Health Policy 114 (2014) 215–225

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Sexual and reproductive health of migrants: Does the EU care?☆

Ines Keygnaert[a,*,1], Aurore Guieu[a,1], Gorik Ooms[a,b,1,2], Nicole Vettenburg[c,3], Marleen Temmerman[a,1], Kristien Roelens[a,1]

[a] ICRH – Faculty of Medicine & Health Sciences, Ghent University, Ghent, Belgium
[b] Institute of Tropical Medicine, Department of Public Health, Antwerp, Belgium
[c] Department of Social Welfare Studies, Ghent University, Ghent, Belgium

ARTICLE INFO

Article history:
Received 24 April 2013
Received in revised form 7 October 2013
Accepted 26 October 2013

Keywords:
Migrants
Sexual health
Inequity
Human rights
European Union
Policy development
Migration

ABSTRACT

The European Union (EU) refers to health as a human right in many internal and external communications, policies and agreements, defending its universality. In parallel, specific health needs of migrants originating from outside the EU have been acknowledged. Yet, their right to health and in particular sexual and reproductive health (SRH) is currently not ensured throughout the EU. This paper reflects on the results of a comprehensive literature review on migrants' SRH in the EU applying the Critical Interpretive Synthesis review method.

We highlight the discrepancy between a proclaimed rights-based approach to health and actual obstacles to migrants' attainment of good SRH. Uncertainties on entitlements of diverse migrant groups are fuelled by unclear legal provisions, creating significant barriers to access health systems in general and SRH services in particular. Furthermore, the rare strategies addressing migrants' health fail to address sexual health and are generally limited to perinatal care and HIV screening. Thus, future European public health policy-making should not only strongly encourage its Member States to ensure equal access to health care for migrants as for EU citizens, but also promote migrants' SRH effectively through a holistic and inclusive approach in SRH policies, prevention and care.

1. Introduction

Migration policy has become a prime area of EU activity with the development of the "Common European Asylum System", five-year migration programmes, and partnerships with neighbouring countries.

However, there exists no consensual definition of "migrants" yet [1], which makes international comparison of data on these heterogeneous groups and the interpretation of legal, policy and academic documents a hazardous endeavour [2,3]. A frequently used terminology in migration policies is based on legal residence statuses, distinguishing regular (documented), whose entry and residence are authorized by State authorities; from irregular (undocumented) migrants. The former refers to people with a temporary residence authorization, as asylum seekers, foreign

* Corresponding author. Tel.: +32 485 96 14 04.
E-mail addresses: ines.keygnaert@ugent.be (I. Keygnaert), aurore.guieu@ugent.be (A. Guieu), Gorik.ooms@ugent.be, gooms@itg.be (G. Ooms), nicole.vettenburg@ugent.be (N. Vettenburg), marleen.temmerman@ugent.be (M. Temmerman), kristien.roelens@ugent.be (K. Roelens).
[1] ICRH-Ugent, De Pintelaan 185 P3, 9000 Ghent, Belgium. Tel.: +32 9332 35 64; fax: + 32 9332 38 67.
[2] Institute of Tropical Medicine, Department of Public Health, Nationalestraat 155, 2000 Antwerp, Belgium. Tel.: +32 3 247 66 48.
[3] Sociale Agogiek Ugent, H. Dunantlaan 2, 9000 Ghent, Belgium. Tel.: +32 9264 64 02; fax: +32 9264 64 93.

0168-8510/$ – see front matter © 2013 The Authors. Published by Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.healthpol.2013.10.007

students and temporary migrant workers, but also people with long-term resident or citizenship status as permanent immigrants, official family reunification migrants and refugees. Irregular/undocumented migrants are persons who enter a host country without a legal authorization or overstay authorized entry as tourists, foreign students, temporary contract workers or rejected asylum seekers.

Regular migrants constitute an essential part of the European population. A mere 10% of the EU population in 2011 was born outside their country of residence, two thirds of them descending from a non EU Member State (MS) [4,5]. "Third-country" or "extra-EU" nationals accounted in 2011 for 6.6% (33.3 million) of the EU population against 4.4% in 2001 [5]. According to UNHCR, the 27 EU MS received between 2008 and 2012 2.6 asylum seekers per 1000 inhabitants with 296.700 new asylum claims in 2012, reaffirming the recent upward trend with an increase of 7% compared to 2011 [6]. Refugee status was granted to 14% of those applicants [7]. Accounting for irregular migration in the EU is extremely difficult, however the latest Frontex quarterly report (July–September 2012) states that more migrants were denied entry in the EU than in any other quarter since the peak of 2009 [8], where estimates were made of 1.9 million to 3.8 million irregular migrants in the EU [9].

