MIGRATION AND HEALTH

SOCIAL DETERMINANTS AND MIGRANT HEALTH

LIVING CONDITIONS, MIGRATION CONDITIONS, EXPOSURE TO VIOLENCE,

PROBLEMS ACCESSING HEALTHCARE

QUALI-QUANTITATIVE SURVEY IN NIGER, TUNISIA AND MOROCCO

2017-2018

DOCTORS OF THE WORLD

Summary

DEFINITION OF THE SURVEY

- **OBJECTIVE**

  To give an overview of the health and determinants of migrant health based on the testimonies of migrant populations encountered by the Doctors of the World teams and/or its partners in four strategic locations along current migration routes.

- **TARGET POPULATION**

  461 migrants answered a questionnaire, and 18 migrant focus group. sessions were held. A migrant **was considered as a person who had migrated from their country of origin to the location in which the survey was taken, regardless of whether that location was their final destination, and irrespective of their reason for departing, situation or duration of stay.**

- **LOCATIONS**

  The survey was carried out in **four different places**:
  - Agadez in Niger (100 surveys, 8 focus groups)
  - Tunis in Tunisia (181 surveys, 2 focus groups)
  - Oujda in Morocco (80 surveys, 4 focus groups)
  - Rabat in Morocco (100 surveys, 4 focus groups)

- **PERIOD**

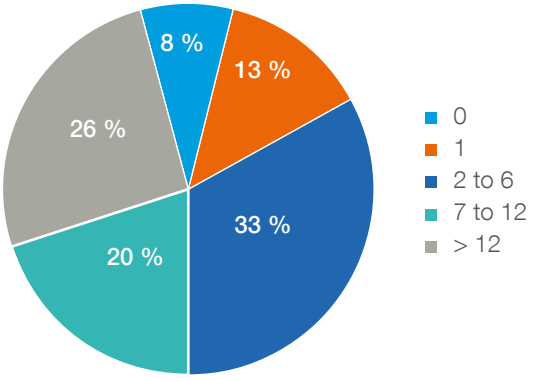
  Data was collected between **December 2017 and March 2018.**

KEY FINDINGS:

- **PROFILE OF MIGRANTS SURVEYED:**
  - 59% women, 41% men
  - Median age: 28 years old (14 to 62 years old) – 20 minors
  - Origin: 98.5% sub-Saharan Africa
  - Administrative status: 63% unregularised, 16.5% regularised, 9% asylum seekers, 3% on tourist or work visas, 8.5% other

- **JOURNEY DURATION:**

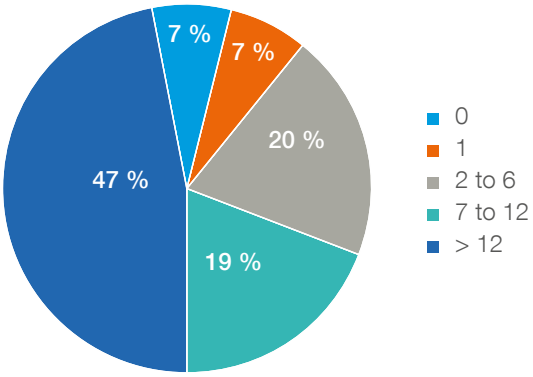
Journey duration (in months) n = 228



The length of migration was long. For nearly half (46%) of the migrants surveyed, it had already lasted more than six months.

- **DURATION OF STAY IN THE SURVEY LOCATION**

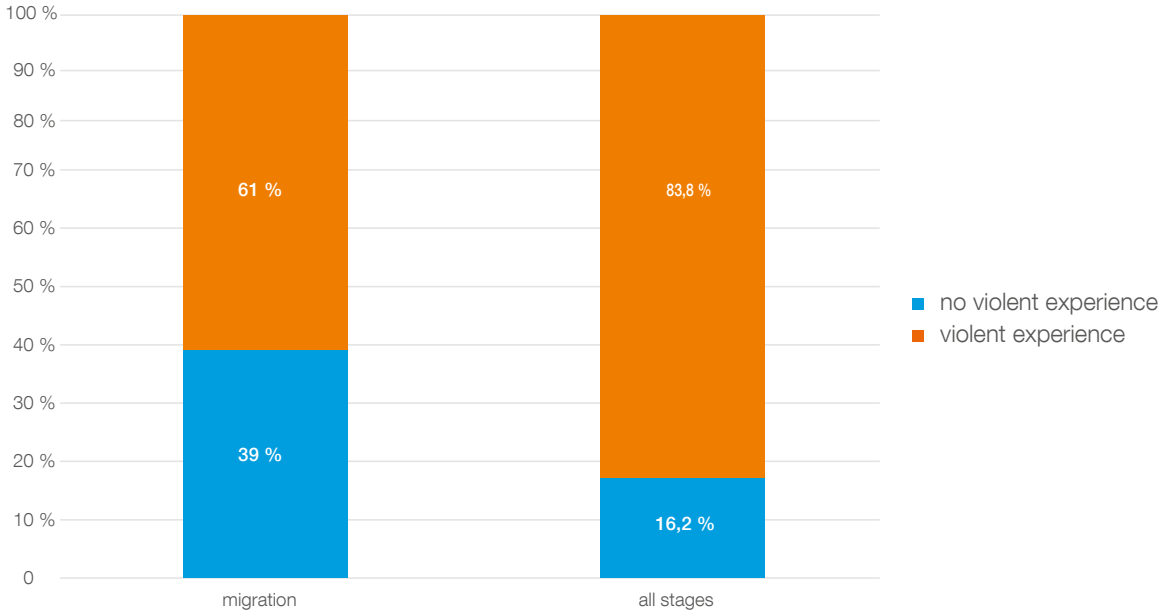
Stay duration (in months) n = 458



The duration of stay was highly variable, particularly depending on gender and on administrative status. It was generally very long; for nearly half (47%) of the migrants interviewed, it had already exceeded twelve months on the day of the survey.

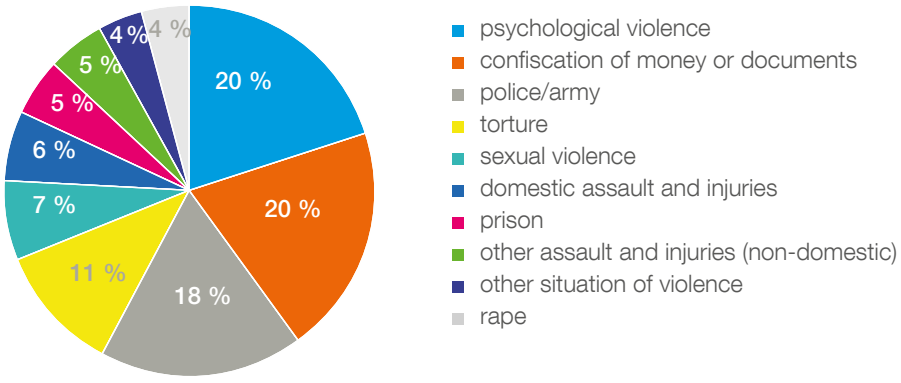
VIOLENCE

% of people who had experienced violence



83.8% of the respondents stated that they had experienced violence during their lifetime and 61% during the migration process.

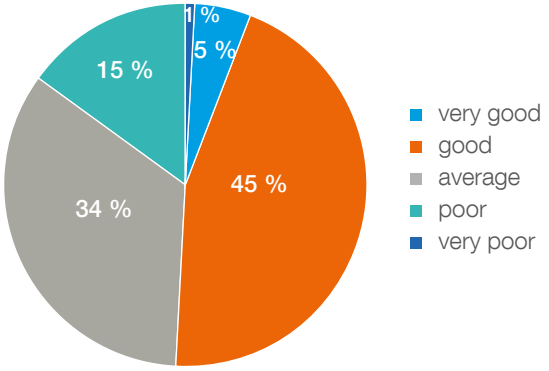
Breakdown of all violence reported by type



The three most common types of violence encountered at all stages of the migration process were psychological violence, and two types of institutional violence: confiscation of money and/or documents and violence by security forces, the police and/or the army. These three alone accounted for 58% of the violent experiences.
The profile of the violent experiences varied according to gender, and migration stage – country of origin, en route or survey country – particularly between the country of origin and the two others involved in the migration process.

HEALTH

HEALTH, % OF PEOPLE BY CATEGORY, N = 461

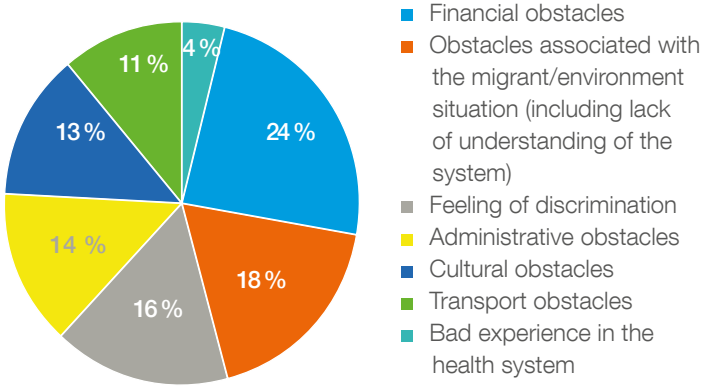


One in two of the migrants interviewed considered their health as not good, but rather perceived it as average to very poor.

ACCESS TO HEALTHCARE

Only 39% of migrants stated that they had not encountered any obstacles to accessing healthcare.

Breakdown of total reported healthcare barriers by type



The barriers to accessing healthcare varied, but the most frequently mentioned were financial obstacles, lack of understanding of the system and the feeling of discrimination. These three accounted for more than half of the obstacles mentioned.

CONCLUSIONS

Migration is a complex and variable phenomenon given the different migration circumstances. It is difficult, therefore, to generalise about migrant status. However, certain events seem highly recurrent during the migration process. These are, for example, violence, poor living conditions and difficulties accessing healthcare, all of which lead to a deterioration in health. For a more detailed analysis by country, please see **www.medecinsdumonde.be**

RECOMMANDATIONS

Based on these findings, Doctors of the World makes three types of recommendation: firstly, general recommendations concerning the structural context of migration; secondly, operational recommendations for players in the field of migration; and thirdly, recommendations for research to improve understanding of the factors that affect migrants' health.

1. Introduction

Doctors of the World is an international medical development NGO that is part of an international network. We provide medical assistance to vulnerable population groups in Belgium and around the world.

We want universal health coverage in which everyone has access to healthcare without barriers (financial, cultural, geographic, etc.).

To achieve our mission, we base our work on three pillars:

- ➔ *Medical care: provide populations with real access to healthcare.*
- ➔ *Support for change: more than just helping, we want to change things in the long term.*
- ➔ *Give testimony: we do not turn a blind eye. Thanks to our experience and our presence in the field, we lobby authorities (local, regional and (inter)national) using facts, figures and testimonies of realities on the ground.*

On this basis, Doctors of the World has developed health and migration programmes based on three principles: **providing medical, social and psychosocial care to people who need it, building the capacities of local medical staff to provide quality services and treatment, developing advocacy work on the barriers to healthcare access and on migrants' rights.** The goal of these projects is to identify and address migrants' vulnerabilities in the field of health.

Doctors of the World runs 'Health-Migration' projects in various countries. Through some of these projects and using the experience gained, a survey was conducted to collect a range of information on the profile of migrants, their health, and certain migration-related social determinants of health, from migrants encountered in several countries where Doctors of the World runs migrant projects.

In order to provide a framework for these aspects and a good understanding of the concepts and data discussed, it is important to remember the following:

The World Health Organization (WHO) states that:

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

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.'

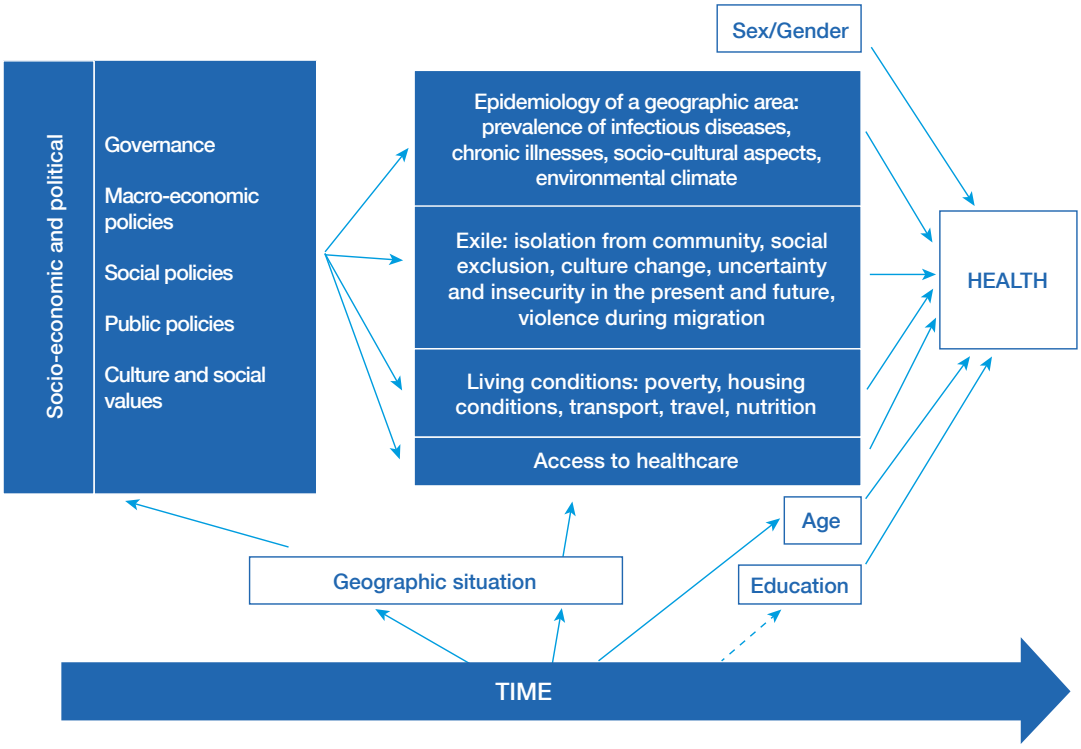
The migrant population is often young and in good health when starting the migration process. However, given the particular situation of migration and its circumstances, we can identify four aspects that increase vulnerability and have an impact on health.

These aspects are determinants of health as defined by the WHO:

'Social determinants of health are circumstances in which the individuals are born, grow up, live, work and age as well as the systems in place to address illness, its circumstances being determined by several forces: the economy, social policies and politics.'

The WHO and many publications consider migration to be a determinant of health combining a variety of factors (1,2).

At Doctors of the World, based on the notions provided in current literature and recommendations, particularly those by the WHO (1, 2, 3), we established a model that enabled us to categorise these factors, which are social determinants of migrants' health:



1. Exposure to certain diseases given the following factors: the higher prevalence of infectious diseases, chronic illnesses, socio-cultural aspects (dietary and buying habits, preventive or risky practices, 'traditional' practices, etc.) and environmental climate, which determine the specific epidemiology of a geographic area.
2. Aspects directly associated with exile: isolation from the community, change of culture, violence during migration, social exclusion, uncertainty and insecurity in the present and future. All these aspects have direct consequences on both physical and mental health.
3. Migrants' living conditions, which increase their direct exposure to the risks: housing with poor sanitation, travel conditions, working conditions, poverty, insufficient and poor-quality food.
4. Limited access to healthcare in the transit or host country, including barriers to healthcare access.

It is also important to **take into account the changing and evolving nature of all these factors** given the geographic movements of migrants and therefore change in context over time, and the progress of the migration process. This changing nature has an impact on one criterion that defines the quality of healthcare: **continuity, which is therefore difficult to achieve and often lacking**.

The other well-known social determinants of health, not specific to migrants, are age, sex and level of education.

As regards social determinants of health specific to migrants, we identified violent experiences, which are known to usually be inherent to the migration process. To define cases of violence in our survey, we used the WHO's definition of violence as a reference:

> *'Violence is the use of physical force, or threats against oneself, against others or against a group or community that result or may strongly result in trauma, psychological harm, ill development or death.'*

Violence is therefore understood as any intentional act against others, oneself, a group or a community.

2. Survey objectives

The goal of this survey was to give an **overview of the general health and of certain determinants of health, directly related with migration, of the migrant populations** that Doctors of the World encounters in its projects along the migration routes in sub-Saharan Africa and the Maghreb, with a focus on three key countries: Niger, Morocco and Tunisia.

This survey was conducted by Doctors of the World with the cooperation of a number of its partners in the field, which have expertise in migration and the local context. The objective was to gain a better understanding of migration conditions and their possible impact on health, and to **develop an argument to provide information or warnings about the health of these populations over the course of the migration process**.

The survey does not claim to be exhaustive or representative of all migration at the present time. However, the findings obtained and presented offer a good snapshot, at a given moment, of a situation that is evolving over time, concerning certain migrants currently encountered in a few of the projects being run by Doctors of the World.

This report aims to describe the actual situations experienced by migrants, through the presentation of concrete data from populations who are in certain critical conditions, along with testimonies of their experiences during their journey.

3. Survey methodology

The concept of the survey arose as a result of the project by the European Observatory whose report showed that **the majority of people concerned by the failure in universal healthcare coverage in Europe were migrants** (4). Because Doctors of the World runs migrant assistance projects, it felt it was important to improve knowledge on the issues associated with their health. The survey, therefore, was developed on the basis of the information in the European Observatory's report and knowledge of migrant issues.

It was divided into two parts, a questionnaire with closed questions for the **quantitative aspects**, and migrant focus groups to supplement the information with a **qualitative aspect**.

In addition to data on socio-demographics and on the perceived health of each individual, the questionnaire included certain key determinants of health associated with the migrant condition. These determinants were:

- **ADMINISTRATIVE STATUS** (residence permit, asylum seeker, tourist/work visa, recognised refugee, unregulated/undocumented, other, unknown)
- **JOURNEY DURATION** (time since leaving the country of origin, in months)
- **DURATION OF STAY** (time spent in the survey country up to the day of the survey, in months)
- **HOUSING** ('on the street or in emergency housing < 15 days', 'housed with an organisation or association > 15 days', 'ghetto, encampment, shanty town, squat', 'residing with family or friends', 'workplace', 'shared rental', 'staff housing', 'reception centre', 'other')
- **VIOLENCE EXPERIENCED** (war/armed conflict, prison, torture, police/army, domestic assault and injuries, other assault and injuries (non-domestic), sexual violence, rape, psychological violence, confiscation of money or documents, hunger, subject not discussed during the consultation)
- **BARRIERS TO ACCESS TO HEALTHCARE:** administrative obstacles (e.g. problem of lack of supporting documents for treatment), financial obstacles (e.g. consultation or treatment too expensive, no insurance, someone paid for me, no health cover, etc.), cultural obstacles (e.g. language barrier), transport obstacles (e.g. lack of familiarity with the town, lack of means of transport), obstacles associated with the migrant/environment situation (e.g. lack of understanding of the system, fear of arrest, trafficking network, etc.), bad experience in the system, feeling of discrimination, not attempted to visit a medical facility, no obstacles.

