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Migration and the Right to Health:

**A Review of European
Community Law and Council
of Europe Instruments**

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IOM International Organization for Migration

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FOREWORD

Migration today involves diverse categories of people: migrants, asylum seekers, refugees, victims of trafficking and others in need of international protection and assistance. Their respective migration processes vary widely and, for some, the migration experience poses a number of challenges to their physical, mental and social health.

The objective of this study is to provide a legal perspective on migration health in Europe through a review of European Community Law and Council of Europe instruments. As will be seen, numerous instruments exist in the European context recognizing that the right to health is a fundamental human right applying to nationals and non-nationals alike. Their aim is to ensure protection of health and equitable access to health care of appropriate quality for all, in accordance with the individual's medical needs.

Nevertheless, health inequalities between nationals and those who have migrated persist in the region, both in terms of health status as well as in access to health services of equal quality. This study seeks to highlight these challenges to migrant health within Europe, both in law and in its application. It seeks to draw together the multitude of legal instruments that exist into one document as a basis for further thinking and work in this important field.

Human rights are migrant rights. The right to health is not, and must not be, the exclusive right of nationals, nor is its application dependent upon legal status. It is hoped that this study brings us one step closer to ensuring respect for the right to health for all those who migrate, regardless of their status.

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The approach and content of this study have been influenced by the work being carried out by IOM colleagues, the European Network for Exchanges and Cooperation on Migrants Social Exclusion and Health Issues (SESAME NETWORK), the health practitioners working with persons involved in migration in various European Union and Council of Europe Member States, the Migrant-Friendly Hospitals Project Group, the Platform for International Cooperation on Undocumented Migrants (PICUM) and other intergovernmental and non-governmental organizations. In addition, the author would like to acknowledge the suggestions and comments from IOM colleagues: Ryszard Cholewinski, Jillyanne Redpath, Jacqueline Weekers and Anita Alero Davies. Mary Haour-Knipe, a former IOM colleague, should also be acknowledged. The author also thanks Piotr Mierzewski for gathering comments from the Council of Europe (CoE): Henrik Kristensen and Rona Sterricks from the Directorate General of Human Rights and Legal Affairs; Petya Nestorova from the European Committee for the Prevention of Torture (CPT) and Gerald Dunn from the European Court of Human Rights should be thanked for their valuable contribution.

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INTRODUCTION

The objective of this study is to provide a legal perspective on migration and health in Europe through a review of European Community Law and the Council of Europe instruments.

This study, before compiling the various legal instruments, examines health and migration in the region. Part I briefly describes the migration phenomenon in Europe and the health implications it has for persons involved in migration. It shows that migration in and of itself is not a risk factor to health. Individually or collectively, however, the process of migration can result in vulnerability to physical, mental and social health problems, depending on the migration conditions. It also highlights that the right to health as a human right applies to nationals and non-nationals alike, and examines the competence of the European Union in health matters as well as the limits and evolution of the EU's influence over health issues. It then undertakes an in-depth analysis of the entitlement to health care, which should include prevention, treatment, care and support, starting with EU citizens and third country nationals requiring health care abroad within the EU. It continues by dealing with access to health care for: irregular migrants, victims of trafficking, asylum seekers, refugees, and other persons in need of international protection. It then illustrates the barriers persons involved in migration in general, and specific groups in particular, encounter when accessing health care services. Finally, it offers some recommendations regarding the situation as described and the way forward.

The second part (Part II) commences with a short glossary of sources of European Community Law and Council of Europe instruments to guide the reader through instruments, both hard and soft law that follow¹. It is divided into two sections: European Community Law (II.1), consisting of both

¹ While European Community law is binding, the same cannot be said of all Council of Europe instruments. Some of these, like the Convention for the Protection of Human Rights and Fundamental Freedoms and other treaties, are binding while the various recommendations and resolutions are “soft law” only. The Council of Europe, established in 1949, is a different organization from the European Union. Its membership is also different: whilst EU has 27 Member States as from 1 January 2007, the Council of Europe has a membership of 47 countries. However, the Council of Europe and the European Union have worked in parallel and on a comparative basis (e.g. a country willing to join the EU must also pass the “political criterion” which means that it has to show a high level of respect of human rights, democracy and the rule of law).

primary (II.1.1) and secondary legislation (II.1.2); and Council of Europe instruments (II.2), including conventions (II.2.1) and recommendations, resolutions and guidelines (II.2.2).