Academic and grey literature are unanimous: the health and health needs of extra-EU migrants may differ greatly from those of the general European population [2,10–15]. Upon arrival, migrants' general health status might be comparatively better ("the healthy migrant effect") [16] yet depending on the policies and practices of the host country regarding migrants, they may experience discrimination and a drop in their socio-economic status. This does not only enhance their vulnerability, defined by the UN as "*a state of high exposure to certain risks and uncertainties, in combination with reduced ability to protect or defend oneself against those risks and uncertainties and cope with their negative consequences*" [11] but it also induces ill-health [17,18]. Their sexual and reproductive health (SRH) needs are considered "*particularly pressing*" [11]. Compared to the general EU population, extra-EU migrant women are less often screened for cervical and breast cancer [19], have less access to family planning and contraception [20] and a lower uptake of gynaecological healthcare [21], are more at risk of unintended pregnancies, pay fewer and later antenatal care visits [22,23], have poorer pregnancy outcomes (notably more induced abortions and complications except for lower birth weight for which current findings differ from migrant group, generation and EU host country) [20,22,24,25] and have higher infant and maternal mortality rates [20,23]. Both migrant women and men are more at risk of sexually transmitted infections (STIs), including HIV and hepatitis B [2,19,24,26,27] and of sexual violence [18]. Migrants also access general and SRH services far less than EU citizens [15] and health practitioners stress that "*some come only to die*" [28]. Female migrant sex workers (MSWs) are more at risk of acute STIs compared to non-migrant colleagues in high-income countries [29]. The EU Agency for Fundamental Rights (FRA) consequently stresses that migrants' SRH vulnerability and specific needs should be considered in a public health perspective within EU societies [30]. Yet, those topics remain largely ignored.

Since the 1946 Constitution of the World Health Organization (WHO) and the 1948 Universal Declaration of Human Rights (UDHR) the enjoyment of the highest attainable standard of health is put forward as a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition [31]. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966. [31]. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued "General Comment 14", an authoritative explanation of the Article 12.1 on the right to health of the ICESCR. It states in paragraph 12 (b) that governments have legal obligations to ensure that "*health facilities, goods and services are accessible to all, especially the most vulnerable of marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds*" [32], defined as "*race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status"* (§18 [32]). In addition, the CESCR specified that States have an obligation to respect the right to health "*by refraining from denying or limiting equal access (. . .) for all persons, including (. . .) asylum seekers and illegal immigrants, to preventive, curative and rehabilitative health services*" [31]. All 27 EU MS ratified the "International Bill of Human Rights" (= UDHR, ICESCR and ICCPR) obliging them to comply. The EU prides itself as a promoter of human rights stating "[the EU sees] *human rights as universal and indivisible. It actively promotes and defends them both within its borders and when engaging in relations with non-EU countries*" [33]. It consequently adopted its Charter of Fundamental Rights in 2000. Yet, the Charter allows national conditioning for the right to health.

The first comprehensive framework on sexual health (SH) was drawn at the 1994 International Conference on Population and Development (ICPD) in Cairo, which put SH forward as a human right. The ICPD final declaration stated that "*for sexual health to be attained and maintained, sexual rights of all persons must be respected, protected and fulfilled*" [34], which was re-emphasized in the General Comment no. 14 [32]. Furthermore, the ICPD Action Plan fostered specific actions to overcome migrants' vulnerability and was endorsed by the EU MS. Hence, SH was defined as "*a state of physical, emotional, mental and social well-being related to sexuality [and] not merely the absence of disease, dysfunction or infirmity*" [34]. While SH has long been considered subsumed to reproductive health, the WHO proposed in 2010 to reverse this understanding by stating that "*sexual health requires a positive, respectful approach to sexuality and sexual relationships and that sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction*" [35]. It re-asserted the need to ensure SRH through a "*positive approach*" [35] stressing good health and well-being aspects rather than the absence of diseases. This also echoes research defining