MIGRANT WOMEN’S HEALTH ISSUES: ADDRESSING BARRIERS TO ACCESS TO HEALTH CARE FOR MIGRANT WOMEN WITH IRREGULAR STATUS

Introduction
Women globally migrate at a rate similar to men (1), but migration affects them differently (2). As the Committee on the Elimination of Discrimination against women (CEDAW Committee) has noted: “To understand the specific ways in which women are impacted, traditional female roles, a gendered labour market, the universal prevalence of gender-based violence and the worldwide feminization of poverty and labour migration (3).” All of this has an impact on the health of migrant women, whose physical, economic and social well-being is also undermined by intersecting forms of discrimination linked to ethnicity, race and poverty.

This is especially true for undocumented women – that is women who, for a variety of reasons, do not have a valid permit to remain in the country in which they live. Many undocumented migrants enter the European Union (EU) with a valid permit to study or work, to seek family reunification or asylum and later lose that status, often because of job loss, administrative delays in processing their immigration application, expired documents, having been born to undocumented parents, or having left an exploitative employer or abusive partner on whose status they depended. For women without residence status, or whose residence status is precarious or uncertain, the insecurity of their situation and legal barriers to obtaining health services are themselves drivers of poorer health outcomes.

Barriers to accessing health care in Europe for undocumented women
In the majority of EU countries, undocumented migrants’ right to access health services is severely limited. In just 10 of the 28 EU Member States do undocumented migrants have the right under national law to access primary care; in 6 their access is limited to emergency care (and in some countries, like Bulgaria, they may even be expected to pay for it). The remaining 12 EU countries are in between, entitling undocumented migrants to something more than emergency care, but often far less than the full complement of primary and secondary health care services. Indeed, in many cases, any entitlement to non-emergency care in these countries is limited to specific categories of people, such as undocumented pregnant women or undocumented children, or to certain communicable diseases like HIV – and is disconnected from any broader right to primary care, limiting their effectiveness. Even when they are legally entitled to care, undocumented women face practical barriers. These can be due to complex administrative requirements, cost, or the risk (sometimes imposed by law) of being denounced by hospital administrators to immigration authorities.

The impact of undocumented women’s restricted access to health services
Exclusion from health services means that undocumented women face delayed access to screening, treatment and care (4), limited access to contraception and pregnancy termination and heightened levels of discrimination and gender-based violence, all of which damages women’s health and perpetuates health inequities. Difficult pregnancies and poor pregnancy outcomes are disproportionately experienced by migrants throughout Europe including: low birth weight; infant and maternal mortality; and the increased likelihood of migrant women delivering their babies without professional assistance (5). Of 310 pregnant women in situations of vulnerability from whom data was collected by Doctors of the World in Europe in 2014, 54.2% had no access to antenatal care (4). At the country level, a 2015 report found that the rate of maternal death in the United Kingdom was significantly higher for foreign-born mothers compared to United Kingdom-born residents (6).

Pregnant women and adolescents arriving at the EU’s borders are acutely affected by inadequate access to medical care and are also at increased risk of sexual violence. Migrant women in detention face a double blow to their health, as detention is both a cause of diminished physical and mental health (7), as well as a place where access to adequate care is generally limited. Detention has corrosive and well-documented effects on the health of all migrants. The situation of girls (and children more generally) and of pregnant women has been given particular attention, with frequent calls to end their detention (8).

The central role of women as care givers and bread winners in many migrant households also means that poor health – linked to their exclusion from

RECOMMENDATION
The European Commission, in collaboration with the WHO and other relevant partners, including professional partners such as EBCOG, should establish a working group to develop a European wide human rights and evidence-based policy on ensuring access to health care for all migrant women and their families, regardless of their migration status.

