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Basic requirements in the provision of healthcare to returnees (voluntary and forced) with a particular focus on vulnerable groups

Report with Recommendations for Good Practice

Prepared with the support of the European Commission

1966 International Covenant on Economic, Social and Cultural Rights.

The State parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Article 12

1985 Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live

'Nothing in this Declaration shall be interpreted as legitimizing the illegal entry into and presence in a State of any alien, nor shall any provision be interpreted as restricting the right of any State to promulgate laws and regulations concerning the entry of aliens and the terms and conditions of their stay or to establish differences between nationals and aliens. However, such laws and regulations shall not be incompatible with the international legal obligations of that State, including those in the field of human rights.'

Article 2.1

Contents

Preface

This report has been prepared in the context of the European Commission financed project He.Re. (Health and return of illegal residents: Good practice for basic requirements in the provision of healthcare to returnees with a particular focus on vulnerable groups.)

The project is co-funded by the European Commission in the context of its RETURN programme (Call for Proposals 2006) which has been established to support preparatory actions in the area of return management. This programme aims at improving the management of return of illegal migrants in all its dimensions, by supporting and further developing cooperation among Member States, as well as by encouraging cooperation with countries of return.

Ulss20 Verona (Veneto Region), an Italian local Public Health Authority, is leading this project in collaboration with a team of European partners. (AUSL Ferrara (IT), CID (ES), AUSL 7 Ragusa (IT), Caritas Bulgaria (BG), 3rd Regional Health Authority of Macedonia (GR) and IOM Vienna (AT).

The aim of the project is identify good practice in the Member States in the provision of Healthcare for returnees with a particular focus on vulnerable groups.

The report is the result of a collaborative research effort on the part of the above-mentioned team of European organisations operating both in the public and private sectors.

The first draft of this report has been presented at the project final conference that was held in Ragusa, Sicily (IT) June 09 and the main topics have been discussed in specialised workshops during this conference. The report has then been updated on the basis of discussions and outcomes of the meeting.

Introduction

The provision of healthcare for illegally staying third-country nationals varies in the different Member States and in general, they have difficulty in accessing healthcare services. Furthermore, due to their status, illegally staying third-country nationals often live in conditions of extreme poverty without proper access to food and adequate shelter, which, coupled with the lack of access to medical care, can have negative implications for their physical and mental state.

Moreover, persecution or traumatic experiences coupled with the experience of flight and rejected asylum applications can leave people in a fragile state of mind leading also to mental health problems. The likelihood and the scale of such negative consequences is greatly increased for vulnerable persons[1]. Linguistic and cultural barriers can often further complicate the issue.

The extent of the problem is difficult to asses given that illegal staying immigrants, due to their irregular status, fall outside the national records and information systems which only contain data on citizens and legal residents.

However, at the moment when an illegally staying third-country national comes into contact with the authorities in a host country in order to be retuned to their country of origin, either through a voluntary or a forced procedure, their mental and physical well-being becomes the responsibility of both the returning and receiving state under international humans rights law.

Indeed, when the idea for a common EU return policy was first being conceived, it was proposed that such a policy should set basic requirements for the physical and mental capacity of the persons concerned before embarking upon return.[2]

However, in spite of the important piece of legislation that subsequently developed with the adoption in December 2008 of the Directive 2008/115/EC on common standards and procedures in Member States for returning illegally staying third-country nationals, there are still no clear common guidelines at EU level on the provision of healthcare to returnees, either in terms of whether care should be provided and how Member States should deal with returnees in case health problems are identified.

Therefore, with a view to proposing recommendations for good practice in the provision of healthcare to returnees, this report aims to address a number of key questions on this subject, namely:

- What are the health concerns for returnees in all stages of the return process and how are these concerns linked in to the issue of vulnerability?
- What are the obligations of the Member States in this regard in the framework of both the developing EU immigration and return policy as well as in the in the context of international human rights law?
- What are the current practices relating to the provision of healthcare to returnees both at the level of individual member states and internationally as well as in which capacity (public, private, NGO) ?
- In the return process, is the provision of healthcare considered by the country of origin and if so how (component of readmission agreements between states, supported by international organisations, ….etc)

[1] Coehlo P. "The Return of Asylum Seekers whose applications have been rejected", ECRE (2005)
[2] Green Paper On A Community Return Policy on Illegal Residents – COM (2002) 175 final

The above information has been identified through a literature review, a legislative review, a mapping exercise (ad hoc questionnaires sent to relevant organisations), and workshop discussions in the final project workshop in Ragusa, Sicily (June 09).

On the basis of the information gathered and analysed, a number of recommendations for good practice in the provision of healthcare to returnees have been elaborated and are presented in the final section of this report

1. Definitions and Scope

1.1 Vulnerable groups among Returnees

1.1.1 Introduction.

In January 2008, the first technical meeting of the project was held in order to agree on a work-plan, including a schedule of activities for the 24 month implementation period of the project. "The Provision of Basic Healthcare to Vulnerable Groups returning or being returned to country of Origin" focussed on the scope of the project and the main project themes. In this context, a definition of this concept was necessary in order to facilitate literary and legislative review. Therefore this paper aims to examine the main existing definitions of "vulnerability" and "vulnerable groups" in order to put forward a suitable definition to be utilised in the context of the project. The concept of healthcare is treated in section 1.2 of this report.

1.1.2 The Definitions of Vulnerable Groups

There is quite an extensive body of literature related to vulnerability covering a variety of fields including development and poverty studies, public health, climate studies, engineering, geography, political ecology and disaster and risk management. The following sections outline the findings of some of these main areas of research according to the following four subject areas: (1) Vulnerable Groups; (2) Conditions of Vulnerability; (3) Assessing or measuring Vulnerability (4) Vulnerability as part of a system.

The first section outlines the position of key European and International Organisations that consider particular groups to be vulnerable from the outset. The second section examines the concept of vulnerability as the result of an element that creates or exacerbates a condition of vulnerability ("Vulnerable to……"). The third section considers the measurement or assessment of vulnerability as a means of protecting identified vulnerable groups. The final section combines aspects of each of the previous sections and assess vulnerability as part of a system which includes the base condition of vulnerability and the external factor that can create or exacerbate vulnerability. The level or length of exposure to the external factor as well as the coping mechanisms of the vulnerable group and or of the social/natural/political system is also taken into consideration.

While there is no common definition of a "Vulnerable Group" as such, it is common to read about vulnerable groups that refer broadly to the elderly, women, children, the young, and the poor, persons with disability, migrants and ethnic minorities.

- *Definitions in Europe*

The European Directorate General for Employment, Social Affairs and Equal Opportunities, in the context of social inclusion, refers to vulnerable and marginalised groups as including but not limited to: *people with disabilities, migrants and ethnic minorities (including Roma), homeless people, ex-prisoners, drug addicts, people with alcohol problems, isolated older people and children*.[3]

In a Council Directive stipulating the minimum standards for the reception of asylum seekers[4], vulnerable persons are listed as *minors, unaccompanied minors, disabled people, elderly people, and pregnant women, single parents with minor children and persons who*

3 European Commission, The EU Social Protection Social Inclusion Process (Fact Sheet 7): The Inclusion of the Most Vulnerable Groups in Europe http://ec.europa.eu/employment_social/spsi/vulnerable_groups_en.htm

4 COUNCIL DIRECTIVE 2003/9/EC of 27 January 2003 stipulates minimum standards for the reception of asylum seekers.

have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence. (Art.17)

It is worth noting that the UNDP has described the *Roma* as the most vulnerable group in Europe in terms of poverty and the risk of falling into poverty, due to lack of education and employment opportunities, inadequate personal (physical) security, poor housing and poor access to health care[5].

The European Parliament and Council Proposal for a Directive on common standards and procedures in Member States[6] regarding the return of third-country nationals that stay illegally indicates that particular attention shall be paid to the situation of vulnerable persons, in reference to conditions of temporary custody (Art 15). However the article refers to *minors and unaccompanied minors* only. Indeed, during the stakeholder consultation on the proposed Directive, prominent NGOs underlined the importance of including a reference to "appropriate safeguards for the treatment of vulnerable groups such as *minors, ill or physically handicapped persons, elderly persons and victims of trafficking*".[7]

This Directive has now been finalised[8] and a definition of vulnerable groups has been included in art 3 as follows*: "vulnerable persons" means minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence.*

However, the Directive foresees that particular attention shall be paid to vulnerable groups (as defined above) pending return (art. 14) or while detained (art. 16 and 17). There is no reference to minimum standards in this regard during the actual return process itself or at the moment of arrival in the country of origin.

- *International Definitions*

In the WHO Glossary of Globalization, Trade and Health Terms[9], vulnerable groups are examined in the context of globalization. The examples given of vulnerable groups are the elderly, the young and the poor.

The International Labour Organisation considers *migrant workers* and *irregular migrant workers* in particular as vulnerable groups.[10]

The ICRC identifies *women and children* as vulnerable groups in a situation of war or conflict. Indeed, under international humanitarian law, women and children are the object of special consideration and must be protected against all forms of indecent assault (Protocol I addition to the 1977 Geneva Conventions). Such special protection is granted to children because of their age, whereas in the case of women it is granted in consideration of their specific health, hygiene and physiological needs and their roles as mothers. Under humanitarian law, women are not considered "vulnerable" as such. Rather, the law recognizes that women are vulnerable in certain circumstances owing to their physical

[5] UNDP, At Risk: Roma and the Displaced in Southeast Europe (Bratislava, 2006)

[6] Proposal for a directive of the European Parliament and of the Council on common standards and procedures in Member States for returning illegally staying third country nationals, COM (2005) 391 final

[7] Commission Staff Working Document, Annex to the Proposal for a European Parliament and Council Directive on common standards on procedures in Member States for returning illegally staying third country national, Impact Assessment, Brussels 1.9.2005 (C6-0266/05)

[8] Directive 2008/115/EC on common standards and procedures in Member States for returning illegally staying third-country nationals as published in the Official Journal (L 348 of 24.12.2008).

[9] World Health Organisation: http://www.who.int/trade/glosssary

[10] International Labour Organsiation, United Nations Commission on Human Rights, 59th Session, 17 March – 25 April 2003 (http://www.jcwi.org.uk/policy/uklaw/ilo_vulnerablegroups.pdf)

characteristics and specific needs, such as those of pregnant women, maternity cases or mothers of young children. As for children, they are rightly considered vulnerable because of their physical and mental immaturity, their limited abilities and their dependency on adults.

The IOM refers to the special needs of vulnerable groups such as *unaccompanied minors, women, victims of smugglers and traffickers and persons in need of medical care* during rescue operations of persons in distress at sea.[11]

The World Bank, in the context of social funds programmes[12], defines a vulnerable group as a population that has specific characteristics that place it at higher risk of falling into poverty than others living in areas targeted by a project. Vulnerable groups include *the elderly, mentally and physically disabled people, at-risk children and youth, ex-combatants, internally displaced people and returning refugees, HIV/AIDS- affected households, communities and ethnic minorities and, in some societies, women*.

1.1.3 Conditions of Vulnerability

As indicated above, many of the examples of vulnerable groups relate to the conditions or situation to which the group is exposed: war, discrimination, poverty, migration, asylum, social exclusion, etc.

Indeed, according to the ICRC[13] (International Committee of the Red Cross) in order to assess vulnerability, it must be considered the extent people are exposed to a specific risk, problem or abrupt change in situation, then take into account their coping mechanisms and resilience. The vulnerability of various groups – men, women, children and elderly people – will vary according to the nature of the problem and its consequences and the extent to which these groups are exposed, the impact on these groups and their ability to overcome the problem.

This section examines some of the main conditions resulting in vulnerability, noting that some of the below-mentioned examples can be interrelated.

- S*ocial, economic, political and cultural factors*

Social relations and historically-rooted patterns of discrimination, inequity in access to resources and power are important determinants of vulnerability.[14]

A common definition of vulnerability in the literature on poverty and development focuses on social, economic and political conditions, with vulnerability described as "An aggregate measure of human welfare that integrates environmental, social, economic and political exposure to a range of harmful perturbations".[15]

The precarious conditions of existence of individuals, families or communities in such situations can be further threatened by armed conflicts and situations of internal disturbances.

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[11] Ninth Meeting of the United Nations Open-ended Informal Consultative Process on Oceans and the Law of the Sea General Assemble, Luca Dall'Oglio, Permanent Observer to the United Nations (26.6.2008): http://www.iom.int/jahia/Jahia/cache/offonce/pid/1336?entryId=17669

[12] Social funds are multi-sectoral programs that provide financing (usually grants) from the World Bank for small-scale public investments targeted at meeting the needs of the poor and vulnerable communities, and at contributing to social capital and development at the local level.

[13] International Committee of the Red Cross: http://www.icrc.org

[14] Jörn Birkmann & Ben Wisner (2006). "Measuring the Un-Measurable The Challenge of Vulnerability". UNU Institute for Environment and Human Security (UNU-EHS).

[15] Downing T.E, Patwardhan A: Assessing Vulnerability for Climate Adaptation (2004)

This can be especially true for women who are particularly susceptible to poverty, exclusion and suffering caused by armed conflict when they are already subject to discrimination in times of peace. In some conflicts, women, as the bearers of future generations, are considered to be the depositories of cultural and ethnic identity, and may be vulnerable to attacks or threats from within the community if they do not conform to their assigned role. They may also be targeted by the enemy with a view to changing or destroying this role. The use of sexual violence as a method of warfare, and the requirement that women bear more children to replace sons that have died, render women especially vulnerable[16].

- *Institutional Stability*

Institutions play an important role regarding vulnerability. Firstly, institutions such as governments, businesses, markets, health systems, etc. may have more or less the capacity to cope with extreme events and shocks. They may also have the ability to carry on with their normal functions or at least to re-establish them quickly[17]. The manner in which various institutions impact the lives of individuals may make them vulnerable to greater or lesser degrees. For example, a market that systematically exploits poor farmers through unequal remuneration or pays migrants below the cost of production (assuming that women remain in the countryside to feed the next generation of the workforce) may be seen as creating and promoting situations of vulnerability. A corrupt or inattentive government is not neutral with regard to social protection, in fact it may exacerbate the situation through taxation or arbitrary land seizure, increasing the vulnerability of the poor. By contrast, good governance may strengthen the ability of its citizens to protect themselves while providing social security[18.]

- *Environmental Factors*

Climate change, pollution and the slow onset of pervasive hazards such as soil erosion, desertification, decline in biodiversity, and other environmental changes commonly play a role in the vulnerability of the environment[19]. In many cases, environmental vulnerability is strictly linked to policies, economics and social and cultural behaviours as the circumstances of protection versus exploitation of the environment depend on humans.[20] Environmental vulnerability can lead to flash floods, fires, tsunami, mud slides, drought and other natural disasters, all of which render the general population vulnerable and exacerbate the susceptibility of already vulnerable groups.

1.1.4 Measuring or Assessing Vulnerability

Assessing or measuring vulnerability is another important and complex aspect of the data evaluation. As with the definition of vulnerability, the assessment of vulnerability is a complex matter and varies greatly according to the research area.

Vulnerability assessment has been traditionally associated with climate change and climate adaptation in response to future climate risks as well as a means of improving the management of current climate risks.[21]

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[16] ICRC : http://www.icrc.org/Web/eng/siteeng0.nsf/html/women-vulnerability-010307

17 Nikitina;Greiving; Ivanov EWG II 2005.

18 Pelling;Oliver-Smith;Alexander EWG II 2005.

19 . Jörn Birkmann & Ben Wisner (2006). "Measuring the Un-Measurable The Challenge of Vulnerability". UNU Institute for Environment and Human Security (UNU-EHS).

[20] UNEP (United Nations Environment Programme) and SOPAC (South Pacific Applied Geoscience Commission), "The Environmental Vulnerability Index", 2005

[21] Downing T.E, Patwardhan A: Assessing Vulnerability for Climate Adaptation (2004)

Vulnerability assessment techniques are increasingly being used by many organisations as a means of identifying and protecting categories of persons at risk from certain factors such as conflict, hunger, natural disasters or catastrophes.

The World Food Programme, for example, has developed a system of understanding and mapping hunger through VAM (Vulnerability Analysis and Mapping). VAM undertakes in-depth assessments of the nature of food insecurity and the risks to livelihoods, and monitors emerging food security problems[22].

When assessing a population's vulnerability in situations of conflict, the **ICRC**[23] takes into account socio-economic factors such as:

- Employment (or income)
- Human assets (access to education and health care)
- Housing
- Socio-economic roles and their distribution within households
- Social assets (solidarity networks, reciprocal relations between households, relations with the State and private institutions)

From a global point of view, in most societies women are the victims of sexism to a lesser or greater extent, and face discrimination at home, at work and within the community at large. In some contexts, this can make women socially and economically vulnerable and it is a factor that must be taken into account when assessing the situation.

The UNDP has also developed a method of utilising Human Rights records to assess the vulnerability of certain groups or persons in relation to the Millennium Development Goals.[24]

1.1.5 Understanding Vulnerability as part of system

Stephen Devereux, Bob Baulch, Ian Macauslan, Alexander Phiri and Rachel Sabates-Wheeler[25] defined a concept of vulnerability during research on 'Vulnerability to Chronic Poverty and Malnutrition' in Malawi. Several insights from the literature on risk and vulnerability brought the authors to the following propositions: (1) that vulnerability is a complex and multidimensional concept; (2) that vulnerability must be understood in relation to outcomes of interest ('vulnerable to…'); (3) that individuals, households and communities are not passive in the face of vulnerability but adopt a range of responses; and (4) that policy interventions can address vulnerability in many discrete ways.

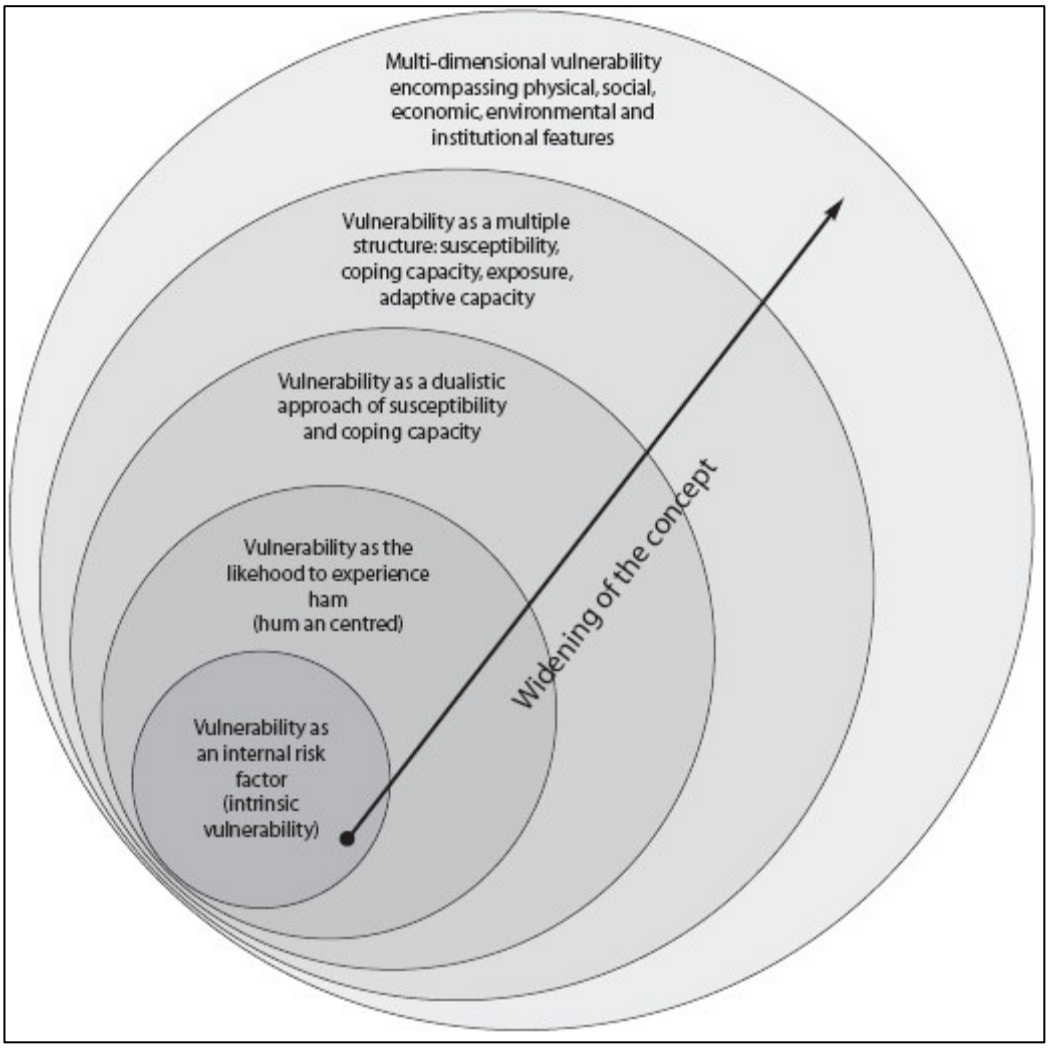
The multifaceted dimension of the concept of vulnerability has been considered by Jörn Birkmann and Ben Wisner[26] in their research into the measurement and assessment of vulnerability of societies at risk. The authors maintain that although there are different schools of vulnerability research, such as the disaster risk community, the food security research or global environmental change research communities, the consensus views vulnerability as an "internal side of risk"[27]. In this context, vulnerability is an intrinsic characteristic of a system where the conditions of the exposed element or community at risk are seen as core features of vulnerability (UN/ISDR 2004;

22 http://vam.wfp.org
23 ICRC : http://www.icrc.org/Web/eng/siteeng0.nsf/html/women-vulnerability-010307
24 UNDP, Human Rights and the Millennium Development Goals: Making the Link, 2007
25 Stephen Devereux, Bob Baulch, Ian Macauslan, Alexander Phiri and Rachel Sabates-Wheeler (2006) "Vulnerability and Social Protection in Malawi".
26 Jörn Birkmann & Ben Wisner (2006). "Measuring the Un-Measurable The Challenge of Vulnerability". UNU Institute for Environment and Human Security (UNU-EHS).
27 UN/ISDR 2004.