Note that for violent events, no definition was given concerning the different types of violence that were possible responses. This means that the responses were based on the perception of the migrants interviewed who decided which category best matched their perception of the experience. For example, police violence must be understood as an act, of any kind, that the migrant perceived as violence carried out by a member of the police force. For the other possible responses, they identified the nature of the violence, but not the perpetrator. So, for assaults and injuries (two types), torture, sexual violence (two types), psychological violence and the confiscation of documents and/or money, the perpetrator was not identified. It is possible, therefore, that there are overlaps between the nature and the perpetrator of the perceived violence and that the migrant made a selection in their response based on their perception of what seemed important to them.

Each focus group brought together several migrants in order to provide more detailed information on a number of indicators and/or themes. These included the circumstances concerning the reasons for migration, the migration journey, the violence experienced, the living conditions in the survey country, particularly housing, access to work, economic resources, access to healthcare, its barriers and the quality of healthcare, and their life plans. The goal of the focus groups was ultimately to impart some of their main experiences.

The questionnaires were presented, adapted and validated by the field teams prior to being used. The researchers were selected within each setting and were either members of Doctors of the World staff, or members of partner associations. They were trained, and were provided with instructions and a survey researcher guide.
The surveys were carried out in various locations depending on the projects, either in the Doctors of the World project's premises and/or in the residences and neighbourhoods known to be populated by migrants.

- In **Niger**, they were held in temporary migrant lodgings in **Agadez**, which are locally called 'ghettos' or 'homes'.
- In **Tunisia**, in **Tunis**, the people surveyed were those using the migrant project health services (no specifics of the project in terms of gender, additional vulnerability).
- In **Morocco**, in **Oujda**, the questionnaire was answered in the neighbourhoods populated by migrants. In **Rabat**, data was collected from those seeking treatment in the Doctors of the World health centre (treatment for pregnant women, victims of violence and children) as well as in migrant housing.

The target population of Doctors of the World and its partners **was all people who had migrated from their country of origin to the survey location, regardless of whether that location was their final destination, and irrespective of their reason for departing, situation or duration of stay**. No sampling method was applied; the people surveyed were those who met the criterion of migrant and who agreed to participate in the survey. It was, therefore, a non-random, opportunity sample.

Using this approach, data was collected from **468 people** using our survey research questionnaire in our organisation's various projects between **December 2017 and March 2018**.

Note that in Tunisia, the project was already using a tool that answered all these questions for any migrant seeking treatment within the project. The questionnaires, therefore, were not used, but the data exported from the tool for all the people who had visited the project during the given period was.

Of the 468 questionnaires, **461 were validated for analysis** (removal of six children aged 0–3 years in Tunisia who were considered unable to answer the questions given their age, and an 8-year-old child in Morocco whose profile was very different and is presented separately).

The focus groups were systematically coordinated by two researchers, one leading the discussions, and the other taking notes. All the conversations were also recorded.

During this survey, **ethical considerations were respected**. The migrants interviewed were informed about the objective and purpose of the survey and their consent was systematically obtained. The participants were guaranteed anonymity and the confidentiality of their data. The participants also had the possibility of withdrawing at any time.

All the data from the questionnaire was encoded in an Excel database. The focus group discussions were transcribed as text.

All the data was processed at Doctors of the World headquarters by a lead researcher, assisted by a think tank of people who knew the local conditions of the survey locations.

Using the data, several analyses were carried out. First, a **general study** was carried out, with no distinction between locations, based on the 461 surveys. Next, a **comparative analysis** between the four survey locations was carried out. Lastly, a **specific analysis** for each of the data collection areas was carried out.

The data concerning housing was not used as it was not relevant as regards the quality of the housing, which is the factor that could have a decisive impact on health.

Due to the intentional nature of violence, as defined by the WHO, which is our reference, and the format of the responses, which did not provide any information about the context, it was decided during the data analysis to remove hunger and responses about war and armed conflicts from the general analysis of violence. These two determinants will be examined separately in this report.

The reports provided by our project colleagues placed the information in context.

This survey, therefore, is quali-quantitative, but does not claim to be representative. It is, in fact, a snapshot **of a given situation at a specific moment in time**. It does not cover the entire migrant population around the world or even in a given region, in this case sub-Saharan Africa and the Maghreb. Nor is it a specific sample, given that the entire migrant population cannot be available due to its very nature, sometimes hidden and always changing. This survey is, however, very helpful in understanding the experience of migrants from all backgrounds. The figures in the survey **provide a detailed picture** of a certain reality, while its testimonies **give a human, living dimension to the data**.

4. Findings

A. GENERAL ANALYSIS OF THE FOUR LOCATIONS

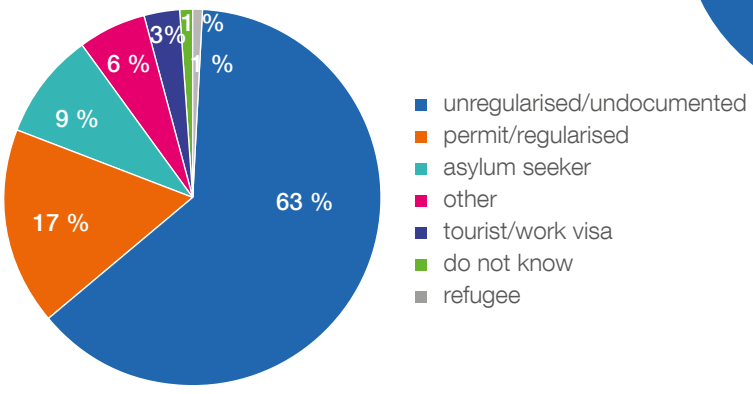
The data collected from 461 people in the four survey locations was analysed. These are broken down as follows: 100 people surveyed in Agadez, Niger, 181 in Tunis, Tunisia, 80 in Oujda, Morocco and 100 in Rabat, Morocco.

I. SOCIO-DEMOGRAPHIC CHARACTERISTICS

Of these people, 59% (272) were women and 41% (189) men. The median age was 28 years old, with a variation of 14 to 62 years old. Twenty of these were children, including fifteen unaccompanied foreign minors. These migrants mostly originated from sub-Saharan Africa (454/461).1 Of the total population surveyed, men and women combined, 55% originated from Côte d'Ivoire and Nigeria. The third most common country of origin was Guinea for the women and Cameroon for the men.

II. ADMINISTRATIVE STATUS

Administrative status n = 459

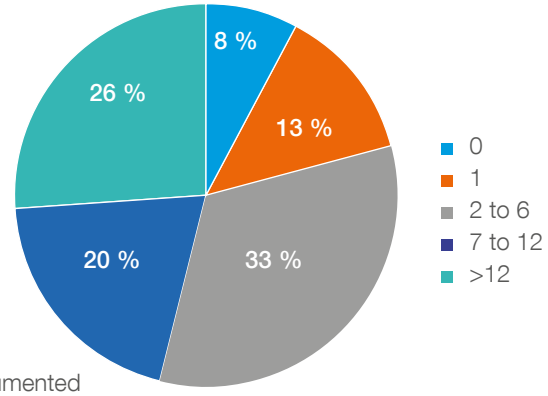


Concerning their administrative status, **289** (63%) were unregularised, compared with just **76** (16.5%) **regularised, 40** (9%) **asylum seekers** and **15** (3%) **tourist or work visas**. The others, in the minority (39 = 8.5%), either had **refugee status, another document** or **did not know** their status.

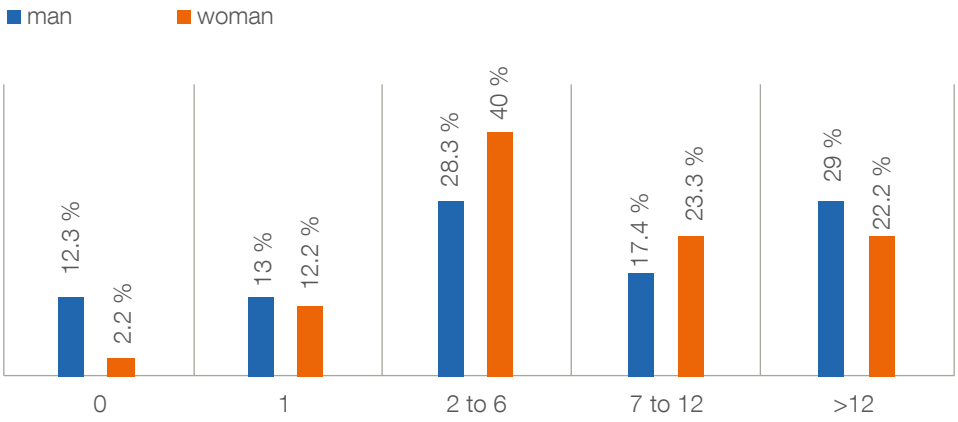
III. JOURNEY DURATION

In **Tunisia** and for the majority of the migrants in **Rabat, Morocco**, totalling 223 of the migrants surveyed, the journey was made **by air**, often under a work 'contract' (payment of the cost of the flight by an intermediary in exchange for five months of work, with confiscation of passport and telephone), or for education purposes.
The following analysis of journey duration will therefore focus on migrants who had to use **a different means of transport**.

Journey duration in months n = 228



Journey duration (in months, n = 228) according to gender



The analysis of the journey duration concerns the **228 people** who did not make the journey by air. The analysis reveals a fairly large disparity: 21% of the migrants had a journey time of less than two months, whereas for 26% of them, their journey had lasted more than twelve months. It is clear therefore **that the migration process can be very long**. The gender-based analysis shows, on the one hand, that only 14.4% of women had spent less than two months travelling, compared with 25.3% men. On the other hand, 22.2% of women, compared with 29% of men, had a journey time of more than twelve months. The women also more frequently reported an average journey time, of between two and six months.

According to the testimonies, **the migrant journey is gruelling**, as explains one migrant in Rabat:

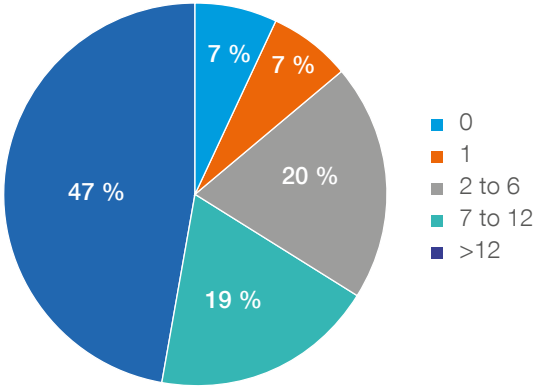
'During the crossings in the Sahara (up to eight days on foot) the young die. You see their bodies right there in the middle.'

It seems **even more challenging for women**.
When asked to talk about their presence on the journey, certain migrant men from Rabat replied:

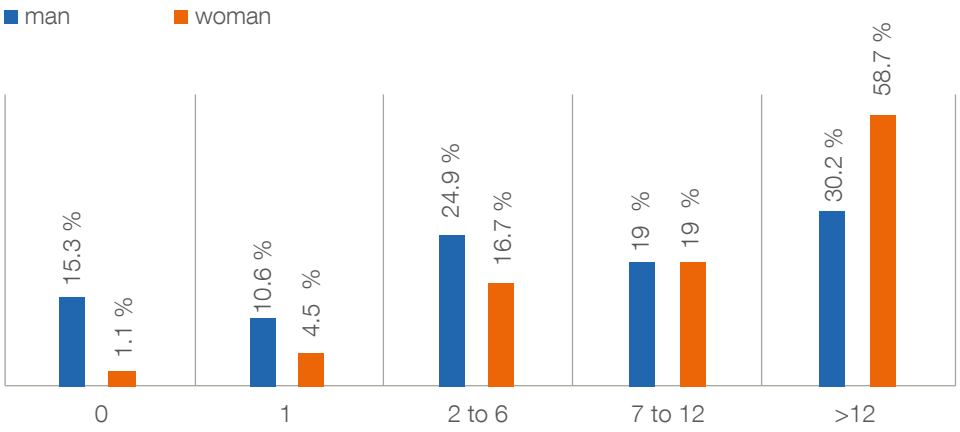
'The journey is not for women.'

IV. DURATION OF STAY

Duration of stay (in months) n = 458



Duration of stay (in months), % by gender by duration of stay (n = 458)



The **average duration of stay** on the day of the survey was **20 months**. For 47% of the people surveyed, the duration of stay, in the countries where the data was collected, was greater than twelve months. This proportion rose to nearly 60% for the women, which was nearly double that of the men (30.2%). Conversely, short-term stays, lasting up to one month, only accounted for a little over 5% of women, whereas they accounted for more than 25% of men. The proportion of people who had stayed there two to six months was slightly higher among the men (25%) than among the women (17%), whereas for stays of between seven and twelve months it was identical at 19%.

The testimonies highlight the **difficulties of life for a migrant**:

'Since I left my country, I've not felt free.'

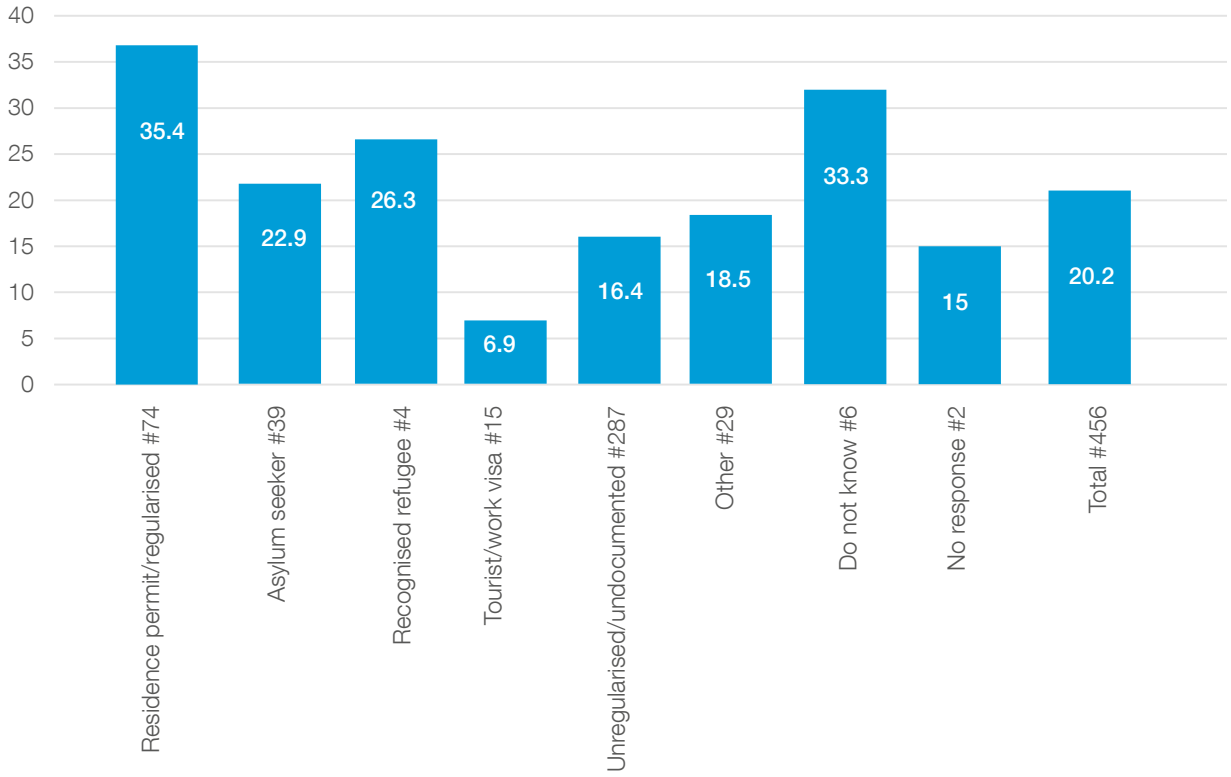
Which he defined as the possibility to move about freely, to find housing, food, access healthcare, etc., adds the researcher.

'Housing is only more expensive for Moroccans.'

'When you come, they put you in a house and they force you to work to pay back the ticket. And they confiscate your passport. Your passport is confiscated by the family where you work.'

'If you say are sick, he (your employer) doesn't agree. He replaces you.When you call to say you're sick, he says no, you have to come, that's what you're paid for.'

Duration of stay (average/person, in months), by administrative status



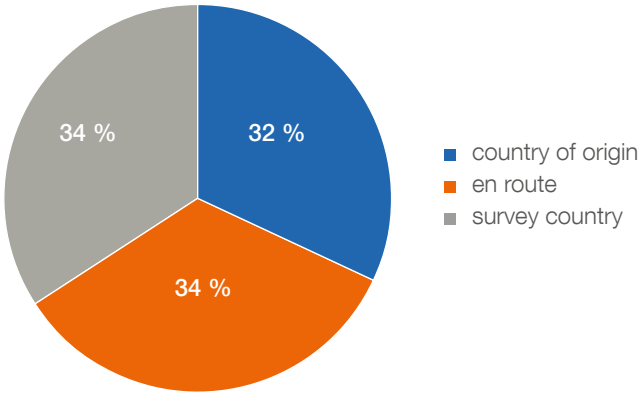
Looking at the duration of stay according to the administrative status of the migrants, we can see that all the people who had a status officially authorising them to stay had a duration of stay that was longer than the overall average, excluding those with a visa (tourist or work). Those who were unregularised/undocumented had a shorter average duration of stay than the overall average.

