Undocumented migrants have diverse health problems

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ABSTRACT

INTRODUCTION: In 2008, 1.9-3.8 million undocumented migrants lived in Europe. We aimed to strengthen the evidence base on undocumented migrants' health problems by describing characteristics of undocumented migrant patients in a Danish non-governmental organisation (NGO) health clinic.

MATERIAL AND METHODS: All patient files from the period from 24 August 2011 to 28 January 2013 were included in the study. Patient contacts were systematically analysed for age, sex, country of origin, medical referrals, symptoms and diagnoses. Contacts were classified by patient complaints or symptoms based on the International Classification of Primary Care, 2nd Edition (ICPC-2).

RESULTS: A total of 830 patients (39.75% women and 60.25% men) visited the clinic, which led to a total of 2,088 visits and 1,384 ICPC-2 classifications. The patients seen had 94 different nationalities. The most common reasons for medical contact correspond well with the pattern seen in general practice and several chronic and severe cases were observed in the NGO clinic. Furthermore, a larger share of pregnant women presented (11.6%) compared with a Danish general practice (5.1%), and these were seen first in a late gestational age on average (16+ weeks).

CONCLUSION: Undocumented migrants presented with diverse health problems. Some patients presented with critical disease, and an alarming number of pregnant women did not seek medical care until a late stage, and they did not return for infant care after giving birth.

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In Europe, undocumented migrants' health has received increasing attention in recent years. There were an estimated 1.9-3.8 million undocumented migrants in Europe in 2008 [1]. It has been estimated that up to 5,000 undocumented migrants reside in Denmark though this estimate is associated with considerable uncertainty [2]. There is increasing research interest in exploring the health characteristics and access to health care among this specific and vulnerable migrant population [3]. Studies have shown that undocumented migrants in Denmark face formal and informal barriers to public health-care access, which influence their care-seeking strategies, and that they tend to avoid or postpone contact with public health care [4, 5].

Moreover, uncertainties exist among health professionals in public health care as to how they should respond to undocumented migrants [4, 6]. In response to undocumented migrants' lack of access to national health care in many European countries, non-governmental organisations (NGOs) are now offering a varying range of services. In Denmark, the Danish Red Cross, Danish Medical Association, and Danish Refugee Council established a health clinic in 2011 that specifically targets this group. The clinic is located close to the central station in the capital of Copenhagen.

So far, there has been little collaboration between NGOs and researchers with a view to documenting the health characteristics and needs of undocumented migrants. This article aims to increase our knowledge on undocumented migrants' health by describing the characteristics of this patient group. This study was carried out in cooperation with the above-mentioned NGO health clinic in Copenhagen that provides primary medical, dental and midwifery care to undocumented migrants.

MATERIAL AND METHODS

All patient files from 24 August 2011 to 28 January 2013 were included in the study and extracted from the patient file software employed at the clinic (EMAR). Patient files were systematically analysed for age, sex, country of origin, medical referrals, symptoms and diagnoses. Patient files were classified according to the International Classification of Primary Care, 2nd Edition (ICPC-2), but a separate category for dental problems was added as dental problems made up a substantial portion of the reasons for consultation. As physicians work in the clinic on a voluntary basis, the clinic experiences a high staff turnover, and classification might therefore have been based on different criteria at the time care was provided. To ensure valid classification, all patient entries were read and classified by a medical doctor with experience in ICPC-2 classification. The files were classified by patient complaints or symptoms. On some occasions, a single patient visit would lead to registration of two or more classifications. In other cases, several visits by the same patient would only lead

ORIGINAL ARTICLE

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TABLE 1

Age- and gender distribution in the population of undcoumented migrants. The values are n (N = 830).

Age, yrs	Female	Male	Total
0-10	11	9	20
11-20	18	10	28
21-30	141	153	294
31-40	92	198	290
41-50	39	82	121
51-60	10	36	46
61-86	19	10	29
Total	330	498	828[a]

a) Gender was not reported for 2 migrants aged 42 and 53 years.

to registration of a single classification if the reason for seeking health care was the same for all consultations.

In this article, undocumented migrants are defined as migrants without a valid residence permit authorising them to regularly stay in the country in which they are currently residing. The United Nations Statistics standard country division was used for grouping of nationalities, but Western Asia was separated from Asia and renamed the Middle East. The study was approved by the Danish Data Protection Agency and the Danish National Board of Health.