Cardona 2004: 37;Wisner 2002: 12/7; Thywissen 2006). These intrinsic (though not necessarily permanent or unchanging) characteristics or conditions of the exposed element or system is often called its "susceptibility". Thus in this broader context vulnerability is composed of "exposure" and "susceptibility."

However, this is only the first inner sphere (see figure below) and various extensions of the concepts can be observed depending on the scale, theme and disciplinary focus, and purpose of the definition. This range is shown in the figure below as spheres of vulnerability.

Key Spheres of the Concept of Vulnerability (Birkmann 2006)



1.1.6 Definition within the context of the project

Firstly, it is necessary to clearly define 'returnees'. Returnees are "Illegally Staying Third Country Nationals" who are going back to their country of origin, country of transit or another third country, whether voluntarily or by force[28]. 'Illegal Stay' means the presence of a third-country national in the territory of a member state who does not fulfil, or no longer fulfils, the conditions for stay or residence in that member state. The decisions that lead to an illegal stay are manifold: expiry of a visa, expiry of a residence permit, revocation or withdrawal of a residence permit, withdrawal of a residence permit for reasons of public policy or public security, negative final decision on an asylum application, withdrawal of refugee status, illegal entrance and so forth.[29]

The project title originally referred to vulnerable groups as *women, children or persons with disability* but considering vulnerability in the context of the return of illegally staying third country nationals, this definition can be extended to include many more categories of individuals.

On the basis of return specifically linked to illegal immigration, which therefore foresees a form of temporary custody, it would be reasonable to consider that vulnerable persons mentioned in the Directive 2003/9/EC include: *minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence.*

Indeed, , the European Parliament 'Committee on Civil Liberties' draft report on the proposed common return directive[30], observes that the conditions of stay of third country nationals under temporary custody are no less favourable than those set out in articles 8 to 10, 15 and 17 to 20 of Directive 2003/9/EC. As stated above, Art 17 of this Directive provides quite an extensive list of vulnerable persons.

Furthermore, organised criminal networks have a direct interest in illegal migration, therefore smuggling and trafficking in human beings has become a prominent activity throughout Europe[31]. Subsequently, it is appropriate to include *victims of trafficking* as vulnerable persons in the context of return.

Moreover, in line with the argument put forward in this paper that vulnerability is to be considered as part of a system, it is necessary to further qualify the description of vulnerable groups by examining a number of different interrelated elements of the return process as follows:

- the reasons for departure of the returnee from the country of origin in the first place; (e.g. civil unrest or war, social, religious or political reasons, economic hardship);
- the conditions of the returnee prior to return (e.g. economic and physical and mental well-being);

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[28] Proposal for a directive of the European Parliament and of the Council on common standards and procedures in Member States for returning illegally staying third country nationals, COM (2005) 391 final

[29] Commission Staff Working Document; Detailed comments on Proposals for a European Parliament and Council Directive on common standards in Member States for returning illegally staying third country nationals (COM(2005)391 final), Brussels 4.10.2005, SEC (2005) 1175

[30] European Parliament, Committee on Civil Liberties, Justice and Home Affairs, Draft Report on the Proposal for a directive of the European Parliament and of the Council on common standards and procedures in Member States for returning illegally staying third-country nationals, (Provisional 2005/0167 (COD)

[31] Commission Staff Working Document; Detailed comments on Proposals for a European Parliament and Council Directive on common standards in Member States for returning illegally staying third country nationals (COM(2005)391 final), Brussels 4.10.2005, SEC (2005) 1175

- the means and process of return: (e.g. availability of support during the return process, availability of medical care; conditions of the journey);
- the situation in the country of return (economic, social, cultural and political);
- The type of reintegration process available on return (financial support, housing support, counselling etc).

To conclude: in the context of return, vulnerable persons can include minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence and victims of trafficking. Furthermore, the vulnerability of the said persons needs to be assessed against all the elements that form an integral part of the return process, from the state of well-being of the person themselves to all the aspects of the return operation itself, including the approach of the returning and the receiving state .

1.2 Basic Healthcare to Returnees

1.2.1 Introduction.

In Section 1.1 of this report, the concept of vulnerability has been put forward considering it as part of a system considering a number of different interrelated elements of the return process.
The focus of the HE.RE project is on the provision of basic healthcare to returnees in the returning state and the project aims also to examine whether reintegration schemes (where they exist) in countries of origin include some form of follow-up medical care and if so in which form.
The purpose of this section of the report therefore, is to examine the main existing definitions of health, health care and basic or primary medical/health care in order to propose an appropriate definition to be used in the context of the project.

1.2.2 WHO Definitions

In the Preamble to the Constitution of the World Health Organisation[32] *health* is defined as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*".

It is worth mentioning that the WHO provides a second definition as it considers that the first definition expresses an ideal, which should be the goal of all health development activities and that it does not lend itself to objective measurements, and for working purposes a narrower definition is required. For this purpose in the Glossary of Health21: The health for all policy framework for the WHO European Region 1999[33] a second definition of health is provided as follows: "*The reduction in mortality, morbidity and disability due to detectable disease or disorder, and an increase in the perceived level of health"*.

Health is also described in the WHO Health Promotion Glossary[34] within the context of health promotion as "*a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities*".

Again in the World Health Organisation Report (2000) "Why do health systems matter?[35] health care is examined in the context of health promotion: " *health care embraces all the goods and services designed to promote health, including "preventive, curative and palliative interventions, whether directed to individuals or to populations*".

In the Alma Ata Declaration[36], WHO introduces the concept of primary health care defining it as *"essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable"*. The Alma-Ata Declaration, also emphasises that *everyone should have access to primary health care, and everyone should be involved in it*. The primary health care concept and theme has been successively reviewed by WHO in 1999 in the Glossary of Health21: The health for all policy framework for the WHO European Region[37]: *"Primary health care is the central function and main focus of a country' s health system,*

[32] Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946 by the representatives of 61 States (Official Records of the World Health Organization, n° 2, p.100) and entered into force on 7 April 1948.
[33] Health21: The health for all policy framework for the WHO European Region 1999
[34] WHO Health Promotion Glossary, 1998
[35] World Health Organisation Report (2000) "Why do health systems matter?
[36] Alma Ata Declaration, WHO, Geneva, 1978
[37] Health21: The health for all policy framework for the WHO European Region 1999

the principal vehicle for the delivery of health care, the most peripheral level in a health system stretching from the periphery to the centre, and an integral part of the social and economic development of a country. In the same publication a distinction between primary, secondary and tertiary care is made. The three different and consequent types of care are described as follows:

> *Primary care - the first level of care, generally provided in an ambulatory setting (as opposed to secondary and tertiary care which would normally be hospital-based).*
>
> *Secondary care – Referral services in the first instance provide secondary health care, which is of a more specialized kind than can be offered at the most peripheral level, for example radiographic diagnosis, general surgery, care of women with complications of pregnancy or childbirth, and diagnosis and treatment of uncommon or severe diseases. This kind of care is provided by trained staff in such institutions as district or provincial hospitals.*
>
> *Tertiary care – Specialized care that requires highly specific facilities and the attention of highly specialized health workers, for example, for neurosurgery or heart surgery.*

1.2.3 Main Health problems

There is unfortunately a scarce body of literature related to health problems affecting returnees. The limited available information can be traced to pilot studies mainly produced in the context of programs of assisted voluntary return and reintegration. Before examining the major health problems affecting returnees, it is important to analyse the main existing definitions of the term *returnee*.

The Communication from the Commission to the Council and the European Parliament on a Community Return Policy on Illegal residents[38] clarifies that "*a returnee is a person who undergoes the process of return, defined as follows: " the process of going back to one's country of origin, transit or another third country, including preparation and implementation. The return may be voluntary or enforced".*

Chapter XI of the Training Manual on Human Rights Monitoring[39] specifies that *"Returnee" is the term used by the international community to identify a person who was a refugee, but who has recently returned to his/her country of origin. Defining a returnee is thus applicable on a person's prior refugee status*. It also underlines that the *term "returnee" is a descriptive term that acknowledges the fact that returning refugees are in need of certain assistance, and sometimes protection, during an interim period until they have re-integrated their communities. Defining the period of time in which a person can continue to be identified as a returnee is difficult and will be different according to each specific situation.*

It is therefore important to stress that a returnee before undergoing the return process could have resided in the hosting country either as an asylum seeker awaiting a decision on an application for refugee status or illegally and for this reason could have had different access to health care services in the hosting country.

It is critical to consider also the health status of the returnee even before he arrived initially in the host country and to consider also the journey undertaken to reach the Union. For example, in 2002/2003, CDC reported clusters of malaria cases in Italy among Chinese immigrants who had

[38] Communication from the Commission to the Council and the European Parliament on a Community Return Policy on Illegal residents – COM(2002) 564 final

[39] Training Manual on Human Rights Monitoring – Chapter XI Monitoring and Protecting the Human Rights of Returnees and Internally Displaced Persons

been exposed to a prolonged journey to Europe (3–9 months) through a number of Asian and African countries.[40]

Therefore when analysing health problems affecting returnees, a number of factors need to be taken into account, namely:

- the individual socio-economic situation of the returnee;
- the status of the returnee prior to a voluntary of forced return procedure (illegal, asylum seeker who has subsequently been denied refugee status….);
- the length and conditions of stay in the country where they have been residing illegally (temporary residence centre, detention centre….);
- the journey undertaken to reach the country where they have been residing illegally (length of journey, conditions of journey, countries of transit etc.)

The available literature reports only on the health status of returnees undergoing a process of voluntary return but unfortunately very little is known about the health conditions of returnees that are enforced to return to their country of origin. Reports from visits carried out in some of the Italian Centres for temporary permanence and assistance contain very useful information on the subject.

The existing studies on return migration have shown that there is often a selection in the people who migrate and that migrants are often healthier than the majority in their countries of origin.
An interesting study developed by Monika Sander: Return Migration and the "healthy immigrant effect"[41] has shown that return migration is influenced by many factors. For example having a spouse and children living in the home country or being non-working or jobless yield a significant higher return probability. Moreover, relative to male immigrants that described their health as very good, men reporting poorer health are significantly less likely to return home. It is worth noting that the same study has indicated that for women the effects are adverse to that of the men.

A pilot study has been carried out in Osijek Region[42] in Croatia in order to assess the health status (physical, mental and social) of refugee/returnee population and their use of health services. The results of the study show good organization of health service in returnees' communities, with exception of gynaecological and dental services. There was also a presence of health transportation problem and the problem in the supply of medicines. The survey included 589 participants from 6 places in Osijek-Baranja County with 43,8% men and 56,2% women. The participants reported 19 chronic illnesses. It has been observed a high frequency of the following chronic illnesses: lumbal pain 34,3 %, rheumatism 26,7 %, varices 22,5%, hypertension 27,5 %, gastritis or ulcer 11,7 %, diabetes 12,9 %, cardio-vascular disease 19,7%, mental illnesses 15,7 %, elevated serum lipids 16,2%, bronchitis 12,2 %.

A different study on the health status of returnees to Kosovo[43] aiming to assess the relationship between living conditions during asylum in Switzerland and health status among returnees has shown that among the 580 participants, 25,5% suffered from PTSD (post-traumatic stress disorder) and 65% lived in extreme poverty.

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[40] Bisoffi Z, Matteelli A, Aquilini D, Guaraldi G, Magnani G, Orlando G, et al. Malaria clusters among illegal Chinese immigrants to Europe through Africa. Emerg Infect Dis [serial online] 2003 Sep [date cited].
Available from: URL: http://www.cdc.gov/ncidod/EID/vol9no9/03-0353.htm

[41] Return Migration and the "healthy immigrant effect", University of Bamberg – Monika Sander - January 2007

[42] Health of Returnees in Osijek Region and Required Special Measures of Health Care and Community Organization. – Lidija Prlič, Zdravko Ebling, Krešimir Glavina, Rudika Gmajnić, Gorka Vuletić, Luka Kovačić, Martin Tokalić - July 2004.

[43] Health status of returnees to Kosovo: Do living conditions during asylum make a difference? – Toscani Letizia, Deroo Lisa A., Eytan Ariel, Gex-Fabry Marianne, Avramovski Vlatko, Loutan Louis, Bovier Patrick – 2007.

In the research article entitled "Mental Health of returnees: refugees in Germany prior to their state sponsored repatriation[44] 47 participants of programs for assisted voluntary return were interviewed about their present living situation, their view regarding their home country and voluntary return. These findings were compared to a group of 53 refugees who had decided to remain in Germany (stayers).

The results show that there is a prevalence rate of 44% psychiatric disorders in the group of returnees and a rate of 78% in the group of stayers. It is noteworthy that in almost two thirds of the participants the decision to return was not voluntary but strongly influenced by immigration authorities. The most important reason for participants to opt for a stay in Germany were the children, who have been born and raised in Germany.

A report on Italian Centres for temporary permanence and assistance[45] indicates the main pathologies that have been identified during the permanence of illegal residents in such centres, namely HIV, dental pathologies, respiratory infections, skin diseases, psychosomatic diseases, anxio-depressive status, tuberculosis, scabies, fractures.

In particular, tuberculosis is seemingly on the increase in the EU. Recent research indicates that between 5 % and 10 % of tuberculosis patients are illegal immigrants. Illegal immigrants do not always have access to medical care and treatment. Treatment is necessary, of course, both for the patient and in order to prevent any further spread of the disease. Treatment takes a long time (six to eight months), and must be completed. Otherwise there is a serious danger that the disease will recur and that resistance to antibiotics will arise. Multiple drug resistant (MDR) tuberculosis requires longer treatment (approx. 2 years), using powerful drugs with unpleasant side-effects, and is many times more expensive. Despite this, some Western countries, including EU Member States (the UK, Austria), do not defer deportation of illegal immigrants who are suffering from tuberculosis until the treatment has been completed.[46]

1.2.4 Proposed basic standards

The Danish Refugee Council and the German organisation Bayerischer Flüchtlingsrat developed in May 2008 in the context of the EC co-financed project "Design and Facilitation of sustainable Voluntary Return to Kosovo" a report[47] describing valuable lessons learned and outlining a set of best practices for NGO-assisted mandatory return.

One of the suggested best practices regards health issues and medical services. Returnees may have mental and/or physical health problems and may thus be in need of medical health care upon return. In such cases the following recommendations are proposed:

1. Information on relevant healthcare institutions in the country of origin should be provided to returnees prior to return, in coordination with local authorities and NGO's;

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[44] Mental Health of returnees: refugees in Germany prior to their state sponsored repatriation. – Ulrike von Lersner, Ulrike Wiens, Thomas Elbert, Frank Neuner.- 2008

[45] Libro Bianco – I Centri di Permanenza temporanea e assistenza in Italia – Nicoletta Dentico, Maurizio Gressi.

[46] Written Question from the European Parliament on the subject of tuberculosis among illegal immigrants – 17 February 2009.
Available at: http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+WQ+E-2009-0942+0+DOC+XML+V0//EN&language=EN

[47] Recommendations for the Return and Reintegration of Rejected Asylum Seekers – Lessons Learned from Returns to Kosovo - Danish Refugee Council

2. Returnees must bring their translated medical records with them from the host country as this will serve as a solid base for continued treatment in the country of origin;
3. Upon return, returnees should be provided with medicine and care for a certain period of time (up to 12 months) to allow time to contact relevant organisations and receive proper information about available services;
4. If needed, long-term capacity building of local health institutions must be supported to ensure that long-term sustainable care is available to both returnees and the resident population;
5. Healthcare and medical support projects must be based on a comprehensive approach, taking into account socio-economic, educational and cultural issues;

1.2.5 Conclusions

The concept of health is a complex matter. Internationally recognised definitions classify health in terms of an ideal (*complete physical, mental and social well-being),* in more concrete terms *(reduction in mortality, morbidity and disability due to detectable disease or disorder, and an increase in the perceived level of health*) and in relation to the level of healthcare that is provided (*primary, secondary or tertiary healthcare).*

For certain, all Member States struggle with providing healthcare to its citizens and the costs of public health represent a significant financial burden in all Member States but this does not excuse it from its human rights obligation to provide healthcare to those persons in their territory regardless of their administrative status. Indeed, whatever the approach of the Member State, as outlined in section 2.1 of this report, the same level of healthcare that is afforded to citizens of the Member State should also be guaranteed to a returnee whether partaking in a voluntary or forced return procedure.

Furthermore, specific healthcare and medical programmes that reflect the needs of returnee in the context of the return process need to be developed. Such programmes should be based on global approach taking into account socio-economic, educational and cultural issues

2. International and European Standards

2.1 Provision of Healthcare and Protection of Vulnerable Groups according to Human Rights Instruments

2.1.1 Introduction

It is widely accepted that health is a basic human right. It is also generally recognised that certain groups or individuals can face specific difficulties in relation to the right to health due to a number of different factors including biological or socio-economic factors, discrimination and stigma, or, generally, a combination of these.[48] This is certainly the case for illegal immigrants whose health can be at risk due to poverty, powerlessness, discrimination, vulnerability to labour exploitation and lack of access to health care and social services in host countries[49]. In the European Union, Illegal immigrants are, in principle, not entitled to receive medical care from public services, except in some countries case of emergencies, but it is unclear where and how they receive medical care in case of needs. This situation has already been the cause of much debate in the Union and on 16 January 2007, 87 MEPs signed a written declaration concerning access to basic healthcare to immigrants residing illegally in the EU and invited the Commission to propose a European Directive guaranteeing basic healthcare to all foreign nationals, including those without a residence permit. This Directive has not since been realised but the question remains a pressing one given that denying healthcare to this category of persons is in violation of international human rights norms. This said, a European Union Directive on a Common Return Policy has been elaborated and the core of this piece of legislation is the respect of fundamental freedoms and human rights. This section of the report, therefore examines how health is treated as human right under international human rights law, how the European Union ensures the respect of this right when it comes to illegal immigrants and in particular Returnees.

2.1.2 The Right to Health under International Human Rights Law

The right to health was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

The 1948 Universal Declaration of Human Rights also mentions health as part of the right to an adequate standard of living (art. 25). The rights of everyone to the enjoyment of the highest attainable standard of physical and mental health (art. 12) is recognized in the 1966 International Covenant on Economic, Social and Cultural Rights.

Also the Charter of Fundamental Rights of the European Union (EU 2000) (art.35) recognizes 'the right of everyone to access to preventive health care and the right to benefit from medical treatment'.