V. VIOLENCE

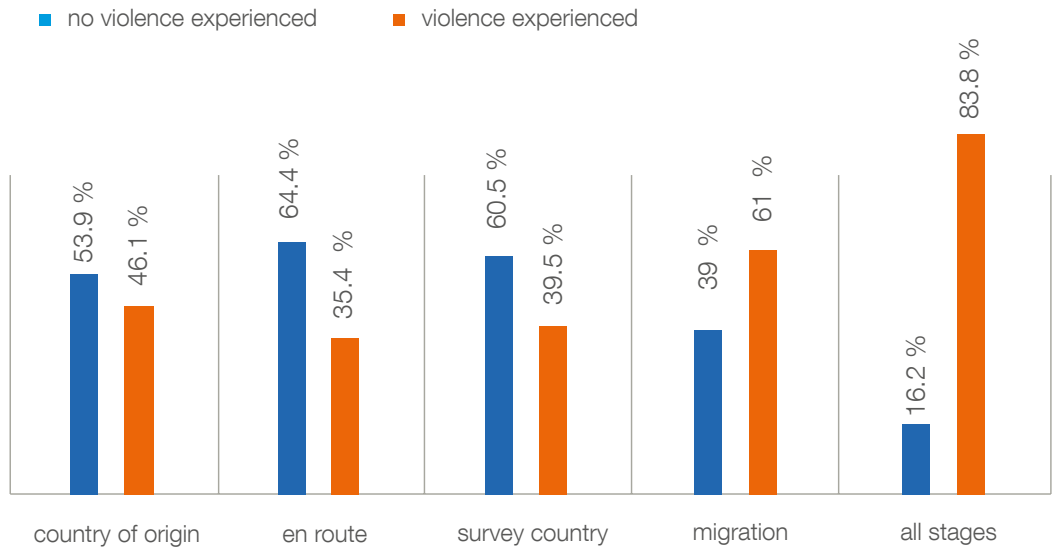
Concerning the cases of violence reported by those surveyed, **more than eight out of ten migrants**, 83.3%, **stated that they had experienced violence in their lifetime**, in other words, in at least one of the given stages of migration: country of origin, en route, in the survey country.

The stages of migration in which the events occurred were divided equally between the country of origin, during the journey and in the various survey countries.
When we look purely at the **migration process** (en route and in the survey country, excluding the country of origin), **61% of individuals reported they had experienced violence**.
When we look at all the violent events reported, **68%** were experienced during the migration process.

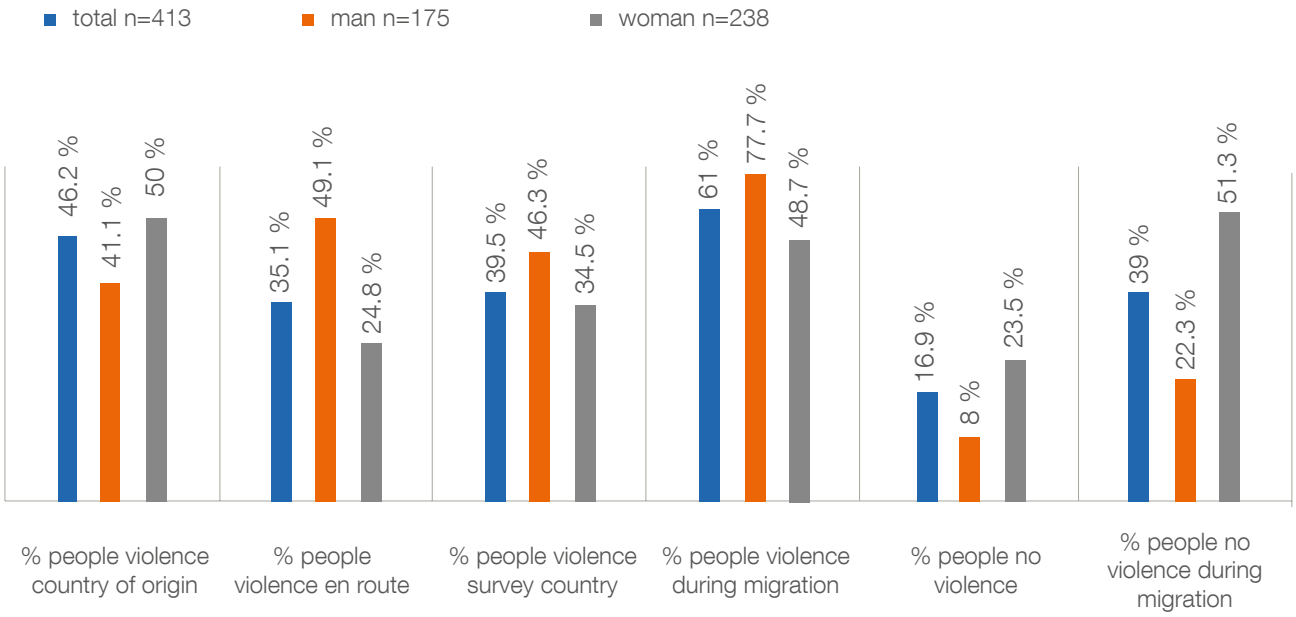
Breakdown of total reported violent experiences by migration stage (n=670)



% of people with or without violent experiences according to migration stage



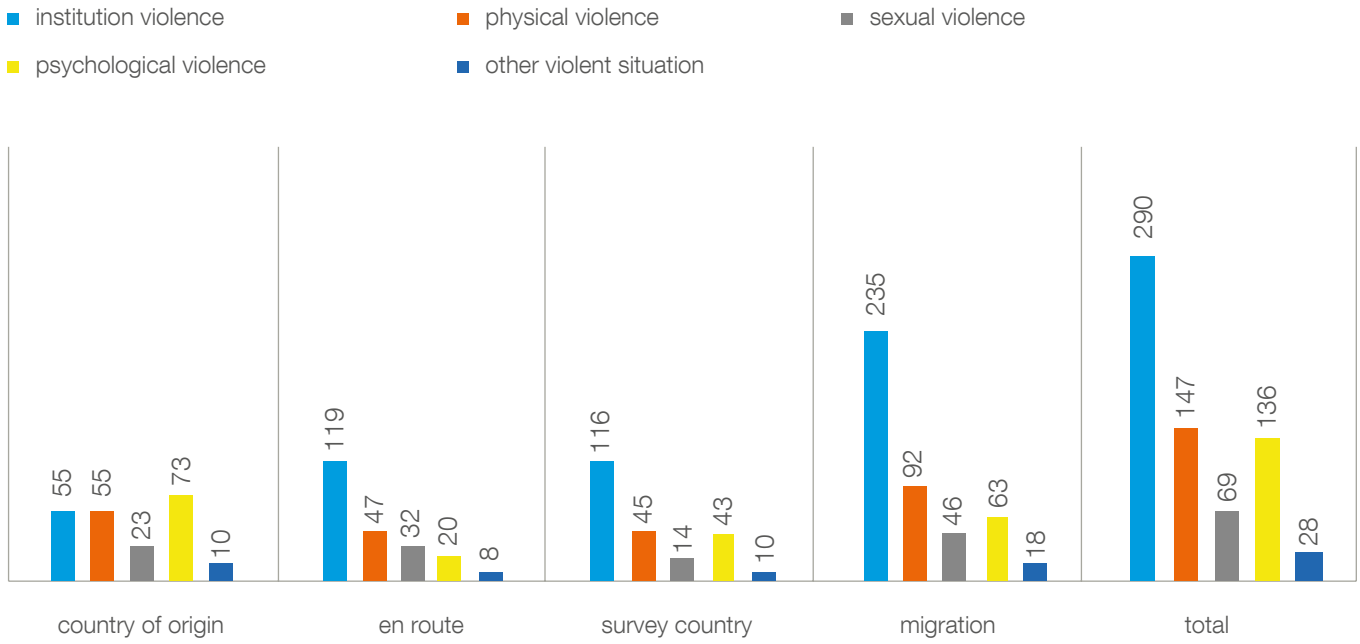
% of people with or without violent experiences, according to gender and migration stage



When we focus on the details of the violent events reported by gender, we can see that **49% of women** declared they had experienced violence during migration, while for **men** this percentage stood at **78%**. Across all migration stages – country of origin, en route and survey country – only 23.5% of women declared that they had experienced violence and 8% of men. **In general, more men than women declared that they had experienced violence, except for the country of origin** where more women declared they had experienced violence.

To gain a better understanding of the share of violent experiences reported, these were grouped into five categories: **institutional violence** which covers the confiscation of documents and money, prison, and violence by the police/army; **physical violence** including torture, non-domestic assault and injuries, and domestic assault and injuries; **sexual violence** which comprises sexual violence and rape; **psychological violence;** and other **violent situations**.

Number of violent events by migration stage and category



During migration, **institutional violence** clearly predominates, followed by **physical violence**. A number of testimonies confirm this.

'Despite our documents, at the Niger-Nigeria border, the police harassed us and took our money.'

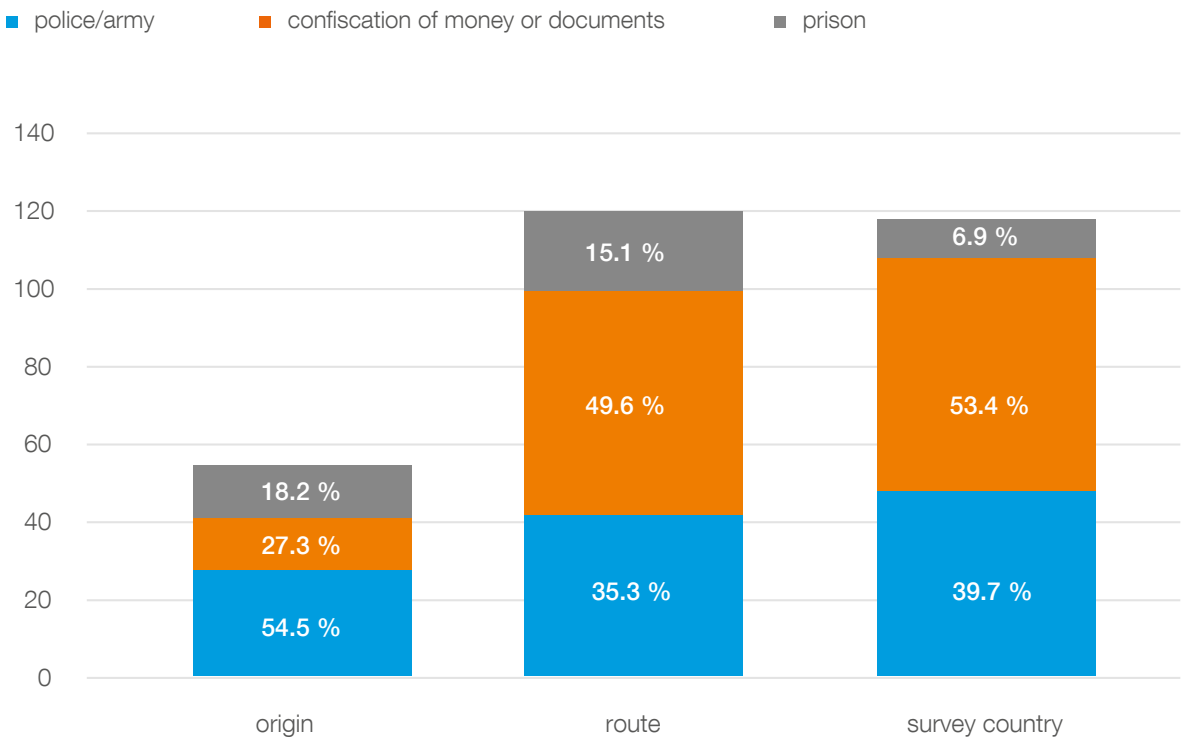
'On the road, the police put up barriers at checkpoints. The police told us that the authorities said they had to stop young people from migrating…'

'(…) People tend to follow you quietly (citizens who harass and attack)… (…) But luckily, we managed to save the telephone. That's what happened, they tried to take the bag, punches as well… They couldn't get the bag, she (his companion) was injured.'

It was only in the **country of origin that psychological violence** was reported most often.

'I have experienced a lot of psychological and physical violence, not just in Cameroon… In my family as well, there were too many assaults, too many deaths… (…). Here in Tunisia, I was assaulted, but I wasn't hurt. (…) - Did you report it (…)? - No.'

Breakdown of institutional violence



The **majority** of cases of institutional violence experienced during migration were the **confiscation of money/documents**, both en route and in the survey countries. Violence by the police/army was also well represented, whereas prison was a less frequent event.

Cases of sexual violence were cited slightly less frequently compared with the other categories. This information should be taken in **perspective** given the **testimonies** collected during the focus group discussions.

IN TUNISIA:

'Once, there was a man selling sheep. He took his underwear off in front of me, and there were people nearby.'

'Once, I was in a taxi, sitting in the front seat; the guy undid his trousers, he undressed, he had his weenie out.'

'He had sex with me up against the house. That's how I got pregnant.

-And did you consent?

To start with no, but after, I didn't have the choice.'

IN NIGER :

'(…) a Libyan calls you (…) in general, when they call migrants it's to force them to do things that aren't acceptable, for example, to demand money from some or sex from others…' 'Almost always, we saw cases of Africans shot if they refused.'

'We also heard cases of women being raped at the border between Burkina and Niger.'

IN OUJDA, MOROCCO:

When collecting the testimonies of a focus group, a researcher concluded:

'All of the women in Libya had been raped.' (young Cameroonian).

'They also attested to constant rape in the homes in Algeria.'

IN RABAT, MOROCCO:

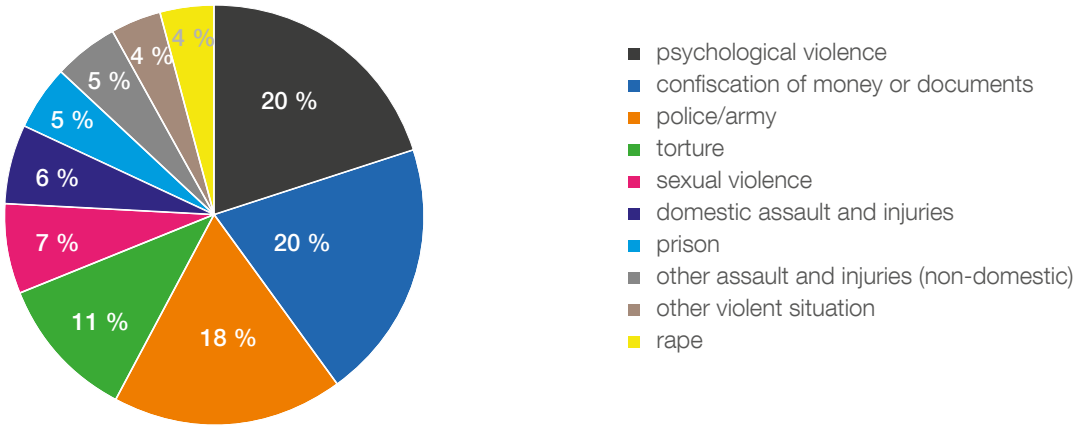
One researcher who had facilitated a focus group discussion stated:

'All of the women in Libya had been raped.' (young Cameroonian).

'They also attested to constant rape in the homes in Algeria.'

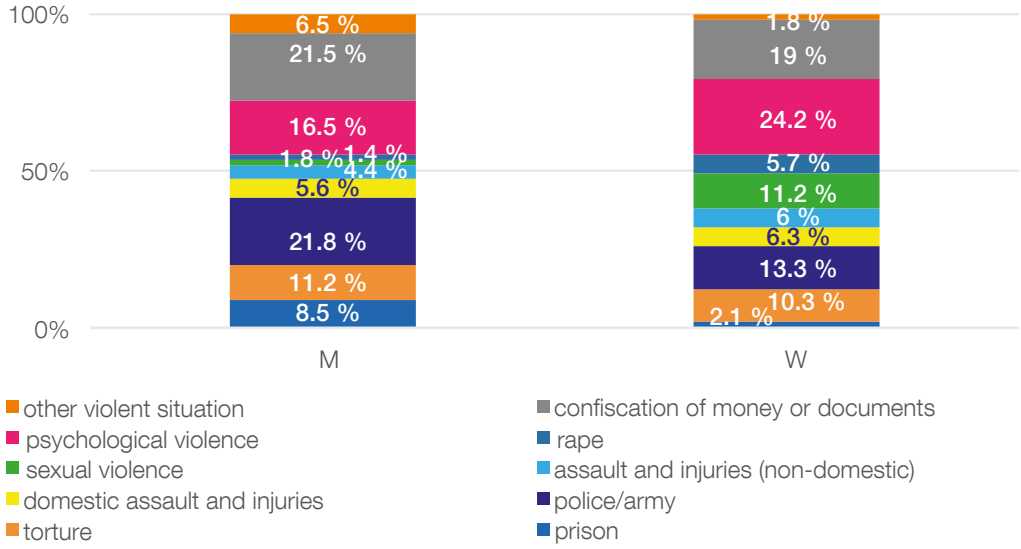
The five major categories of violence each comprise several types of violence.

Breakdown of all violent events reported by type



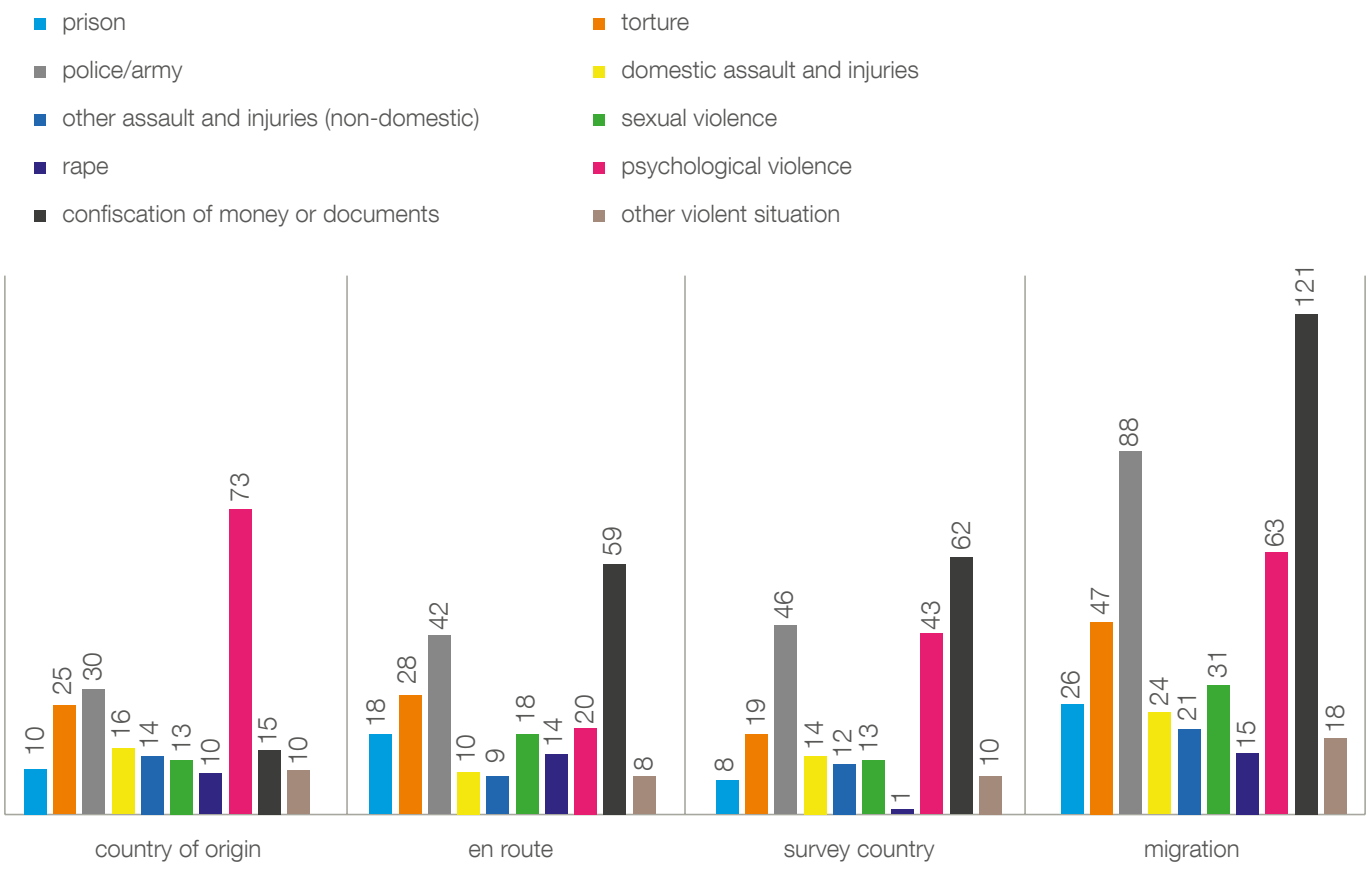
Across all cases of violence reported, the **three most common types of violence** were **psychological violence**, on a par with the **confiscation of money or documents**, followed by **violence associated with the policy and army**, which represented 58% of the total violent events reported. Two of these three types fall into the category of institutional violence.