Concerning **European Community Law**, Part II.1.2 groups secondary legislation instruments according to the different categories of persons involved in migration, extracting the provisions related to health and health care. It looks at: equal treatment between persons irrespective of racial or ethnic origin in the area of social protection, including social security and health care. It also examines various provisions specifically addressing the health of regular and irregular migrants, victims of trafficking in human beings, asylum seekers, refugees and other persons in need of international protection. It further deals with social security and patient mobility, including EU nationals and third country nationals, and sexual and reproductive health and rights.

With regard to the **Council of Europe's** recommendations, resolutions and guidelines, Part II.2.2, the instruments extracted cover the following topics: health conditions of refugees and irregular migrants; health care systems and services, exploring their adaptation and accessibility for persons involved in migration; and the right to health for young migrants and migrant students, irregular migrants, victims of trafficking, asylum seekers, refugees, and other persons in need of international protection.

I. MIGRATION HEALTH IN THE EUROPEAN CONTEXT

1. Health and Migration

Migration in Europe²

Migration is not new in Europe, however, over the last few decades, the nature of migration to Europe has changed considerably. Movement was traditionally unidirectional and permanent, based on geographic, cultural, linguistic or historical proximity. Today migration is diverse and complex: multi-directional and often temporary. Further, many countries of origin have become countries of destination and *vice versa*.

Migration to and within Europe today involves diverse categories of persons including: migrants, be they in a regular or irregular situation, or intending a long or short term stay; students; victims of trafficking in persons; asylum seekers; refugees; displaced persons; and returnees. Their respective migration processes vary widely, and for some, the migration experience poses a number of challenges to physical, mental and social health.

Migrating populations: health status and health inequalities

As previously mentioned, migration in and of itself is not a risk factor to health. However, individually or collectively, the process of migration can result in vulnerability to physical, mental and social health problems, depending on the migration conditions³.

The determinants of migration, including education, poverty, environment and gender, also determine the health of people who migrate. Further, the specific vulnerability to physical, mental and social health problems of various people migrating depends on the risk factors surrounding the migration process: including pre-migration circumstances, travel conditions, the transit or arrival phase, as well as return phase.

The factors affecting the evaluation of the health and vulnerability of persons involved in migration prior to arrival in the host country include firstly, the individuals' socio-economic and cultural background, their health history together with the health care they had access to prior to departure; secondly, circumstances surrounding the migration process, including

² See *World Migration 2005: Costs and Benefits of International Migration*, IOM, pp. 139-159. See also C. Boswell, *Migration in Europe: A Paper Prepared for the Policy Analysis and Research Programme of the Global Commission on International Migration*, September 2005.

³ *Migrant Health for the Benefit of All*, Geneva, IOM, 2004, MC/INF/275.

the health environment in the place of origin, transit and destination (i.e. disease prevalence), as well as the different patterns of mobility influencing the conditions of the journey and the impacts on health. On arrival, the immigration status accorded under the immigration law of the host country often determines access to health care and social services in the receiving country. It is noteworthy that the socio-economic conditions in the receiving country of persons involved in migration, including living and working conditions, physical and psycho-social environments correlate directly to rates of long-term illness and chronic disease. Finally, familiarity with the culture and language of the host community is also a factor influencing the health of persons involved in migration⁴.

Differences in mortality rates have been found between those who have migrated and those who have not⁵. Mortality rates are higher for those disadvantaged by their lower socio-economic position indicated by education level, occupational class, or income level. Many studies show that the general health status of persons involved in migration is worse than that of the native population. The Amsterdam Declaration⁶ recognizes this by highlighting that persons involved in migration are more vulnerable due to their lower socio-economic status, and sometimes because of traumatic migration experiences and a lack of adequate social support. Occupational diseases and accidents among persons involved in migration today represent a large proportion of all reported diseases and accidents⁷.

⁴ *Ibidem*.