2.1.3 The Right to Health for specific groups

The right to healthcare is guaranteed in many of the UN human rights treaties both in general terms and with respect to certain specific individuals or groups.

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[48] UNHCHR, The Right to Health, Fact Sheet N° 31, June 2008, ISSN 1014-5567
Available online: http://www.ohchr.org/Documents/Publications/Factsheet31.pdf

[49] IOM "Migration Health Report", (2004)

- The 1965 International Convention on the Elimination of All Forms of Racial Discrimination: art. 5 (e) (iv)
- The 1966 International Covenant on Economic, Social and Cultural Rights: art. 12
- The 1979 Convention on the Elimination of All Forms of Discrimination against Women: arts. 11 (1) (f), 12 and 14 (2) (b)
- The 1989 Convention on the Rights of the Child: art. 24
- The 1990 International Convention on the Protection of the Rights of
- All Migrant Workers and Members of Their Families: arts. 28, 43 (e) and
- 45 (c)
- The 2006 Convention on the Rights of Persons with Disabilities: art. 25.

2.1.4 Realising the Right to Health

The right to health is widely considered to be best articulated in the International Covenant on Economic, Social and Cultural Rights. The nature of the legal obligations of State parties for the realisation of all the rights set down in this Covenants are set out in article 2.

The Committee on Economic, Social and Cultural Rights in General Comment No. 14[50] have also defined the obligations that States parties have to fulfil in order to implement specifically the right to health at the national level.

The obligation to *respect* the right to health requires States to, *inter alia*, refrain from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services.

Indeed, non-discrimination is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health. Therefore, in theory, the human rights of returning illegal immigrants should be protected the same way as any other category of persons under international human rights law. Unfortunately, however, these rights can often denied to illegal immigrants by States on the basis of their administrative status.

In Europe, it is generally the case that Member States do not extend full healthcare coverage to illegal immigrants.[51] This varies of course from Member State to Member State. Italy for example guarantees access to illegal immigrants to emergency healthcare, essential care (diagnostic and therapeutic relative to non life-threatening pathologies in the immediate but that could further damage the health of the person) and maternity care to female illegal immigrants on a par to that with Italian citizens. Furthermore, in some countries "alternative health care providers such as non-governmental organisations (NGOs) offer medical care, often supported with public funds[52].

The situation with regards to Returnees is even more blurred and Member States do not have specific protocols in place that lay down the provision for healthcare in all phases of the Return process (prior to departure, during the trip home to the country of origin, and for a certain period following return in the country of origin itself).

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[50] CESCR: *The right to the highest attainable standard of health, CESCR General Comment 14.* 11/08/2000 - E/C.12/2000/4New York, Committee on Economic, Social and Cultural Rights, United Nations; 2000 Available on line: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument

[51] R. Romero – Ortuno (2004), Access to health care for illegal immigrants in the EU: should we be concerned? European Journal of Health Law 11: 245-272. p249

[52] Torres A.M., Sanz B., "Health care provision for illegal immigrants: should public health be concerned?" , Jech online, (2000)

The European Union has recently introduced new legislation (Directive on Common Standards and Procedures in Member States for Returning Illegally Staying Third-Country Nationals)[53] that sets down a common framework for Member States for the implementation of common return policy that respects human rights and fundamental freedoms of returnees. This Directive considers the provision of healthcare in (art. 14) but it is vague and lacks detail as described in the following paragraph .

2.1.5 European Convention of Human Rights

The European Convention of Human Rights does not explicitly contain the right to health; nevertheless, the European Court of Human Rights (ECtHR) showed in its jurisdiction that the Convention has also very important implications for the human rights and the provision of health care to returnees.

In its decision *D v the United Kingdom*[54] the Court found that the expulsion of a seriously ill person would violate Art 3, the prohibition of torture and inhuman and degrading treatment and punishment, of the Convention. According to the judgement,[55] in the return decision the state of health of the returnee, for example advanced stages of a terminal and incurable illness, access to health care and care (no family member or friend would be in the position to attend to the needs of the applicant, no bed in the hospitals) in the country of origin has to be taken into account.
The Court stressed that the source of the risk is irrelevant, even if the proscribed treatment in the country of origin stems from factors which cannot engage either directly or indirectly the responsibility of the public authorities of the returning country, or which, taken alone, do not in themselves infringe the standards of Art. 3. Furthermore, since the prohibition of torture and inhuman and degrading treatment or punishment is absolute, the criminal record of the person and any risk to public order and security the person in the host country is irrelevant.

Nevertheless the Court stressed that these principles can be only applied in *"very exceptional circumstances"*, in a number of related cases the Court found no violation of Art. 3 of the Convention. In particular, in the most recent decision *N. v. the United Kingdom* the Court stressed *"Article 3 does not place an obligation on the Contracting State to alleviate [such] disparities through the provision of free and unlimited health care to all aliens without a right to stay within its jurisdiction"*.[56] The Court argued that the case does not encompass very exceptional circumstances because the applicant is not critically ill. Even, if the return would negatively affect the applicant's life expectancy, the *"deterioration which she would suffer […] would involve a certain degree of speculation."*

From the jurisdiction of the Court follows that with regard to the most serious cases Art. 3 of the European Convention of Human Rights prohibits the return of illegally resident third-country

[53] Directive 2008/115/EC on common standards and procedures in Member States for returning illegally staying third-country nationals as published in the Official Journal (L 348 of 24.12.2008).
[54] ECtHR, D. v the United Kingdom, 2 May 1997 (30.240/96).
[55] The applicant in this case was a national of St. Kitts who had been convicted and sentenced in the United Kingdom in connection with a drug offence. He was to be deported after he had completed his sentence of imprisonment but was, however, by this time in the advanced stages of AIDS. The applicant had by this time suffered severe and irreparable damage to his immune system and appeared to be close to death. The attending doctors stated that in the face of the advanced status of the illness the applicant's life expectancy is poor even under continuance of treatment in the United Kingdom and that it would be further lowered if being removed to St. Kitts. The removal would not only result in a diminution of the applicant's life expectancy but would cause severe mental and physical suffering. In addition to the lack of appropriate medical treatment the Court found the lack of social and moral support to be of importance in this case. The applicant did not have relatives or friends who could take care of him in St. Kitts and it was doubtful if he would be hospitalized there.
[56] ECtHR, N. v the United Kingdom, 27 May 2008 (26.565/05).

nationals, however it does not establish the right to reside in a country to continue a medical treatment in less critical cases.

2.1.6 Human Rights and the EC Directive on procedures for returning illegally resident third-country nationals

The Brussels European Council of 4 and 5 November 2004 called for the establishment of an effective removal and repatriation policy, based on common standards, for persons to be returned in a humane manner and with full respect for their fundamental rights and dignity.

Since the European Commission first tabled the proposal for this Directive in 2005, the respect for human rights has remained at the forefront of debate and negotiation in the different drafts.

The Directive provides a framework for common standards for Return in the European Union with the purpose not only of facilitating administrative cooperation among MS is this field but also of providing fair common rules that take full account of the respect for human rights and fundamental freedoms of the persons concerned.

Indeed art. 1 of the Directive (Subject Matter) states that the "Directive sets out common standards and procedures to be applied in Member States for returning illegally staying third-country nationals, in accordance with **fundamental rights** as general principles of Community law as well as international law, including refugee protection **and human rights obligations."**

In terms of healthcare and the provision of healthcare to vulnerable groups, as stated in the next section of this report, article 14 of the directive (Safeguards Pending Return) foresees (b) emergency health care and essential treatment of illness are provided and (d) special needs of vulnerable persons are taken into account.

However, the approval of this Directive was not a simple process and indeed, it was first presented in 2005 and approved by the European Parliament on 18 June 2008. In fact, many of the stumbling blocks in the process related specifically to the human rights dimension of the directive and in the end, many MEPs from the Socialist Group (PES), the Greens and the left (GUE/NGL), refused to support it, saying it breached EU human rights standards. This feeling was echoed by many human rights groups organisations such as Amnesty International, the European Council on Refugees and Exiles (ECRE) as well as from developing countries such as Venezuela and Brazil.[57]

The UNHCR also issued a statement [58] on the Directive criticising a number of different points of the Directive including the unspecific reference to the needs of vulnerable persons.

2.1.7 Conclusions

The question of the provision of healthcare to illegal immigrants at the moment in which they are returned to their country of origin is made even more complex by the lack of a common position in the European Union with regard to immigrants while residing illegally in a given Member State. This said, an important piece of legislation now exists in the EU providing a framework for a common return policy and although, as the saying goes, "you can't learn to run before you can

[57] EurActiv.com - http://www.euractiv.com/en/socialeurope/fighting-illegal-immigration-return-directive/article-174876
[58] UNHCR Position on the Proposal for a Directive on Common Standards and Procedures in Member States for Returning Illegally Staying Third-Country Nationals – 16 June 2008 - http://www.unhcr.org/refworld/pdfid/4856322c2.pdf

walk", it is important to take advantage of this common framework to build upon the important question of the provision of healthcare to returnees. This is a basic human right which is rendered even more urgent by the condition of vulnerability of returnees. (See Section 1.1).

2.2 Healthcare in the context of Immigration and Return Policy in the European Union

2.2.1 Introduction

All Member States of the European Union (EU) are affected by the flow of international migration. In spite of the restrictive immigration policies which have been in place since the 1970s in most Member States, large numbers of legal and illegal migrants have continued to come to the EU together with asylum-seekers.

In response to this trend, EU Member States have agreed to develop a common immigration policy at EU level. The European Commission has made proposals for developing this policy, most of which have now become EU legislation.

Realising that a new approach to managing migration was necessary, the leaders of the EU set out at the October 1999 European Council in Tampere (Finland) the elements for a common EU immigration policy. The approach agreed in Tampere in 1999 was confirmed in 2004 with the adoption of The Hague programme, which sets the objectives for strengthening freedom, security and justice in the EU for the period 2005-2010.

Return policy is considered to be an integral and crucial part of fighting against illegal immigration[59] and an important Directive for a common return policy has recently been approved by the European Parliament and the European Council. (See Section 2.2.3)

The following sections examine where the issue of healthcare fits into the common EU immigration and return framework.

2.2.2 Healthcare and EU Immigration policy

The main developments in the area of EU immigration Policy focus on the management of migration flows rather than on the management of illegal immigrants while on the territory of the Member States. All Member States are of course bound by the provisions contained in the international human rights treaties and instruments but when it comes to the provision of healthcare, each Member States adopts varying approaches.

Indeed, this issue has been raised by the European parliament and on 16 January 2007, 87 MEPs signed a written declaration concerning access to basic healthcare to immigrants residing illegally in the EU and invited the Commission to propose a European Directive guaranteeing basic healthcare to all foreign nationals, including those without a residence permit.

In general, access to emergency healthcare is guaranteed to illegal immigrants in the majority of European Union countries. Italy, Spain and France, countries which are subject to the pressures of intense migration flows are particularly sensitive to the needs of illegal immigrants and therefore offer also a wider form of assistance to illegal on the basis of certain conditions.

[59] Green paper on a Community Return Policy on Illegal residents (COM (2002) 175 final)

The provision of healthcare can even vary at a regional level. The health authorities of the Autonomous Community of Valencia, for example, have introduced a "Solidarity Card" which enables illegal immigrants living in this region to receive the same medical care as other citizens. This solution ensures that all resident citizens have access to public health services, irrespective of their legal status. Immigrants' personal details are registered on a file which is available to all public health centres.[60]

Finally, it is important to pint out that, in many countries is that health care managers and providers are unaware of the legislative developments concerning access to health care for illegal immigrants which can hinder the normal provision of those minimum services. Even when that information has been made available to first-line health care workers, problems remain when the entitlements are ambiguously or imprecisely defined, allowing excessive room for discretion in the implementation process.[61]

Section 3 describes in more detail how the different Member States address the issue.

2.2.3 Healthcare and EU Return Policy

When the He.Re project first commenced, the proposal for a Directive on Common Standards and procedures in Member States for returning illegally staying third-country nationals was still very much under discussion. Indeed, during the project lifetime, the proposed directive underwent numerous changes following intense negotiations, also in the realm of the provision of healthcare, before it was finally approved in December 2008.

The following is an account of the main steps involved in the approval process with a focus on the discussion relating to the provision of healthcare

- On 1 September 2005, the European Commission presented a "Proposal for a Directive on common standards and procedures in Member States for returning illegally staying third-country nationals". The object of this proposal is to provide for clear, transparent and fair common rules concerning return, removal, use of coercive measures, temporary custody and re-entry, which take into full account the respect for human rights and fundamental freedoms of the persons concerned.
The concept of healthcare appears indirectly in Chapter III – Procedural Safeguards - article 13 – Safeguards pending return - and is only oriented towards third-country nationals for whom the enforcement of a return decision has been postponed or who cannot be removed, that means it does not refer to returnees in general. Article 13 states that Member States shall ensure that the conditions of stay of third-country nationals for whom the enforcement of a return decision has been postponed or who cannot be removed for the reasons referred to in Article 8 of the Directive are not less favourable than those set out in article 7 to 10, Article 15 and Articles 17 to 20 of Directive 2003/9/EC. The above mentioned Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers, makes a clear reference to healthcare when talking about reception conditions (Chapter II – General Provisions on reception conditions - Article 9: "Medical Screening" and Article 15: "Health care"). Article 9 states: "Member States may require medical screening for applicants on public health grounds". Article 15 suggests: "Member States shall ensure that applicants receive the necessary health care which shall include, at

[60] Council of Europe, Parliamentary Assembly (2000) *Health conditions of migrants and refugees in Europe* (Doc. 8878). Strasbourg: Council of Europe, Social, Health and Family Affairs Committee. <http://assembly.coe.int/Documents/WorkingDocs/doc00/EDOC8878.HTM>

[61] R. Romero – Ortuno (2004), Access to health care for illegal immigrants in the EU: should we be concerned? European Journal of Health Law 11: 245-272. p264

least, emergency care and essential treatment of illness. Member States shall provide necessary medical or other assistance to applicants who have special needs." In other words, the "Proposal for a Directive on common standards and procedures in Member States for returning illegally staying third-country nationals" specifies that Member States shall ensure that third-country nationals for whom the enforcement of a return decision has been postponed or who cannot be removed, receive the necessary health care which shall include, at least, emergency care and essential treatment of illness. Presumably, this procedural safeguard refers only to third-country nationals for whom the enforcement of a return decision has been postponed or who cannot be removed and not to illegally staying third country nationals who are in the process of being removed or returned to their country of origin.

- The European Commission then sent its Proposal to the Council and the European Parliament, the two institutions responsible for reviewing its contents and its subsequent adoption, using the co-decision procedure in this field for the first time. The Directive was therefore negotiated within the two institutions, in parallel.

- On 13 June 2006, The European Parliament – Committee on Civil Liberties, Justice and Home Affairs- developed a draft Legislative Resolution on the Proposal. The European Parliament tabled an amendment to Article 15 – Conditions of temporary custody- paragraph 1 a new. This amendment states: "Member States shall ensure that the conditions of stay of third country nationals under temporary custody are not less favourable than those set out in Article 8 to 10, 15 and 17 to 20 of Directive 2003/9/E. The European Parliament provides the following justification: "This is an additional safeguard providing besides others the right of family unity. The right to medical assistance is guaranteed, as well as the right to education for children"… "Rapporteur considers it necessary to add these detailed guarantees in order to ensure and provide clear safeguards and rights to the third country national who is to be returned." It is evident that once again this additional safeguard is provided for a special category of returnees, namely those third country nationals that are kept under temporary custody because there are serious grounds to believe that there is a risk of absconding or it would not be sufficient to apply less coercive measures.

- On 20 September 2007 the European Parliament developed a second Draft Legislative Resolution on the Proposal.
Amendment 53 to article 13, paragraph 1, introduces the following sentence: "The same conditions shall be granted to third-country nationals during the period for voluntary departure and to third-country nationals awaiting the outcome of appeal proceedings" to the existing paragraph: "Member States shall ensure that the conditions of stay of third country nationals for whom the enforcement of a return decision has been postponed or who cannot be removed for the reasons referred to in Article 8 of the Directive are not less favourable than those set out in article 7 to 10, Article 15 and Articles 17 to 20 of Directive 2003/9/EC".
The procedural safeguard, for the first time is extended to third-country nationals during the period for voluntary departure and to third-country nationals awaiting the outcome of appeal proceedings.

- On 23 April 2008, a compromise was reached between the Council and the European Parliament on the text of the Returns Directive.

- On 5 June 2008, the EU Home Affairs Ministers agreed on the directive.

- On 16 December 2008, the European Parliament and the Council of the European Union adopted Directive 2008/115/EC on common standards and procedures in Member States for returning illegally staying third-country nationals as published in the Official Journal (L 348 of 24.12.2008). **The transposition deadline for the Member States is 24.10.2010.**

Article 14 of the proposal on safeguards pending return states that Member States shall ensure that a set of principles are taken into account as far as possible in relation to third country nationals during the period for voluntary departure and during periods for which removal has been postponed in accordance with Article 9. One of the principles is the provision of emergency health care and essential treatment of illness. Article 16 on the conditions of detention states that particular attention shall be paid to the situation of vulnerable persons. Emergency health care and essential treatment of illness shall be provided.

2.2.4 Conclusions

Although the final version of the Return Directive was widely disputed, in particular by Human Rights organisations, the question of the provision of healthcare was formulated better in the final version with respect to the original version whereas many other critical issues (in particular that concerning detention) were more restrictive in the final version. This said, the reference to the provision of healthcare remains vague and does not address either the big picture of the return process (prior to return, during return and arrival in the country of origin) and neither does it deal with the complexities of the issue of vulnerability which is very much interlinked with each of the above-mentioned phases of the return process.

3. Policy and Procedures at National Level

3.1 Provisions for the guarantee of healthcare for illegally staying third country nationals while in the Member States

With regards to the provision of healthcare to illegal immigrants in the Member States, there is a very useful report on this subject that has been prepared by the Italian Ministry of labour, health and social policy. (Department for prevention and communication – Directorate General for relations with the European Union and international Relations – Office VI).[62]

This report has been compiled on the basis of information collected between February 2006 and June 2007, and has been updated in June 2008. The information has been provided by the Italian diplomatic representations in the European Union through the relevant office of the Ministry for Foreign Affairs.

Four main questions have been drawn up and representations in all 27 Member States have been consulted. 23 Member States provided responses as follows: Austria, Belgium, Cyprus, Denmark, Estonia, Finland, France, Germania, Greece, Ireland, Italy, Latvia, Luxembourg, Malta, The Netherlands, Poland, Portugal, the United Kingdom, the Czech Republic, the Slovak Republic, Spain, Switzerland and Hungary.

The four issues addressed were as follows:

1. Requirement for obligatory medical check-ups prior to being granted a residence permit. Possibility of being denied a permit in case of serious pathologies (TB, HIV etc)

2. Requirement for obligatory medical check-ups for illegal immigrants present in temporary residence centres

3. Type of health care offered free of charge to illegal immigrants who present themselves spontaneously at public healthcare facilities.

4. Requirement to report illegal immigrants who present themselves at public healthcare facilitates to the judicial authorities

Question 3 is of most relevance to the subject matter of this report but the responses to all four questions are presented here in order to provide an overview of the situation.

AUSTRIA

- A health certificate should be enclosed to the residence permit application only if requested.
- Vaccinations offered to asylum applicants include those against mumps, rubella, measles, diphtheria, tetanus, whooping cough, polio (2 combined vaccinations). Only a few applicants refuse vaccinations.
- Asylum applicants may undergo medical screening at initial reception centres (voluntary consent).