Breakdown of types of violence according to gender



The different types of violence are **distributed differently according to gender**. Women were less frequently put in prison, and experienced less violence from the police/army. However, they reported **more experiences of sexual violence, rape and psychological violence**.

Breakdown of violence according to migration stage



Looking at the details of the types of violence by stage of migration, the distribution profile of the reported violent events during migration, both en route and in the survey country, highlights the confiscation of money or documents, and violence perpetrated by the police/army, both belonging to the same category of institutional violence. Next comes psychological violence, in the survey country, and acts of torture, en route. Lastly, there are cases of sexual violence, with a few variations between the journey and the survey country, but as the fifth most frequently reported type of violence, during migration and overall, given that cases of sexual violence were very often underreported.
In the country of origin, the profile is relatively different, with psychological violence clearly predominating.

IN NIGER :

'The police made us all get out of the vehicle and we each had to pay some money to be able to continue on our way. Those who refused or who didn't have any money were beaten with batons then stripped. They searched for money everywhere, even in their underwear.'

IN OUJDA, MOROCCO:

'One person filed a report (for assault) and afterwards the police arrested her because she didn't have any documents. When she was released, she was assaulted again by the same person.'

VI. HUNGER

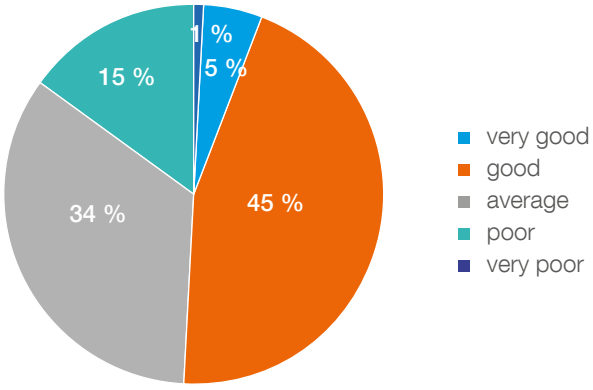
Hunger was reported as a violent experience **108 times**, 75 times of which were during migration. In all, 8% of individuals reported having suffered from hunger in their country of origin, 8.5% en route and 9.7% in the survey country.

VII. WAR/ARMED CONFLICT

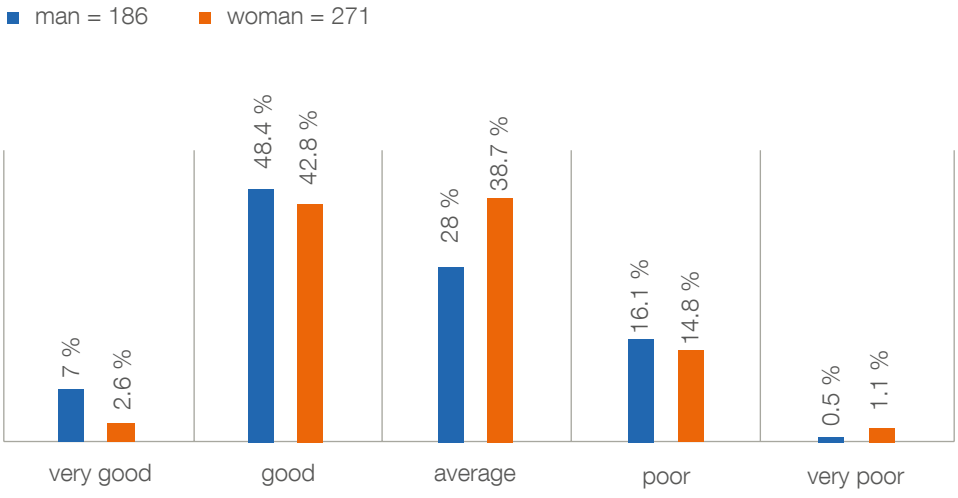
Situations of war/armed conflict were reported as **situations of violence experienced in the country of origin by 31.7% of individuals**, but only by 2.4% of individuals during migration.

VIII. ÉTAT DE SANTÉ

HEALTH, % OF PEOPLE BY CATEGORY, N = 461



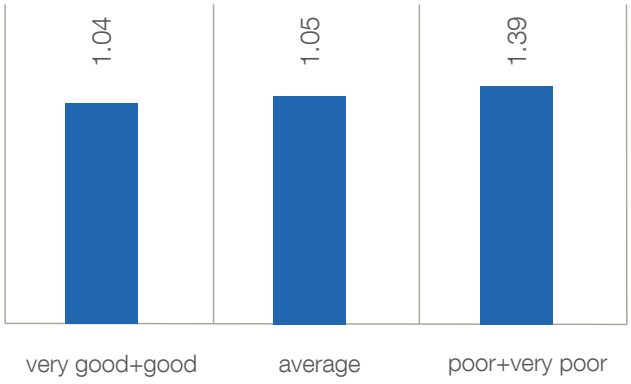
Health according to gender



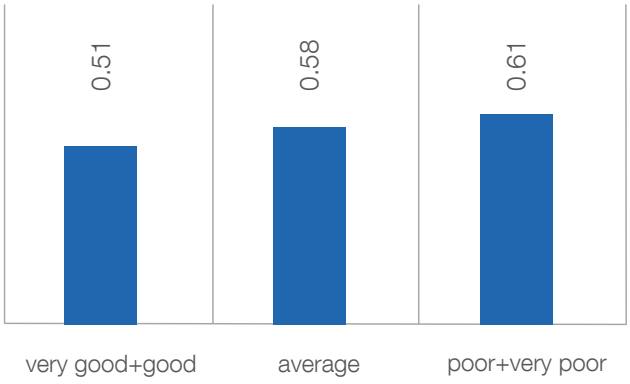
In order to gain a better understanding of the consequences of the situation on the health of migrants, it must be remembered that the **median age of those surveyed was 28 years old**, with a variation from 14 to 62 years old. It was, therefore, a very young population group. While half of them described themselves as being in good or very good health, 50% of the migrants felt their health was average or below average and 16% felt their health was poor or very poor. A priori, **women perceived their health to be poorer than men did**, with more feeling 'average', and fewer 'good' and 'very good'.

'We might feel well physically, but we aren't relaxed because psychologically there are things worrying us: like the end of the month when we have to pay the rent and always thinking about money and how to work around the little you have so you don't lose your house.'

Number of violent situations during migration (average/person) according to health



Number of violent situations in the survey country (average/person) according to health



There appears to be a trend regarding the possible existence of a link between the deterioration in perceived health and the number of violent events experienced by the person during migration. **It seems possible that health deteriorates as the number of violent events experienced (average) grows, both en route and in the survey country.**

IX. ACCESS TO HEALTHCARE

Only 39% of the migrants surveyed reported that they had encountered obstacles accessing healthcare. However, 23.5% of them also reported that they had not attempted to visit a medical facility. Among the individuals who felt they needed healthcare (not taking into account those who did not respond, those who said they had not encountered any obstacle and those who said they had not attempted to visit a health facility without mentioning any obstacle as a reason for this behaviour), **more than half (51%) had encountered an obstacle accessing healthcare.**

Among the barriers reported, the most frequent barrier to healthcare mentioned was the **financial obstacle** (24%), followed closely by **lack of understanding of the system** (19%). Another major factor hindering access to healthcare that should be mentioned is **discrimination** (16%).

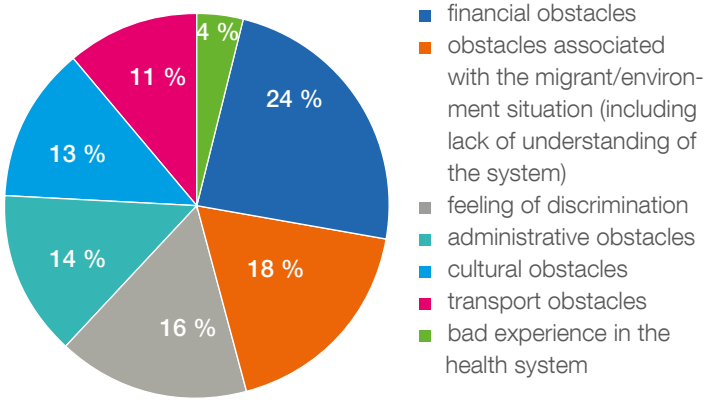
A few testimonies illustrate these obstacles:

'Two Cameroon brothers went through Libya and one of them fell ill due to the food and the cold. He said that because of the war he couldn't get healthcare, he was only able to buy pills from a pharmacy.'

'If you don't have money, you can easily die.'

-When you get sick, you wait to heal naturally because you don't have the money to go to the doctor.'

Breakdown of total reported barriers to healthcare access by type



'The basic problem is still lack of resources. For example, while travelling, before settling in Agadez, to access healthcare in a foreign country, you have to pay, but we didn't often have any money. And when you go to the health centre or pharmacy without money, they turn you away.'

'They didn't want to touch me with their bare hands because a doctor had said: it's a suspected disease.'

'I don't know if it's the fact that we can't talk properly, we are… Well, maybe, I don't speak Arabic, I don't know but… (…). She (the healthcare worker), to even stop and listen to you, often it's a problem.'

'Because we arrived in Agadez recently, we don't know about the health system yet. Even those who feel their health is not so good do not know where to go for treatment at the moment. For that, we buy the medication we think appropriate for our illness from street vendors.'

X. LIFE PLANS

An idea of the life plans of the migrants encountered can be established using the group interviews. Some wanted to continue their migration to Europe via Libya, **whatever the cost**.

'We haven't reached our goal of reaching Europe yet. So, we have to keep battling, until we achieve our goal.'

'We have information about the risks on the road through friends returning from Libya. (…). But it doesn't put us off, because we are preparing psychologically and financially to continue our journey.'

'Our ultimate wish, of all of us here, is to be able to continue our journey to reach Italy. In our countries, there are no job prospects, that is why we decided to leave in search of a better life.'

For others, information concerning the violence against migrants in Libya, the torture and rape, had **dissuaded them from continuing** their migration plans. However, among those who had given up their plans to migrate to Europe, a portion of them did not wish to return to their country of origin.

'We have learned from the people coming back, that people have lost their lives in Libya and that others have been raped. Because of this news, we prefer to stay here in Agadez and make return trips to the country if necessary.'

'We know via social networks that people are being killed in Libya. Libya is a dangerous country for foreigners. We have also had concrete proof from the people coming back. That's why we're staying here in Niger.'

In **Tunisia**, the situation of migrants and the reasons they were there, were often very different. Because of this, their life plans were also different. Many envisaged returning to sub-Saharan African countries. Some wanted to leave for Europe, **but a few of them saw a future for themselves in Tunisia.**

'It could be in Cameroon or abroad, but not in Tunisia, or France, Canada…'

'As I have a qualification, some training, I'm going to work or as a sales person, in a clothes shop. I'd like to work… At home in Senegal!'

'I dream of having a start-up, the location doesn't matter, if I see the opportunity to do it, I'll do it. It could be in Tunisia, in Cameroon or elsewhere in the world.'

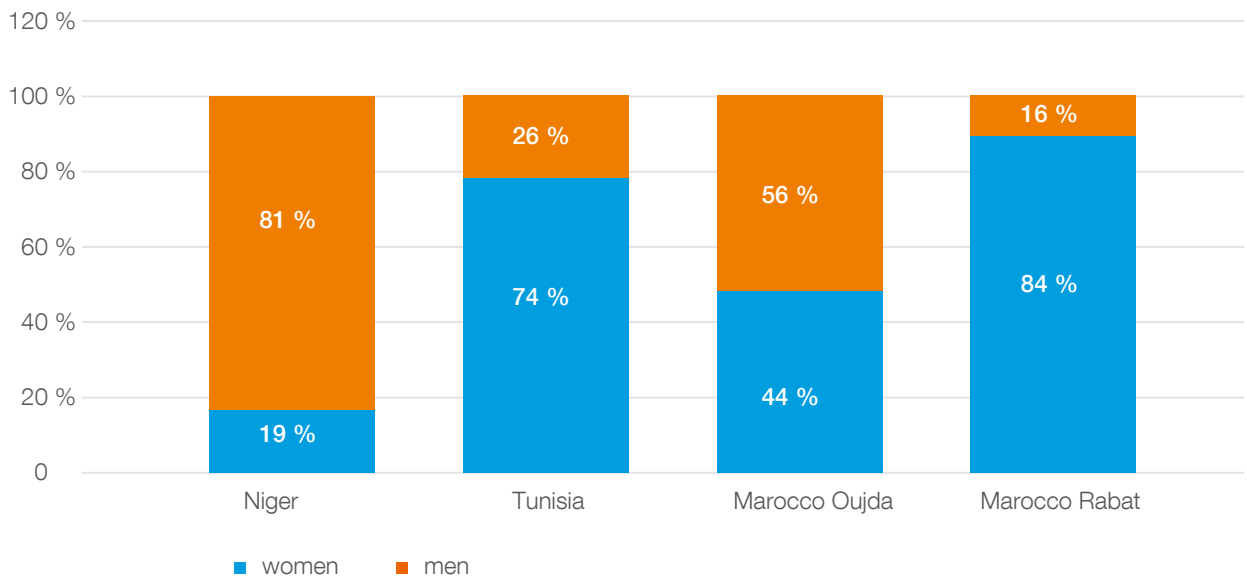
For most of the people in **Morocco**, the objective was clear: **cross the Mediterranean and continue on to Europe**. Some, however, envisaged not leaving for Europe, but staying in Morocco '*if they found work*' or a training opportunity which would prepare them to later '*return to their own country.*' Another responded that he simply wanted '*to have a normal, stable life – to have his freedom back.*' Lastly, another with a strong sense of hatred towards Morocco told us: '*even if I earned 10,000 dirhams, about €1,000 a day, I wouldn't stay in Morocco.*'

B. COMPARATIVE ANALYSIS OF THE FOUR LOCATIONS

It should be noted that the researchers in each location were different. There is, therefore, possible bias in the comparison. It should also be remembered that, out of a total of 461 surveys, the figures are divided as follows: **in Morocco, 81 in Oujda and 100 in Rabat, 100 in Agadez, Niger, and 181 in Tunis, Tunisia.**

I. SOCIO-DEMOGRAPHIC CHARACTERISTICS

Comparison of locations of the migrant share by gender



In Niger, the migrants surveyed were mostly men, probably representing the migrant population in Agadez. In Rabat and Tunis in Morocco, more women than men answered the survey. In Tunisia, a large proportion of migrants were women who arrived with a work 'contract' as 'domestic workers', which may explain this proportion. However, in Rabat, the high proportion of women was due to a selection bias by the target population of the Doctors of the World project, which is pregnant women, women with SRH (sexual and reproductive health) problems, victims of violence, and their young children. In Oujda, Morocco, the proportion of men to women was almost equal.

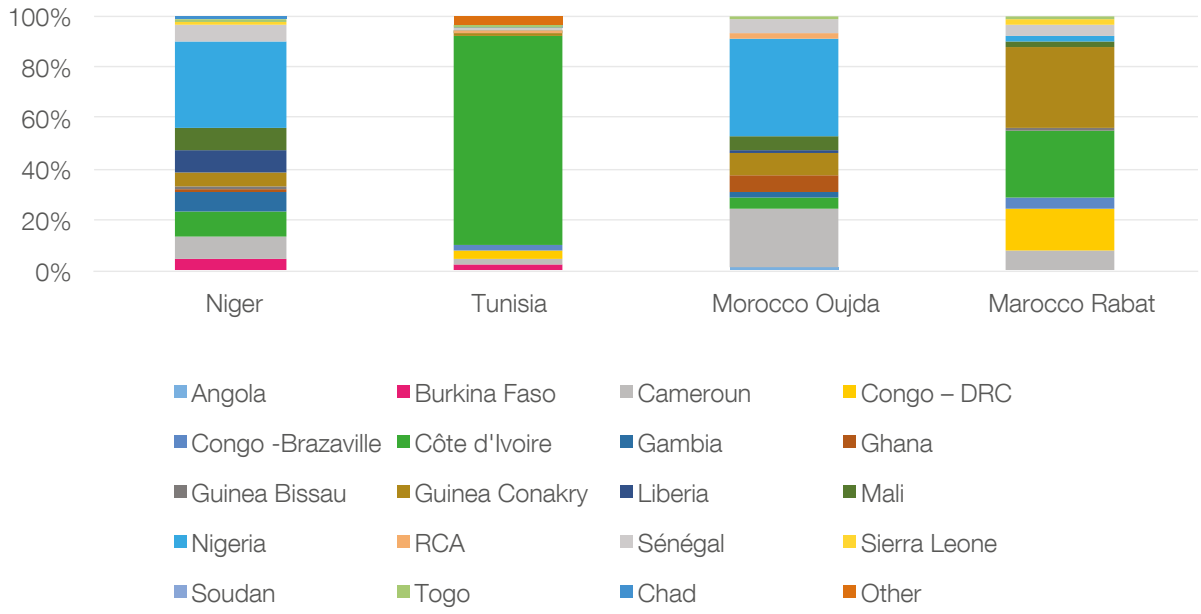
Age

The median age was **nearly equivalent in the four survey locations** (27.5 – 29 – 26.5 – 28), but the oldest women were recorded in Tunisia. There were minors, including unaccompanied minors, in three of the four locations, but not in Tunisia.

