature on migrants health care in the country's national

language and Uppsala University reviewed the literature produced in English in all 10 countries, plus summaries of national language literature. The attempt of this report is to compile and review the literature on the topic of health care and migration that finds a balance between the specificities of the countries, their health systems and policy measure and scientific production and general features of migration and health care in Europe.

1.2. Aim and research questions

The aim of this report is to provide an overview of evidence made available by academic articles and grey literature on the topic of health care and migration in the 10 European countries involved in the project. The research questions are as follows:

- What is known about the physical and mental health status of migrants and refugees in the EU member states?
- What is known about the health care needs of migrants and refugees in the EU member states?
- What health care and social services are available for migrants and refugees?

2. Methods

2.1. Sources of evidence

A non-systematic review of the academic and grey literature in different European languages (English, Swedish, German, Italian, French, Spanish, Greek, and Maltese) was undertaken by the consortium partners.

Evidence to collect included:

- Academic articles and literature reviews (each country in its own language)
- Grey literature (think tanks, non-governmental organisation and government reports)
- Descriptions and evaluation of the legal and institutional framework (laws, policies, regulations, guidelines) governing health and migration in the different European countries (at least in the 9 countries that are part of the consortium)
- Existing EU projects such as MiMi, Care, EUrHuman, EUBorderCare

The search was conducted according to the following main criteria specifying time frame, databases and search terms:

- Time frame: 2011 onwards (the rationale for this is that 2011 saw the beginning of the Syrian and Libyan revolutions accompanied by an increase in the flow of migrants towards the EU 28 countries)
- Data bases: Web of Science, PubMed, ScienceDirect; ProQuest, Scopus, PsycInfo, PILOTS (this is the Post-traumatic database of ProQuest, may be redundant), Social Services Abstracts (also in ProQuest). Cochrane library, CABI. Eurostat, OECD,

Eurofound, CORDIS and any other databases that are available in the different languages included in the search

- The search terms: Topic: (migrant* or migration or immigrant* or foreign* or (minority near groups) or refuge* or asylum) AND TOPIC: (policy or policies or intervention* or law or laws or program* or service* or reform* or access* or planning or delivery) AND TOPIC: (health or medical), dental care, obstetrics/gynaecology, mental health, social care

Seventy one papers were included in this review.

3. Results

The analysis of the reviewed literature showed that scholarly publications and reports can be divided under the following five categories:

Health status of migrants;

Social determinants of health;

Access to health care;

Use of health care services and finally;

Challenges to health care provision.

Under each category a summary of the main points is provided.

3.1. Health status of migrants

- Studies of migrant health focus more on communicable diseases and less on non-communicable diseases, preventative care and equity in health and in health care access
- Newly arrived migrants are healthier than the non-migrant population
- Some migrant groups tend to have higher risks for both communicable and non-communicable diseases. However, a conclusive result cannot be drawn from the studies.
- Some migrants may have a higher risk for mental and dental illnesses
- Evidence on health status of migrants shows contradictory results. There is lack of standardized and shared procedures for routine collection of health data on migrants in European member states making generalisation difficult.

The collection of data on migrants' health status is fragmented, which is an obstacle to monitoring and improving migrants' health status. The lack of reliable, standardized and shared procedures for routine collection of health data on migrants in European member states represents a significant impediment to ascertaining migrant health status across Europe (Rechel, Mladovsky, & Devillé, 2012). The lack of consistent and comparable data for health status of refugees prevents the development of comprehensive knowledge and understanding and the need for more collaborative

research to close existing evidence gaps e.g. in the field of childhood illnesses and maternal health (Bozorgmehr et al., 2016) is underlined. Practice around the demographic classification of populations varies with the disclosure of “ethnic” information forbidden in Sweden, for example, on the grounds of anti-discrimination legislation. This makes it difficult to provide a detailed picture of the health status of particular ethnic groups, which may overlap substantially with migrant groups at specific moments in time.

Studies of migrant health tend to focus on communicable diseases that are regarded as public health threats, with less consideration of non-communicable disease, not to mention preventative care and the question of equity in health and in health care access. Evidence regarding the general health status of migrants is contradictory and partial (studies are conducted in different settings and time periods), with some suggestion that hardships of the migration process negatively affect the health status of migrants. A German study found an association between depressive symptoms and migration status in the older migrant population (Aichberger et al., 2012). While the healthy migrant effect has been noted in the 20th century literature, more recent evidence from France suggests that migrants are unlikely to be in a better health than native populations. The health of immigrants tends to deteriorate with duration of stay in France and proposed reasons include discrimination and poor employment conditions. The study suggests that the migrant health deficit effect (as compared with natives), is less pronounced for people born in France to foreign born parents. Migrants originally from richer countries tend to be in better health than migrants from poorer countries. Immigrants tend to seek less health care than natives, whereas their offspring’s care seeking is similar to native patterns (Berchet & Jusot, 2012).

Few studies consider mental health condition of migrants and how this compared with non-migrants. Only one study conducted in France focussed on the health effects of violence. This study showed that 84% of 128 women migrants consulting a ‘Médecins du Monde’ clinic in Paris had faced violence, whether verbal, physical or sexual. The main form of violence was verbal, followed by threats of denunciation because of their precarious legal situation (Estrada & Lazimi, 2013). More than half of the women, who had, on average been in France for 1.7 years, reported health consequences (chronic pain, depression) of the violence and yet less than half of them had reported the violence to a doctor previously.

Below we review literature which has a specific focus on communicable and non-communicable diseases, mental health, children’s health status and oral health.

3.1.1. Communicable and non-communicable diseases

A consistent component of both research and grey literature focuses on the link between migrant background and health related behaviours and risk factors. Newly arrived migrants are usually relatively healthy compared to the non-migrant population, but they are more prone to certain non-communicable diseases. Some of

the reasons for this apparent vulnerability are that migrants especially when certain vulnerable groups such as first generation migrant women, make more sparing use of preventive screening and preventative services (Rechel et al., 2012; Rommel, Saß, Born, & Ellert, 2015). Data on the health status of migrants are insufficient, but the available studies suggest that migrants are more vulnerable to communicable diseases, occupational diseases, poor mental health, injuries, diabetes mellitus, and maternal and child health problems (Rechel et al., 2012). An Austrian study underlines how the population of migrant origins suffers to a greater extent than the resident population from heart disease, allergies, digestive and urogenital and dermatological problems and explores the link between migrants' health conditions and the stressful situations they face in the workplace and the community at large (Biffl, 2015).