[62] "Le procedure sanitarie europee per il rilascio del permesso di soggiorno in favore di cittadini extracomunitari e possibilità di cura per gli irregolari" - Ministero del lavoro, della salute e delle politiche sociali – Dott.ssa Stefania Ricci

- Compulsory medical check-ups shall be carried out whenever tuberculosis cases are diagnosed, and relevant treatments shall be allowed.
- Freedom restrictions may be imposed by court order, followed by warrant of arrest if necessary, in the event that a treatment prescribed for tuberculosis is interrupted (the same applies to Austrian citizens).
- Medical officer inspections shall be carried out in relation to prostitution practices.
- Medical assistance for refugees and for asylum applicants who need health care services shall be provided against payment of health insurance contributions and through electronic health card, or equivalent document. Other health services which are not covered by health insurance may be provided after evaluation of individual cases. Asylum applicants are entitled to receive the same health care services provided to Austrian citizens who hold a health insurance.
- Anyone else who doesn't hold any health insurance and, in particular, illegal immigrants, when experiencing any health problems or when in need of medications, can only use the services provided by NGOs, especially by AMBER (a kind of joint venture between parishes and Red Cross). However, emergency care shall always be provided.
- There is no obligation to report or communicate the identity of any illegal immigrants who receive health care services from public health facilities.

BELGIUM

- A medical certificate should always be enclosed to any application for a temporary residence permit.
- In Belgium, a temporary residence permit may be granted after a medical certificate has been submitted. In case of doubt, the diagnosis may need to be confirmed by a medical board. The permit shall expire a the end of the treatment period prescribed by the doctor who issued the medical certificate.
- If an immigrant suffering from a disease is deported, the doctor shall check whether the relevant treatment can be administered in the immigrant's country of origin or in the country where he/she is going to obtain a residence permit.
- Illegal immigrants receive health care services from MADA (a medical association operating at country borders). If they need any specific treatment, they are transferred to relevant health care facilities.
- With reference to foreign nationals hosted at immigration centres, they shall undergo a medical check-up before expulsion to establish whether they are fit to fly.
- Immigrants who are hosted at an immigration centre are entitled to receive social and medical assistance, as well as psychological help even if they are removed from the centre.
- Shortly after being admitted to an immigration centre, immigrants shall undergo medical screening and tests and, if they need special care, they may be sent to suitable health care facilities. In the event that an immigrant is diagnosed a mental or physical condition, the doctor in charge may request that he/she is removed from the centre in order to be sent to hospital, or to a suitable health care facility.
- Illegal immigrants are entitled to receive urgent health care treatments.
- Asylum applicants who are admitted at federal reception centres shall receive the treatments they are entitled to according to their status.

CYPRUS

- Political refugees and asylum applicants are entitled to receive the same health care services offered to Cyprus citizens, as long as they hold suitable documentation required by competent authorities (for example, proof of employment for political refugees, and/or social insurance certificate for asylum applicants).
- Other foreign nationals coming from third countries who are not insured by foreign bodies or authorities shall have to pay themselves for any health care services they receive.
- Any health care services concerning prevention treatments (e.g. vaccinations), and those related to prevention/treatment of tuberculosis and HIV, are provided free of charge.

DENMARK

- In Denmark, asylum applicants are offered a health screening. Over 90% of them accept to undergo such a check-up.
- Refugees who apply for a residence permit (as agreed with the United Nations High Commission for Refugees), shall undergo a compulsory medical check-up carried out by the International Organization for Migration.
- Danish regulations concerning foreign nationals access - Section 10 (II) – provides for that a residence permit shall not be granted if a serious threat to public safety is identified, or to safeguard social safety and public health. However, it should be pointed out that, in practice, such provisions are not applied.
- There are no special provisions for foreign nationals.
- According to circumstances, illegal immigrants, including asylum applicants, are not covered by the Danish health care system, therefore, they have restricted access to public health care services.

ESTONIA

- Foreign nationals who apply for a residence permit for the first time do not have to undergo any compulsory medical screening.
- Applicable laws do not expressly provide for that a resident permit may be denied if the applicant suffers from a serious disease (e.g. tuberculosis, HIV, etc.). A residence permit application may be rejected if the applicant's stay in the country is considered a threat for public safety.
- Illegal immigrants who are hosted at relevant centres do not undergo any compulsory health screening. However, as per current laws, such check-ups should be carried out if they are deemed necessary.
- Emergency services are free for all, even if the person in question is not covered by regular health insurance.

FINLAND

- Information on health care procedures carried out for non-EU nationals applying for a residence permit mainly concern asylum applicants. The latter are offered a free medical screening within two months from the date they entered the country and, if they've been admitted at reception centres, they are entitled to have basic health care assistance free of charge.

- Asylum applicants over 7 years of age shall undergo a lung x-ray screening. In the event that any of them refuses to undergo clinical tests (lung x-ray), a compulsory procedure may be arranged for.
- Within three months from their arrival in Finland, immigrants are checked for other diseases too, such as HIV, hepatitis, syphilis.
- Pregnant women shall undergo routine tests and, if HIV or hepatitis B test results are positive, they shall receive full treatment for such diseases.
- Immigrants who are found to be carriers of tuberculosis shall undergo compulsory treatment at suitable health care facilities, either public or private ones.
- No special provisions are in force to impose on health care authorities the obligation to report illegal immigrants to Police authorities.
- However, a residence permit may be denied to foreign nationals who are deemed dangerous for public safety, health, or international relations.

FRANCE

- A compulsory medical screening is carried out when a residence permit is granted for the first time. The purpose of such a check-up is to identify any disease (e.g. tuberculosis) that may imply the need to suspend the permit to stay in the French territory. A similar measure shall be applicable in the event of serious mental conditions whom immigrants may suffer from that may endanger people safety. If an immigrant is diagnosed tuberculosis, he/she shall be classed as contagious and that implies that he/she cannot live in France.
- As far as the HIV virus is concerned, no similar measures need to be applied, and diagnoses may be made anonymously and free of charge.
- Asylum applicants undergo a medical check-up when they are admitted at reception centres and when they leave them. While their application is processed they receive assistance from OFPRA – the French office for the protection of refugees and stateless persons – or from CRR – the Commission for refugee appeal.
- Illegal immigrants who have been living within the French territory for at least 3 months are entitled to receive the whole range of health care services free of charge, including hospital admittance and medical services for any kind of health conditions, whether they require urgent treatment or not.
- No obligation to report foreign nationals receiving health care services to Police authorities is provided for.

GERMANY

- Within the German Federal Republic the national health care service is based on an insurance system – i.e. all citizens have the right/duty to take out a health insurance (2007 health care reform).
- Regulations concerning foreign national residence do not provide for any right to receive health care services for those who don't comply with legal provisions on residence permit.
- As per the provisions of entry and residence regulations - Aufenthaltsgesetz – any public medical or hospital facility has the duty to report the presence of illegal immigrants to the immigration office. In practice, the associations that provide health care services to illegal immigrants do no report them to competent authorities. In effect, the sanctions provided for those who fail report are not applied, neither for doctors nor for hospital facilities providing health care assistance to illegal immigrants.

- Asylum applicants are entitled to receive health care services for a three-year period (while their application is processed). Once such period has expired, either the applicant shall have to leave the country, or he/she is going to be granted the refugee status and is entitled to access the health insurance system. Within the above-mentioned three-year period, any health care costs are paid for by social services.
- No medical check-up is carried out when the first residence permit is granted, nor when a denial of permit is provided for if the applicant is affected by serious health conditions. No compulsory health screening is carried out on illegal immigrants hosted at reception centres.
- However, German embassies located in countries experiencing epidemic outbreaks or endemic diseases, may require a medical check-up before issuing a residence permit.

GREECE

- Non-EU citizens applying for a residence permit for the first time shall have to enclose a medical certificate to their application, together with relevant documentation. Those who don't hold any, shall undergo a medical screening before the permit is granted.
- Refusal to grant the residence permit, or expulsion from the country are considered justified in the event of infectious diseases or epidemic outbreaks – as communicated by the World Health Organization – in order to safeguard public health.
- Health care services provided to illegal, non-EU citizens suffering from tuberculosis, HIV, or other contagious diseases, are free of charge if their countries are not able to provide such services. During the treatment period a temporary residence and work permit shall be issued.
- Illegal, non-EU nationals hosted at reception centres shall undergo a health screening, to be carried out by a special medical team from the Health Ministry Disease Prevention Centre, which includes:
    - General medical consultation;
    - Mantoux test;
    - Lung x-rays;
    - Any other test that may be deemed necessary for the protection of public health.
- If any emergency treatment is needed, illegal, non-EU citizens are entitled to receive those health care services that are necessary to ensure their recovery, or stable health conditions.
- Health care facilities do report illegal immigrants to Police authorities.

IRELAND

- Current laws and regulations do not provide for health care assistance to be provided to illegal, non-EU nationals.
- Illegal, non-EU citizens, or asylum applicants, may request to undergo a medical screening at reception centres. Such a check-up does not affect the application for a residence permit.
- Illegal, non-EU citizens holding relevant certificates issued by the Irish Social Services, may request health care assistance free of charge.
- Health care facilities have no obligation to report illegal, non-EU citizens to Police authorities.

ITALY

- No medical screening needs to be carried out for residence permit purposes.
- Immigrants hosted at temporary reception centres are entitled to receive emergency treatments and, if needed, to be admitted at suitable health care facilities.

- Non-EU citizens who do not comply with regulations concerning entry and residence requirements are entitled to receive health care services at national health service facilities, including:
  1. urgent out-patient and in-patient care (that cannot be delayed without causing harm to the person's health or life), or essential care (health care, diagnostic, and therapeutic services related to diseases which, even though they are not dangerous, may nevertheless cause some major harm to the person's health or life) in case of diseases or accidents;
  2. prevention services and related care in order to safeguard individual and community health, as described in Sections a)-b)-c)-d)-e) of Paragraph 3, Art. 35 of the Italian Legislative Decree 286/98, specifying what follows:
     - same pregnancy and motherhood protection treatments as those provided to Italian women;
     - protection of under-age persons' health;
     - compulsory vaccinations within the scope of community prevention measures authorized by regional authorities;
     - international preventative treatments;
     - prevention, diagnosis and treatment of infectious diseases and possible clearing of related focuses.
- Health care services provided to immigrants who are unable to pay for them are free of charge.
- Access to health care facilities does not imply any reporting to public safety authorities, except for those instances when reporting is deemed compulsory.

LATVIA

- Residence permit may be denied if the applicant's health conditions or disease may damage the whole population. The most serious diseases are detailed in a list approved by the Health Ministry. The Health Ministry may allow entry into the country for the treatment of serious diseases.
- Residence permit may be denied if applicants are affected by specific diseases, such as tuberculosis (active phase), syphilis, serious mental conditions, drug addiction or psychotropic drug addiction.
- Asylum applicants shall undergo a compulsory medical screening, in the interest of public health. Medical costs related to tuberculosis and prevention treatments administered to asylum seekers and detained immigrants are paid for by the Ministry of Interior, except for emergency treatments which are financed through the health budget or through voluntary insurance taken out by foreign nationals.
- Country border Police may detain foreign nationals who don't comply with entry and residence requirements.

LUXEMBOURG

- Medical screening is compulsory when resident permits of over 3 months are applied for. Medical check-ups are carried out by national health service doctors residing in the country and consists of a medical-clinical consultation and lung x-rays.
- In the event that immigrants are diagnosed some disabilities, the Health Ministry may suggest to the Foreign Affairs Ministry that the immigrants in questions should be removed from the country, in compliance with the Geneva Convention of 28 July, 1951 concerning political refugees.

MALTA

- The Maltese Emergency Response Team has the duty to perform a medical screening on immigrants on their arrival. Those who need further tests are sent to the main hospital. Immigrants in need of less urgent treatments, or of special care shall undergo further medical tests. All immigrants shall undergo x-rays to check whether they are affected by tuberculosis. All immigrants shall receive vaccinations against diphtheria, polio and tetanus.
- Resident permits shall not be denied on health-related grounds.
- All immigrants, regardless of their status (humanitarian or refugee) are entitled to receive health care services free of charge, as Maltese citizens do.
- No compulsory reporting of illegal immigrants being treated at public health care facilities to Police authorities is provided for by law.

THE NETHERLANDS

- Compulsory medical screening, including tuberculosis tests, shall be carried out on any applicant for a residence permit. If any immigrant is diagnosed tuberculosis (but no other serious condition, such as HIV, for example), he/she may still be granted a residence permit. In the event that a residence permit is denied, the immigrant in question shall be treated accordingly, and shall not be subject to expulsion until fully recovered.
- In addition to the initial compulsory screening, immigrants admitted at reception centres receive medical assistance as needed throughout their stay at the centres.
- Illegal immigrants should pay for the health care services they receive.
- There is a foundation which take care of unpaid medical fees for services provided by health care professionals.
- No compulsory reporting of illegal immigrants accessing public health care facilities to Police authorities is provided for by law.

POLAND

- Medical screening is not compulsory in order to obtain the first residence permit.
- Residence permits are not denied to seriously ill applicants.
- Entry into the country may be denied due to public safety reasons.
- Compulsory medical screening and disinfection procedures (people and clothing) are carried out on illegal immigrants admitted at reception centres waiting to be granted the refugee status. The same procedures are performed at country borders for foreign nationals who live within Polish territory requesting to be granted the refugee status.
- No free health care coverage is provide to illegal immigrants voluntarily requesting treatments at public health care facilities. They may receive health care serviced only if they hold relevant health insurance.
- Compulsory treatment, hospitalisation, isolation, quarantine and epidemics screening in the event of infections and infectious diseases being diagnosed.
- No compulsory reporting of illegal immigrants being treated at public health care facilities to Police authorities is provided for by law.

PORTUGAL

- Portuguese laws and regulations concerning health care provides for equal rights for both legal and illegal immigrants. However, it often happens that health care facilities and social services are not familiar with such legal provisions and, therefore, refuse to treat illegal immigrants, or ask them for documents which are not necessary.
- HIV tests are administered free of charge.
- The international organization called "*Medici del Mondo*" (Doctors of the World) manages mobile emergency units providing health care services to immigrants (often illegal ones). Moreover, the organization accompany immigrants to reception centres in order to speed up bureaucratic procedures.
- No compulsory reporting of illegal immigrants accessing public health care facilities to Police authorities is provided for by law.

UNITED KINGDOM

- The Immigration Office is entitled to request immigrants to undergo a medical screening. Results of such screening are kept into consideration by the Immigration Officer for admittance purposes.
- Residence permits shall not be denied just for medical reasons, unless the immigrant in question suffers from infectious tuberculosis.
- Rigorous check-ups are currently performed to verify whether lung tuberculosis was still an issue in the country of origin before the immigrant departure from there, in relation to foreign nationals over 11 years of age requesting a visa for over 6 months. In the event of unclear x-ray results, the immigrant in question shall have to provide some saliva samples to perform further tests.
- Illegal immigrants shall undergo a general medical screening within 24 hours after their arrival at temporary reception centres.
- Foreign nationals who are identified as possible illegal immigrants, and who are detained for further investigations, may be sent to the port authority medical officer for any health problems.
- Immediate emergency treatments are provided to illegal immigrants whenever needed.
- Out-patient practices or clinics providing primary care may decide to enter any immigrant name in to the NHS list, either on a temporary (up to 3 months) or a permanent basis. Health care services are guaranteed as long as patients are included in the list. Illegal immigrants' names whose asylum application is turned down are added to the list temporarily (3 months).
- Illegal immigrants are entitled to receive free health care services for three months as long as their name is include in the NHS list.
- Whenever they go to an emergency unit, they shall be treated. However, if the hospital ascertains that they are illegal immigrants, they shall have to pay for the treatment received.
- Special "Foreign Visitors Managers" are on duty at hospitals, in order to identify non-UK residents who need to pay for health care treatments.
- NSH staff do not have to report illegal immigrants to Police authorities, unless some public order problems arise.

CZECH REPUBLIC

- Non-EU nationals who are admitted at reception centres shall undergo a compulsory medical screening for prevention purposes when they enter the country, as well as regular follow-up consultations and a further check-up before leaving the Czech Republic.
- Whenever it is considered necessary by health care personnel, some extraordinary measures may be undertaken, such as laboratory and diagnostic tests, vaccinations and prevention procedures as specified by public health protection bodies.

- In the event of a refusal to undergo medical screening by any immigrant hosted at reception centres, Police officers shall be authorized to 'neutralize such a resistance'.
- Non-EU illegal immigrants under 18, shall be administered compulsory vaccinations against measles, mumps and rubella, within 48 hours from their arrival at reception centres. Moreover, they shall undergo lung and heart x-rays as well. Illegal immigrants under 15 shall also be tested for tuberculosis.
- Illegal immigrants over 15 years of age shall undergo blood and syphilis tests.
- Written consent shall be obtained from the immigrant involved in order to take a blood sample for HIV tests.
- Any costs related to health care services provided to foreign nationals, as the above-mentioned ones, shall be charged to the Reception Centre Department of the Ministry of Interior.
- Illegal immigrants being treated at healthcare facilities are rarely reported to the Immigration Police, in particular when such immigrants are found to be indigent.

SLOVAK REPUBLIC

- Any application for temporary or permanent residence permit from non-EU citizens shall be accompanied by a medical certificate concerning the applicant's overall health conditions. Such a certificate may be issued by a Slovakian health care organisation too.
- Non-EU nationals hosted at reception centres shall have to undergo a medical screening which includes blood tests, vaccinations, and any other test that may be needed in order to produce a diagnosis, as well as any prevention measures required by health care authorities. In the event of any disease that cannot be treated at reception centres, the immigrant involved may be sent to a suitable health care facility and, if needed, he/she may be placed into isolation and quarantine at special health care centres.
- Free health care services shall be provided in case of altered health states or life-threatening conditions.
- Illegal immigrants being treated at hospitals may be reported to Police authorities if the staff involved suspect that a crime may have been committed by the immigrant in question.

SPAIN

- When applying for a residence card, a medical certificate needs to be submitted too, where it is stated that the person in question is not affected by any disease requiring quarantine.
- Illegal immigrants hosted at internment centres are entitled to receive proper health care services within the centres.
- If registered at the local registry office where they have their permanent residence, illegal, non-EU citizens shall be entitled to receive health care services. If they are not, they may receive emergency care or may be treated for serious diseases or accidents until their GP considers them recovered. Health care assistance shall be provided to pregnant women, before and after the baby's birth.
- No compulsory reporting of illegal immigrants being treated at public health care facilities to Police authorities is provided for by current laws and regulations.

SWEDEN

- Residence permit applications are processed regardless of any kind of illness or disease that applicants may suffer from.
- Medical screening is not compulsory at reception centres, but health care assistance and follow-up consultations are offered to immigrants hosted at such centres.
- Illegal immigrants requesting to be treated at health care facilities shall be given the necessary assistance, although they shall be charged for the related costs.
- No compulsory reporting of illegal immigrants accessing public health care facilities to Police authorities is provided for by law.

HUNGARY

- As from 1st January 2006, regulations concerning the entry of foreign citizens in Hungary, do not provide for a medical certificate to be submitted, or a medical screening to be performed. However, when applying for a residence permit, applicants shall be asked some questions about their health state.
- Any illegal, non-EU immigrants who is admitted at a reception centre, when applying for a residence permit shall be placed in quarantine so that a proper medical screening may be carried out to prevent any outbreak of epidemics or infectious diseases.
- Health care services provided free of charge to immigrants hosted at reception centres, refugees and asylum applicants include emergency care and any treatment needed to make the person recover, or to ensure that he/she reaches stable health conditions.
- Illegal, non-EU immigrants receiving hospital care my be reported to Police authorities if serious injuries are involved or if consulate protection is needed.
- Regulations concerning refugees are different from those related to immigration control. Immigrants who request to be granted the refugee status shall have to undergo medical screening, treatment, and vaccinations as provided for by applicable laws.

3.2 Case Studies: Greece, France, Spain and Italy

3.2.1 Methodology

A literature and legislative review have been carried out by project partners in the following countries:

- Greece
- France
- Spain
- Italy

All project partners after having identified the main relevant sources of information with regard to literature and legislation in their country of origin, have summarized their findings under the following three headings:

A) Procedures for return of illegally staying third country national (respectively in Greece, France, Spain and Italy)

B) Provisions for the guarantee of healthcare for illegally staying third country nationals while in the Member States (respectively in Greece, France, Spain and Italy)

C) Provisions for the guarantee of healthcare for illegally staying third country nationals at the moment of return. (respectively in Greece, France, Spain and Italy)

In the coming pages an analysis report on International Literature and existing legislation at European level will be presented in form of the following four case studies:

3.2.2 Greece

Introduction

"*The coast guard* yesterday rescued a total of 192 illegal immigrants *from a ship that had been floundering in choppy waters off the southeastern coast of Crete for several hours. The migrants, declared Iraqi nationality, but are believed to be Egyptians. One migrant was found dead – a diabetic whose blood sugar had fallen too low. The vessel was towed to shore and the migrants were given medical assistance and accommodated in a local hotel. A team of local doctors and Red Cross officials were on standby at the hotel yesterday. "We have a duty to look after these people until the state decides upon their status," deputy prefect of Lasithi Theodoris Paterdakis said*".