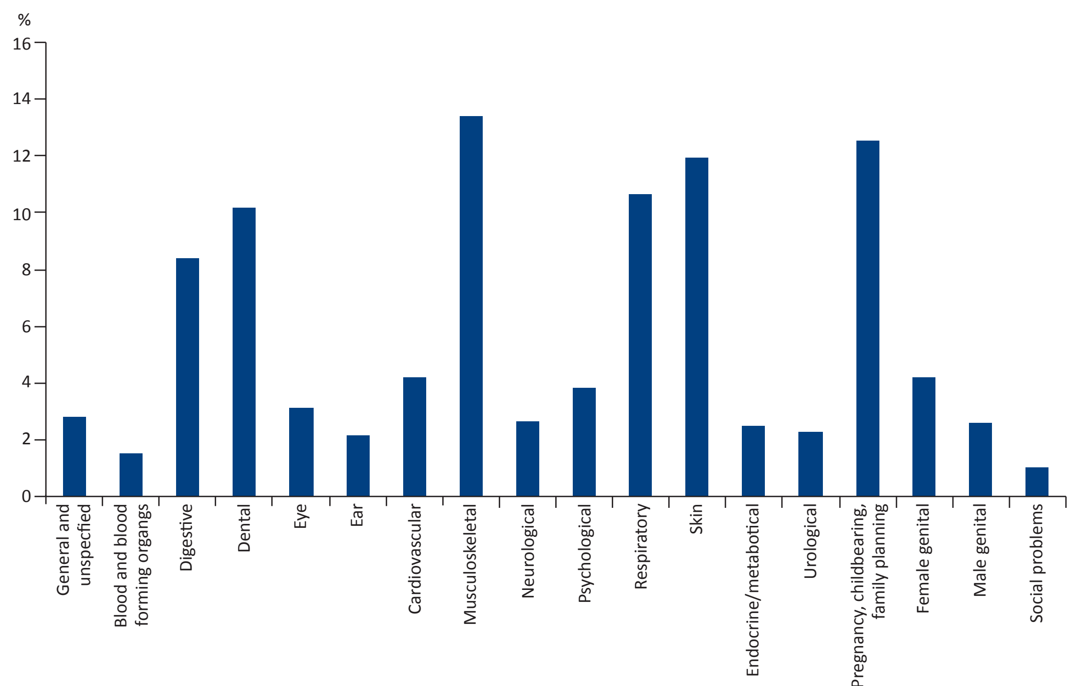
Trial registration: not relevant.

RESULTS

A total of 830 patients (39.75% women and 60.25% men) visited the clinic which led to a total of 2,088 visits and 1,384 ICPC-2 classifications. The age- and sex distribution among patients is presented in **Table 1**. The patients in the clinic were from Africa (33.4%), Eastern Europe (22.0%), Asia (18.3%), the Middle East (11.9%), Western Europe (8.7%), South and Central America (3.4%), North America (1.1%) and Oceania (0.2%). The clinic was visited by patients of 94 different nationalities, with the largest groups being from Romania (13.8%), Nigeria (9.9%), Ghana (7.0%), and the Philippines (6.0%) (see **Table 2**).

Figure 1 shows the distribution of the patients' complaints based on ICPC-2 classification diagnoses. The five most common classifications were related to the musculoskeletal system (13.5%); pregnancy, childbearing and family planning (12.9%); skin (11.8%); respiratory issues (10.8%); digestive issues (9.4%); and dental issues (9.2%). In all, 96 of 830 patients (11.6%) contacted the clinic to access services related to pregnancy. The first contact to the clinic was made at a median of 16 + 4 gestation weeks (range: 4 + 2 to 38 + 1). Among pregnant women, two (2.1%) patients were diagnosed with human immunodeficiency virus (HIV) and one (1.0%) with chronic hepatitis B virus infection. In total, five (0.6%) patients tested HIV positive. In 63 (3.0%) cases, patients were referred for immediate hospital treat-

FIGURE 1



The percentage distribution of the patients' complaints based on ICPC-2 classification diagnoses (n = 1,403).

ICPC-2 = International Classification of Primary Care, 2nd Ed.

ment; and in 108 (5.2%) cases, patients were referred to a specialist in private practice. A total of 11 (0.5%) patients were referred acutely or sub-acutely to a hospital for assessment for tuberculosis (TB); and of these, two proved to be TB positive, four were TB negative and five were lost to follow-up. Several patients with critical diseases were seen in the clinic, for instance acute angle-closure glaucoma, AIDS, anterior uveitis, cerebral palsy, multiple sclerosis, severe anaemia, symptomatic chronic lymphatic leukaemia and upper gastrointestinal bleeding.

DISCUSSION

We present the hitherto largest study based on validated health data in undocumented migrants in Northern Europe. While it may be challenging to conduct research on undocumented migrants as they lead invisible lives hidden from the public, the patient files from the health clinic provide a unique opportunity to describe the health characteristics of a large sample of undocumented migrants. However, apart from medical data and basic demographic information, there is limited information about the background of the patients as clinic staff do not request this information. Moreover, as the clinic is based on voluntary staffing, the resources to continuously collect and process data are limited.