Some groups might be at particular risk of non-communicable diseases arising from obesity and insufficient physical activity. This is explained by the patterns of disease in countries of origin, disadvantageous living conditions, precarious employment and trauma. However, it is difficult to compare across countries as studies seem to focus on specific health conditions and ethnic groups. For example, some studies focussed on specific conditions such as ophthalmic disease (D'Hermies and de Champs-Léger 2015), HIV (Lot et al., 2012), tuberculosis (Che & Antoine, 2011)¹ or skin diseases (Spanish and Malteste study) (Albares et al. 2016 Duran and Sánchez Martínez 2014; Calderón Sandubete 2014; Casabona et al. 2011; Castro Vázquez 2013, MSc thesis, London School of Hygiene and Tropical Medicine, 2012), gynaecological concerns and other unattended health related problem. In studies focussing on vulnerable migrants living in open centres in Malta (Padovese et al. 2014) and in detention centres in Greece and Malta (Ioanna Kotsioni & Stella Egidi, 2013) the prevalence of HIV, tuberculosis and non communicable disease (eg. hypertension and diabetes) is larger among the non European migrant population ².

¹A study from 2011 focuses on the tuberculosis in France showing that a total of 5,758 tuberculosis cases were notified in France in 2008, a rate of nine cases per 100,000 inhabitants. The median age was 45 years and 59% of cases were male patients. The rate of tuberculosis was higher in individuals born abroad (43.2/10(5) vs. 5.0/10(5) than for individuals born in France), especially those recently arrived in France. The majority of the notified cases were pulmonary tuberculosis (72%), 76% of which were potentially contagious (positive sputum smear, or culture). To cope with the situation, a national tuberculosis control program was launched in France in 2007 in order to reduce epidemiological disparities. The main challenge identified in Che & Antoine (2011) study is that of providing the clinical and public health expertise on all the territory in order to have an impact on the epidemiology of the disease (Che & Antoine, 2011). [The last bit of the sentence is not very clear.]

² In the French study ophthalmic diseases (D'Hermies and de Champs-Léger 2015) and HIV (Lot et al., 2012,) and an Austrian study focussing on skin diseases. In these studies there was an overrepresentation of migrants especially those coming from outside Europe when it comes to these specific diseases.

Additionally, according to the French national health database, among the 6,700 new HIV diagnoses and 5,276 tuberculosis cases reported in 2009, nearly half of them were migrants. Among the 1,715 HBsAg-positive patients newly referred for antiviral treatment in 2008-2009, three quarters were migrants. The proportion of individuals born in sub-Saharan Africa was high among migrants diagnosed with HIV infection (70%), migrants newly referred for chronic HBV infection (54%) and tuberculosis cases notified in migrants (33%). Rates of new HIV diagnoses and tuberculosis cases in migrants were respectively 10 times and 8 times higher than in persons born in France

3.1.2 Mental health in adult refugees and migrants

Refugees and migrants tend to have higher prevalence of mental distress compared to non-refugees. A recent study described the mental health condition of asylum seekers who passed through Médecins sans Frontières clinics in Sicily between October 2014 and December 2015 and, when invited, presented themselves for mental health screening. Of the 385 who were screened, most were young men who had left their home countries in West Africa more than a year prior to arrival. The most common mental health conditions were post-traumatic stress disorder (31%) and depression (20%). Most of the potentially traumatic events were reported to have been experienced in the home country (60%) and during the journey (89%), but also the trauma of being a refugee was also reported, with activity deprivation, worries about people who were left behind, loneliness and fears of being sent back (Crepet et al., 2017).

A study in Malta showed that migrants' previous traumatic experiences such as war have a great effect on their mental health. A study conducted by the Jesuit Refugee Service (JRS) in 2010 states that 80% of Asylum Seekers interviewed reported a deterioration in their mental health since their arrival. The JRS conducted a follow up study in 2014 which corroborated these findings. From a population of around 500 detainees, 74 individuals required in-patient psychiatric care (Rachel Taylor-East & Julian Caruana, 2014).

Studies of refugees' mental health show how structural barriers impeded the effective transfer of patients to further care facilities. High levels of stress in detention centres (Kotsioni 2013) are linked to the reporting of non-specific physical symptoms (Padovese et al. 2014) as a form of somatization of psychosocial stress suggesting underlying mental disorders. The 'Stakeholder Information Sessions'-SIS project showed how mental health was the major health issue affecting a large proportion of the refugee community, including post-traumatic stress disorder, depression, anxiety, psychosis, paranoia and self-harm; feelings of isolation and loneliness were also mentioned by refugees as major concerns to service providers (Aditus (NGO); UNHCR 2013). Other symptoms reported included stress anxiety disorders, panic attacks, and other psychiatric problems (Pavlopoulou et al., 2017) were said to be the most common symptoms in a particular camp (Simonnot et al., 2016). An Italian report underlines that although empirical data and scientific research on the topic on migrants mental health is still rare, practitioners and sector operators have experienced the increase in requests for psychiatric care from migrants who have lived traumatic situations, social marginalization, lack of social support and are therefore at higher risk of post-traumatic stress disorders (ANCI, CARITAS ITALIANA CITTALIA FONDAZIONE MIGRANTES SERVIZIO CENTRALE DELLO SPRA, 2016)

3.1.3 Children's health status

References describing child migrants' health status are country specific and focus on specific illnesses, making it difficult to draw comparisons and commonalities across

countries. As an example a French study looked at hepatitis A and showed that children born in an endemic area have a significantly higher prevalence of hepatitis A seropositivity compared to children born in France, possibly as a result of exposure during overseas trips to visit family or of family members visiting from the endemic areas, implying an urgent need to vaccinate children (Burbotte et al. 2011). Another study in France underlined the lack of clinical practice recommendations for the care of unaccompanied refugee minors as causing significant disparities depending on the *department* or region in which the young person arrived. The most frequently diagnosed serious conditions were digestive parasitoses, schistosomiasis, filariasis, hepatitis B and iron deficiency and the failures of care implied the need for standard care to be defined (Monpierre et al., 2016).