Greece is a unique country as regards its landscape, coastline and nature. Given its special geographical location among three continents, three major migrant inflows from Africa, Asia and the Middle East, and the Balkans and Eastern Europe intersect at Greece. Afghans, Iraqis, Iranians, Turks, Pakistanis and Palestinians transit through Greece to get to Europe. Greece is therefore primarily a transit country for those who hope to continue their journey into Italy. There are also a large number of migrants from former Eastern European countries (Albanians, Georgians, and Bulgarians). The number of foreign nationals in Greece may be up to 1 million people, including 13,000 asylum seekers (HCR figures 2006).

Thus, thousands of economic migrants try every year to reach Europe by crossing Greece's sea and land borders illegally from Asia and Africa, often perishing in the attempt. The Greek authorities are doing their best to deal with the situation but they are faced with a daunting task, that is why they are seeking the widest possible European and international cooperation and assistance in order to cope as best as they can. According to Interior Ministry figures, 95,239 illegal migrants have been held in 2006, an increase by 43.5% in regard to 2005, while in the first 10 months of 2007, the figures stand at 95,318.

According to the formal Statistical Data on the first Nine Months of 2008, 69,071 individuals have been arrested on the Greek border and 30,154 individuals in the hinterland (in total 146,377 persons). The country borders with non-EU states, and in a region where peace is threatened, a phenomenon which result in waves of illegal immigrants attempting to enter the east Mediterranean nation's borders.

Cooperation on Migration

Greece has signed readmission agreements with Bulgaria, Croatia, France, Hungary, Italy, Latvia, Lithuania, Romania and the Russian Federation. It has also concluded cooperation agreements with neighboring states to combat, *inter alia*, irregular migration. These include a Police Cooperation Agreement signed with Albania and Turkey respectively, which also contain a Readmission Clause. All these agreements cover issues related only to involuntary returns.

More Recently, Greece, Italy, Malta and Cyprus have signed a joint declaration for the combating of illegal migration. A four-partite meeting among the four countries' ministers of Interior, Justice and Public Order preceded that development. Interior Deputy Minister Thanasis Nakos represented Greece. In the declaration reference is made to the importance of combating illegal migration, as well as to support EU actions to boost legal migration in cooperation with migrants' country of origin.

A. Procedures for return of illegally staying third country national

Introduction

The legislative review concerning the Greek laws for immigrants includes mainly Decree-Laws which aim to adapt European Directives. The main themes which include the adaptation of Greek Law to the European Law for immigrants are: The protection of immigrants, which includes entry, exit, residence, employment, and deportation issues; the recognition of illegal immigrants from third countries; the assessment of the minimum prerequisites for the illegal immigrants; issues concerning the family reunification of illegal immigrants; there is a clear identification of the processes concerning immigrants and ways of collaboration with the National Human Organization; protection of the illegal immigrants in case of massive entry to the country, description of the prerequisites concerning the employment of the illegal immigrants; there is a Decree-Law which defines the organization and the enactment of the existing Asylum for illegal immigrants located at Lavrio-Athens; and finally there is a Decree-Law which determines the establishment of a Centre for temporarily placement for illegal immigrants.

The principal aim of the above Decree-Laws is the protection of immigrants and the creation of a safer environment for people who request asylum in Greece.

Legislative instruments and provisions

To address illegal immigration problem, an Immigration (Foreigners) Law was passed in 1991 mainly to provide the legal basis for decrees to discourage the irregular entry of foreigners to Greece. According to the Law, foreigners could not enter the country without a work permit that provides the basis for issuance of a residence permit. Under the Law of 1991 (No. 1975/1991), a

special police force was created for the efficient control of the border (Law No. 2458/1996 amended the Law of 1991).

The asylum-related provisions of this Law, in particular, established a general asylum framework to allow the Greek state to regulate significant, practical details through Presidential Decrees. A number of such decrees constitute the main body of current Greek refugee law. These are Presidential Decree 61/99 issued by the Ministry of Public Order and Presidential Decrees 189/98 and 266/99 issued by the Ministry of Health and Social Insurances.

Thus, Presidential Decree 61/1999 establishes more detailed procedures to asylum-related issues in accordance with the 1951 Geneva Convention. According to Article 6 of Presidential Decree 61/1999, recognized refugees who have withdrawn their refugee status under the provisions of Article 1c of the Geneva Convention may be deported, if the provisions of Articles 32 and 33 of the Geneva Convention are satisfied.

According to Article 2 of Presidential Decree 61/1999, asylum applications are considered within three months of the date of their submission. If asylum is denied, the asylum seekers may appeal within 30 days from notification of the rejection decision, to the Minister of Public Order for reconsideration who, within 90 days, issues, on recommendation by a six member committee, the final decision.

Any final rejection is notified to the asylum seeker with the order to leave the country at the earliest possible time on his/her own volition (Article 3). In exceptional cases, the Minister of Public Order may, particularly for humanitarian reasons, approve the temporary stay of rejected asylum seekers, until their departure from the country becomes possible (Article 8). If the foreigner violates laws related to residence in Greece, it is possible, instead of being deported, to be given a time limit of 15 days to depart from the country.

Rejected asylum seekers who are allowed to stay temporarily for humanitarian reasons are granted medical-pharmaceutical and hospital care, or other socio-economic assistance to cover their immediate living needs (Presidential Decree 61/1999, Article 25).

As described above, the numbers of irregular immigrants continued to rise during the 1990s. This prompted a public debate about migration that led the Greek authorities to reform the legal framework. In 1997, the Greek state adopted legal measures to regularize irregular migrants and expel those not admissible through the regularization programme. Relevant legislation was enacted in November 1997, through Presidential Decrees 358 and 359, allowing irregular immigrants to apply for legal status. Despite massive expulsions, and the creation of the special police force for stricter border controls, irregular migrants continued entering Greece.

To address this, a second regularization process was enacted in 2001, regulated by the new Immigration Law No. 2910/2001, and consequently amended by Laws No. 3013/2002 and

3202/2003. Law No. 2910 and its amendments attempt to reorganize and update the legal status of migration in Greece, addressing issues related to the entrance and settlement, including integration, of new immigrants, while at the same time containing articles applicable to those already resident in Greece.

Thus, residence permits may be revoked, leading to the expulsion of those affected within 30 days, as decided by the Secretary General of the Region on recommendation of the Ministry of Public Order or the Ministry of Health and Welfare. Following are the grounds for expulsion: National security and public order; Protection of public health; Violations of obligations under the immigration act; Presentation of forged documents to the authorities; Revocation of work permit or of the permit to undertake an independent economic activity. This development can be seen in the light of efforts by the European Union to harmonize its immigration policy.

The 2001 population Census indicates some 800,000 foreigners out of a total of 10,946,080 inhabitants. This figure includes regularized immigrants and refugees. The number of asylum seekers is rather small if compared with asylum applications in other European Union Member States.

Operational Steps for Involuntary Return

Irregular migrants apprehended at entry points and those in police custody, are escorted by the police when deported. There have been some cases of mass deportations effected following police orders and with the use of police escorts. For this purpose, the state authorities charter buses and bear the relevant costs. As a rule, deportation expenses have to be borne by the foreigner. If the latter cannot provide these, the state will cover them. If the foreigner in question entered the territory upon a letter of guarantee by a third person, the latter will also be responsible for covering the expenses (50/50 with the foreigner). An employer engaging a foreigner without a work permit must bear his/her deportation expenses. Carriers and travel agents are responsible for subsistence and removal costs for foreigners they have transported to Greece.

Prosecution and Detention Procedures

In the case of an Administrative Deportation, the foreigner concerned has 48 hours to present his/her objections to the decision. If the foreigner is considered dangerous, the decision may include the order for his/her detention, which cannot exceed three months. In this case, the foreigner shall be detained on the premises of the appropriate police authority. Objections to detention can be lodged before the President of the Administrative Court. The latter may decide to convert the detention into an order to leave the country within 30 days. The foreigner may appeal against the deportation decision within five days to the Secretary General of the Region, who must decide within three days. The appeal can result in a suspension of the decision.

The Secretary General of the Region may temporarily suspend deportation on humanitarian or health grounds. The Secretary General of the Region where a foreigner resides may temporarily suspend his/her administrative deportation, following a relevant application or *ex officio*, if the suspension is prescribed for "humanitarian reasons, force-majeure or public interest, such as on exceptional grounds regarding the foreigner's family, life or health." The above decision of the regional Secretary General is to be preceded by a non-binding opinion of the Regional Immigration Committee responsible for providing opinions on foreigners' applications for residence permits (Article 9 of Law No. 2910/2001). The law does not provide for the duration of the suspension of deportation.

Similarly, deportation of those who denounce or bear witness against acts of procurement of prostitution may be suspended pending the final decision on the acts denounced; and the foreigner is provided with a temporary residence permit. If immediate deportation is not possible, the Secretary General of the Region may issue a decision allowing the foreigner to stay in the country, with a decision imposing restrictive terms.

Judicial Deportation

If the execution of a foreigner's deportation is not possible on any grounds whatsoever, especially if the foreigner's life is in danger, this dangerous situation is to be certified by the competent police authority. The Public Prosecutor may then bring the case before the Court (three-member Court of Misdemeanours – Magistrate's Court) to decide on the actual suspension of deportation, before or after the completion by the foreigner of any sentence that may have been imposed.

B. Provisions for the guarantee of healthcare for illegally staying third country nationals while in the Member States

'Documented' migrants

According to the literature review, the issue of migrants' health only entered the policy agenda in the 2000s. The recent Immigration Bill (Law 2910/2001) has granted officially equal rights regarding National Insurance and social protection for foreign nationals legally resident in Greece, as they apply to Greek citizens. However, it was only in 2002 that the government launched for the first time a set of measures aiming specifically at integration: the 'Action Plan for the Social Integration of Immigrants 2002-2005' which includes provisions on the health care of immigrants.

Formal access to the free services of the National Health System (NHS) has been dependent on registered employment and regular status, which was not the case for the majority of Greece's immigrants throughout the 1990s. In July 2000, the Ministry of Health and Welfare issued a

Circular on the 'medical treatment and hospital admission' of nationals of countries outside the EU and the EEA. Accordingly, regular immigrants may have access to the national health system as long as they possess a health book issued by the Insurance Fund they are registered with.

Ethnic Greek migrants can also benefit from the public health services if they are able to present the necessary documents, which include, for those not insured, a health book for low-income people eligible for a special welfare programme. In either case, the member of the household who is insured or benefits from special welfare programmes covers dependent family members.

Conclusion

The Non-EU citizens who apply for a residence permit for the first time shall have to enclose a medical certificate to their application, together with relevant documentation. Those who do not hold any certificate, shall undergo a medical screening before the permit is granted.

Refusal to grant the residence permit, or expulsion from the country are considered justified in the event of infectious diseases or epidemic outbreaks – as communicated by the World Health Organization – in order to safeguard public health.

The Health care services which provided to illegal, non-EU citizens suffering from tuberculosis, HIV, or other contagious diseases, are free of charge if their countries are not able to provide such services. During the treatment period a temporary residence and work permit shall be issued.

All the illegal, non-EU nationals hosted at reception centres shall undergo a health screening, to be carried out by a special medical team from the Health Ministry Disease Prevention Centre, which includes: General medical consultation; Mantoux test; Lung x-rays; Any other test that may be deemed necessary for the protection of public health.

In the case were any emergency treatment is needed, illegal, non-EU citizens are entitled to receive those health care services that are necessary to ensure their recovery, or stable health conditions.

The health care facilities and practitioners are obligated to report illegal immigrants to Police authorities.

C. Provisions for the guarantee of healthcare for illegally staying third country nationals at the moment of return.

Undocumented migrants

Undocumented migrants in Greece are entitled to very restricted rights, compared to many EU countries. They only have access to hospital emergency rooms for the treatment of life-threatening conditions. The only exception is for foreign patients with HIV or other infectious diseases, who can benefit from free medical care and hospital admission, provided that the

appropriate treatment is not available in their country of origin; in that case they are also entitled to temporary stay and work permits (Law 2955/2001).

Asylum seekers and refugees

Asylum seekers are also entitled to the same access to health care as Greeks. However, until they succeed in obtaining an asylum seeker's status they are only entitled to emergency care, like undocumented migrants.

Good practices

"Antigone", is an organization that works on the defense of human rights, nonviolence, peace and conflict resolution. They were responsible for documentary research and the practical organization of field visits. They run a number of programmes for migrants in Greece. The centers visited were chosen according to the size of the country, their geographical location, their accessibility and the proportion of vulnerable persons in the centre. We encountered a specific problem due to the policy of opening and closing centers according to arrivals, in particular in the Evros region and the Dodecanese.

The Greek Ombudsman is a constitutionally sanctioned Independent Authority. It was founded in October 1998 and operates under the provisions of Law 3094/2003. The Ombudsman provides its services to the public free of charge, and received more than 82.535 complaints during its eight first years of operation (from 1 October 1998 to 31 December 2006).

The Greek Ombudsman investigates individual administrative actions or omissions or material actions taken by government departments or public services that infringe upon the personal rights or violate the legal interests of individuals or legal entities.

Before submitting a complaint to the Greek Ombudsman, the complainant should first come into contact with the public service involved with his or her case. Only if the problem is not resolved by the service concerned should a complaint be submitted to the Ombudsman.

The principal mission of the Greek Ombudsman is to mediate between the public administration and citizens, in order to help citizens exercise their rights effectively. The Greek Ombudsman also: defends and promotes children's rights, promotes equal treatment and fights discrimination in the public sector based on race or ethnicity, religious or other conviction, disability, age or sexual orientation, promotes and monitors the equal treatment of men and women in matters of employment both in the public and the private sector.

As a mediator, the Greek Ombudsman makes recommendations and proposals to the public administration. The Ombudsman does not impose sanctions or annul illegal actions by the public administration.

The Greek Ombudsman of Health and Social Solidarity is focusing his/her mediating and controlling power in order to help vulnerable groups like elder people, handicapped people,

mentally and physically ill and also refugees and immigrants. Based on the experience gathered by the handling of relevant cases, the ombudsman is focusing on the problems that these vulnerable groups have to face in their effort to approach health services and is also proposing measures to the Ministry of Health and Social Solidarity regarding the fulfillment of those need that the vulnerable groups have. (http://www.synigoros.gr/allodapoi/).

PRAKSIS is an independent, Non Governmental Organisation, aiming principally at the creation, application and implementation of humanitarian and medical action programs.

PRAKSIS' programmes did not start from scratch, as they constitute the day after of the within the country actions which until October 2004 were run by the Greek Chapter of Médecins Sans Frontières (MSF, Doctors Without Borders). Based on two Polyclinics in Athens and Thessaloniki, these programmes have offered for 12 years now:

- immediate and free medical and pharmaceutical care
- psychological support
- social support (complementary supportive services)
- legal aid
- shelter
- career advice

PRAKSIS offers services to any socially excluded group, which has not got access to health services and/or social and legal support, such as:

- the poor, the homeless, the uninsured
- street children
- refugees/ asylum seekers
- economic immigrants
- single-parent families
- ROMA
- victims of trafficking

The Hellenic Migration Policy Institute is a research organization, which study the phenomenon of migration in Greece. The Aeneas Programme, is a programme for financial and technical assistance to third countries in the area of migration and asylum.

3.2.3 France

Introduction:

As in many other countries of Europe, in France the migration debate is mainly focussed on security issues at national and international levels. In fact, French policy currently focuses on measures to combat illegal migration.
A new asylum legislation tightening the conditions for asylum and emphasizing faster asylum determination and more effective removal procedures has been adopted in France on 19 November 2003. On 26 November 2003, the 1945 Ordinance on conditions of entry and residence of foreigners in France was amended by Act No. 2003–1119 relating to rules on immigration, foreigners' stay in France and nationality.

A. Procedures for return of illegally staying third country national

The French government uses different procedures for the return of illegally staying third country nationals.

Expulsion

Concerning the rejection at the border, the Article 5 of the 2 November 1945 Ordinance states the conditions of entry and residence of foreigners in France. It also states that the national police and customs officers have the competence for rejecting non nationals at the borders.
The three major reasons for refusing entry to foreigners are:

- due to a lack of valid travel documentation,
- due to insufficient means to maintain themselves during the time of their stay,
- when they pose a threat to public order and security or when they have been subject to an enforced expulsion or interdicted entry order.

According the Article 35 of the same Ordinance of 1945, asylum seekers can apply for asylum at the border. During this process, their entry is withheld and they are placed in waiting zones at the port of entry with a provisional residence permit.

Concerning the return to the border stipulated in Article 22 of the 2 November 1945, an court order to be returned to the border will be issued by the Prefect in three cases of:

- illegal entry or unlawful stay in France,
- residence permit refusal or withdrawal,
- falsified documents use.

In order to appeal against the return to the border, foreigners have 48 hours if notified in person or 7 days if notified by mail or 1 month to the asylum seeker to arrange his departure.
In case of criminal offences, a judicial expulsion order will be pronounced. In fact, expulsion orders issued by one EU Member State are mutually recognized by all Member States.

The expulsion of the alien for a limited period or lifetime plus a penalty can be ordered by the court, it is called the judicial order of expulsion "interdiction du territoire français" ITF.

Deportation

Asylum seekers in the process of asylum need to wait for the decision from the court to be deported or not as stated in the Article 12 of the Asylum Act (Law of 25 July 1952).

Detention

According to the Ordinance of 2 November 1945 and its amendment the Act of 1998, asylum seekers may be detained no longer than 12 days and 32 days for undocumented foreigners until a

decision on their application is made by the OFPRA (Office for the Protection of refugees and stateless persons). Like this, French authorities have more time to identify the non-national and arrange his return.

▪ In case of unfounded asylum (absence of valid travel documents), the alien may be detained at the point of entry, in waiting zones at ports, airports and railway for no longer than 4 days. An extension of detention can be asked by the court in order to check the applicant's identity and consider if removal is necessary. However, after 20 days of detention and if the removal is not enforced, the asylum seeker must have the right to enter into the French Territory.

▪ No court decision is needed for detention at detention centres according to the Article 35 bis of the Ordinance of 2 November 1945, it is under the Prefect's decision. The detention period will be prolonged to a maximum of 5 days and further 5 days if necessary, (and then it will depend of a court decision), if the person:

- does not have valid travel documents,
- does not disclose his identity,
- resists removal.

▪ Detention can also take place in the police stations holding rooms no longer than 2 days according to the 19 March 2001 Decree.

Removal

As stated in Articles 26 bis, 31 bis and 32 bis of the 2 November 1945 Ordonnance, the French State takes the financial responsibility of the removal.

Also there are administrative steps to take into consideration for involuntary return:

- **Escorts**

Need of two escorts per deportee.

- **Chartered flights**

Collective removals are organized with special chartered flights

- Framework agreements with countries of origin or transit

Germany, Austria, the Benelux countries, Spain, Italy, Poland, Portugal, Slovenia, Sweden Switzerland, Romania and Senegal have concluded readmission agreements with France. With Mali and China, negotiations are in progress. Due to the low acceptance of the EU removal document by other governments, France has decided not to use them.

- **Costs**

This information is not available.

-**Passport stamps**

No system of stamped passport set up in France. Nevertheless, a prohibition on re-entry in France for a certain period of time (from a few months to up to 10 years) will be mentioned on the expulsion order. The migrant can apply for re-entry documentation, only when this period is over.

-**Detention**

The Decree of 19 March 2001 harmonized the conditions of detention in France (holding rooms, detention centres). Detention centres cannot be considered as prisons, detainees are allowed to move freely. There 22 detention centres and 122 waiting zones (at port of entry) in France. Foreigners who arrive without valid travel document are held in the custody (from 4 to 8 days) of the border police in waiting zones, pending an admission decision.

-**Fingerprints**
The Schengen Information System (SIS) collects information on rejected asylum seekers. SIS registration can be very useful when identifying rejectees are applying for asylum in any other State Member.