Origin

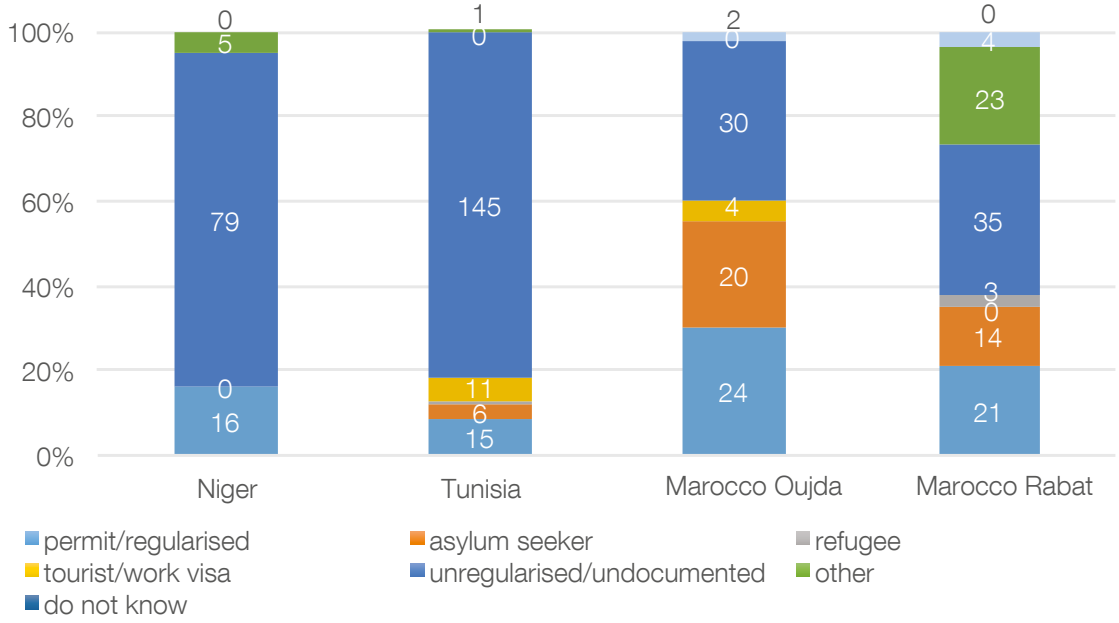
In Tunisia, a vast majority (81.2%) were from Côte d'Ivoire, which corresponds with an organised migration network for a 'conditional work contract'. In the other locations, the share was more even; however, there was a predominance of Nigerians in Niger and Oujda, and Guineans in Rabat. In Niger, the majority of the women surveyed came from Nigeria (16/19). Nigerian women also accounted for 55% of the Nigerians interviewed in Oujda, and half of all female respondents in Oujda. In Oujda, Cameroonian women were also well represented, being 42% of the Cameroonians surveyed.

Comparison of locations of migrant origins



II. ADMINISTRATIVE STATUS

Comparison between administrative statuses



In **Niger** and Tunisia, the **majority of the migrants who took part in the survey were unregularised/undocumented**. In **Morocco**, there were fewer unregularised migrants, and **mostly asylum seekers**. This is perhaps due to the fact that, in Morocco, access to rights, including healthcare, is clearly dependent on having some form of identification. This may encourage migrants (informed of this by Doctors of the World staff) to apply, regardless of the result, or the result they desire.

III. JOURNEY DURATION

In **Tunisia**, all the migrants interviewed had arrived **by air** under a 'conditional work contract' (confiscation of identity documents and personal telephone), so their journey time was zero months.

> *'I was aware of the situation here under contract, so I bought my ticket myself. They buy your ticket, and when you arrive, they put you in a house and force you to work to pay off the ticket. And they confiscate your passport. The passport is confiscated by the family where you work.'*

More than 50% of the migrants interviewed in **Rabat, Morocco,** had also arrived by **air, all women**. In the other locations and for the other portion of migrants encountered in Rabat, the **journey time varied greatly** from zero to several dozen months.

In **Niger**, this reached **as much as 100 months**, probably representing migrants who had already stayed in Libya and due to their experience there had returned to Agadez, to reconsider their plans, wait for another opportunity.

The journey duration was longer for the women surveyed in Niger than for men, whereas it was shorter for women in relation to men in Morocco.

IV. DURATION OF STAY

The duration of stay was highly variable, **from zero to several dozen months**, in the four locations. As mentioned earlier, this represents the effective duration of stay at the time of the survey. The average duration of stay was clearly shorter in Niger (7.7 months) and longer in Rabat (31.1 months) in relation to Oujda (19.7 months) and Tunis (21.7 months).

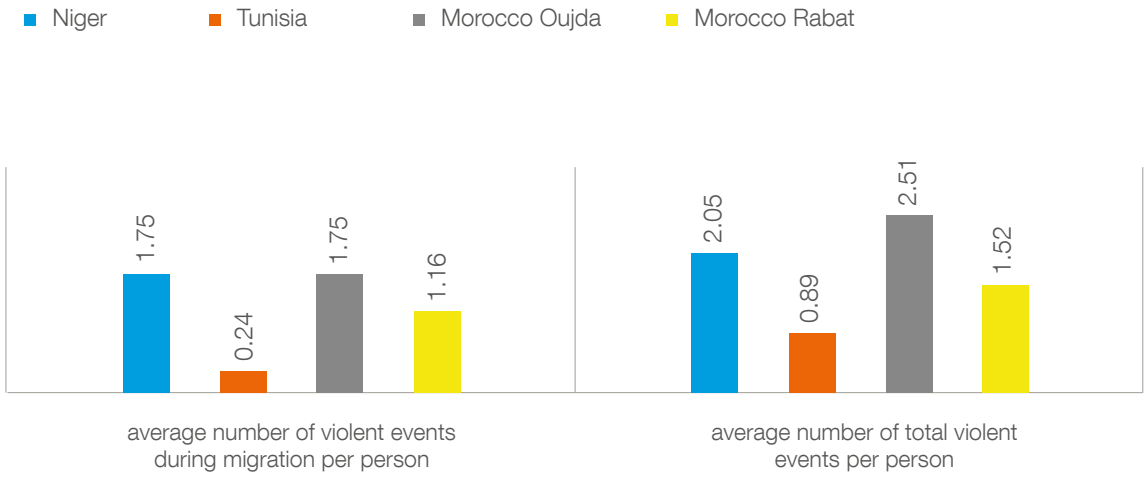
Women had stayed longer than men in Niger and Rabat, whereas in **Oujda and Tunis, men had an average duration of stay that was slightly longer** than the women.

The percentage of migrants surveyed who had a long duration of stay (> 1 years) was higher in Tunisia and Rabat, probably corresponding with a different migrant profile than that encountered in Oujda and Niger. Indeed, once again in these two locations, the proportion of people with a very short duration of stay (≤ 3 months) was higher than in Rabat and Tunis.

V. VIOLENCE

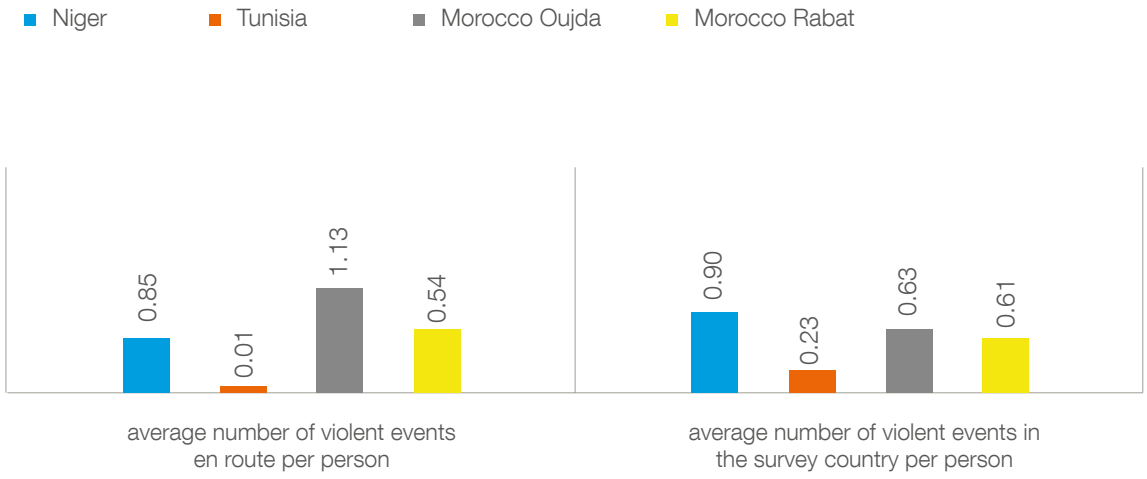
When analysing the findings concerning all the violent events reported and comparing them, the proportion of violence experienced by stage of migration – country of origin, en route and survey country – **varied according to the country in which the migrants were surveyed.**

Comparison of the number (average/person) of violent events during migration and in total



The **migrants surveyed in Oujda reported the most violent events** on average per person (during migration and overall), followed in descending order by the migrants in Niger, Rabat and lastly Tunisia.

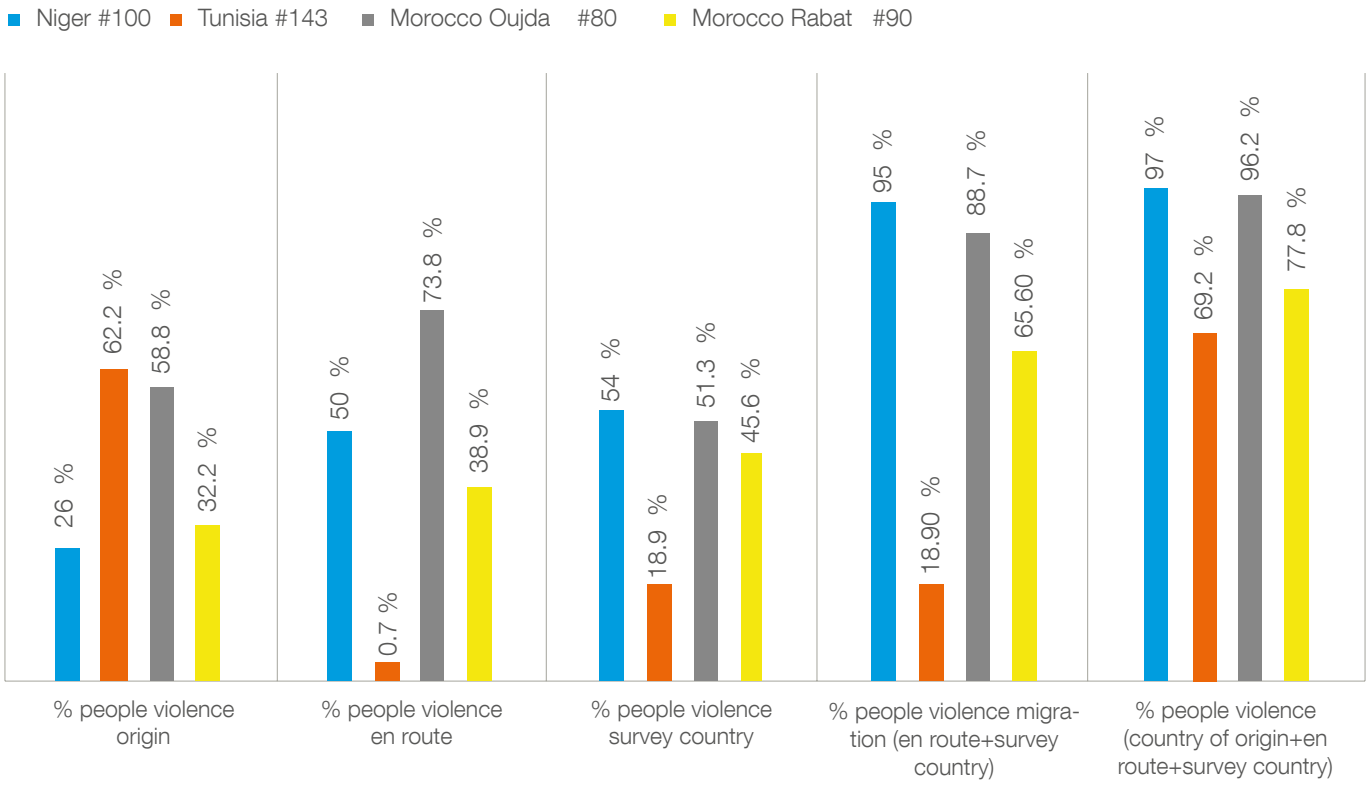
Comparison of the number of violent events (average/person) en route and in the survey country



As regards the number of violent events experienced en route, the **most violent events reported occurred en route to Oujda**, followed by Niger, then Rabat, and lastly Tunisia where the journey was made by air.

To conclude, for the cases of violence experienced in the survey country, there was a higher rate of incidence in Niger, followed by Oujda, Rabat and lastly Tunisia.

Comparison of % of people who had experienced violence



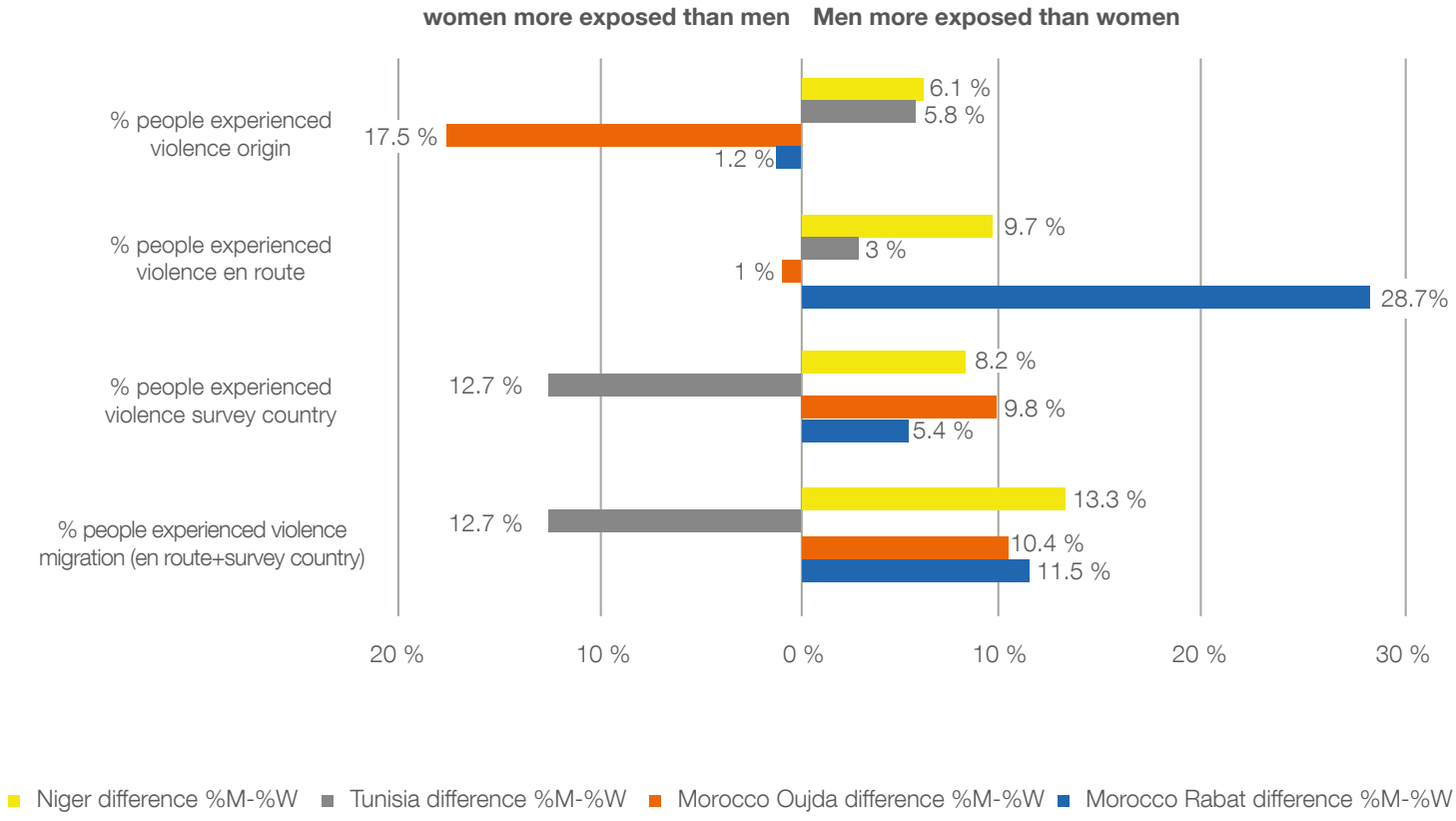
When analysing the percentage of people who reported that they had experienced violence, for violence 'en route', **73.8% of the migrants interviewed said they had experienced violence en route to Oujda**, 50% en route to Niger, 38.9% en route to Rabat, and lastly 0.7% on route to Tunis.
For this same percentage, but for **violence in the survey country**, **in descending order, 54% of the migrants interviewed stated they had experienced violence in Niger**, 51.3% in Oujda, 45.6% in Rabat, and 18.9% in Tunis.

All of these areas of analysis show the same trend: **most people were affected by violence during migration to and in Niger, and to and in Oujda in Morocco.**

The majority of people reported having had a violent experience during migration, with the exception of those in Tunisia. Most of these violent events occurred in Niger and in Oujda, Morocco. Lastly, the cumulative effect the journey and the survey country gives a high percentage of migrants in Rabat who had been victims of violence during migration.
In Tunisia, compared with the other locations, only a minority of people stated that they had experienced violence.

Lastly, across all four locations, and systematically, the majority of migrants stated that they had experienced violence in their lifetime (origin, journey and survey country).