The health problems addressed in a Greek study of child migrants included unknown vaccination status, dental issues, Latent Tuberculosis Infection (LTBI), anaemia, low serum ferritin, eosinophilia, and protective antibodies (Pavlopoulou et al. 2017). Reports of hypothermia after arrival by sea and mental health challenges associated with the experience of violence, separation from family, insecurity, inadequate housing, trafficking, and sexual exploitation (Giannakopoulos & Anagnostopoulos, 2016). Systematic clinical examination, chest radiography, and tuberculin testing for asylum seekers before placement in shelters were recommended to tackle such problems (Pavlopoulou et al., 2017).

Oral health and dental care has been found to lack among child migrants. A study of 12 years old Austrians showed that the prevalence of caries among children born to migrants was 42 percent higher compared with children who did not have a migrant background. Children with a migrant background are more affected by gingivitis (gum inflammation) and less likely to seek orthodontic treatment or counselling compared with other twelve-year-olds. The report underlines how better use of group prophylaxis and individual health care prevention would be a means of reducing unequal distribution of health risk (Bodenwinkler, Kerschbaum, & Sax, 2012).

3.2 Social determinants of health

Most of the studies on social determinants of health among migrants are conducted in France

Social determinants negatively influence migrants' health status and access to health include housing conditions, legal status, social inequalities and discrimination.

Most of the studies focusing on the social determinants of health among migrants were conducted in France (Kaoutar B et al., 2014; Kaoutar B, Mathieu-Zahzam L, Lebas J, & Chauvin P, 2012; Barda, Chappuis, Godard, & Médecins du Monde, 2016; Nigel Camilleri MD MRCPsych DCP & Rachel Taylor East MD MSc, 2010)

A series of French studies reported on the increased health risks for homeless migrants (Kaoutar B et al., 2014)³, including chronic diseases. A hospital polyclinic in Paris overwhelmingly used by migrants was surveyed in April and May 2009 and, although their average duration of stay in the country was 12 years, about half of the sample were undocumented and a quarter had no health insurance (Kaoutar B et al., 2012)⁴. Vulnerable migrants in France (including minors, women, and people with disability) were found to have poor self-rated health and living conditions as well as being exposed to violence. Prevalence of having experienced violence was higher for people living in public emergency accommodation and those who were homeless (Barda, Chappuis, Godard, & Médecins du Monde, 2016)⁵. According to a systematic literature review, the link between socio demographic conditions and health is stronger for migrants than for the native population (Berchet & Jusot, 2012). Migrants and especially women migrants from sub-Saharan Africa in France in 2012-2013 faced precarious administrative and social conditions, which is associated with poor health outcomes, including the frequent non-disclosure of HBV status. Chronic hepatitis B tended to only be diagnosed after arrival in France, and even then only after a median delay of 3 years. While routine screening tended to lead to diagnosis among the women, among the men in the sample less than one third had been diagnosed following a systematic check-up. Compared to women, the men's diagnosis occurred after a longer delay following arrival in France and occurred more frequently during an active phase of the disease⁶ (Dray Spira et al., 2015). An ethnographic study from 2015 looked at migrants living in squats to assess the effect of getting an

³The results showed that 65% of the free access patients are men, their average age is 42 years old, half of them are homeless, 80% are a migrant background and, more than 17% have no health insurance. More than half of these patients have a chronic disease, while only 1/3 have a medical follow-up, 17% have a psychological disorder. The study concludes that the health status of the population is worse than the one of the general population

⁴ The study conducted in 2012 describes both the socio demographic profile of patients in free access to health care facilities at the Baudelaire hospital, and their health issues. Results show that 62% are men, the average age is 45 years old, 49% are undocumented migrants, the average duration in France is 12 years old, more than 20% have no health insurance, 55% have a chronic disease (20% have high blood pressure, 12% have diabetes, 7% have infectious chronic disease).

⁵ This study was based on the population of Médecins du Monde health centers in Paris and Saint Denis focused on vulnerable migrants who faced accommodation issues. 99.5% are national foreign. 80% are irregular migrants. 14% have a chronic disease. 54% judge their health status bad or very bad. 16 % of people living in camps or at somebody else's' declare to have been exposed to violence. The situation gets worse for people in public emergency accommodation (22% declare exposure to violence) and with no accommodation or living on the street (48% declare exposure to violence and 86% feel insecure

⁶Data comes from a national survey. Results show that the average age is 39 years old, this population is sustainably settled in France (since 10 years in median), they face precarious administrative or social situation (12% without a stable accommodation, 32% without employment, more than 5% have no health coverage, more than 20% benefit to the health coverage for undocumented migrants) especially among women. Non-disclosure of HBV status is frequent, especially in men (23.9%). In most cases, chronic hepatitis B was diagnosed after arrival in France, after a delay of 3 years in median. While routine screening is predominant among women, among men only less than 1/3 have been diagnosed following a systematic check-up. Compared to women, diagnosis occurred within a longer time from arrival in France and more frequently during an active phase of the disease among men

accommodation on access to health care. When migrants were no longer living on the street and had access to, for instance, collectively managed accommodation, they started or resumed seeking access to health care (Bergeon & Hoyez, 2015).

A qualitative investigation of social inequality and discrimination as determinants of unequal health among French migrants demonstrated discrimination against migrants in either employment or health care access to be a pressing issue. With a life course focus, rather than on newly arrived immigrants, discrimination due to a migrant's country of origin is shown to have consequences for health status (Cognet, Hamel, & Moisy, 2012).