In France, several important changes were introduced to fight against illegal entry and residence and the abuse of asylum procedures through new laws on asylum and immigration implemented on 19 and 26 November 2003 and effective on 1st Janaury 2004. The Asylum Law sets up the notion of "safe country" and "safe third country", also the notion of "internal asylum" and express the need of speeding time the asylum processing time, etc.

B. Provisions for the guarantee of healthcare for illegally staying third country nationals while in the Member States.

Concerning undocumented migrants a system, called "State Medical Assistance" (Aide Médicale de l'Etat- AME), allows undocumented migrants and their dependants to access public health care upon compliance of certain conditions. The AME entitles undocumented migrants who have been residing in France for more than three months and are below a certain economic threshold (576.13 EUR for one-person households in 2007) to access all kinds of health care free of charge (including abortion). However, there are limitations to the amounts covered on the official reimbursement scheme, preventing access to dental prosthesis and corrective lenses for example impossible. For undocumented migrants who do not comply with these conditions, only emergency care is covered by the state with the exception of children who are entitled to access all kind of health care free of charge regardless of their eligibility for AME. According to the applicable legislation, "emergency care" (soins d'urgence) means not only care in life-threatening situations but also treatment of contagious diseases (necessary to eliminate a risk for public health), all types of health care for children, maternity care and abortion for medical reasons. The treatment of chronic diseases is excluded.

In addition, all undocumented migrants also have access to public centres providing screening of sexually transmitted diseases and HIV/AIDS, family planning, vaccinations and screening and treatment of tuberculosis. None of these centres require any kind of identification to provide. Undocumented migrants who have been living in France at least three years are also eligible for "home medical assistance". This allows them to consult general practitioners free of charge.

Undocumented migrants can obtain the AME before they get ill, therefore they do not need a medical certificate to get the AME.
The AME is initially granted for one year but can renewed and has to be shown every time undocumented migrants seek care, tests or medicine.8
Access to emergency care for undocumented migrants is organized through the "health care centre offices" –PASS, that are in charge of providing medical and social support to underprivileged persons thus facilitate their access to health care in public hospitals. A high percentage of undocumented migrants residing in France who are in principle entitled to AME do not receive it for various reasons.In 2005, the report of the observatory on access to health care of Médecins du Monde France revealed that 93.7% of undocumented migrants assisted in their shelters CASO (Centers d'accueil, de soins et d'orientation) throughout France in 2005 were potentially entitled to the AME but did not have their rights recognized. There are many difficulties facing undocumented migrants needing to prove their residence in France for more than three months. Given their poor housing conditions, it is not always easy for undocumented migrants to provide electricity, gas, or other bills that are required by the regulations.Health care professionals and pharmacies may also deny treatment or medicine to undocumented migrants. In the opinion of the Observatoire du droit de la santè des ètrangers (ODSE), these discriminatory practices are justified neither by the risk of

late reimbursement nor by the freedom that general practitioners have to choose their patients. All doctors, general practitioners and specialists are bound by medical professional ethics and by public health considerations. Therefore, they must always provide medical help to everyone regardless of their nationality, economic situation or administrative status.

In fact, there are many aspects of the Aide Médicale De l'Etat that are still failing and have to be solved. The National Human Rights Commission has acknowledged this and recommended that "it is necessary to bring to an end all the difficulties associated with the granting of the AME in order to avoid the failure of the system of health protection and prevention that would be unacceptable from a humanitarian as well as from an efficiency perspective".
Problems are also encountered with the mechanisms created to facilitate access to hospitals for the most marginalized groups, including undocumented migrants who do not have the AME recognized. Many undocumented migrants face serious marginalization as regards access to health care. Due to isolation or language barriers, they are often unaware of their rights and only try to obtain the AME when they are severely ill. Given this lack of information, many are reluctant to use hospital services because they think that they will not able to afford medical costs. In addition, they often are afraid to approach any kind of public administration since they confuse any kind of public administration since they confuse the different level of administrations and wrongly believe that the police have a link with them.

Asylum seekers are submitted to an obligatory check-up at the entry and the exit from the Centres of Reception during the period of their asylum request. They are assisted by the OPFRA (Office for the Protection of refugees and stateless persons). A check-up is mandatory at the moment of the grant of the first residence permit. The purpose of the check-up is to find possible pathologies In the case of tuberculosis the patient has to be declared contagious and this excludes the possibility to stay in the French Territory. Serious mental illnesses are also considered, they could threatened public safety and security. Regarding the HIV virus, the possibility of individualization of the virus is anonymous and free.

C. Provisions for the guarantee of healthcare for illegally staying third country nationals at the moment of return.

The 1945 Ordinance on the Conditions for Entry and Residence of Foreign Nationals in France identifies 4 different types of voluntary return mechanisms (although they are not often used):

- Public Assistance for Reintegration (APR) established in 1984

It allows foreigners with a valid residence permit) to return in their home country carrying out a project with reintegration purpose.

- Invitation to Leave the National Territory

In case of rejection of the residence permit or asylum application, the third-country nationals are invited to contact the Office for International Migration (IOM) for travel arrangements and repatriation allowance.

- Repatriation for Humanitarian Purposes based on a Circular from the Ministry of Socials Affairs dated 14 September 1992

This concerns third country-nationals and their families living in precarious conditions wishing to return to their country of origin.

- Local Development/Migration Programme implemented since 1995.

With this programme, the returnee will be helped in the creation of individual enterprises.

In general, voluntary return assistance includes the cost of transport payment, the administrative assistance concerning the organization of the departure and the financial assistance per adult and per minor child.

The Ministry of Social Affairs, through the Office of International Migration (IOM), is responsible for implementing assisted voluntary programmes.
For the Invitation to leave the national country, it provides financial assistance in organizing departure (EUR 153 per adult and EUR 50 per minor child) and in order to ease the reintegration of the returnee (case by case basis) with the support of IOM.
For the Humanitarian repatriation, it consists in assisting destitute foreigners who are unable to return in their country of origin. Financial assistance prior to the departure (EUR 153 per adult and EUR 50 per minor child is provided) is provided.
For the Local Development/Migration Program, it provides assistance in offering technical and financial support, training and monitoring to nationals from Mali, Mauritania and Senegal. After submission of their proposals, they will be assisted within 6 months after their return.
For the AVR Programmes, only Afghans citizens residing in France are eligible to this programme since 2002.

As framework agreements with countries of origin or transit, a tripartite agreement between the French government, UNHCR and the Afghan Transitory Administration was signed in 2002.

3.2.4 Spain

Introduction:

The general perception of immigration in Spain is rather negative. During the 1990s Spain was subjected to a quick transformation from an emigration to an immigration country. Spain's migration policy is influenced by two major tendencies in public opinion, that is the public fear of being overrun by an uncontrollable wave of third-country migrants, which endanger the national welfare system and labour market and growing xenophobia and acts of violence against migrants63.

A. Procedures for return of illegally staying third country national

Law 4/2000 on the Rights and Freedoms of Foreigner in Spain and their Integration came into effect in January 2000. This Law clearly focuses on integration and the political and social rights extended to non-EU foreigners, as well as for its recognition of the permanent dimension of immigration. Under its Greco Plan in the year 2001 Spain established four basic lines of action:

- A coordinated overall framework for immigration as a desirable phenomenon for Spain within the context of the European Union
- Integration of foreign residents and their families as active contributors to the growth of Spain
- Admission regulation to ensure peaceful coexistence within Spanish society
- Management of the shelter scheme for refugees and displaced persons

In October 2003 a third reform of the Spanish Aliens Law was introduced. The main adopted changes were the introduction of a three-month visa allowing entry into Spain for the purpose of seeking a regular job, the tightening of the rules on family reunion and additional measures to

[63] The racist acts of violence at Ca n' Anglada (Province of Barcelona) in 1999 and at El Ejido (Almeria, Andalusia) in 2000.

combat illegal entry such as penal sanctions for traffickers and employers of undocumented migrants. The Ministry of Interior has also been granted access to data of local residents registration offices and social security authorities in order to locate undocumented migrants.

Spain has signed readmission agreements with Morocco, Colombia, Ecuador, the Dominican Republic, Poland, Romania and Nigeria. They regulate labour opportunities and provide for the communication of employment offers, the assessment of professional requirements, travel and reception. Furthermore the agreements have special provisions for seasonal workers and measure to facilitate their return to their home countries.

FORCED RETURN

Spanish law foresees that return of persons without a valid residence permit has to be executed within 72 hours of the order of expulsion. Staying illegally in Spain can be sanctioned with fine that varies from € 300 to € 6.000. Once the asylum application is rejected, the person becomes an illegal resident, if he/she does not obey the order to leave.

Spanish legislation distinguishes between three kinds of removal:

- Rejection at the border – immediate removal at the latest within 72 hours.
- Expulsion within the territory of Spain – foreigners in irregular circumstances to depart on their own volition within 15 days of notification.
- Deportation order that includes a prohibition on re-entering a European Union Member State territory for three, five or ten years – enforced as soon as possible.

The Spanish central government installed the Ministry of Interior as its main migration management agency.

DETENTION

Detention is considered to be an exceptional measure and special accommodation centres are used for this purpose. A foreigner may be maintained for 72 hours without judicial authorization. The maximum period for detention, with judicial authorization is 40 days. Detention of asylum seekers normally occurs at the border.

Rejected asylum seekers are detained in special Removal Centres. Minor children are placed with the competent agencies of Minors Protection in a special centre for refugee minors in Madrid. In some cases however, after a favourable report from the Public Prosecutor, the judge can authorize the children to stay with their parents if the Detention Centre provides special facilities for families.

EXPULSION AND DEPORTATION

Expulsion is normally ordered for the following cases:

- Undocumented aliens sentenced for offences punishable by imprisonment, except in exceptional cases.
- Undocumented migrants convicted of offences punishable by expulsion

Undocumented immigrants sentenced to less than six years of prison can be expelled from Spain with a prohibition to return for ten years. Five to ten years imprisonment are foreseen for trafficking for the purpose of exploitation of trafficked person. Up to twelve years imprisonment are foreseen for female genital mutilation. A removal decision is suspended in the following cases:

- Aliens applying for asylum
- Vulnerable persons (pregnant women, elderly, sick persons, etc…)
- Foreigners collaborating in investigations concerning trafficking and illegal immigration or other matters of public interest.
- Asylum seekers who are rejected but cannot be repatriated due to an unsafe situation in their countries of origin.

The travel documents of deported or expelled migrants are stamped to prohibit them from re-entering Spain for a period of three to ten years. Escorts are always used for removals by air, in order to ensure safety of the aircraft and minimize disruption for other passengers. The escorts are always police officers and two per detainee.

B. Provisions for the guarantee of healthcare for illegally staying third country nationals while in the Member States.

The Law 4/2000 in the article 12 of the Title I, section I foresees the same rights to healthcare for illegally staying third country nationals as for Spanish inhabitants in the following cases:

- urgency of contraction of a grave disease or of the accidents (independently of the cause of accident).

Healthcare for illegally staying third country nationals till 18 years old and pregnant women during the pregnancy, the childbirth and the period after the birth is guaranteed as well.

This law has been amended by Law 8/2000 and by the Royal Decree 2393/2004 of the Ministry of Foreign Affairs in Spain, but no additional provisions with regard to the guarantee of healthcare for illegally staying third country nationals have been added.

The order of the Health Consultancy of Andalusia, 20th July 2006, published in Official Gazette of Andalusia provides the Collaboration Agreement between the Ministry and trade unions and non-governmental entities from provincial level healthcare to immigrants and it is in the line with the above mentioned laws.

The organisations encharged with the provisions for the guarantee of healthcare for illegally staying third country nationals are Consultancy of Healthcare and Regional Healthcare Services, depending on Self-governing Municipalities, the same organization charged with the provision of healthcare for Spanish inhabitants.

Non-governmental organizations such as CRE in Madrid, or Cruz Roja Española (Red Cross in Spain) and Médicos sin fronteras (Doctors without borders) deal with the provision of healthcare to illegally staying third country nationals..

The organization Médicos sin fronteras (Doctors without borders) help the populations living in difficult conditions, realize the vaccine and the prevention campaigns on contagious diseases. This association collaborates with the Ministry of Health.

The organization Red Averroes units 19 countries working for the access of the immigrants to Spanish healthcare system.

C. Provisions for the guarantee of healthcare for illegally staying third country nationals at the moment of return.

The Spanish Law does not make differences between the guarantee of healthcare for illegally staying country nationals while in the Member State and at the moment of return. Provisions for the guarantee of healthcare for illegally staying third country nationals are valid for two cases and are defined in the Law 4/2000, Law 8/2000 and in the Royal Decree 2393/2004 of the Ministry of Foreign Affairs and in the Order from 20th July 2006 of the Health Consultancy of Andalusia mentioned above.

The organisations charged with the provisions for the guarantee of healthcare for illegally staying third country nationals at the moment of return are Consultancy of Healthcare and Regional Healthcare Services, depending on Self-governing Municipalities, the same organization charged with the provision of healthcare for Spanish habitants and illegally staying third country nationals during their stay in Spain.

Non-governmental organisations such as organisation CEISCAT and organisation OIM have set in place a number of ad hoc procedures for dealing with returnees.
For example, the organisation OIM (Organisación Internacional para las Migraciones) assists illegally staying third country nationals during the whole return process, ensures the vaccine and pays the flight ticket to the country of origin.

Assisted Voluntary Return Programmes in Spain are not implemented through a central agency and are funded by the Ministry of Labour and Social Affairs. Free assistance is guaranteed by non-governmental organisation during the whole return process and the necessary help to facilitate the reintegration in the country of origin is provided. The following non-governmental organizations are responsible for Assisted Voluntary Return Programmes:

Cáritas Española
ACCEM
Cruz Roja Española
MPDL (Movimiento por la Paz, el Desarme y la Libertad)
OIM (Organisación Internacional para las Migraciones)
Rescate.

The Spanish Commission on Alien Affairs also runs an assisted voluntary return programme specifically for Kosovo Albanians. The programme provides assistance and funding towards obtaining the necessary travel documentation and travel arrangements, as well as a grant of € 385 per adult (over 18 years) and € 89 for those under the age of 18.
The Spanish Red Cross also operates an assisted voluntary return programme, which is open to third-country nationals resident in Spain for more than nine months.

The main countries of origin of applicants who have submitted an application for voluntary return to the selection Commission are Ecuador, Colombia, Bolivia and Argentina. Other regions of return include eastern Europe and sub-Saharan Africa.

Prime Minister of Spain, José Luis Rodríguez Zapatero expressed support for the EU's Return Directive – a policy that allows member states to hold undocumented migrants, including minors, for up to 18 months, and, if deported, bans them from returning. The government is also expending greater resources on preventing migrant-laden boats from reaching Spanish shores, and more frequently deporting those who land. The Spanish government with a very restrictive immigrant policy is struggling to find a balance between limiting immigration and protecting human rights.

3.2.5 Italy

Introduction:

The phenomenon of immigration into Italy began relatively late, after the oil crisis of 1973-84 when England, Germany and especially the neighbouring country of France closed their frontiers to immigration. This resulted in migratory flows being partly "diverted" towards southern Europe, with Italy functioning as a transit country for other destinations for a number of years. The 1981 census revealed an unexpectedly "high" number of foreign residents (210,937) and foreigners present within the country (109,841). The first massive influx of foreigners occurred between 1984-89, when 700-800,000 people entered Italy. Of these, 300-350,000 entered or remained in Italy without a valid stay permit. These figures introduce two important aspects of Italian immigration: intense, high-volume flows; a large number of illegal immigrants.

During the 1980's, Italy and Germany received the largest flows of immigration in Europe. In the period 1992-2000, the average increase in Italian flows was 11.4%. In 1999, Italy (101,200), together with Germany (204,800) and England (161,500), had the greatest increase in foreign-born residents (Eurostat). Italy's long maritime border and proximity to some of the main asylum sending countries in Europe, led to an influx of undocumented migrants, which still continues to challenge the Italian government. In august 2002, the government passed legislation to regulate immigration and in September adopted a decree to provide for the regularization of undocumented immigrants already in the country. Since the 1980's there has been a succession of regularization programmes in Italy.

A. Procedures for return of illegally staying third country national

Italy's migration policy is focused on regulating the entry of migrant workers by a quota system and on combating trafficking. The Italian Quota System aims at limiting the number of incoming third-country nationals. It favours specific countries especially those who have bilateral agreements with Italy.
The 1990 Aliens Act (Martelli Law) sets out the basic rules for admission and asylum processing. It represents Italy's first comprehensive immigration legislation. The Aliens Act of 1998 limited immigrant admission through quotas. In September 2002 the Bossi-Fini law came into force introducing the following new clauses with respect to the 1998 Immigration Act:

- Mandatory employer-immigrant contracts
- Stricter deportation practices
- Amnesty for illegal immigrants who have worked and lived in the country for over 3 months
- New provincial immigration offices to help manage immigrant worker and family reunification cases
- Legalization of two types of irregular immigrants: those employed as domestic workers and home-helpers or as dependent workers.

On the 22nd May 2008 the Italian Cabinet of Ministers approved the so called "security package". A set of new rules applicable to immigrants were established as follows:

A Legislative Decree increases the prison sentence for immigrants in Italy illegally. If an illegal immigrant commits a crime, his/her sentence will be increased by one third. It is possible to deport an immigrant who has been given up to two years prison sentence. Before it was only possible to deport those who had been given a 10 year sentence. There are heavy penalties for landlords who

rent apartments to illegal immigrants. Apart from confiscation of the apartment, the landlord also risks a prison sentence ranging from six months to three years, and a fine ranging from 10,000 to 50,000 euros.

The Government has also prepared a separate bill making illegal immigration a crime. Those who enter Italian territory illegally are punishable by a prison sentence ranging from six months to four years. The maximum period for detaining illegal immigrants in the temporary reception centres, while waiting for identification and deportation, has been increased from 60 days to 18 months. A judge will, however, have to approve further detention every two months. A foreign spouse will only acquire Italian citizenship after living regularly in Italy for two years after marriage, and not after six months as before. Those who live abroad will qualify for Italian citizenship after three years of marriage. But if the couple has children, then this period will reduced by half. Money transfer agencies have to ask for and make a copy of the sender's ID and Permit of Stay. If the sender doesn't have the Permit of Stay, the money transfer agency will be required to forward the person's personal data to the police. Those who fail to do this will risk having their license withdrawn. The Security Package also puts forward a change of denomination of the so called Centres of Temporary Permanence and Assistance (CPT, CPA). The same structures are substituted with the new denomination "centres of identification and expulsion".

The following institutions in Italy are responsible for involuntary return:

The Ministry of Welfare determines annually the quotas for admission of third-country nationals and funds specific projects in favour of third-country nationals. Its General Directorate for Immigration is responsible for monitoring immigration, including permits, entries, quotas and regularizations, planning the annual quotas for foreign workers in agriculture and tourism, stipulating bilateral agreements on migration and assist in drafting legislation and consultation with the Parliament.
The Ministry of Interior regulates migration in general. Both police and prefectures implement the regularization and the local Immigration Councils come under the Ministry of Interior's responsibility. The territorial Immigration Council is a provincial forum, where immigration-related issues and trends are discussed and coordinated with local integration programmes.

Italy has readmission agreements with all its neighbouring countries. Readmision agreements have been signed with Algeria, Austria, Bulgaria, Croatia, Estonia, France, Yugoslavia, Georgia, Greece, Hungary, Latvia, Lithuania, Macedonia, Romania, Slovakia, Slovenia, Spain and Switzerland. Preferential quotas have been established for Albania, Argentina, Morocco, Egypt, Nigeria, Moldova, Sri Lanka and Tunisia.

ASYLUM PROCEDURE

Italy does not have any specific legislation for refugees or asylum-seekers. In the majority of cases, political asylum is regulated by Article 1 of the Italian Law n. 39 of February 28, 1989, and by a few articles of the Bossi-Fini Act of 2002. The 1989 law abrogated the Italian clause to the Geneva Convention limited refugee status exclusively to persons from authoritarian countries in Europe. This law did not contain any provisions defining the rights of asylum seekers, but focused on processing procedures. The Dublin Convention of 1990 (ratified by Italy in 1992, but only in effect since 1997) introduced a second norm by which a request for asylum can be refused if such a request has already been approved by a country which guarantees political and civil rights.
The Bossi-Fini Law of 2002 introduces the National and the Territorial Commissions, which are entrusted with local asylum processing. The new regulations provide for a decentralized, yet centrally coordinated asylum system.