Based on our data including 830 undocumented migrants seeking health care over a period of 17 months, the estimate that only 5,000 undocumented migrants should be residing in Denmark seems to be an underestimation. Undocumented migrants may experience difficulties accessing care. Some undocumented migrants have no knowledge of the existence of the NGO clinic, and many undocumented migrants may also be based outside the capital area. Others might not seek care in a clinic due to fear of being handed over to the authorities. A study from Denmark has shown that fear of being reported to the authorities is a barrier in undocumented migrants' access to public health care [4]. We do not know if the demographic composition of the undocumented migrants analysed in this article is representative for undocumented migrants in Denmark as the data needed to ascertain this are not available. A new NGO clinic has recently opened in the second largest city in Denmark, which will contribute to obtaining additional information about undocumented migrants outside the capital area.

A large proportion of the patients seen in the clinic are from Eastern Europe, including EU countries such as Romania. In relation to this, it is important to note that EU citizens may travel visa-free in the Schengen region for a maximum of 90 days during any 180-day period. If the migrants are applying for work, they can stay 180 days and longer, provided they can document that they

TABLE 2

Patients seen in the Clinic for Undocumented Migrants, by country of origin. The values are n (N = 828).

	Female	Male	Total
Africa	100	177	277
Nigeria	35	47	82
Ghana	18	42	60
Morocco	4	17	21
Uganda	9	4	13
Algeria	2	9	11
Egypt	0	10	10
Cameroun	8	1	9
Kenya	7	2	9
Tunesia	0	8	8
Guinea Bissau	1	5	6
Somalia	3	3	6
The Ivory Coast	1	4	5
Gambia	1	4	5
Sierra Leone	2	3	5
Others	9	18	27
Eastern Europe	58	161	219
Romania	20	93	113
Poland	4	30	34
Bulgaria	7	12	19
Albania	4	6	10
Slovakia	7	3	10
Macedonia	2	7	9
Latvia	3	3	6
Others	11	7	18
Asia	105	47	152
Philippines	47	6	53
Afghanistan	18	7	25
Pakistan	11	8	19
Bangladesh	8	10	18
India	1	12	13
Thailand	7	1	8
Others	13	3	16
Middle East	38	59	97
Turkey	18	13	31
Iraq	6	17	23
Iran	6	11	17
Lebanon	5	3	8
Syria	3	5	8
Palestine	0	7	7
Western Europe	10	28	38
Spain	2	6	8
Denmark	3	3	6
Italy	1	5	6
Portugal	2	4	6
Others	2	10	12
Central and South America	15	13	28
Brazil	4	1	5
Argentina	1	3	4
Chile	2	2	4
Others	8	7	15
North America	2	7	9
USA	2	5	7
Canada	0	2	2

Danish Red Cross Clinic for Undocumented Migrants.
Photo: Vibeke Lenskjold.

are applying for work. A visa or work permit has to be obtained if they are staying for more than 90 days [7]. According to these regulations, migrants from EU countries may be categorised as undocumented migrants if they do not meet the requirements for legal residence 90 days after entry into Denmark. The clinic does not question patients in detail about their migratory status; however, experience has demonstrated that many of the migrants from Eastern Europe struggle to get formal jobs and hence could be categorised as undocumented migrants 90 days after entry into Denmark.

Undocumented migrants have limited access to public health-care services in the majority of European countries, and NGOs are therefore central actors in providing health care for this group [3]. Overall, our findings showed that many of the most common reasons for medical contact correspond well with the pattern seen in general practice. However, it was found that the distribution of first-time contacts related to pregnancy was higher in the clinic for undocumented migrants (12.9%) than in a selection of general practices in Denmark (5.1%) [8]. Also, the time of first contact varies, and the median time of first contact for pregnant women (+16 weeks) is later than recommended by the national Danish guideline. This is consistent with the findings of a German study, which established that many pregnant undocumented migrant women did not appear in the NGO clinic until their final trimester [9], and a similar conclusion was reported in a Swiss study [10]. Similarly, we found that the number of contacts regarding care for infants and children was very low, which raises concern as to if these children are seen for vaccination and child examinations as they represent a particularly vulnerable group among undocumented migrants. Lastly, like other NGO clinics, the service was suitable for primary care contacts; yet, several patients presented with severe disease that was beyond the treatment possibilities of the clinic. Further research is needed to identify if undocumented migrants have any concerns about bringing infants or children to the NGO clinic or if they use other options.

CONCLUSION

Undocumented migrants presented with diverse and occasionally critical health problems. An alarming number of pregnant women did not seek medical care until a late stage, and they did not return for infant care after giving birth. There is a need for future collaborative research between NGOs and researchers to build knowledge on the health issues of undocumented migrants.

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