Only one other study in our review reported on how both social inequalities, and the migration process itself, affect migrants' health status (Valeska Padovese, Tanya Melillo Fenech, Daniele Didero, & Concetta Mirisola, 2014). Over 2,000 immigrants to Malta, living in open centres were assessed between August 2010 to June 2011 and the following factors were found to be detrimental to health outcomes: the environment in detention homes including exposure to cold, a lack of space and overcrowding, a lack of activity, poor diet and high levels of stress; together with a lack of systematic and/or preventive medical care and a lack of treatment for infections and diseases⁷. Furthermore, the report emphasizes how the detention context poses additional significant challenges for asylum seekers and migrants with chronic medical conditions, disabilities or mental health problems.

In Malta looking at the social and economic environment of migrants, tense living conditions have been shown may lead to negative health outcomes (Valeska Padovese et al., 2014). Other factors such as limited access to paid work was raised as a concern in some literature. Reference was made to particular Sub-Saharan African asylum seekers who seemed especially vulnerable to exploitation and abuse (Manwel Debono, 2016).

Although these results emphasize the need for stable accommodation available regardless of the migrant's legal status as a key means of promoting increase health equality for migrants, the studies only reflect findings from France and to some extent Malta. While it is not appropriate to generalise to other settings, since how the social determinants of health affect access to health care for migrants in other countries is likely to differ, it is nonetheless likely that access to secure, safe housing, is of paramount importance regarding health status.

3.3 Access to health care

Access to health care for refugees, asylum seekers and migrants varies across the European countries in terms of regulation and laws

Evidence on access to health care is scant

⁷ Including scabies, bacterial and fungal infections, gastrointestinal problems including gastritis, constipation and haemorrhoids as well as musculo- skeletal complaints

- Language and communication difficulties
- Unavailability of health information in different languages
- Lack of migrants' knowledge in health issues and policies
- Discrimination

Access to health care for refugees, asylum seekers and migrants varies across the European countries in terms of regulation and laws (Bradby et al., 2015). Even when laws and regulations grant access to health care, difficulties in accessing health care for migrants, asylum seekers and refugees have been documented by studies conducted in different countries (Mara Tognetti, 2015; Mario Affronti, Giovanni Baglio, Salvatore Geraci, Maurizio Marceca, Maria Laura Russo, 2014; D’Hermies & de Champs-Léger, 2015). Only a few studies focus on the conditions discouraging migrant from seeking for care (Pithara, Zembylas, & Theodorou, 2012; Kouta, Phellas, & Charis, 2013). There is a focus on the needs of undocumented adult migrants that in most European countries are only entitled to emergency treatment (Simonnot et al., 2016; Suess, Ruiz Perez, Ruiz Azarola, & March Cerda, 2014). As the literature is scant and scattered we outline those cases that have been described below.

Persistent inequalities in the access to care between migrants and non-migrants in Italy are linked to insufficient and inappropriate use of health services (Mara Tognetti, 2015). The challenge of providing equal access to care for the migrant population is exacerbated by the administrative organisation of the Italian health care system, characterized by a “*pendulum of competences*” between State and region and by as many guidelines and ways of implementing those guidelines as there are regions (Mario Affronti, Giovanni Baglio, Salvatore Geraci, Maurizio Marceca, Maria Laura Russo, 2014). Commissioned by the European Commission and drawing on the results of a survey of experts in the field in EU, the report specifies relevant laws and regulations addressing access to care for undocumented migrants in Austria, specifying access, specific entitlements to and costs of different types of health care (Cuadra, 2010).

A French study showed how inequalities in access to specific treatments can affect health outcomes among immigrants from Asia and North Africa to France (D’Hermies & de Champs-Léger, 2015). Delays in getting HIV testing and referral for treatment were found for immigrants from Asia and North Africa compared with faster treatment and referral for patients born in sub-Saharan Africans are referred quicker.

A study in Cyprus focused on “temporary migrants” defined as those that undertook “*migration for a specific motivation and/or purpose with the intention that, afterwards there will be a return to country of origin or onward movement*” (Pithara et al., 2012). The study looked at the conditions affecting access to and effective use

of health care services among temporary migrants concluding that the availability of information in English about the local health system, for example about the relationships between public and private providers, insurance options and coverage were influential factors. The effectiveness of access was influenced by migrants' capacity to communicate with the providers and a lack of understanding discouraged migrants from using the health care system (Pithara et al., 2012). A lack of information about the care options available and language barriers were identified among the factors contributing to HIV vulnerability of ethnic minorities (Kouta et al., 2013).

Migrants' perceptions of the process of integration in Malta were investigated through focus group interviews with asylum seekers and refugees. Most satisfaction was expressed with access to education, employment and learning the national language of the recipient country followed by access to community services. Areas of concern had to do with access to opportunities for budgeting and personal finance, housing opportunities followed by general access to health care (Bugre et al. 2016). General accounts of the challenges faced by refugees and migrants having entered Malta dominate reports identified from NGOs. The lack of a holistic approach to protection from the impact on the physical and mental health of new arrivals is regretted. One report, for example, presents the outcomes of two different but linked integration projects, both implemented in cooperation between UNHCR and the Aditus Foundation. The Meet The Other project - MTO found that a majority of refugees confirmed that they were generally able to access public health centres without major problems. Overall, quality of health-related services received was considered very good but communication remained a significant challenge (aditus, 2013). The 'Stakeholder Information Sessions' project - SIS project (aditus, 2013) shows mental health problems to affect a large proportion of the refugee community with symptoms including post-traumatic stress disorder, depression, anxiety, psychosis, paranoia and self-harm. Feelings of isolation and loneliness were mentioned by refugees as major concerns to service providers.

An observatory report on access to care for refugees looked at different European countries, including Greece (Simonnot et al., 2016). The report examined a polyclinic run by Médecins du Monde (Doctors of the World), that provides free care to migrants in Greece when they do not qualify for care from the public hospitals. The data were collected through patient interviews covering topics such as: "living conditions, activities and resources, administrative situation, isolation, health coverage and barriers to accessing health care, perceived health, vaccination, women's sexual and reproductive health, health state, and experiences of violence" (Simonnot et al., 2016). The report covers organisational and management problems, such as the lack of institutionalized procedures for taking care of unaccompanied minors and frequent breaks in the continuity of care.