B. Provisions for the guarantee of healthcare for illegally staying third country nationals while in the Member States.

Article 32 of the Italian Constitution (1948) envisages a wide area of protection and in particular the right to health extended to all individuals, the right to health as individual and collective right and as a right to enjoy free treatment for people in need. According to the Italian Immigration Act (art. 35) all migrants resident lawfully and unlawfully in Italy can benefit from "urgent and essential healthcare and treatments (also continuous treatments). Urgent and essential treatments refers to health services, including the diagnosis and the treatment of pathologies that can in the future cause higher damages to health or risks for the life. Furthermore Article 35 establishes that all migrants can also benefit from prevention medicine programmes. In particular special protection for pregnancy is guaranteed to all migrant women at the same level with respect to Italian citizens. Migrant women are also given a special residence permit that lasts until the child is 6 months old. Moreover, a recent decision of the High Court of Appeal (Corte di Cassazione) extended the expulsion ban also to the husbands who live together with pregnant women that is in a condition of irregular stay. Special attention is also given to the health of minor migrants .They can benefit from a special protection, are entitled to receive a residence permit and cannot be expelled. Vaccination, international prophylaxis interventions, general prophylaxis, diagnosis and the treatment of all infective diseases are also guaranteed to illegal residents.

The Security Package does not amend the content of Art. 35 of the Italian Immigration Act. All irregular migrants will keep receiving essential and urgent care and doctors will not have to denounce them to the police. Besides the pregnant migrant women, that, as mentioned before, are granted special residence permits, all the other irregular migrants, while being treated, remain in an irregular situation. Residence permit for reasons of health, in fact is generally granted only to people that, still in their country of origin, request and obtain a special Visa for health reasons, because they can not be adequately treated in their country. Unfortunately in some cases, treatments are time consuming (HIV/TBC treatments) and it is very difficult for sick migrants to stay irregularly on the Italian territory for long periods of time. In fact, even if they have access to healthcare, as irregular migrants, they can not work, hire an apartment and so on. Lawyers and NGOs have struggled in order to find a solution for all those cases that need special assistance that is, irregular migrants that have to remain on the territory for special treatments for a long time and that cannot continue the treatment in their country of origin. Article 5, clause 6 of the Italian Immigration Act prevents the Police from refusing the release of a residence permit when there are serious humanitarian reasons, while Article 11 of its implementation rules (D.P.R. 394/99) establishes that, based on the documentation provided related to serious and objective personal conditions, the Police can issue to the irregular migrant a residence permit for humanitarian reasons. Thanks to this interpretation many sick migrants have been granted regular stay, in particular migrants affected by HIV in treatment with antiretroviral agents, migrants with cancer requiring chemotherapy; renal failure requiring haemodialysis and also migrants with mental disorders requiring intensive treatments.

C. Provisions for the guarantee of healthcare for illegally staying third country nationals at the moment of return.

As explained in the chapter above the following procedures are followed by Italy for non - EU nationals without a residence permit, and for residence permit applicants.

- No medical screening needs to be carried out for residence permit purposes.

- Immigrants hosted at temporary reception centres are entitled to receive emergency treatments and, if needed, to be admitted at suitable health care facilities.
- Non-EU citizens who do not comply with regulations concerning entry and residence requirements are entitled to receive health care services at national health service facilities, including:
  1. urgent out-patient and in-patient care (that cannot be delayed without causing harm to the person's health or life), or essential care (health care, diagnostic, and therapeutic services related to diseases which, even though they are not dangerous, may nevertheless cause some major harm to the person's health or life) in case of diseases or accidents;
  2. prevention services and related care in order to safeguard individual and community health, as described in Sections a)-b)-c)-d)-e) of Paragraph 3, Art. 35 of the Italian Legislative Decree 286/98, specifying what follows:
     - same pregnancy and motherhood protection treatments as those provided to Italian women;
     - protection of under-age persons' health;
     - compulsory vaccinations within the scope of community prevention measures authorized by regional authorities;
     - international preventative treatments;
     - prevention, diagnosis and treatment of infectious diseases and possible clearing of related focuses.
- Health care services provided to immigrants who are unable to pay for them are free of charge.
- Access to health care facilities does not imply any reporting to public safety authorities, except for those instances when reporting is deemed compulsory.

The return process of asylum seekers, persons with refugee status and victims of trafficking is normally assisted by IOM the leading agency entrusted by the Italian government with the implementation of return programmes in close cooperation with ANCI, the network of Italian Municipalities. The Ministry of Interior in cooperation with IOM and a number of counter-trafficking organisations manages the return programme for victims of trafficking (especially women and children). A number of local authorities and NGOs also operate some return programmes, particularly relating to unaccompanied minors. Under current legislation, such programmes are not open to other irregular migrants.

The main state-funded voluntary return programme has been the National Asylum Programme. It was established in 2001 by the Ministry of the Interior, ANCI and UNHCR with funding from the European Refugee Fund to provide a systematic and comprehensive structure to support reception, integration and voluntary return. This programme provides pre-departure assistance, transport assistance (i.e: documents and formalities, transit and reception assistance) and reintegration assistance (i.e. pre-departure grant amounting to € 200 per person and a post-arrival reintegration grant amounting to € 1450 per case/family. IOM Rome is also assisting the voluntary return and reintegration of women and minors, victims of trafficking, through counselling, legal and medical services, education and labour reinsertion assistance.

4. Policy and Procedures at Third Country Level for the provision of healthcare to returnees

4.1 Introduction

The Green Paper on a Community Return Policy on Illegal Residents[64] when considering Return programmes states that experience has shown that it was often very important for the project to have **a follow up component in the country of origin** otherwise the returnee had a tendency to attempt to go back to the host country in the face of physical hardship, lack of employment or other difficulties.

Aside from some individual initiatives[65], preliminary research has shown that reintegration tends to focus on incentives such as providing support with housing, employment, training or direct financial benefits.

The provision of healthcare, by its very nature, is an area where a follow-up component in the country of origin could prove vital.

In general, it seems that re-admission agreements concluding with the country of return are considered quite effective. [66] However, more from the point of view of ensuring that the person effectively leaves the territory of the Member State rather than in terms of how the expulsion is conducted and whether a follow-up support is provided to the returnee.

This section examines the importance of collaboration between the returning and receiving State and in this regard, presents a number of examples of cooperation experiences between hosting countries and countries of origin of returnees and good practice in the provision of healthcare in third countries.

4.2 **Examples of Cooperation Experiences and Good Practice in selected third countries**

One of the activities foreseen by the HE.RE project was to carry out a **mapping exercise of experiences in Member States and third countries** (e.g. pilot projects) and documents (e.g. protocols) with relation to the provision of healthcare to returnees. For this purpose, an ad hoc questionnaire was devised for the mapping exercise. This questionnaire was established specifically for the purposes of this project. It was pilot tested and adjusted accordingly. The questionnaire has been sent by post or by e-mail to 300 contacts mainly provided by IOM Vienna and the project partners. It has been well received and it has provided us with some important information as to what is happening in terms of the provision of healthcare to returnees in the Member States and at the moment of their return to their country of origin.

An interesting example of good practice has been offered by IOM Moldova that very kindly took some time to complete the questionnaire. The Chisinau Protection and Assistance Centre in Moldova provides temporary residence, psychological counselling, social support, medical assistance, legal support and recreational activities to trafficked persons and their children, unaccompanied minors and individuals at risk of trafficking. The Centre is often the first contact point in Moldova for returnees who return after a dreadful trafficking experience abroad. The Centre has been operational since 2001 and provides crisis interventions in a safe and friendly environment. The centre provides crisis intervention in a safe and friendly environment.

[64] COM (2002) 175 final
[65] IOM foresees medical elements such as rehabilitation of healthcare infrastructure as part of its reintegration assistance.
[66] Higgins. I, "Migration and Asylum Law and Policy in the European Union – FIDE National Reports 2004", Cambridge University Press 2004

Beneficiaries normally stay in this centre for four weeks. If needed, sometimes beneficiaries can stay for a longer period up to 6 months. Upon registration beneficiaries are offered to participate on a voluntary basis in the medical programme which begins with a three-day diagnostic phase. All participants normally take part to this medical programme which covers general and specific examinations and treatments including gynaecological and STDs, HIV/AIDS test and counselling. Diagnosis and counselling take place mostly within the Centre, whereas most testing and some treatments are conducted in a partner hospital. The medical component of the Rehabilitation program is supported by a number of highly qualified professionals in charge of the specific activities within the medical component:

• Medical coordinator/general practitioner in charge of arranging individual medical programmes and general assessment, facilitating contacts/patients, referrals for examination/ treatment within the Rehabilitation Centre;

• Medical nurse providing medical escort and overall support during stay at the Centre;

• Consultant - Psychiatrist - the Principal Psychiatrist, Assistant Professor at the Psychiatry and Narcology Department of State University of Medicine of the Republic of Moldova; consultants are available within the Rehabilitation Centre on an on-call basis, based on referral by medical coordinator.

• Consultant Dermatologist-Venereologist - practitioner doctor at Municipal Dermato - Venereological Hospital, professor at State University of Medicine and Pharmacy of the Republic of Moldova; has regular consultation hours within the Centre

The medical component includes the following activities:

- All Victims of Trafficking referred to the Rehabilitation Centre receive direct health care, and if necessary, patients shall be referred for specialized treatment to an appropriate health facility;
- All beneficiaries received standardized general medical exams, and bases on referral also received gynaecological care and blood tests, including the diagnosis and treatment of sexually transmitted infections;
- Voluntary HIV testing and counselling; All beneficiaries with positive HIV tests receive free of charge ARV treatment under the UNAIDS programme;
- Diagnosis and treatment for hepatitis B and C as well as other chronic diseases;
- Pre- and post-natal care for pregnant women;
- Reproductive and sexual health treatment including STIs (sexually transmissible infections); based on positive STI tests, patients treatment administered by a venereologist at the same location.
- Treatment for malnutrition, paediatric cases and ophthalmology carried out according to the 25 medical standards for Victims of Trafficking, developed and adopted by IOM in coordination with the Moldovan Ministry of Public Health;
- Expanded dental care – given that a high percentage of beneficiaries who applied for medical assistance were in need of dental care, as a direct result of beatings, torture and malnutrition suffered during the trafficking experience;

While receiving care, victims are hosted in the rehabilitation centre's bedrooms, located on the same hallway as the medical examination rooms, and receive medical care and monitoring by the nurse and medical coordinator. Victims are fully informed about their conditions and options and must give their consent before undergoing any treatment, medical test or examination. The Rehabilitation Centre staff is trained in sensitivity, safety, and confidentiality requirements; on reproductive health counselling, on treatment of some sexually transmitted diseases (STDs), on HIV counselling, on general mental health/well being counselling and on post-traumatic stress syndrome; trafficking and human rights issues; and national and international efforts to combat trafficking. Additional trainings are scheduled.

The major problems and challenges encountered among the Rehabilitation Centre beneficiaries are chronic and untreatable diseases, as well as mental disorders. Such cases require long-term medical attention, which needs to be administered at home or in long-term residential institutions. At the moment Centre struggles to provide more long term medical assistance to beneficiaries after they leave the Rehabilitation Centre. Such medical assistance is to be delivered throughout Moldova by a

relative small professional team based in Chisinau. Consequently the Centre seeks to integrate long-term medical services into a National System.
IOM medical officers have developed best-practices for medical treatment, protocols, statistics, and psychological and vocational counselling. For example, a special questionnaire is used by IOM Moldova in Counter Trafficking programmes in order to examine if a returnee is fit for travelling (FIT FOR TRAVEL PROGRAMME). This questionnaire is used with the purpose of a medical examination and is usually administered by an examining physician. The questionnaire is divided in two parts. The first part is to be completed by the returnee and the second part is to be filled in by the examining physician. A preliminary assessment of the returnee data is requested (i.e. Family name, given names, previous family name, sex, date of birth, years old, nationality, birthplace).
In order to identify the health status of the returnee the following questions are asked:

1. Are you currently receiving any form of medical treatment?
2. Have you ever lost your consciousness?
3. Please indicate any concerns or questions you have about your health.
4. Have you ever had epileptic convulsions or seizure?
5. Underline any of the following symptoms you have experienced in the last 3 months? Difficulty in sleeping lasting more than 3 consecutive days, undue tiredness, feeling sad and despondent, crying, despairing thoughts about your life, unable to cope with work, unduly irritable with colleagues or people your live with, problems in your sexual relations, frequent headaches, taking a drink to help cope with a difficult situation, feeling panicky, avoiding particular situations.
6. How long ago have you had fever?
7. Have you ever been hospitalized?
8. Have you had any of the following symptoms? - coughing or spitting blood, blood in your stools, blood in your urine, chest pain, palpitation, jaundice, back pain, fainting, loss of consciousness, change in your behaviour? Underline the symptoms concerned and give details.
9. For Women: Have you been pregnant? If yes, how many times?
10. Have you ever undergone abortion? How many times?
11. Do you have child? How many?
12. Do you drink any alcohol? Has your alcohol consumption ? Please specify average units/day 1 unit = 1dl wine or 2,5 dl beer or 0,25 dl spirits.
13. Did you ever use any drogue or psycho-active substance? If yes, please specify ! _____ Give the date and the name of substance you took last time.
14. Do you smoke? (cigarettes, cigars, pipe). If yes, please specify average. _____/day.

The second part of the questionnaire is completed by an examining physician on the basis of the patient's examination. The following questions are identified for an accurate examination:

1) Date of the examination:
2) Height cm
3) Weight kg
4) Does the patient appear healthy?
5) Are there any deformities?
6) Are there any obvious symptoms (e.g. dyspnoea , cough, tremor)?

SKIN

a) Jaundice or cyanosis?
b) Rash, ulcers, pigmentation?
c) Scars?

EYES (vision)

a) Pupils; equal? ……. Regular?..... Reflexes?.....

MOUTH –NECK

Tongue: …….. Teeth :……. Pharynx:…… Thyroid:……

CARDIOVASCULAR SYSTEM

Pulse rate: …….. Pulse rhythm :……..
Blood pressure:…… Systolic…….mmHg* Diastolic ……mmHg*
Heart Auscultation…….. Varicose veins…… Pedal arteries: right…….left…….

RESPIRATORY SYSTEM

Movement/percussion/auscultation: ……..

DIGESTIVE SYSTEM

Enlargement of liver or spleen? ……..
Palpation of abdomen ……
Any hernia? …….

OTHER SYSTEMS

Lymph nodes: ……..
Breasts:…….
Spine:……
Extremities: ……
Articulations: ……..
Tendon reflexes: ……

MENTAL STATE :……

GINECOLOGICAL EXAMINATION:

Vulva and perineal areas for warts, inflammation, sores, swelling: ……..
Specify:…….
Speculum examination:
Vagina:……

Cervix: ……
Bimanual examination:……..

STD tests: …….. **Specify: ……**

Treatment:

Chlamidia: ……..
Gonorrea: ……
Siphilis:…….
Trichomoniasis:…….

Result of control test: ……

*** If the systolic blood pressure exceeds 150 mm Hg or the diastolic blood pressure exceeds 90mmHg when first measured, another recording should be carried out at the end of the examination.**

Result …../……. mmHg

CONCLUSIONS

1) Overall health status and fit to fly/travel …… FIT TO TRAVEL
2) Conditions requiring treatment …….
3) Risk factors requiring action/further medical consultation ……..

Name of the examining physician (in block capitals): …….
Address: ……
Tel. :……..
Fax: …….
E-mail: ……
Signature:…….
Date:……..

The questionnaire is really exhaustive, represents an important piece of documentation on the health status of returnee and provides information that could be useful for the prosecution of medical treatments.

Another remarkable response to the mapping questionnaire was sent by the NGO PRAKSIS, "PROGRAMS OF DEVELOPMENT, SUPPORT AND MEDICAL COOPERATION" located in Athens. PRAKSIS' main target is the creation, application and implementation of social and medical act programs. Those benefited from PRAKSIS' activities are Greek indigents, economic immigrants, asylum seekers/refugees and every socially excluded group, such as drug-addicts, gypsies, trafficking victims, homeless, ex-prisoners, street children and fellow human beings with little or no access to health services, psychosocial and legal support. PRAKSIS programs include providing medical/ pharmaceutical care, psychological and law support in new-comers seeking asylum, refugees and immigrants, people moving back, street children, ex-prisoners and other socially excluded groups. A significant number of PRAKSIS' beneficiaries visit PRAKSIS' programs for medical advice. At the same time, PRAKSIS provides health care to returnees, with a

particular focus on vulnerable groups (women, children and disabled persons), prior to departure from country of illegal residence.
PRAKSIS has not experienced significant problems with regard to health related issues when returning third country nationals. In a few cases a request of stay due to humanitarian purposes was made by the organisation for returnees with serious health problems. PRAKSIS underlines that in general, Middle Asia countries face the most problematic circumstances of return, due to their specific economic, political and social conditions (wars, civil wars, terrorism, poverty etc). PRAKSIS also described the main challenges and problems that the organisation had to face when dealing with returnees. Language barriers for example lead up to the limited information and knowledge of the third country nationals in Greece about their rights and obligations according the law. What is more, language problems are responsible for the limited access of the third country nationals to public services. In many cases bureaucracy leads up to slow and not immediate satisfaction of the needs of the target group by the public services. The services applied by the public organizations and/ or bodies have significant time delays, a problem that develops dissatisfaction within the target group. Civil servants (at hospitals and public authorities and organizations in general) lack on knowledge about the legal context concerning the refugees or immigrants in Greece and about legal or administrational procedures concerning the third country nationals. The limited sensitisation and information of the public opinion about migration issues sometimes causes phenomena of xenophobia and/or racism among the general population.

A very interesting report[67] has been prepared by IOM in January 2009 with regard to the possibilities and constraints of voluntary return for African rejected asylum seekers and irregular migrants living with HIV in the Netherlands. This report examines under which conditions HIV-positive migrants may be able to return voluntarily in a manner that allows for a sustainable situation in the country of origin. This report is primarily based on interviews with twelve migrants living with HIV in the Netherlands and consultations with stakeholders in the following five African countries: Sierra Leone, Ghana, Nigeria, Angola, Cameroon.
Most of the migrants living with HIV have responded that for a sustainable return and reintegration the following conditions that are seen as very closely interlinked are necessary:

1) Availability of necessary medical treatment (antiretroviral drugs, testing, treatment of opportunistic infections) and *durable access* to such treatment;
2) Possibility of the returnee to acquire a sufficient income to cover regular expenses (food, accommodation, education, etc.) for him/herself and the family *and* to cover all costs related to medical treatment (also including transport to hospital, health insurance fees, etc.);
3) Possibility of the returnee to find a place within a supportive social network (family, peers, etc.) and has the ability to cope with possible stigma from society as a whole.

Assistance by third parties (IOM, civil society actors) in the return process is most likely to be useful with regard to:

1) information gathering on medical, economic and social conditions in the countries of origin and provision of referrals;
2) providing resources to assist the development of income generating activities for the returnee and/or his/her family. A stable economic situation is a precondition for durable access to medical treatment and can have a very positive impact on the social support network available to the returnee.

Dutch immigration policies are not always conducive to making voluntary return a viable option for migrants living with HIV for the following reasons:

[67] Health, Hope and Home? January 2009 IOM

1) There is an enormous gap between the legal focus on *availability* of medical treatment in countries of origin, and the basis for decisions of migrants to return, which is related to de facto *accessibility* of this treatment.
2) Returning without any option to come back to the Netherlands deprives returnees of a medical (and sometimes socio-economic) 'safety net'. This is a major deterrent for migrants living with HIV to think about return.
3) The consequences of not having a legal status (e.g. no access to social benefits, housing, etc.) can force migrants living with HIV in a very basic 'survival mode', which does not allow for reflection on future options, including voluntary return.