Comparison of the gender difference in the exposure to violence

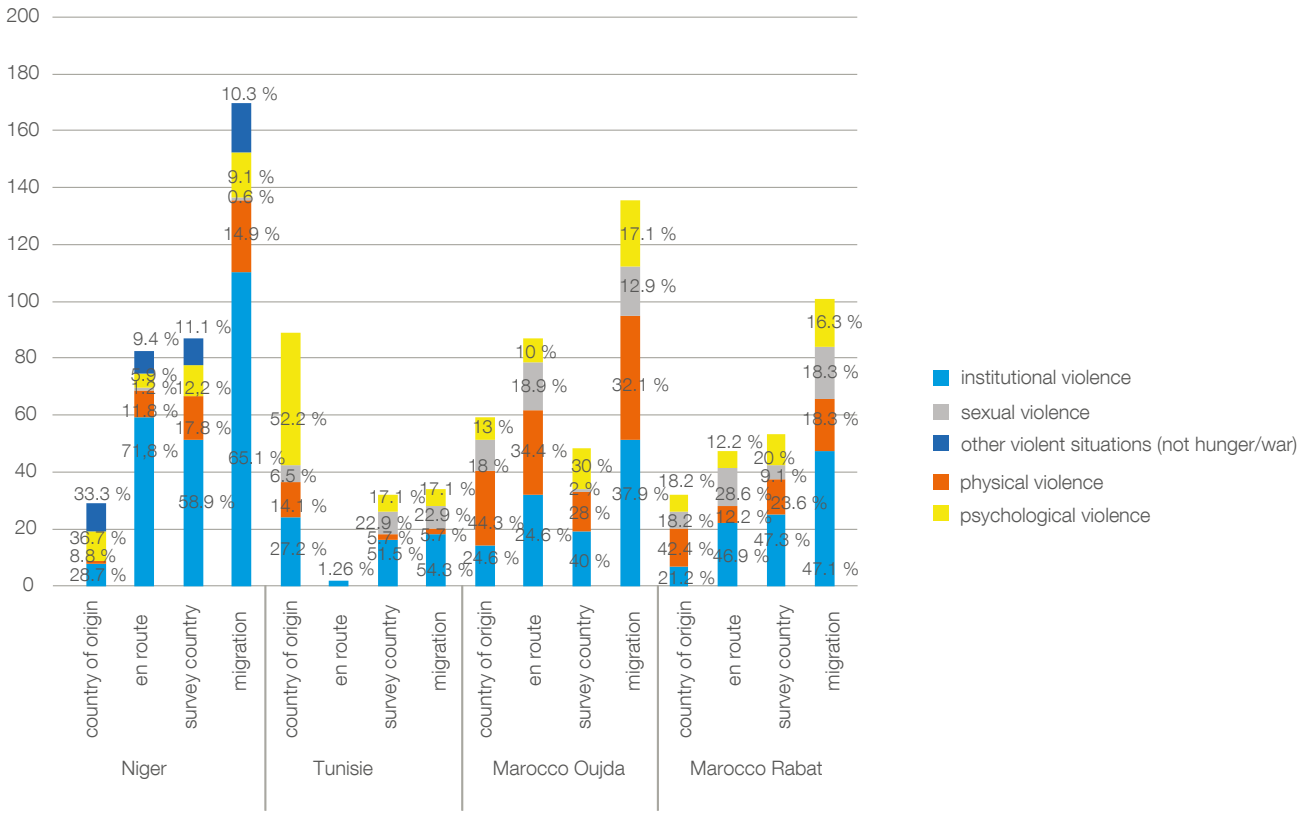


When comparing the findings based on **gender**, for the stages and locations there is **a stark difference between men and women** in the proportion of people who had experienced violence. On the road to Rabat, there was the greatest gender difference with a clearly higher proportion of men who had experienced violence than women. Next, there was a clear gender difference for the violence experienced in the country of origin, affecting the women interviewed in Oujda the most. A much higher proportion of men than women had experienced violence in Niger. Lastly, a higher percentage of women in relation to men stated that they had experienced violence in the survey country Tunisia.

The gender comparison shows that women were most affected (higher percentage of women than men stated that they had experienced violence) in the country of origin for those interviewed in Oujda, and in the survey country and during migration for those interviewed in Tunisia. There was almost no gender difference for migrants in Rabat as regards violence in the country of origin, or in Oujda and Tunisia for violence during the journey. For all other categories, men were affected most (percentage of men having experienced violence higher than that of women).

In other words, **during migration to and in Tunisia, a higher percentage of women said they had been victims of violence** in relation to the percentage of men who said they had been victims, whereas **the opposite trend is true for migration in the three other locations**.

Comparison of share of violence by category



When comparing the **cases of violence grouped by category, cases of institutional violence were the predominant form of violence during migration**, in other words, en route and in the survey country. They even accounted for more than half of the migrants interviewed in Niger and Tunisia. However, **in the country of origin, psychological violence was the main type of violence for those encountered in Niger and Tunisia, and physical violence was the main type for those in Morocco**.

There were more cases of sexual violence reported in Morocco, in Rabat, even more than in Oujda. In Niger there were particularly few. Nevertheless, this information must be put into perspective by analysing the testimonies from the migrant focus discussions:

IN NIGER :

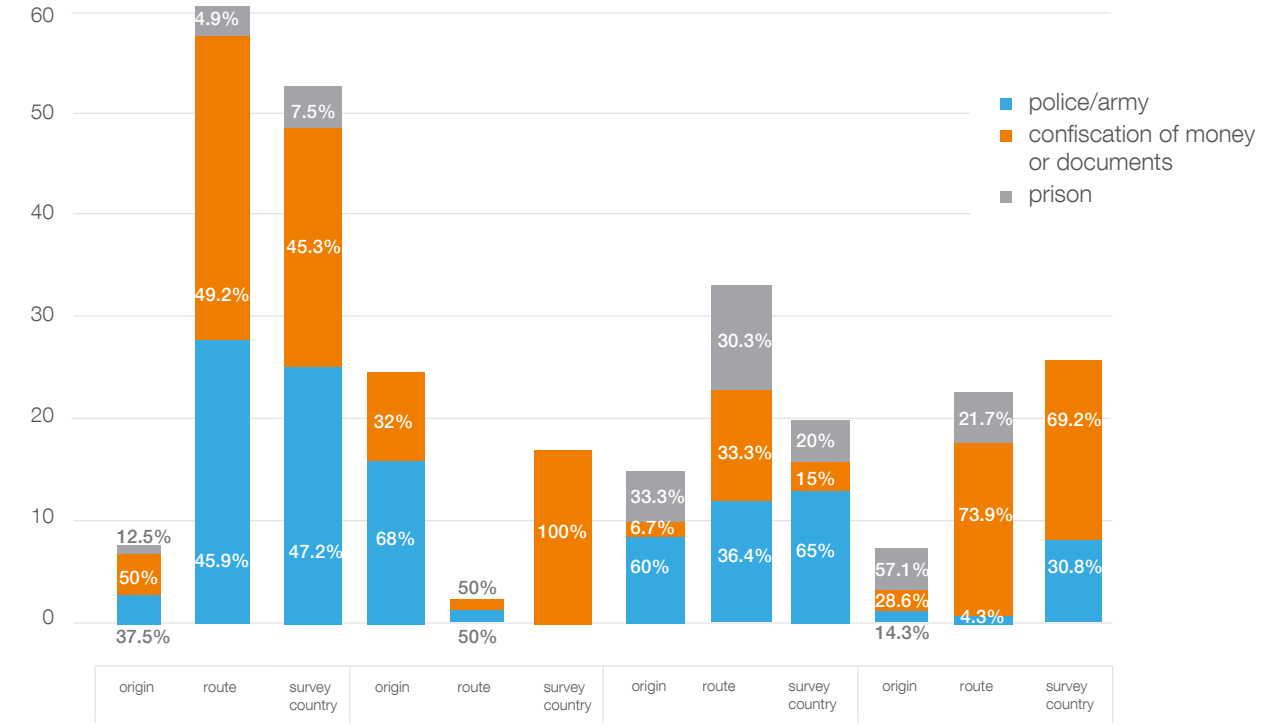
The migrants encountered during a focus group discussion stated:

'We have also heard of cases of women being raped at the border between Burkina and Niger.'

When analysing the recurrence of the different types of violence by migration stage, three types of violence were most frequently reported:

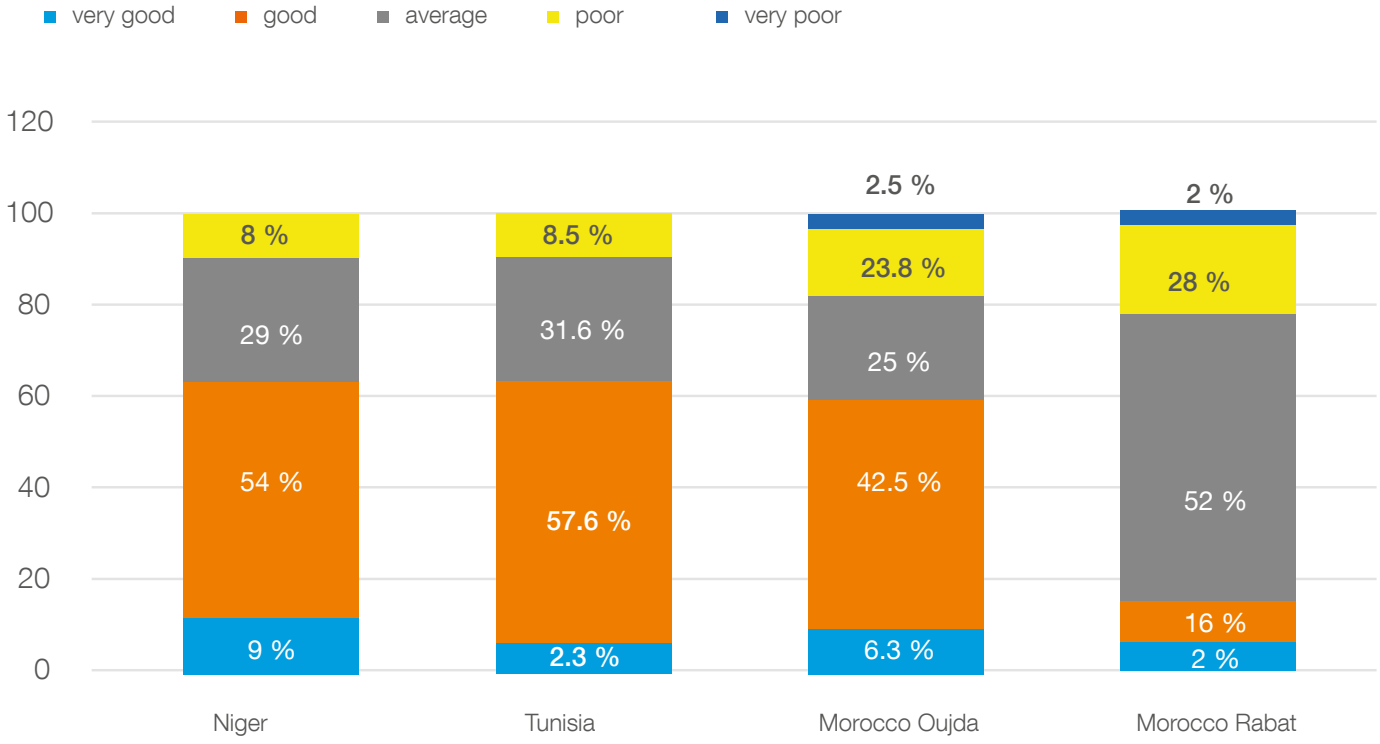
- **In the country of origin, psychological violence systematically appeared.**
- **En route, the confiscation of money and/or documents was present in each location, and violence by the police/army in three of the four locations (not in Rabat).**
- **In the survey country, psychological violence was reported in all locations, and the confiscation of money and/or documents and violence by the police/army were reported in three of the four locations. Sexual violence appeared once in the three most reported forms of violence.**

Comparison of the share of institutional violence



VI. HEALTH

Comparison of health



More people said their health was unsatisfactory (average, poor or very poor) in Morocco, in Rabat particularly and Oujda, than in Niger and Tunisia. In Morocco, this number was more than half of the population surveyed.
The migrants who had had the opportunity to see a doctor in Rabat said:

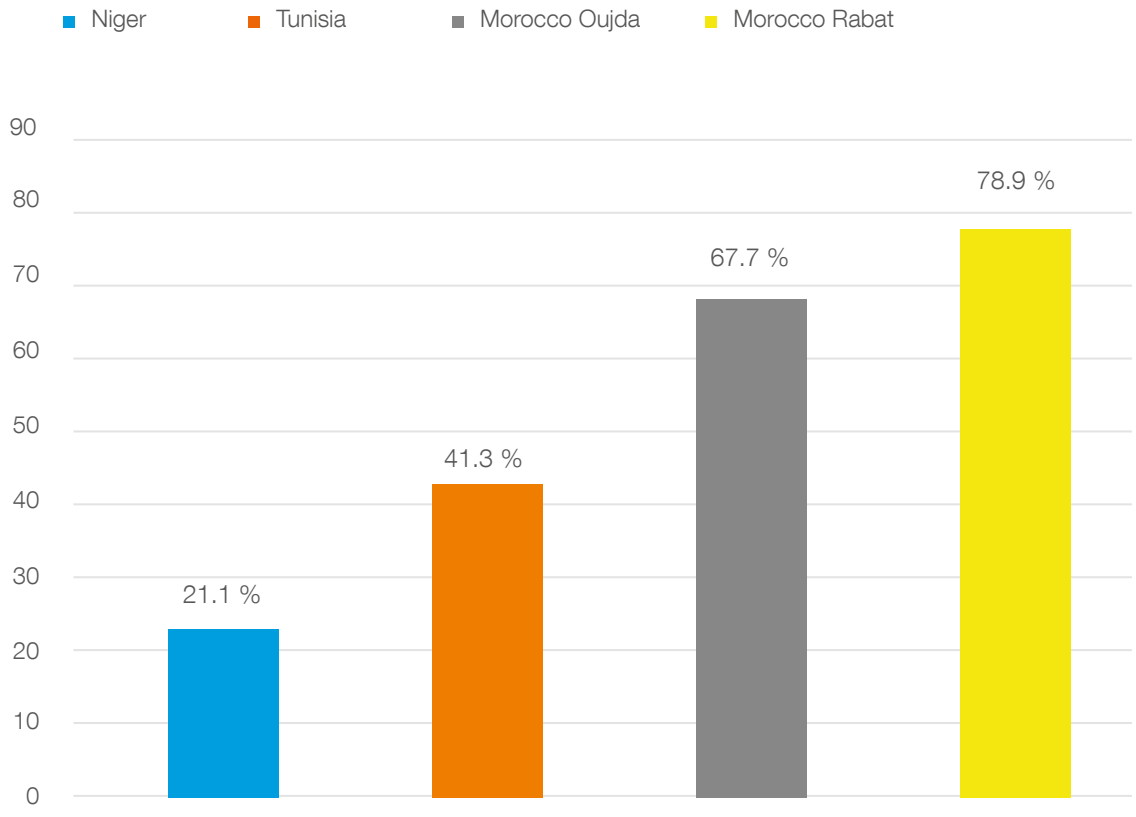
'You have to be on your deathbed for the doctor to treat you.'

'In Morocco, they prescribe treatments without taking the time to examine you.'

Everywhere, there appears to be a **link between health and the number of violent events experienced**. In Niger and Tunisia, this link seems to appear with the number of violent experiences during migration and in Niger itself. In Morocco, in Oujda, it also appears with the number of violent experiences during migration, but also en route, and in Rabat, it is also with the number of violent experiences en route, but also with the overall number of violent experiences.
There was also a clear trend between the **journey duration and health**. Health seems to deteriorate the longer the journey time in Niger and Morocco (Rabat), two out of three locations given that the analysis is not relevant for Tunisia as all the people interviewed had travelled by air.

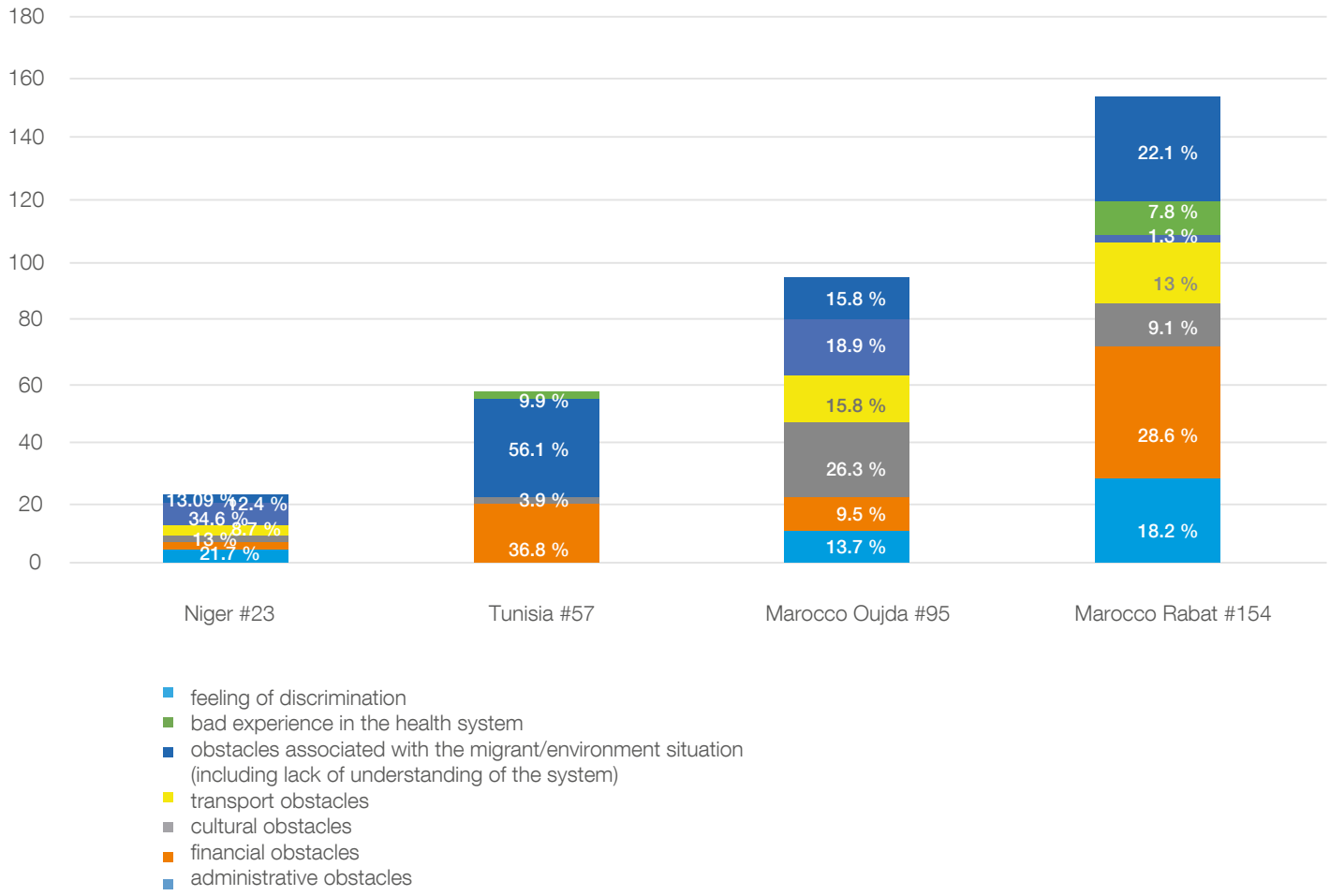
VII. ACCESS TO HEALTHCARE

Comparison of % of people who had encountered one or more obstacles to healthcare access



The proportion of migrants who had encountered obstacles in accessing healthcare was higher in Morocco than in Tunisia and much higher than in Niger. It should be remembered that the migrants in Niger had access to healthcare through the Doctors of the World programme.