A small number of reports and reviews focus on the struggle of undocumented migrants to obtain care when they are not in emergency condition in European settings (Marques, 2012). A report entitled "Refugees and migrants struggle to obtain

health care in Europe” focuses on barriers to access to care, citing in particular: the high cost of care and complex reimbursement procedures; a lack of awareness of migrants’ entitlements both on the side of health providers and of the beneficiaries; fear of detection due to information passed on to the police; discretionary power of public and health care authorities; and problems with the quality and continuity of care (Marques, 2012),

Some studies in France show difficulties for migrants to access care. Even though it exists health coverage of both documented and undocumented migrants, the effectiveness to access to health coverage is a challenge. Firstly, non-take-up can be explained by four major factors: lack of knowledge of the scheme (37%); administrative requirements (33%); language difficulties (20%); and fear of being called in for questioning (30.5%). Secondly, discriminatory practices and refusal of care are mentioned (Médecins du Monde Mission France, 2014).

One Spanish qualitative study examined perceptions and experiences of access to health in migrants in Campo de Gibraltar. Narratives were collected using focus group discussions and analysed through Nvivo. The study concluded that there is the need to increase health literacy among migrants and that this would be best done through action-research methodology (Bas Sarmiento et al. 2015). However, the value of the study seems to be in the solutions suggested that are more bottom up and participatory, rather than in the findings, which are consistent with mainstream discourses about how to improve access and use of health care services among migrants.

A number of studies highlighted unaddressed cultural and communication issues (Kohls, 2012; Laura Frank, Rahsan Yesil - Jürgens, Oliver Razum, Kayvan Bozorgmehr, Liane Schenk, Andreas Gilsdorf, & Alexander Rommel, Thomas Lampert, 2017; Razum, Neuhauser, & Robert-Koch-Institut, 2008; Taglieri, Colucci, Barbina, Fanales-Belasio, & Luzi, 2013) as leading to weak health services provision for migrants and also to governance problems and an incoherent distribution of power and responsibility for the provision of health care between different actors as reported by an Italian study (Osservatorio sulla salute, 2016).

Overall the evidence which exists on access to refugees, asylum seekers and migrants is scant and so that it is difficult to draw any general conclusions about the patterns through which these groups access health care.

3.3.1 Access to maternal health services

Similarly the evidence on maternal health was scant, focussing on specific issues such as female genital circumcision (Grech & Pisani, 2016), the use of maternal health services (Råssjö 2013) and inequalities in pregnancy and childbirth (Villadsen 2016).

Female genital circumcision or mutilation (FGM/C) was investigated together with prenatal care in refugee women from Syria, Somalia, Libya, Eritrea, Ethiopia, and the

Ivory Coast in Malta. The study looked at service providers⁸ and identified obstacles preventing access to pre-natal care. In general the language barrier was pointed out as an obstacle for women, not only within the health care setting, but also in using transport to reach health care services. Insufficient interpreters, a lack of cultural mediators, a gap in capability to communicate with one another in a cultural sensitive way were pointed out by both women and service providers. These obstacles led to consequences such as missing important appointments, not completing all required medical tests as requested by medical staff, women feeling uncomfortable and not making available all the important information (Grech & Pisani, 2016). In a Danish study an overview of inequalities in pregnancy and childbirth for migrant women showed that they are documented in Europe, North America and Australia, but underlined the lack of evidence for planning improved care and access to care (Villadsen, Mortensen, & Andersen, 2016).

The perceptions of migrant women on their pregnancy and childbirth and their experience within the Danish health system were studied. Among the main issues identified, was a link between the quality of care, the use of interpreters and effective cross-cultural communication. The fundamental question of universal entitlements to access health care was also raised, with the authors referring to the Danish MAMA ACT study as offering a strategic perspective on how to move forward in pregnancy and delivery care for migrants. Main elements of the strategy are: use of professional interpreters in maternal care provision in order to ensure equality of care; mutual trust between migrant women and health-care providers in order to ensure quality of care; ensuring that migrant women know how to navigate the health system as a way to reduce delay in health-care seeking and appropriate treatment (Villadsen et al., 2016)

3.3.2 Health literacy and perception of health among migrants

In addition to the research already described, focusing on the health of migrant women, children, middle aged men and older people (see Austria, France, Germany), we found a few reports (e.g. the Austrian GLM study) on the health literacy of migrants compared with that of the local population. A study in Austria considered two groups of migrants: those who did not feel at home at all in Austria (TR) and those who had had bad experiences with health care providers and had little confidence in the treatment system (BKS). The evidence suggested that these two groups of migrants had health literacy no worse than the general population (Ganahl, 2016)

Concerning the perceptions of their own health and unmet health needs, an Italian study among migrants in Spain and Italy shows that perceptions of unmet health care needs were found to have increased from 2007 to 2012 among the migrant population

⁸midwives and practitioners from Obstetrics, Gynaecological Out-Patients Dep (GOP), Bereavement Midwifery Clinic, and Genitourinary Clinic (GU)s

in Italy. However, this did not increase among migrants in Spain, because in 2012 also the native population perception of unmet needs increased ⁹ (Rosano, 2015).

Another study on the unmet need for medical care among migrants was carried out in Finland. The study focused on migrants from Russian, Somali and Kurdish background. The study showed that the unmet needs varied from 4% in the overall population to 31% in people from Kurdish origin, 17% in those of Russian origin and 7% in those with Somali origin. The unmet needs were highest among Kurdish women with chronic conditions (76%). Among the factors increasing perception of unmet needs the study mentioned those preventing or discouraging migrants from accessing the health care, in particular “high cost, lacking awareness of the health care system, culturally insensitive services, different perceptions of illness and stigma, as well as limited language skills” (Koponen et al., 2014)

A lack of knowledge concerning specific diseases such as HIV and AIDS and other sexually transmitted diseases was reported by a questionnaire survey of 600 migrants from third countries in two cities in Cyprus¹⁰ (Kouta et al., 2013).