This work should be undertaken in the framework of the EU’s commitments under the Sustainable Development Goals (SDGs) to women’s equality, universal access to health care, including SRH services, and facilitating orderly, regular and safe migration. It should build on: the recommendations of the European Commission’s Expert Panel on Effective Ways of Investing in Health; the resolutions adopted at the 66th session of the WHO Regional Committee for Europe on creating a roadmap to implement the SDGs; and action plans for refugee and migrant health. EBCOG has the expertise to offer support in developing European wide standards of care for these vulnerable women.
Sexual and reproductive health (SRH): human rights and medical ethics

Restricting access to health care for a segment of the population because of their administrative status is also a violation of international human rights norms. The right to health, protected under international human rights law, is a core right, essential to the realization of all other rights. States have a duty to respect and guarantee this right without discrimination to everyone within their borders (10). The use of health services to “fight” irregular migration by creating intolerable conditions in the name of deterrence, is not only ineffective, but institutionalizes discrimination, is incompatible with states’ obligations and is an erosion of the entire framework of rights that undergirds democracy.

The EU Fundamental Rights Agency, the Council of Europe, the UN Secretary General and the UN Special Rapporteur on the Rights of Migrants have all called for governments to establish a ‘firewall’ separating the provision of basic services from immigration control (11). In practice, this requires limiting the sharing of personal data between health care providers and immigration enforcement authorities so that undocumented migrants can go to health care facilities without fear of being arrested.

Human rights not only create obligations for states: they also underlie health professionals’ duties towards those to whom they provide care. Traditional medical ethics is dominated by a concern for the doctor-patient relationship. Human rights provide a complementary perspective that focuses on issues of equity, of discrimination and social exclusion that often drive abuses against patients (12). It also provides clarity about the duty of health professionals when laws and policies violate the rights of their patients (13). The World Medical Association has underscored the duty of physicians to provide appropriate care to all, whatever their status, and to speak out against laws that would compel them to violate patients’ rights, including by turning them away (14). Other associations of health professionals have taken a public stand against laws and policies contrary to medical ethics and their patients’ fundamental rights.

CASE STUDY

In July 2016 a woman arrived at a general hospital, in Cyprus’ largest city, bleeding and suffering from exhaustion. Before coming to hospital, the woman had given birth to a stillborn baby. Health professionals reported her to the police and she was later detained and charged with “concealment of child birth”, “participating in a conspiracy for the concealment of child birth” and “overstaying” her visa.

She had not sought medical attention during her pregnancy because her work permit had expired, leaving her undocumented and without any right to health care under Cypriot law. News media picked up the story, portraying her as a villain. Left out of the narrative was the situation of migrant women in Cyprus who face extremely limited access to health services and frequently precarious status, dependent on the whim of their employers. Lost was the individual tragedy of a stillborn child, delivered without access to support or assistance, or any discussion of the role of health professionals, charged with her care, in denouncing the woman to the immigration authorities.

This is not an isolated case. Cyprus is one of 7 EU countries where undocumented women have no specific entitlement to maternity care. Limited or no entitlements to maternity care, as well as fear of being reported or arrested, have prevented undocumented women across Europe from accessing essential, timely information and care.
MIGRANT WOMEN’S HEALTH ISSUES: ADDRESSING BARRIERS TO ACCESS TO HEALTH CARE FOR MIGRANT WOMEN WITH IRREGULAR STATUS (CONTINUED)

Addressing issues around service delivery

It is well recognized that migrants who do not speak the native language and those from less affluent parts of the world are at increased risk of higher maternal morbidities, mortality and poor perinatal outcomes. It is important that all stakeholders involved in the care of pregnant women and babies (clinicians, researchers, healthcare planners, policy makers and users of healthcare systems) work together to streamline the provision of care for these vulnerable women.

In order to improve perinatal outcomes, concerted efforts by all Member States are required in order to implement high quality overarching standards of care for maternity and gynaecological services. The European Board and College of Obstetrics and Gynaecology (EBCOG), an umbrella representative body of the specialists in obstetrics and gynaecology in 37 countries across Europe have developed standards of care for women’s health in Europe. These standards focus on the safety, care, dignity and treatment of patients. They reflect the care that a health service and prudent healthcare professional should provide in order to be effective and safe for the patient. These standards define a roadmap of quality service underpinned by clinical governance, safety and patient experience. They cover all aspects of a woman’s journey through her life: from preconception, pregnancy, delivery and post delivery care to her post reproductive stage of life. These standards were launched at the European Parliament in November 2014. Now these standards have also been translated into Russian (accessible at: www.ebco2g.eu). Highlights from the EBOG standards are presented in Table 1.