Comparison of types of obstacles to healthcare access



The types of obstacle varied according to the location in which the migrants were interviewed. In Niger and Tunisia, the most frequent obstacles were those in the category 'associated with the migrant/environment situation', which comprises lack of understanding of the system. In Niger, the second most common were administrative obstacles, whereas in Tunisia, financial obstacles were also frequently reported. In Morocco, there were more obstacles reported, with a variation between the two locations: in Oujda, cultural obstacles were declared most frequently, followed by those associated with migrant/environment situation and the feeling of discrimination, whereas in Rabat, the most frequently reported were financial obstacles and the feeling of discrimination, then administrative obstacles.

Lack of understanding of the system was a major barrier, as shown by this testimony:

'Because we arrived in Agadez only recently, we don't know anything about the health system yet. Even those who feel their health is not so good, don't know where to go for treatment at the moment.'

5. Discussion

Among the determinants examined in the survey, it is important to point out that the **time factor** can make certain vary, as mentioned in the model proposed in the introduction. The administrative status represents their situation on the day of the survey, but for certain migrants this could change with time, for example, in the case of a visa expiry or recognition of refugee status for certain asylum seekers, etc. The data on the reported journey durations and stay durations are underestimated given that they were recorded on the day of the survey, at a point in time when the stay and journey had not finished. Likewise, given that **the migration process had not finished for the majority of the people interviewed**, they may still encounter new violent experiences and new obstacles to healthcare access.

This survey of 461 people shows that it is i**mpossible to reduce migration to a single, identical pattern**.
Nevertheless, although the stories of the migrants that we met were all unique, the difficult conditions of migration were a common point and these conditions are some of the social determinants of health.

The total population surveyed was **mostly female**. In the three locations where the way in which the survey was conducted had no impact on gender, in Niger, men were predominant, in Tunis it was the opposite, and in Oujda the gender distribution was almost equal. In Rabat, however, the female predominance was determined by the method of selecting the survey participants and may therefore have influenced the overall female majority.
It is known, as regards migration in the African continent, that this population is **young**, with a high number of minors, except in Tunis, a majority of whom are unaccompanied.
The countries of origin were essentially West African countries, and to a lesser extent, Central African countries, which is logical given that the survey was carried out in locations on certain migrant routes from these regions. In Tunisia, the majority were from Cote d'Ivoire, which leads us to believe that there is a preferred, organised migrant route between these two countries. We will see later that other arguments support and even confirm this idea.

The **vast majority** of the migrants surveyed had an **unregularised administrative status**, which has an impact on their rights, particularly the right to healthcare, as noted in the WHO report on migrant health (reference). Given this limited right to health, they in particular must search for alternatives to the local health system and therefore receive assistance from NGOs such as Doctors of the World. They are therefore one of the organisation's specific target groups. There were more migrants with a permit or an asylum application in Morocco given that the players assisting migrants encourage them to undertake these procedures, even if they do not want it, in order to facilitate their access to rights and particularly healthcare.

The **duration of the migration journey** is a **highly variable characteristic** among the population surveyed. For many migrants to Tunis and Rabat, the journey was made by air, with the cost of the ticket paid for as part of a contract between the migrant and an intermediary. This contract typically involves the financial payment of the journey by air and the provision of a job in the destination country (cleaner, domestic worker, farm labourer, etc.) in exchange for full payment of the migrant's salary to the intermediary for the work undertaken for a minimum of five months. Their identity documents are also withheld (in order to prevent any possibility of the migrant escaping) and often their personal belongings, such as their telephone. It is clearly apparent to us that this mechanism is a type of **human trafficking**[1]. For another group of migrants, the journey was essentially made by land and its duration can take up to several months. This is because the journey is interrupted due to circumstances, often the need for money to enable them to continue the journey. The amount of money needed is often higher than estimated at the time of departure, given the increase in the price of fares, necessary payments required at certain strategic points, the loss of belongings, etc. Gathering the resources needed is often difficult given migrants' limited access to work. They may then have to rely on family remaining in the country of origin to raise the funds. All of these eventualities extend the duration of the migrant journey and make the conditions even harder, to the extent that some migrants die while en route.

[1]Definition of the Council of Europe Convention against Trafficking: The expression 'Trafficking in human beings' shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.' (5)

Concerning the **duration of stay in the survey country**, it seems **very long for a majority of the migrants, and even more so for the women**. It should be noted, however, that without specific information concerning the exact reasons why these people were still in the survey country, we do not know whether this was a deliberate choice on their part.
It would seem that certain places, such as Agadez in Niger and Oujda in Morocco, are transit places, whereas capitals like Tunis and Rabat where there are financial opportunities for migrants, seem to be places where migrants stay longer and where sometimes, for some of the them, a future might be possible. However, this needs qualifying, since it seems true that the majority of the migrants surveyed in the focus groups often reported the desire to reach Europe, even to the detriment of their physical and psychological health, and aware of the kinds of violence they may encounter. We can also see that the people with an administrative status officially authorising them to stay, for any status other than a tourist or work visa (which have a limited duration in any case), had on average a longer duration of stay than the people who were unregularised.

According to many migrants stories, **the migrant journey is an ordeal**, particularly due to the violence they face while on the journey. A very large majority of the migrants (more than 80%) said that they had been a victim of violence. When this was narrowed down to the migration period itself (en route and in the survey country, without taking into account the country of origin), more than 60% of them stated that they had been a victim of violence, 35% en route, and 40% in the survey country with, therefore, a certain percentage who had experienced violence at both stages of migration. A total of 46% said that they had experienced violence in their country of origin, more frequently women than men. This would suggest, therefore, that although it is impossible to confirm based on the results of our survey, **the violence experienced in the country of origin could be a factor forcing people to migrate, particularly for women**.
Between the four survey locations, there were differences in the percentages of migrants who said they had been victims of violence, with higher figures for Niger and Oujda than for Rabat and especially Tunis. However, in three of the four locations (not in Tunis), the majority of migrants had experienced violence during their journey. In Tunis, the exposure to violence during migration was higher for women, whereas in the other locations it was lower for women. When it concerns violence including the country of origin, Tunis joins the other three locations to show a majority of people who had experienced violence.

It is fair to say, therefore, that **one violent experience can be expected in the story of any migrant**.
Out of the total number of violent experiences reported, the share is near equivalent between the three stages of migration – origin, journey, survey country – which means that more than two thirds of them occurred after the start of the migrant journey. It is even possible that this survey underestimates the number of cases of violence reported given the formulation of the corresponding survey questions (see chapter on limitations). Women seem slightly more protected during migration, as fewer women said they had been victims during this period than men. The data shows that trafficking systems such as those described earlier mostly concern women, which means they avoided violence en route and partially explains the fact that fewer of them had been victims of violence as a migrant.
The migration locations that do not offer the possibility of settling locally like Agadez and Oujda and the route leading to them seem to give rise to more violence than those where migration is to some extent more organised, as in Rabat and Tunis. The highest number of cases of violence were reported on the routes leading to Oujda and Niger.
Before looking at the types of violence that the migrants stated they had experienced, it is important to remember that no definition was given concerning the different types of violence that were possible responses. This means that the responses were based on the perception of the migrants interviewed who decided which category best matched their perception of the experience. For example, police violence must be understood as an act, of any kind, that the migrant perceived as violence carried out by a member of the police force. For the other possible responses, they identified the nature of the violence, but not the perpetrator. So, for assaults and injuries (two types), torture, sexual violence (two types), psychological violence and the confiscation of documents and/or money, the perpetrator was not identified. It is possible, therefore, that there are overlaps between the nature and the perpetrator of the perceived violence and that the migrant made a selection in their response based on their perception of what seemed important to them.
To gain a better understanding of the **violent events experienced during migration**, it is worth noting that the category of institutional **violence (violence by the police/army, confiscation of documents/money and prison) is the main form of violence, in general and also separately in each survey location, followed by the category of physical violence** (torture, and domestic and non-domestic assault and injuries).
The focus groups revealed that, in addition to the confiscation

of documents, body searches were made, combining institutional violence with physical, psychological and sometimes sexual violence. We can say that this extortion certainly has an additional impact on the health of the migrants since **one of the recurring obstacles to healthcare access is the lack of financial resources**.
Moreover, although the category of **sexual violence** appears infrequently in the responses, according to the migrants interviewed during the focus group discussions, **it would seem that it is frequent** and that women are systematically raped or forced to use their body as currency.
Among the cases of **institutional violence**, the **confiscation of documents/money** was most common. This can increase the vulnerability of migrants in terms of resources and therefore living conditions and access to healthcare. Violence by the police and army accounted for a third of the cases of institutional violence reported. However, in this distribution between violence by the police, confiscation of documents/money and prison, there are variations between survey locations which can be associated with the context. For example, the fact that in Tunisia confiscations accounted for 100% of the institutional violence suggests there is a trafficking network. Confiscations accounted for 100% of institutional violence, supporting or bolstering the argument that there are trafficking networks.

This same situation appeared in Rabat.
Men and women did not seem to be victims of the same types of violence; **gender had an impact on the type of violence experienced**. Men were more likely to experience institutional violence such as imprisonment and violence by the police/army, whereas women were more often subjected to sexual and psychological violence. For sexual violence, there was a big difference between locations, with very few reports in Niger and a lot more in Morocco. The culture (of the researchers) could be an aspect that may help explain these reporting differences, especially as the spontaneous testimonies in the focus group discussions tended to show that sexual violence occurred everywhere.
The stage of migration – country of origin, en route, and survey country – also had an impact on the type of violence reported, with essentially differences between country of origin and the two migration stages, en route and in the survey location.

Hunger also appears to be an area of concern for migrants. A significant number of migrants reported hunger, and once again, due to our survey methodology, it is highly probable that this is underestimated. Yet it is clearly recognised that under and poor nutrition have an impact on health.

Lastly, of the events we consider potentially traumatic, a **situation of war/armed conflict** was reported as a **life event for a third of the migrants** encountered, with 32% of them reporting such an event as a violent experience in their country of origin. These figures may be underestimated given the manner in which this information was obtained. This leads us to wonder whether fleeing a conflict setting is a factor forcing people to migrate.

What we can say about the health of the migrants that we had the opportunity to interview, what is clear and is of great concern to us, is the **fact that such a young population feels that their health is not good, women perhaps even more than men.** We know that **when setting out** on their journey, migrants are **younger and in better health than the average** of the general population. This survey shows to what extent migration, as it is at present, has a **negative impact on health**. The self-perceived health of migrants clearly deteriorates over the course of the migration period.
According to this survey, it seems that the health of these populations may be impacted by several factors including violence and the journey duration. We think that these two aspects should be considered as determinants of health that have a strong impact. We believe that other factors could also play a role in migrants' health: **living and socio-economic conditions, barriers to healthcare access, exposure to and the prevalence of certain diseases, which are therefore social determinants of health, with their specifics for migrants**.

As for access to healthcare, we can say that **a minority of migrants said that they had not encountered any obstacles**. The migrants who felt they needed healthcare were those who mentioned either one or more obstacles (including those who said that they had not attempted to visit a health facility but mentioned obstacles, which might explain this fact), or replied that they had not encountered any obstacle. Looking at those who felt the need for healthcare, 51% had encountered one or more obstacles to access, with variations between the locations, Morocco seemingly accounting for the most. So, **more than half of the migrants who felt the need for medical care had had difficulties obtaining it**. We can therefore say that access to healthcare for migrants is far from easy and far from being a respected right. The most frequently mentioned

barriers to healthcare were **financial obstacles** and it is safe to say that migration conditions have a direct impact on this aspect since, as seen earlier, migrants often run out of financial resources after paying the costs of the journey and having their money confiscated. The second most frequently mentioned barrier can also be considered to be a result of migrant **status** as it is poor knowledge/understanding of the healthcare system, in countries that are not their own and which operate differently, and due to their administrative status, which makes their right to healthcare more complicated. Lastly, **discrimination** seems to be the third biggest barrier and once again this is directly associated with the migrant status. **We can therefore say that being a migrant directly or indirectly leads to barriers to healthcare access**.

Lastly, testimonies regarding their life plans show that, for some, the terrible conditions of migration had made them change their plans and want to return to their country of origin despite all the reasons that made them leave. However, the vast majority told us that they wanted to **continue their journey, at all costs** and however they could, despite all the hazards and violence experienced and with the knowledge that there will always be other difficulties and violence on the way. Despite all the obstacles the migrants had encountered on their journey, this had not prevented them from wanting to continue.

From these results, we can see that there are **several 'types' of migrants**, associated with the manner in which they start their journey and their objectives, at least those in the interim. It seems that the primary goal of the migrants encountered in Tunis and Rabat was to settle there, at least temporarily. In those locations, there are in fact income-generating activities to which they seem to have access. However, in Agadez and Oujda, migrants had, at least at the time of departing, no intention of staying there longer than the time to find the means to continue their journey. They sometimes changed their plans, either by choice, also given the circumstances, or by constraint due to lack of resources.

There are also gender differences, differences in resources for the journey, and more.

It is therefore essential to remember that generalisation should be avoided when talking about migration.

6. Limitations of the survey

This survey has limitations and possible bias.
Firstly, the survey and its report are **not intended to be scientific**. We present results that have been analysed statistically. They therefore **reflect testimonies and trends, not certainties.** The report is a working paper and not a scientific article. However, it still provides very important and interesting information about migration conditions and their impact on the individuals concerned.

The possible limitations in the data collection include the language barriers encountered, limited access to the migrants for security reasons, and the movement of migrant populations.
In addition, Doctors of the World and its partners only had access to certain communities of migrants, those who were in contact with the Doctors of the World projects. **The population interviewed was therefore an opportunity sample associated with our NGO's projects**.
In addition, the researchers were workers directly associated with the projects, leading to bias in the responses to the questions that concern the projects' areas of work. Each survey location therefore had its own researchers, who were different in each location. This did not provide consistency and certainly resulted in bias in the comparisons between the four survey locations.
It should also be noted that the definitions of the possible responses was sometimes not precise and could therefore have led to a certain degree of interpretation.
For example, the responses were based on the perception of the migrants interviewed who decided which category best matched their perception of the experience. For example, police violence must be understood as an act, of any kind, that the migrant perceived as violence carried out by a member of the police force. For the other possible responses, they identified the nature of the violence, but not the perpetrator. So, for assaults and injuries (two types), torture, sexual violence (two types), psychological violence and the confiscation of documents and/or money, the perpetrator was not identified. It is possible, therefore, that there are overlaps between the nature and the perpetrator of the perceived violence and that the migrant made a selection in their response based on their perception of what seemed important to them.
In addition, for the responses to the questions on the violence experienced, an individual could only report a maximum of two violent experiences per stage. Therefore, even if the person reported two violent experiences per stage of migration, that person may have experienced more.
Moreover, the questionnaire included 'hunger' and 'war/armed conflict' in the possible responses for violence, yet these two items were removed a posteriori from the analysis of all the violent experiences in order to correspond with the WHO's definition of violence (see introduction).
These last two results, hunger and war/armed conflict, were analysed separately. Moreover, where hunger or war/armed conflict were reported as a violent event, this might have limited the reporting of other violent experiences. It is therefore possible that the figures on violence are again underestimates. Likewise, hunger and war/armed conflict were perhaps under-reported in the separate analyses for the same reason.
Again, the number of possible responses to the questions regarding barriers to access to healthcare were limited, so this element is perhaps also underestimated.

7. Recommendations

Based on the results and the information provided in this report, we believe we can make three types of recommendations: **general recommendations** aimed at policy makers, **operational recommendations** for those involved in assisting migrants, including Doctors of the World, and r**esearch recommendations,** for continuing and furthering awareness of the problems encountered by migrants, aimed at the academic community.

I. GENERAL RECOMMENDATIONS

1. For issues concerning violence, we refer to Objective 7 of the Global Pact for Migration adopted in Marrakech in December 2018 (6,7):
   We ask governments, to address the **structural factors, at all levels of authority, which lead to vulnerability among migrants, in this case the violence against them**. The circumstances or situations encountered at different stages in the migration process (country of origin, en route, host country), detailed in this report, increase the risk of exposing migrants to violations of their fundamental rights. As such, we ask that vulnerable migrants, regardless of their migrant status, have **access to quality services and healthcare, ensuring that their rights and dignity are respected.**

2. For issues concerning access to healthcare, we also refer to the Global Pact for Migration, more specifically Objective 15 (6,7):
   All migrants should have **safe access to basic services, particularly healthcare services, a fundamental human right**. We ask that the physical and mental health needs of migrants be taken into account in policies and plans at all levels of power, by building the capacities of services, and by reducing the barriers to access as described in this report.

II. OPERATIONAL RECOMMENDATIONS

1. The analysis of migrant health is multidimensional and complex, depending particularly on the risks and exposure to the factors during the journey and the migration process. In this respect, we propose an operational framework for migrant assistance projects, the **model of social determinants of migrant health** that we have established.

2. We think **mental health** should be **systematically taken into accoun**t in the operationalisation of projects. There are many risk factors associated with mental health, and these depend on the conditions of the migration process.

3. We must ensure, in our programmes, that we **build the capacity to care for victims of violence, taking a holistic and integrated approach**, tackling the consequences of these traumatic experiences on health on a somatic, psychological and social level.

4. To qualitatively tackle disease linked with epidemiology in the country of origin or migrant transit country, we propose building **the capacity of local health workers on these sometimes less well-known themes** given the different regional epidemiology.

5. We think that, in our projects, we should **develop cooperation with community leaders** in order to inform them and raise their awareness on **human rights** issues, and to increase their consideration in their relations with the migrants they may encounter.

6. Health is a universal right and access to healthcare is an essential factor. We ask that this fact be taken into account by all healthcare players in order to give migrants the same access to healthcare as the countries' nationals, thereby **removing the barriers that restrict migrants' access to healthcare**.

7. We think it would be worthwhile implementing, in areas where there is a conflux of migrants, a **0.5 operation in the healthcare lines**. Implementing this outreach function **aims to bring health professionals into con-**

tact, **in the places they live, with population groups who do not often seek healthcare even when they feel it is necessary**. The goal would be to raise awareness, gain the trust of, inform and thereby eliminate barriers to access to healthcare, the final objective being to bring people into the health system.