A total of 455 adult refugees speaking Arabic, Dari, Somali or English were contacted via 16 language schools for immigrants in Sweden, responded to a questionnaire.¹¹ The majority of these refugees were found to have inadequate or limited health literacy, both functional health literacy and comprehensive health literacy. The only association between country of origin and health literacy was found for people originally from Somalia. The study concluded recommending that levels of health literacy should be taken into consideration in activities addressing migrants (Waangdahl, Lytsy, Maartensson, & Westerling, 2014).

3.4 Use of health care services

- Evidence on use of health care services is scant
- Migrants tend to overuse emergency services and underuse

primary health care services. However, this result is not

⁹This study compared health self-perception and access to health care services (in particular the risk to perceive a bad or very bad health and the unmet need for medical examination and treatment) between migrant and native population in Italy and Spain in 2007 and 2011. The study relied on the data from the Italian and Spanish 2007 and 2011 European Union Statistics on Income and Living Conditions (EUSILC), (n = 40,000 in Italy and n = 28,000 in Spain). The results show that self-perception of health among migrants did not change from 2007 to 2011 what changed and got worse was the perception of unmet needs, which increased among migrants both in Spain (from 3 to 4%) and in Italy (from 5 to 9%), being significantly higher than natives in Italy in 2007 (OR = 2.0; 95% C.I.: 1.5–2.6) and 2012 (OR = 2.4; 95% C.I.: 2.0–3.0), in Spain only in 2007 (OR = 2.0; 95% C.I.: 1.4–2.8), since here UNMET among natives also increased from 1.5 to 5.4% (2007–2012)

¹⁰The study sampled 600 migrant from third countries from two cities in Cyprus (Nicosia, Limassol), both men and women were included in the study sample. A closed-ended questionnaire referring to the knowledge, attitudes and behaviour of the participants in relation to HIV/AIDS was used

¹¹Health literacy was measured using the Swedish Functional Health Literacy Scale and the HLS-EU-Q16 questionnaire. Uni- and multivariate statistical methods were used to investigate group differences.

There is a focus on the use of emergency room (ER) or acute care provision, with migrants found to have a higher use of ER, a higher likelihood of visiting ER during unsocial hours and a higher use of obstetrical and gynaecological services among migrant women than non-migrant women (Credé, Such, & Mason, 2017). However, as with the other work reviewed, the studies focused on the use of health care are country specific and fragmented and it is difficult to evaluate to what extent their evidence can be generalised.

Migrants in Austria were found to make more use of first-aid stations, to show predictable communication and understanding difficulties and different views about or constructions of health and illness. By contrast, non-migrants made more use of medical benefits, outpatient nursing services, rehabilitation services and family doctor. These results may signal the presence of barriers to the use of regular health care services among migrants (Kohls, 2011).

Migrants originally from former Yugoslavia were compared with non-migrants aged over 50 years in Austria, along a number of dimensions¹² including self-assessed health, disease profile, symptoms, mental health, activities of daily living among aging migrants, and access to health (number of medical consultations, consultations with general practitioners, access to specific health services, hospitalisation) (Mag.a Nicole Halmdienst, Mag. Michael Radhuber, & Univ.-Prof. Dr. Rudolf Winter-Ebmer, 2013). A study commissioned by the City of Vienna investigated the reasons for a lower use of professional health care services even when needed, focusing on older migrants from Turkey, Former Yugoslavia (Bosnia, Serbia), Poland and Iran (Reinprecht, Rossbacher, Wilczewska, Alpagu, & Koyupinar, 2016.) The study evaluated the relevance of different orders of reasons, from primary structural reasons (poverty, marginalization, discrimination), to a lack of knowledge about the care system to “culturally competent nursing care” (Douglas et al., 2014).

A study of how migrants in Greece made use of the health care available to them, showed that compared with non-migrant patients, hospitalization rate was lower for chronic conditions but higher for accident-related diagnoses, treatments for infectious disease, and medical conditions related to depression or alcohol use. This study was not disease- or condition-specific, but covered a range of problems for which hospitalization is required (including: TB, gastritis/gastroenteritis, hepatitis, pneumonia, alcohol-related conditions, poisoning, and allergy) (Tsitsakis et al., 2017).

¹² This study is based on the data collected by European project Share and was published in 2013

A study of the utilization of hospital services by the patient's country of origin in Aragona, Spain showed that foreigners tend to use the public hospital less than the native population. However, this observation only tells part of the story since the variation in prevalence of different diseases in immigrants' countries of origin meant that the reason for using hospitals services varied by country of birth of the immigrants (Ben Cheikh et al., 2011).

A review of mainly survey-based evidence on the use of health care services among migrants covered 29 studies of general practitioners (9 from Spain) and 15 of specialist physician (7 from Spain). The results show that the immigrant population in Spain have a similar use of general medical services as compared with the native population, but that the two populations diverge in the use of specialist physician services. The results, in line with studies in other countries, shows that the migrant population and the native population have a similar use of general medical services and less or similar use of the specialist physician services. (Carmona, Alcázar-Alcázar, Sarria-Santamera, & Regidor, 2014).

An interview study with health care providers in Spain asked about the use of health care services by migrants. Providers shared the perception that the emergency service was the main access route for migrants and reported failures in the continuity of care for immigrant patients. According to professionals the access and use of health services varied according to both the origins and the level of social integration of the immigrant group (Llosada Gistau, Vallverdú Duch, Miró Orpinell, Pijem Serra, & Guarga Rojas, 2012).

A study in France in five free clinics in the Paris region shows that 80% of their patients are migrants, and, more than 17% have no health insurance. More than half of these patients have a chronic disease, while only 1/3 have a medical follow-up, 17% have a psychological disorder (Kaoutar B et al., 2014).