Table 1. EBCOG European Standards of Care.

<table>
<thead>
<tr>
<th>1. All pregnant women should be offered information on the full range of options available to them throughout pregnancy, birth and early parenthood, including locally available services, screening tests, types of antenatal and postnatal care and place of birth.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Maternity services should ensure that there are comprehensive, culturally sensitive, multidisciplinary policies, standard operating procedures, services and facilities for the management and support of families who have experienced a maternal loss, early or mid pregnancy loss, stillbirth or neonatal death.</td>
</tr>
<tr>
<td>3. There should be effective systems of communication between all team members in each discipline as well as with women and their families. The team members should be trained to recognize signs of domestic abuse and serious psychiatric illness.</td>
</tr>
<tr>
<td>4. Interpreting services should be provided for women where the local language is not their first language. Relatives should not act as interpreters. Arrangements should be in place for interpreting services in the community, especially in emergency or acute situations.</td>
</tr>
<tr>
<td>5. Services should be flexible enough to meet the needs of all women including pregnant teenagers, those with learning and physical disabilities, women from ethnic minorities, vulnerable women, hard to reach groups, asylum seekers and refugees.</td>
</tr>
<tr>
<td>6. Migrant women may be at increased risk from previously undiagnosed existing medical conditions. Clinicians should ensure that a comprehensive medical history has been taken at booking and, where appropriate, a full clinical assessment of their overall health is undertaken as soon as possible.</td>
</tr>
<tr>
<td>7. Local protocols should be developed to support equal access to healthcare needs for all vulnerable groups, including the migrant population and those who do not speak the host country’s language. They should respect cultural differences relating to women’s health and modesty.</td>
</tr>
<tr>
<td>8. Clinics need to be aware that in some cultures women are reluctant to share information relating to women’s health with males. Where possible clinics should be sensitive to this issue and identify a way to communicate that builds trust.</td>
</tr>
<tr>
<td>9. Migrants in an irregular situation seeking medical assistance should not be apprehended at or next to medical facilities.</td>
</tr>
<tr>
<td>10. Clinics should ensure regular training of their front line staff in communication skills, cultural/gender awareness, equality and diversity and safeguarding vulnerable individuals.</td>
</tr>
</tbody>
</table>
Conclusion
Migrant women are women, with the need – and the right – to access basic services, including health care, that ensure their physical and mental well-being, whatever their residence status. Yet they are systematically excluded from health systems on the basis of their migration status alone, deepening inequities across Europe at the expense of the most marginalized. Policies that prioritize migration enforcement over human health and human rights damage migrant women's health and are incompatible with broader societal goals relating to the empowerment and equality of women. International human rights law, well-established principles of public health and sensible financial planning require that no segment of the population be limited to emergency care. Health care professionals have an important role, not only in filling the gap in service created by restrictive laws, but also in speaking out against them as inconsistent with medical ethics and their commitment to do no harm – recognizing that patients’ interests, dignity and health are undercut not only by improper action, but also by failing to act, to treat and to speak up.

Alyna C. Smith,
Advocacy Officer, Platform for International Cooperation on Undocumented Migrants (PICUM)

Michele LeVoy,
Director, PICUM

Tahir Mahmood, CBE, MD, FRCPI, FRCOG, FFSRH, MBA, FRCPE, FRCOG,
President, European Board and College of Obstetrics and Gynaecology (EBCOG)

Charlotte Mercer,
Chief Administrator, EBCOG

Correspondence to: charlotte.mercer@btinternet.com

References
3. CEDAW Committee, General Recommendation No. 26 about women migrant workers, para. 5.