With regard to the provision of healthcare this report provides an overview of the availability and access to medical care and medical treatments for HIV-positive migrants in the following countries of origin: Sierra Leone, Ghana, Nigeria, Angola, Cameroon. Treatments are generally available in capitals and in the hospitals but the access to treatment and care is problematic in rural areas. Some medication are provided free of charge but this free treatment programme usually does not cover the treatment of opportunistic infections. In some cases the unavailability of qualified health care staff is recognised as a problem. Lack of nutrition has also been identified as a major impediment to adherence of HIV treatment. To sum up this report explores the possibilities of providing assistance to help create conditions for voluntary return but also critically discuss constraints that are likely to be encountered in this return. This report clearly underlines as an example of good practice that it is essential for HIV-positive migrants to be educated regarding their health status and to be given good and reliable information on the available situation in their country of origin prior to return.

The Federal Office for Migration in Germany also completed the He.Re project Mapping questionnaire. The questionnaire explains that the 2008 Reintegration and Emigration Programme for Asylum Seekers in Germany and the Government Assisted Repatriation Programme are Humanitarian Assistance Programmes of the Government of the Federal Republic of Germany and its Federal States which provide financial assistance to destitute returnees and third country migrants. Those programmes support voluntary return and third country migration, offer start up and represent a steering instrument for migration movements. The REAG/GARP programme is administered by IOM implemented in cooperation with local and regional authorities, voluntary welfare organizations, specialized NGOs and the United Nations High Commissioner for Refugees (UNHCR).
The program supports the orderly preparation and implementation of voluntary return and third country migration. Prerequisite is that neither the departing person him/herself nor any other person or agency responsible for his/her support can provide the necessary financial support. Any costs incurred during preparation for the departure (e.g. fees for passports or visas, trips to consular interviews or to the airport upon departure and the like) must be borne by the responsible social welfare office or any other responsible authority or NGO. In the event of a third country migration, the corresponding visas have to be presented on behalf of the Ministry of the Interior and the relevant Federal States. REAG/GARP applications can only be submitted through one of the local or regional authorities (e.g. social welfare office, aliens´ affairs offices), voluntary welfare agencies, specialized NGOs or by the UNHCR.

The following types of assistance are granted within the framework of the program:

a) payment of transportation costs (by plane, train or bus)

b) petrol allowance: € 205,- per car

c) travel assistance: up to the amount of € 100,- for adults/youths and up to € 50,- for children under 12 years of age, depending on the Federal State where the migrants are registered

Moreover, the Government Assisted Repatriation Programme provides a cash start-up of € 200 per adult/youth and € 100 per child under the age of 12 (max. € 600 per family) for nationals of:

Algeria, Angola, China, DR Congo, Ethiopia, Ghana, India, Lebanon, Morocco, Nigeria, Pakistan, Sri Lanka, Syria, and Vietnam. For nationals of Armenia, Azerbaijan, Georgia, Iran, Macedonia, Montenegro, Russian Federation, Serbia (incl. Kosovo) except Serbian and Roma minorities from Kosovo, Turkey and Ukraine a cash start up of € 250 per adult/youth and € 125 per child under the age of 12 (max. € 750 per family) is provided. A cash start up of € 500 per adult/youth and € 250 per child under the age of 12 (max. € 1.500 per family) for nationals of Afghanistan, Iraq and Serbia (only for Serbian and Roma minorities from Kosovo) is foreseen.

Only the following target groups are eligible to receive REAG/GARP assistance

- Persons that are eligible under § 1 of the German asylum seekers' benefit act;
- Foreigners whose sojourn is due to the law of nations, humanitarian or political reasons;
- Victims of trafficking or forced prostitution
- Recognized refugees

All returnees/third country migrants, upon departure must be at least in possession of a border crossing certificate as well as valid travel documents. For returnees returning to the Serbian province of Kosovo, an EU-Laissez-Passer can be issued. In case of land return to Montenegro, Serbia, Kosovo and Bosnia Herzegovina a so-called return vignette is additionally necessary.
By signing the REAG/GARP application, the applying persons confirm that they intend to return voluntarily to their home country or migrate to a third country. They have to waive their right to appeal
or remedy and also abandon their sojourn status if required. There should be no indications for a permanent return to the Federal Republic of Germany. There is no legal claim for REAG/GARP assistance.
Since 1 January 2004, citizens from member states of the European Union (EU) will no longer be granted REAG/GARP assistance. This does not apply to victims of trafficking or forced prostitution.

4.3 **Conclusions**

The presented examples of Cooperation Experiences and Good Practice in selected third countries demonstrate that return assistance is complementary to migrants' own efforts to try and realise their own return and that a follow up component in the country of origin is essential. Investigating available reintegration options in the country of origin is essential for returnees who intend to return to their country of origin. The situation in the country of origin normally requires some extensive information gathering activities. Some information (i.e. the existence of a social network) can be provided by the returnee, but he/she might not always be aware of the current state of treatment options and/or economic opportunities in the area where he/she wants to return. Assistance providers normally play an important role in the return process. They usually complement migrant's activities by mobilising or providing resources that are vital for returnees. It is worth mentioning that the implementation of certain assistance activities often depends on the availability of resources at the disposal of the organisations providing assistance.
Taking into consideration the above mentioned good practice examples and the expressed needs of returnees, a set of recommendations for good practice in the provision of healthcare to returnees are presented in the following pages.

5. Recommendations for Good Practice

5.1 Introduction

This report does not intend to propose a detail of what type and level of healthcare should be afforded to returnees. It does however propose that this is an area that requires investigation and definition and puts forward the different dimensions of the matter that need to be considered when devising a suitable approach.

5.2 Key Concepts

Healthcare

The concept of health is a complex issue. Internationally recognised definitions classify health in terms of an ideal (*complete physical, mental and social well-being),* in more concrete terms *(reduction in mortality, morbidity and disability due to detectable disease or disorder, and an increase in the perceived level of health*) and in relation to the level of healthcare that is provided (*primary, secondary or tertiary healthcare).*

For certain, all Member States struggle with providing healthcare to its citizens and the costs of public health represent a significant financial burden in all Member States but this does not excuse it from its human rights obligation to provide healthcare to those persons in their territory regardless of their administrative status. Indeed, whatever the approach of the Member State, the same level of healthcare that is afforded to citizens of the Member State should also be guaranteed to a returnee whether partaking in a voluntary or forced return procedure. Furthermore, specific healthcare and medical programmes that reflect the needs of returnee in the context of the return process need to be developed. Such programmes should be based on global approach taking into account socio-economic, educational and cultural issues.

Vulnerable Groups

Physical and mental problems of returnees can be aggravated by a condition of vulnerability of certain persons. It is important not to limit the definition of a vulnerable group only to a certain number of pre-defined categories but to consider also the wider context of the return process and to assess vulnerability on a case by case basis, against all the elements that form an integral part of the return process, from the state of well-being of the person themselves (social, economic and cultural background) to all the aspects of the return operation itself, including the approach of the returning and the receiving state.

Stakeholders

The management of the return process may be organized by the immigration authorities, the judiciary, delegated to an NGO or a combination of all the above. Whatever the format, **it is important to identify** a similar management structure in the receiving State to ensure the continuity of the return process. For example, if the judiciary is responsible for the return process in the returning state, then it will find it easier to dialogue with an equivalent counterpart rather than an NGO or social services in the country of origin.

5.3 Policy and Practice

Common Protocols for the Provision of Healthcare to returnees

It is necessary to define a common protocol for the EU with some basic parameters for the type of healthcare that should be provided to a returnee prior to departure, during the journey home and in the country of origin. Such a protocol should be elaborated as the result of a consultative process with **all** of the stakeholders involved which takes into account the obligations of both the returning

and receiving state in terms of human rights obligations as well as the practicalities of fulfilling the provision of such healthcare to returnees.

Such protocols could include provisions for:

Medical Check-ups
Medical check-ups should consider both the mental and physical health of the returnee.

Background checks
In order to carry out the most appropriate medical check-ups on returnees, it is important to establish the history of the returnee that includes the following information:

- the journey undertaken to reach the country where they have been residing illegally (length of journey, conditions of journey, countries of transit etc.)
- the status of the returnee prior to a voluntary of forced return procedure; (illegally-resident third-country national/asylum seeker whose refugee application has been rejected..)
- the length of stay in the country where they are residing illegally; (immediately or after a number of years living illegally in the host country, overstayers)
- the conditions of living while in the country where they are residing illegally (in a temporary residence centre, a detention centre or in a more regular setting alongside citizens of the State)

Medical Card
The solution found in Valencia for providing medical care to all those in need of it – in the form of the "Solidarity Card" which enables illegally-resident third-country national living in this region to receive the same medical care as other citizens – points to one possible way of guaranteeing access to healthcare. Such a card, which foresees that immigrants' personal details are registered on a file which is available to all public health centers, if introduced at a European level, would also facilitate a homogeneous collection of data regarding the types of health problems faced by illegal-resident third-country nationals at a European level (see below).

Medical Treatments
Medical care should not be limited to short-term treatments sufficient to "Patch-up" a returnee until they arrive in the returning State, but should provide long-term solutions. Tuberculosis, for example, is an increasingly common pathology amongst illegally-resident third-country nationals and requires long-term treatment. Measures are needed to ensure that everyone who is diagnosed with tuberculosis receives adequate treatment and completes it, especially in view of the fact that it may not always be possible to secure the continuation of TB treatment in the country of origin.

Information Packs
Information packs could be provided to returnees, and translated into their own language where necessary. The provision of information should be line with the indications below (Information)

5.4 Training and Information

Capacity Building and exchange of information

All actors involved in the return process should be informed, trained and motivated in order to fulfil their responsibilities especially when it comes to addressing the needs of vulnerable groups. Training courses should be organised on the identification and treatment of vulnerable groups as well as on-site training on inclusion provided. Returnees who have participated in voluntary return scheme could be invited to participate as trainers in such courses.

In particular, health care managers and providers working with the authorities in the return process need to be made aware of any legislative developments concerning access to health care for irregular immigrants/returnees so that entitlements are well-defined and there is little room for discretion in the implementation process.

Information

Information should be correct and easily understandable, accessible by all and appropriate to meet the different needs of vulnerable groups. Information should also be positive, encouraging, helpful and financially affordable to everybody. In addition, the effectiveness of information should be monitored. Examples of the type of information that would be useful in the return process are as follows:

- Availability of translated medical records
- "Medical Passport" in case of specific healthcare needs during transport which require the administration of certain medicines
- Contact details of suitable structures in countries of origin in order to follow-up on any specific health care needs

Statistics and Data

Statistics on most frequent types of healthcare problems are essential to allow the competent services that deal with the return process to adequately prepare to address these problems (e.g agreements with appropriate healthcare facilitates, suitably qualified staff). It would therefore be useful to record in a systematic way, at an EU level, the types of pathologies most frequently identified amongst illegal immigrants. This is essential information for the elaboration of an appropriate protocol of the type of mental and physical check-ups that should be provided to returnees prior to departure. At the same time, data protection provisions, especially the EU Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data have to be respected.

5.5 Cooperation and Funding

Cooperation

It is essential to promote constant, permanent and regular collaboration and partnership among all stakeholders. This can be achieved through a stable international network that includes also members from third countries for an effective exchange of experience and knowledge. Such a network will be more effective if based on consolidated regional (e.g European Migration Network) and national networks in each state.

It is important also to set up dedicated institutions for research, expert advice, advocacy and information dissemination, which are of paramount importance in increasing a correct understanding of the matter at all levels.

Funding

Healthcare is an expensive business and if the above-mentioned recommendations are to be implemented, a certain investment of funds on the part of all stakeholders is required. Governments and/or funding agencies could also make funding requests contingent on changes being made from a policy and practice standpoint taking into consideration the healthcare needs of vulnerable groups of returnees.

GLOSSARY:

Alien: In EU-context: A person who is not a national of a Member State of the European Communities.
Globally: A person who is not a national of a given state (IOM Glossary on Migration)
Synonym: Foreigner, non-citizen, non-national

Assisted Voluntary Return: Refers specifically to the provision of (logistical, financial and/or other material) assistance for the Voluntary Return of a returnee.

Asylum (Right of): The right of the State, in virtue of its territorial sovereignty and in the exercise of its discretion, to allow a non-national to enter and reside, and to resist the exercise of jurisdiction by any State over that individual.

Asylum applicant: Means a third country national or a stateless person who has made an application for asylum in respect of which a final decision has not yet been taken. Synonym: Asylum seeker

Country of origin: The country (or countries) of which a migrant has citizenship. In refugee context, from Directive 2004/83/EC, this means the country (or countries) of nationality or, for stateless persons, of former habitual residence.

Country of Return: Whilst not defined in legal terms, this refers to a third country (country of origin, transit or other). In most cases, it is the country of origin to which a return is made, but this definition is used here in order to indicate other (possible) destinations.

Country of Transit: The country through which migratory flows (legal or illegal) move. In EU context, this is taken to mean, the country (or countries) from which a migrant enters the EU if this is different from their country of origin. For example, a Russian national (country of origin: Russia) entering the EU via Ukraine (country of transit).

Deportation: The act of a State in the exercise of its sovereignty in removing an alien from its territory to a certain place after refusal of admission or termination of permission to remain.

Detention: Restriction on freedom of movement, usually through enforced confinement, of persons prior to court appearance, after conviction and sentence, pending sentence, pending a decision on refugee status, admission to or removal from the State, or for purposes of internment, for example, in times of national emergency.

Entry ban: Means an administrative or judicial decision or act preventing entry into and stay in the territory of the Member States for a specified period, accompanied by a return decision.

Expulsion: For the purpose of this Glossary, considered to be a synonym for Removal, i.e. the execution of the obligation to return.

Forced Return: Defined as “the compulsory return of an individual to the country of origin, transit or third country [country of return], on the basis of an administrative or juridical act.

Health care, or healthcare, refers to the treatment and management of illness, and the preservation of health through services offered by the medical, dental, pharmaceutical, clinical laboratory sciences (in vitro diagnostics), nursing, and allied health professions. Health care embraces all the goods and services designed to promote health, including "preventive, curative and palliative interventions, whether directed to individuals or to populations.

Illegal stay: Means the presence on the territory of a Member State, of a third-country national who does not fulfil, or no longer fulfils the conditions of entry as set out in Article 5 of the Schengen Borders Code or other conditions for entry, stay or residence in that Member State.

Immigrant: In European context, means a person undertaking an immigration.

Immigration (illegal) : The movement of a person to a new place of residence or transit using irregular or illegal means, without valid documents or carrying false documents.
Synonym: Irregular immigration, clandestine immigration

Irregular Migrant: Refers to a person who enters a country, usually in search of employment, without the necessary documents and permits. Synonym: undocumented / illegal migrant, clandestine immigrant.

Migrant worker: Refers to a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.

Migrant: A broader-term of an immigrant and emigrant, referring to a person who leaves one country or region to settle in another, often in search of a better life.

Migration: Refers to the crossing of the boundary of a political or administrative unit for a certain minimum period of time. It includes the movement of refugees, displaced persons, uprooted people as well as economic migrants.

Primary care: the first level of care, generally provided in an ambulatory setting (as opposed to secondary and tertiary care which would normally be hospital-based).

Racism: Racism shall mean the belief that a ground such as race, colour, language, religion, nationality or national or ethnic origin justifies contempt for a person or a group of persons, or the notion of superiority of a person or a group of persons. Since all human beings belong to the same species, theories based on the existence of different "races" should be rejected. However, including this term in the definition ensures that those persons who are generally and erroneously perceived as belonging to "another race" are not excluded from the protection provided for by the legislation.

Re-Admission Agreement: An agreement between the EU and/or Member State with a third country, on the basis of reciprocity, establishing rapid and effective procedures for the identification and safe and orderly return of persons who do not, or no longer, fulfil the conditions for entry to, presence in, or residence on the territories of the third country or one of the Member States of the European Union, and to facilitate the transit of such persons in a spirit of cooperation.

Refoulement (Non-): Means the protection of refugees from being returned to places where their lives or freedoms could be threatened.

Refoulement: The return by a State, in any manner whatsoever, of an individual to the territory of another State in which he or she may be persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion; or would run the risk of torture.

Refoulement includes any action having the effect of returning the individual to a State, including expulsion, deportation, extradition, rejection at the frontier, extra-territorial interception and physical return. The prohibition of refoulement of refugees (the principle of non-refoulement) is laid down by article 33 CSR51 and is also generally considered to be part of customary international law.

Refugee status: Means the status granted by a Member State to a person who is a refugee and is admitted as such to the territory of that Member State.

Refugee: Means third country national or stateless person within the meaning of Article 1A of the Geneva Convention and authorised to reside as such on the territory of a Member State. Also a third country national who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion or membership of a particular social group, is outside the country of nationality and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country, or a stateless person, who, being outside of the country of former habitual residence for the same reasons as mentioned before, is unable or, owing to such fear, unwilling to return to it, and to whom Article 12 of directive 2004/83/ECdoes not apply.

Reintegration: Re-inclusion or re-incorporation of a person into a group or a process, e.g. of a migrant into the society of his/her country of return.

Residence permit: Means any authorisation issued by the authorities of a Member State allowing a third country national to stay legally in its territory, in accordance with the provisions of Article 1(2)(a) of Council Regulation (EC) No 1030/2002 of 13 June 2002 laying down a uniform format for residence permits for third country nationals.

Return decision: Means an administrative or judicial decision or act, stating or declaring the stay of a third-country national to be illegal and imposing or stating an obligation to Return.

Return: Means the process of going back to one's country of origin, transit or another third country, in which the third-country national concerned will be accepted, whether in voluntary compliance with an obligation to return, or enforced.

Returnee: Means a non-EU/EEA (i.e. third country) national migrant who moves to a Country of Return, whether voluntary or forced.

Secondary care: Referral services in the first instance provide secondary health care, which is of a more specialized kind than can be offered at the most peripheral level, for example radiographic diagnosis, general surgery, care of women with complications of pregnancy or childbirth, and diagnosis and treatment of uncommon or severe diseases. This kind of care is provided by trained staff in such institutions as district or provincial hospitals.

Smuggling of migrants: The procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a Member State of which the person is not a national or a permanent resident.

Tertiary care: Specialized care that requires highly specific facilities and the attention of highly specialized health workers, for example, for neurosurgery or heart surgery.

Third Country: A country or territory other than one within the European Community.

Trafficking in human beings: Means the recruitment, transportation, transfer, harbouring, subsequent reception of a person, including exchange or transfer of control over that person, where:
(1) use is made of coercion, force or threat, including abduction, or
(2) use is made of deceit or fraud, or
(3) there is an abuse of authority or of a position of vulnerability, which is such that the person has no real and acceptable alternative but to submit to the abuse involved, or
(4) payments or benefits are given or received to achieve the consent of a person having control over another person for the purpose of exploitation of that person's labour or services, including at least forced or compulsory labour or services, slavery or practices similar to slavery or servitude,
or for the purpose of the exploitation of the prostitution of others or other forms of sexual exploitation, including in pornography.
Unaccompanied Minors: Third country nationals or stateless persons below the age of eighteen, who arrive on the territory of the Member States unaccompanied by an adult responsible for them whether by law or custom, and for as long as they are not effectively taken into the care of such a person, or minors who are left unaccompanied after they have entered the territory of the Member States.

Voluntary return: Defined as "the assisted or independent return to the country of origin, transit or third country, based on the free will of the returnee."

Vulnerable persons/groups: in the context of return, vulnerable persons can include minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence and victims of trafficking. Furthermore, the vulnerability of the said persons needs to be assessed against all the elements.

Xenophobia: Stands for 'fear of the stranger', but usually the term is taken to mean 'hatred of strangers' . Xenophobia can be understood as "an attitudinal orientation of hostility against non-natives in a given population". Xenophobia can be defined as the "attitudes, prejudices and behaviour that reject, exclude and often vilify persons, based on the perception that they are outsiders or foreigners to the community, society or national identity."
Xenophobia and racism often overlap, but are distinct phenomena. Whereas racism usually entails distinction based on physical characteristic differences, such as skin colour, hair type, facial features, etc, xenophobia implies behaviour based on the idea that the other is foreign to or originates from outside the community or nation. Because differences in physical characteristics are often taken to distinguish the 'other' from the common community, it is often difficult to differentiate between racism and xenophobia as motivations for behaviour. At the same time, expression of xenophobia may occur against people of identical physical characteristics when such people arrive, return or migrate to States or areas where occupants consider them outsiders.

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