3.5 Challenges of health care provision

Evidence on challenges of health care provision varies across countries. Some of the challenges mentioned are:

- Organisational issues
- Lack of infrastructure in transit countries such as Greece
- Coordination between different levels of care
- Cultural and language problems

Understanding the challenges of providing care for new migrants has had a particular focus in countries such as Greece and Spain that are entry points for arrivals to Europe. A Greek study on “caregivers working in contemporary refugee hotspots” found that care givers suffer from psychological stresses and sleep disturbances as well as post-traumatic stress syndrome (7% PTSD) (Psarros, Malliori, Theleritis, Martinaki, & Bergiannaki, 2016). According to some authors, the challenge that the refugee crises posed to national health services has not received enough media coverage and it is still too marginal in the current public debate (Hunter, 2016).

Organisational issues faced by health care providers included problems of internal and external communication and coordination, cultural and language differences, inadequate funding, inadequate human resources and an overwhelming volume of refugees. Greece in particular was noted one of the countries dealing with sheer numbers of refugees (Dara et al., 2016). Other challenges faced by health care providers working on the front line in Greece included the limited availability of on-site diagnostic tests, electricity, and running water in camps (Morgan, 2016).

Other organisational challenges include insufficient training courses in cultural competence for health and social care professionals in Italy; staff shortages especially on the islands, a lack of interpreters in emergency care departments and a lack of suitable accommodation places for vulnerable populations in Greece; a lack of funding for treating chronic non-communicable diseases in Slovenia; and in Italy, Greece and Slovenia a lack of coordination between participating organisations, for example with regards to supplying with food and clothing to reception and accommodation centres, which often led to an imbalance between demand and supply between the different centres (Psoinos et al. 2017).

An increase of migrants’ requests for hospitalizations and psychiatric care and deficiencies in the services that should provide mental care was reported by an Italian study (Anci, Caritas Italiana Cittalia Fondazione Migrantes Servizio Centrale Dello Spr, 2016). In particular, the report refers to how traumatic and tragic experiences (including torture) and post-migration living difficulties contribute to post-traumatic stress disorder (PTSD). Although some special initiatives to address PTSD exist (the Protection System for Refugees and Asylum Seekers for example), the increase in demand for support has proven difficult for the Italian State (Anci, Caritas Italiana Cittalia Fondazione Migrantes Servizio Centrale Dello Spr, 2016). Serious deficiencies in the availability of cultural mediators and of expertise in migrant mental health, combined with the increase in demand has put the provision of mental health services for migrants under severe strain in Italy (Medici Senza Frontiere, 2016).

The availability and organisation of health assistance for migrants, refugees and asylum seekers through civil society organisations varies across European member

states. A report comparing Italy, Greece and Slovenia¹³ shows that the services are centrally administered in Greece and Slovenia compared to Italy's regional organisation. Health care services for migrants, refugees and asylum seekers in Italy have been provided mainly by health professionals appointed by the ministry of health while in Greece, non-voluntary organisations (NGOs) have been playing a big part in providing health care. Slovenia has state-appointed health professionals undertaking the task alongside NGOs (HCDCP, PRAKSIS, CMT PROOPTIKI, MINSALUTE, AOUMEYER, OXFAM ITALIA, ISS, INMP, NIJZ, 2016). The creation of a Refugees' Health Unit in Greece offered health care providers working with a translator or cultural mediator (Tsiamis, Terzidis, Kakalou, Riza, & Rosenberg, 2016). In Spain, an Intercultural Mediation Programme for women mostly treated reproductive problems among Latin American women. The programme provided information, education and facilitated access to reproductive health services (Alcaraz Quevedo et al., 2014).

These last two examples suggest that integrated provision of care, whereby migrants can access a range of services, together with translation and cultural mediation as appropriate may represent a form of good practice.

4 Discussion

Interest in understanding the barriers to access health care and the creation of inequalities among migrants in marginalized situations, is evident through the range of reports and articles reviewed here. Despite evidence of elevated interest, the research from European countries that has been reviewed for the MigHealth care project is fragmented and scattered, lacking common definitions and clearly defined goals. In reporting on practice, it is often unclear whether a migrant is from outside or within the European Union, perhaps because care providers do not always know and, given the sensitivity of migration status, it may be difficult to establish. A top down approach of evaluation of health care needs of migrants is mostly used. However, there is hardly any investigation of how migrants' own, self-defined health needs can be met. Studies in different countries have different emphases making comparison difficult: some studies compare the health condition of migrants with the local population, with the results often contradictory and context specific; other studies focus on health conditions of children pre-dating their migration (e.g. hepatitis, dental problems); while others consider the mental health unbalance between migrants and non-migrants. While some reports underline the link between housing conditions and health, these reports were mostly conducted in France.

Recent studies have reported a higher use of emergency services by migrants and a higher likelihood of visiting ER during unsocial hours; together with the higher use of obstetrical and gynaecological services among migrant women compared with non-

¹³The report is based on literature review, document analysis, face-to-face interviews and focus groups mainly with representatives from civil society organizations and also representatives from public authorities

migrant women. These discrepancies may signal the presence of barriers to migrants' use of regular health care services. A few studies have investigated the accessibility of health care for migrants, testing intercultural policies aimed at helping health care providers meet the needs of migrants, while others have focussed on the conditions discouraging migrant from seeking care (e.g. a German study focused on communication problems, lack of understanding of the system; bad experiences).

The health care needs of undocumented migrants, who, in some European countries are only entitled to emergency treatments are examined. Existing literature has identified interventions aimed at making "health services accessible and more responsible to migrants", for example by providing interpreting services to assist health providers, or by increasing the cultural competences of the providers; or again by supplying migrants with information on the health system. There has not been a systematic evaluation of these services that can assess their effectiveness (Mladovsky, Rechel, Ingleby, & McKee, 2012a).

Among the measures addressed to providers, there has been an emphasis on cultural policies focused on language and mediation. More recently the target of such policies have become organizations rather than single individuals. Recent examples of this organizational cultural change include diversification of the workforce, investment in resources and infrastructure for migrant health services, adaptation of protocols, procedures and treatment methods aimed at meeting migrants' needs.