8. We think that **Doctors of the World**, in its position as an advocacy organisation and as a player in the sector and with its projects for migrants, **must play a role in the EVAM project (see annexe), which ultimately aims to eliminate violence against migrants.**

III. RESEARCH RECOMMENDATIONS

We think that, based on the information provided in this survey, there is material for scientific research, with a rigorous methodology that would limit the bias we were able to identify in our survey, on subjects such as:

1. What is the impact of violent events on health? Is it a question of number of violent experiences, types of violence? Should we introduce a scale of perceived seriousness of violence in order to measure this factor?
2. What is the impact of the journey duration? Is it a direct impact or indirect factors that determine health?
3. What is the impact of other determinants of health identified in our model and forming part of our questions? Are there others that we have not identified (directly asking migrants about this)?
4. Studying the change in health during migration at different moments in order to gain a better understanding of the impact of migration events and of migration in general.

8. Acknowledgments

We would like to thank all the people who made this report possible, starting with the migrants who agreed to share their experiences with us and also all our colleagues at Doctors of the World Belgium and the partners who did a tremendous job on this survey.

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ENDING VIOLENCE AGAINST MIGRANTS

CONCEPT NOTE

MÉDECINS DU MONDE
22 October 2018

By deliberately restricting its scope, EVAM aims to address one of the most disturbing aspect of migration: widespread violence.

ENDING
VIOLENCE
AGAINST
MIGRANTS

EVAM

Background

Context | Rationale

CONTEXT

The project was born from the observation that despite numerous initiatives trying to cope with migration, contributors consistently ended up in a deadlock situation in which human rights' defenders opposed and criticised policies developed to keep migrants at bay.

The process aimed at improving migration policies has been ongoing for a long time and took a significant turn after the height of the European migrants' crisis in 2015. Discussions on the Global Compacts largely contributed to take the measure of where we were globally.

Unfortunately, **the ability of these processes to translate into concrete change on the ground is likely to remain limited and remote in time**. The daily suffering of the multitude of people on the move, seeking for a safe haven or a better future, **calls for immediate action**.

The political environment in the global north does not encourage more exchanges nor promote permanent migration as possible opportunities. Efforts to challenge existing policies and practices are essential, but not enough. **What is truly needed, are initiatives that can bring some immediate relief now**.

What EVAM proposes is to look into migration issues through a new lens, the one of violence in its many forms affecting migrants, making the assumption that many –if not all– can agree that there is a global interest to reduce harm and suffering.

RATIONALE

In an environment where positions seem often irreconcilable between the champions of migrants' fundamental rights and the defenders of states' sovereign rights to control their borders and regulate migration flows, EVAM does not take sides.

The United Nations General Assembly Resolution 67/185 "Promoting efforts to eliminate violence against migrants" and its technical report dated 2015, had already pointed to the *« continuing instances of criminal acts committed against migrants, migrant workers and their families in all regions of the world, including acts of violence »*, calling for states to *« strengthen their efforts to prevent and combat violence, prosecute its perpetrators and protect its victims »* (*cf.* UNODC/IFRC, Report, *Combatting Violence Against Migrants*, 2015).

The EVAM initiative has been designed to complement and reinforce these efforts aimed at better accompanying and managing migration schemes, specifically or globally (*e.g.*, NY Declaration, GCM, UNGA Res. 67/185, OSCE Migration Report 2017). By deliberately restricting its scope to **violence – understood here as any use of force or power that results in harmful consequences for migrants–**, it aims to address one of the most disturbing and widespread by-products of migration.

EVAM's central assumption is that no actor –or very few– might be reluctant to act to limit the harmful consequences of their policies or practices if these situations of violence are clearly known and identified, and if the proposed corrective measures put forward by EVAM do not contravene their objectives nor interests.

It promotes a pragmatic approach that, instead of looking at the drivers of practices and policies in place, focuses exclusively on their harmful consequences for migrants.

Concept

Genesis | Vision

GENESIS

Since 2016, a group of experts have gathered regularly in Brussels to test this assumption and discuss how it could be translated into concrete action –and all confirmed their belief that EVAM had the ability to deliver significant change in the lives of migrants in the short, medium as well as longer terms.

They exposed their views from their various standpoints as member states' representatives, trade unionists, directors of European institutions, human rights' activists, heads of aid agencies, academics and researchers.

EVAM was born from these consultations. **It is an ambitious process**, meant to be:

- **inclusive and transversal**, by enabling a wide range of public and private actors to engage in the process and become drivers of change;
- **global**, applied at every level involved in the migration process where action is required (*e.g.*, international, national, local levels);
- **effective and accountable**, by assessing the situation and taking stock of the results; and is finally meant to have a:
- **multiplying effect**, as an action at one level may work on perceptions and trigger more initiatives in other domains, and at other levels.

VISION

Harm and violence inflicted on migrants varies in nature and intensity. To reach the objective of ending violence, the involvement of a wide range of stakeholders in a position to act on harmful situations is required.

In the past, initiatives aimed at alleviating violence towards specific groups of people particularly exposed to harm and abuses (*e.g.*, slaves, children, women) required global mobilisation. Nowadays, making progress towards less violence against migrants is likely to require dynamics similar to those previous enterprises that contributed to shape a more humane and dignified world, in accordance with human rights.

To ensure that eradication of all forms of violence against people on the move becomes an overarching priority and a collective endeavour, EVAM intends to involve a large diversity of stakeholders at every relevant level, including states, municipalities or public services, but also trade unions, commercial companies, non-governmental or community-based organisations.

Through this multi-stakeholders' approach, EVAM aims to demonstrate that anyone might act towards, and eventually succeed in, reducing or eliminating violence against migrants.

Methodology

Tracks I Phases

TRACKS

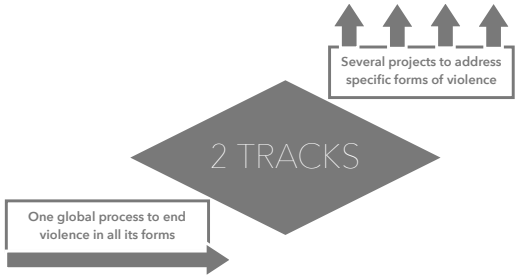
To cover the scope of the problem, EVAM develops a two-tracks approach: the declination of projects aimed at identifying and addressing specific situations of violence, and the systematisation of the process to enable further impact on other situations of violence.

The first track is project-based. EVAM is fundamentally a bottom-up approach. It finds its legitimacy in its ability to bring effective well-being to migrants. Therefore, **each project developed is selected and implemented with one very specific and circumscribed role –the reduction of violence**.

At the same time, and in addition to the immediate benefits brought to their beneficiaries, each of these projects contributes to validate EVAM's postulate that, by making violence visible and mobilising targeted actors, harmful situations can be fixed or improved.

In that sense, they also serve a greater purpose and call for a more global impact and approach: to make *all* situations of violence against migrants visible.

The second track is global: by systematising the collection of data, **EVAM's global demarche sheds light on trends and supports a priority process** that will lead to the identification of situations that require EVAM's immediate attention, and the development of new projects. The global approach will also lead to the development of tools and the promotion of mechanisms adapted to a more holistic response.



PHASES

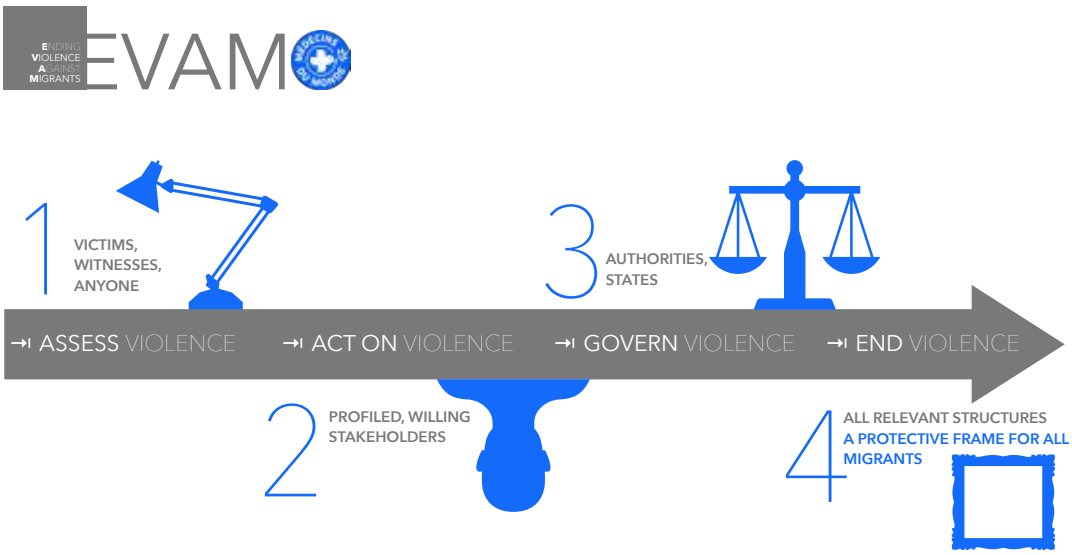
Both the project-based and the global approaches follow the same sequence of documentation, mobilisation, institutionalisation and formalisation phases.

STEP 1 – DOCUMENTATION

Monitor the causes of violence and prioritise the response.

The first step of the initiative is to document acts of violence perpetrated against migrants in order to identify where progress can be made in reducing the occurrence of these acts.

Specific situations of violence are documented **through dedicated projects**. In support of these projects, EVAM can operate **indirectly** with the support of Médecins du Monde (MDM) and other partners already operational where the situations of violence occur. It then promotes and supports its partners in the implementation of its methodology to document harmful behaviours and situations of violence. In a Belgian pilot for instance, the



stakeholder targeted was the Belgian Police, but the action took place through the work of the medical consultations of MDM-BE.

Direct intervention requesting from the main stakeholder to document situation of violence can also be conceived. EVAM provides then guidance and methodological support in the documentation process.

At a global level, a more systematic documentation of abuses is organised. Allegations of harmful behaviours are collected from EVAM's projects, partners (*e.g.*, human and migrants rights organisations), witnesses or victims of abuses.

The gathered elements will feed into **a global monitoring matrix** at an early stage of the process. The matrix will be enriched through time to ensure efficiency and accuracy of the approach. All relevant actors, witnesses and victims will be invited to contribute to the documentation and assessment of violence.

The matrix will set a typology of the main trends of violence and harmful situation impacting migrants. **The information reported will be cross checked and verified. It will lead to a prioritisation process following several criteria, such as:**

- the **frequency** of the abuse;
- the **intensity** of the reported harmful behaviour, taking into account the vulnerability of the victims (*e.g.*, unaccompanied minor, persons with disabilities, *etc.*);
- the **capacity to identify** the main **causes(s)** of the reported behaviour;
- the **ability to influence** some of these **source(s)** through mobilisation.

The protection of the personal data related to the victims of violence will be carefully organised and guaranteed throughout the process.

STEP 2 – MOBILISATION

Eliminate identified causes of violence.

Once the assessment is delivered, **the second step of the initiative is to mobilise all stakeholders in capacity to improve the situation and reduce the levels of violence** inflicted to migrants.

Through dedicated projects, relevant stakeholders are identified, encouraged to acknowledge the situation and to act to prevent and eliminate harm. When feasible, EVAM makes concrete propositions to allow the main stakeholder to reduce violence without challenging its goals.

To promote a more global approach and ensure the widest possible impact, the initiative also proposes to all stakeholders potentially in a position to influence violence to **sign a charter promoting the reduction of violence against migrants**. Those committing to this charter will be encouraged to take measures to eliminate identified violence based on an action-plan tailored to their specific situation and goals.

The charter will operate like a declaration of intent and formalise the acknowledgement by relevant actors of

the need to consider the potential negative impact of their decisions and acts on migrants. The first expected effect of this charter will be to raise awareness and increase vigilance towards possible harmful behaviours. As well, it is likely, on the long term, to have a positive spillover effect and contribute to global awareness.

The mobilisation process:

- **Formalise the initiative through a list of commitments gathered in a charter**, which will remind the main rights and principles applicable to all, and specifically to migrants. It will as well recommend a series of measures aiming at eliminating violence and harmful situations against migrants. Recommendations and proposed approaches will be precise enough to provide guidance but sufficiently open to allow each stakeholder to find its own ways to address problems specific to its field of activity.

- **Pro-actively approach stakeholders** that have been identified as in a position to reduce or eliminate harmful situations that have been previously documented. EVAM will propose concrete actions to address the documented situation and seek their adhesion to a global demarche aiming at reducing violence against migrants, based on the main principles and commitments of the charter. Stakeholders perceived as more likely to endorse the principles and recommendations of the charter will be prioritised.

- **Accompany and support stakeholders** that have adopted the charter and are committed to act to reduce or eliminate violence against migrants.

The multi-stakeholder approach is an essential component of the initiative –as inclusive. It requires as well to adapt the approach to the various type of actors targeted.

STEP 3 – INSTITUTIONALISATION

Request public authorities to lead and promote the process.

States, regional and local authorities have a primary responsibility to protect populations living on their territory. By acting to protect migrants from all forms of violence, public authorities contribute to reduce tensions between communities, restore migrant rights, and enhance their integration capacities.

Like-minded authorities at local, national or regional levels will be sensitised on the need to promote measures aimed at reducing harmful situation against migrants.

The initiative recommends the constitution of **coordination bodies** at local and national levels, in charge of the promotion and implementation of action plans for the prevention and the eradication of violence against migrants.

EVAM will also offer its support as a consultative body to accompany the development and implementation of these action plans.

STEP 4 – FORMALISATION

Promote a normative frame to prevent and eliminate violence against migrants.

At a later stage, migrants should be included amongst the categories of individuals that need specific protection, and the formalisation of a normative framework to fight trends of violence and harmful behaviours against them. These protective norms can be developed at all necessary levels: local, national, international.

To ensure long terms benefits from specific projects, ad hoc corrective measures should be completed by the adaptation of the rules and regulations that constitute the **immediate normative environment** where migrants have been confronted to violent situations. Existing norms should be amended in order to create a more protective environment, better adapted to the risks identified.

More globally, in an environment dominated by negative narratives against refugees and migrants, the promotion of an **international convention** to prevent and eliminate violence against migrants will work as a strong incentive to eradicate violence, amend perspectives and correct perceptions.

Partnerships will be developed with academics and international bodies, such as the Council of Europe, to develop a project of international convention, and seek for the buy-in of key actors (*e.g.*, IOM) and potential signatory states to support and promote the initiative.

Additional benefits

Social I Political

SOCIAL

While preventing and reducing harm is in the obvious interest of migrants, the benefits outspread much beyond. Aiming at ending violence responds to essential political considerations and can work as a strong social incentive.

Setting the objective to eradicate all forms of violence against migrants is a transversal goal that covers all categories of migrants whether they qualify to a refugee status or not. **The reduction or elimination of harm is not an exclusively migrant-centred approach, it also responds to the economic, social and political interests of hosting states and populations.**

Successful social integration improves perceptions of migrants and reinforce the sense of social belonging that constitutes an important factor for integration[1].

A contrario, poor access to resources, decent conditions of living or to basic services fuels a destructive cycle, negative narratives, and exacerbates hostility between host societies and migrant communities. Similarly, excluding irregular migrants from access to healthcare can put their lives and well-being in danger, increase the cost of future emergency care and may also present a health risk for the population[2].

POLITICAL

States are often reluctant to be blamed and identified as unscrupulous in terms of protection: they seek political credibility vis-à-vis the international community and are generally receptive to arguments allowing them to implement a moderate migration policy.

This may include, for example, the development of policies to implement a set of international standards on detention or return. This can also be seen in the desire to align international standards with measures to reduce harm. For example, one may seek to establish an effective return policy that is not violent or to identify measures to better implement the principle of non-refoulement.

[1] Eze Vincent, Kiarie Benard, *Perceptions and Experiences of Social Integration among Adult* Immigrants, Thesis, Faculty of Health and Occupational Studies, University of Gävle, 2016. Last consulted October 18th 2018 on: http://www.diva-portal.org/smash/get/diva2:1033632/FULLTEXT02.

[2] FRA, Report 2011, *L'accès aux soins de santé des migrants en situation irrégulière dans 10 États membres de l'Union européenne*. Last consulted October 18th 2018 on: https://fra.europa.eu/sites/default/files/fra-2011-fundamental-rights-for-irregular-migrants-healthcare_fr_0.pdf

EVAM

HAS NOW ENTERED ITS PILOT PHASE
with studies and projects circumscribed to a sector and limited geographical area.

In 2018, EVAM launched its first pilot project in Belgium focusing on police violence against migrants, first reported through MDM-BE's medical facilities in Zeebrugge, Ostend and Brussels.

The pilot demonstrated marked interest of the Belgian authorities and proved the ability of the EVAM approach to create rapid and concrete changes on the ground.

Preliminary insights revealed by this first pilot should inspire future perspectives and projects.

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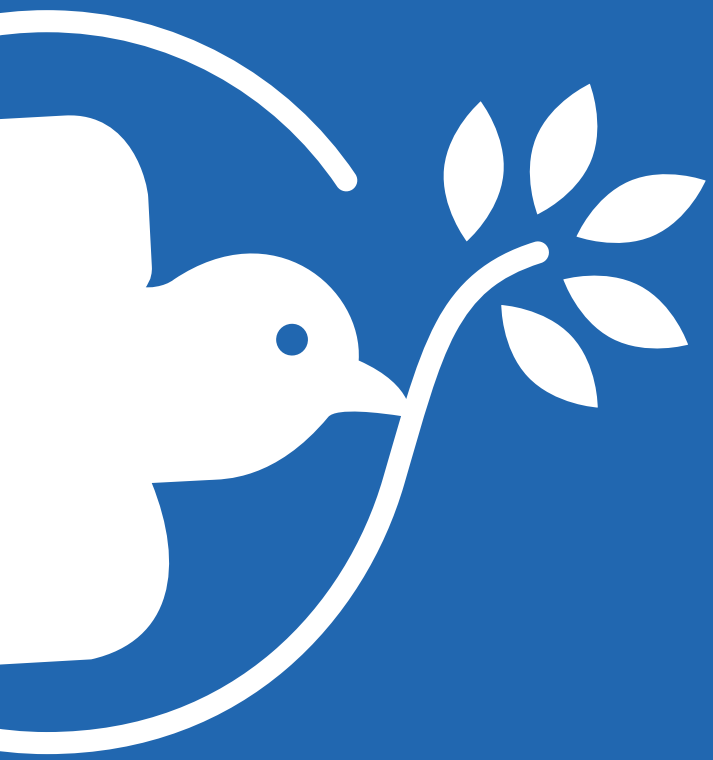

ALSO CURES INJUSTICE

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