Concerning policies addressed to patients, there has been an insistence on making health systems easier to understand and navigate but also strengthening the health literacy of migrants and their participation to the development of health policies. A 'whole organisation approach' to improving services for migrants is advocated, whereby cultural competences pertain to organisations and not just individuals and go beyond translating informative leaflets and consent forms into different languages. A more diverse health care workforce has been identified as one element to strengthen health care provisions for migrants, as showed by the US and UK experiences (Seeleman, 2015) Creating links with migrant communities through outreach activities is another crucial step, promoting migrant health over the long term through literacy and education activities. Equipping the health care system with special services targeted at the hard to reach migrant population has been adopted in places. Despite controversies surrounding 'special' or 'dedicated' services which may increase segregation rather than foster equality, evidence seems to be proving that a 'diversity' approach to pursuing equal health rather than a single service to meet all needs is giving encouraging results. Mobile community clinics in the UK offer examples of good practice (Mladovsky, Ingleby, & Rechel, 2012). Finally, fostering cultural communication through cultural mediators, professionals who know the migrant communities as well as the health care system and bridge between the two, supporting patients in expressing their needs, in voicing disappointment and choosing the health care that they need.

The body of scientific and grey literature review here underlines that migrants' health status and the possibility of health equality is affected by multiple factors that influence migrants' ability to access health care. These include legal entitlement; knowledge of the health system in a new country; previous experience of health care; language and cultural barriers; health beliefs and attitudes; and the structure of the health system itself in the new country (Bradby et al., 2015; O'Donnell et al., 2016). The sources reviewed highlight similarities and differences among the European countries. Although the system of legal entitlement and the health system itself varies across European countries, the problems related to knowledge of health system, language and cultural barriers and health beliefs and attitudes are common. Among the steps and measures identified to cope with the challenge of providing suitable health services to migrants, recent literature focuses on:

To guarantee the same legal entitlement as other residents of the country is a fundamental step towards improving migrants' access to health services. This aspect is particularly urgent for undocumented migrants, such as visa or permit 'overstayers', rejected asylum seekers and individuals who have entered a country without documentation. Limitations to health care entitlement are sometimes justified as a measure to discourage 'health tourism'. This concern and the discriminating rhetoric behind it are not supported by evidence from studies on undocumented migrants. Limiting access to emergency services has been proved both ineffective and costly (Mladovsky, Rechel, Ingleby, & McKee, 2012b).

To foster better living conditions for migrants in host countries, and at least access to fundamental needs (access to potable water, shower and toilets). Studies show the consequences of being homeless: higher risk of physical diseases (scrabies, ...), higher risk of mental health diseases (stress to not know where to sleep, higher risk of violence).

To design health policies that respond to migrants' need. Available studies have emphasised that migrant health policy is often vulnerable to changing political representation, economic and financial circumstances. In order to justify sustainable migrant health policy, good quality data on the health status, needs, and expectations of migrants with regards to health is required. The present literature review confirms the persistent lack of data on perceptions and needs expressed by migrants themselves, with these perceptions and needs all too often described by service providers.

A call for the systematic inclusion of the determinant "migration background" in official health monitoring is underlined by different sources as one path to make available data more precise, reliable and comparable.

The crucial role played by primary care in delivering high quality, culturally sensitive and appropriate care for migrants, especially those in vulnerable situations has been underlined by recent studies (de Brún et al., 2015; Kohls, 2011; O'Donnell et al., 2016). Despite this interest, most of the scientific production on European countries focuses

on the health status of migrants, women, children, middle aged men and older people rather than on when and how the migrants' health needs are met.

Improving the quality of European comparative work. The lack of a rigorous analytical framework to identify and evaluate the different migration health policies in the different European countries is apparent. So too is the need to map regional, sub-national, non-governmental initiatives in order to understand how to develop health policies in such diverse political, social and cultural contexts. The need to maintain migrant health as a European priority, despite the adverse climate of economic austerity and anti-migrant political discourses, is also urgent.

Mental health of migrants is still at a relatively early stage as showed by the fact the the main results of the studies conducted in this field are inconsistent and sometimes even contradictory.

5 Methodological considerations

5.1.1 Limitations and strengths

The project included 10 countries across Europe all of which were included in the literature review. The fact that literature was gathered in the various languages of these countries contributes to the strength of this review. The partners were able to access literature, both peer reviewed and grey literature, in their language which increased our search base and enables the inclusion of a wider variety of reports from NGOs and official agencies, as getting beyond the literature available in English.

The literature reviewed was dominated by certain countries such as France, Sweden, Austria and Greece. The lack of common definition of what constitutes a migrant, an asylum seeker and a refugee and who counts as a vulnerable migrant, as well as the different sample sizes, analytical methods and the focus on specific ethnic groups makes generalisation difficult. There was limited data on mental health status which makes it difficult to draw any conclusions. To gain a full picture of the status of migrant health policies in Europe would require better data on the effectiveness of the measures introduced so far, both the ones addressed to the patients and those addressed to providers.

Existing literature has identified interventions aimed at making “health services accessible and more responsible to migrants” (Rechel, 2011), for example by providing interpreting services to assist health providers, or by increasing the cultural competences of the providers; or again by supplying migrants with information on the health system. There has not been a systematic evaluation of these policy practices that can assess their effectiveness.

6 Conclusion

Evidence from different European countries shows that despite the aspiration inequalities between migrants and non-migrants in health and in access to health care services persist. Inequalities are the results of legal barriers in access to care for refugees and undocumented migrants, but they are also due to the economic situation of migrants who may lack the means to pay for health services or may lack the language and cultural competency to navigate the health care systems, or may be exposed to discrimination.

The European situation concerning migrants' health status and access to health care is heterogeneous and it is difficult to compare and draw any firm conclusions due to the inconsistency of the evidence. Different diseases are prioritised by different countries, although these priorities do not always correspond to the expressed needs or priorities of the migrants. Mental health care, preventive care (immunization) and long term care in the presence of a growing migrant older population are identified as priorities that deserve greater attention. There is a need to improve the existing data on migrants' health status, needs and access to health care to be able to provide optimal health care tailored to the needs of migrants. As migrants own voices were not highly present in the reviewed data, there is need to conduct research to highlight migrants' own views on their health and barriers to access to health care.

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