⁵ J. P. Mackenbach, *Health Inequalities: Europe in Profile*, 2006. See also D. G. Uitenbroek, A. P. Verhoeff, "Life Expectancy and Mortality Differences Between Migrant Groups Living in Amsterdam, The Netherlands", in *Social Sciences and Medicine*, 54(9), 2002, pp. 1379-1388. The latest report from the Confidential Enquiry into Maternal and Child Health indicates that women of "black" and Asian ethnicity in the UK have significantly higher rates of stillbirth and neonatal death than Caucasian women. Nearly 60% of the patients seen at *Project: London* were from sub-Saharan Africa and Asia and there is anecdotal evidence that many were African asylum seekers whose applications have been turned down. This finding suggests that denying women in this vulnerable group access to antenatal care might result in a failure to achieve some of the goals set out in the national strategy to tackle health inequalities. "Confidential Enquiry into Maternal and Child Health Perinatal Mortality 2005 — England, Wales and Northern Ireland", London, CEMACH, 2007; P. D. Williams "Failed Asylum Seekers and Access to Free Health Care in the UK" in *Lancet*, 365, 2005, p. 1767.

⁶ The Migrant-Friendly Hospitals Project Group drew up the Amsterdam Declaration within the framework of the European Commission project "MFH - Migrant Friendly Hospitals, a European Initiative to Promote Health and Health Literacy for Migrants and Ethnic Minorities".

⁷ P. Bollini, H. Siem, "No Real Progress Towards Equity: Health of Migrants and Ethnic Minorities on the Eve of the year 2000", in *Social Science and Medicine*,

Studies show that persons involved in migration are at risk of not receiving the same level of health care in terms of diagnostic, treatment and preventive services, as compared to the native population. Health care services are not responsive enough to the specific needs of these groups. Migrants often lack proper information about appropriate usage of European health care systems⁸. For instance, they may lack information about available hospital and ambulatory care services or about general health matters in the context of European societies. This is one of the reasons persons involved in migration may not use health services effectively. Alternatively, infrequent usage of available health services can in part be attributed to the “healthy migrant phenomenon”⁹, where the strongest and fittest are the ones to undertake the migration process, thereby needing health services less in the host country. Statistics show, however, a consistent decline in perceived health status after two or three years in the host country. Some experts have also noted that the “healthy migrant period” is becoming shorter¹⁰.

Concerning mental health, many studies report a wide range of mental health risks and problems in persons involved in migration in Europe, including high rates of schizophrenia, suicide, alcohol and drug abuse, depression and anxiety¹¹.

41(6), 1995, pp. 819-828. See also E. Q. Ahonen and F. G. Benavides, “Risk of Fatal and Non-Fatal Occupational Injury in Foreign Workers in Spain”, in *Journal of Epidemiology and Community Health*, 60(5), 2006, pp. 424-426.

⁸ Data from Denmark, Germany, and the Netherlands suggest that there are differences in the utilization of health care services between migrants and non-migrants, and between different migrant groups. See J. Pillinger, *Managing Diversity in Public Health and Social Care in the Interest of All Citizens. Report I: Race and Ethnicity*, Dublin, EHMA/European Social Network, 2003.

⁹ This phenomenon was observed by Raymond-Duchosal as early as 1929. Wanner; Manfellotto; Westerling and Rosén have written on it decades later.

¹⁰ See J. Hughes and J.-P. Foschia (eds.), *Migrant-Friendly Health Services and HIV/STI Prevention: A Handbook for Health Practitioners, Managers and Policy Planners*, published by the Veneto Regional Center for Health Promotion (CRRPS), Verona, Italy, with financial assistance from the European Commission (November 2004). In 2004, Médecins Sans Frontières visited and interviewed 770 seasonal farm workers in Italy, 51.4% of whom were in an irregular situation and 23.4% were asylum-seekers. 40% had become ill during their first 6 months in Italy and 93% after 19 months. The most common problems were: infectious diseases, skin problems, intestinal parasites, and mouth, throat, and respiratory infections including tuberculosis. However, 75% of the refugees, 85.3% of asylum-seekers, and 88.6% of irregular migrants were not benefiting from any health care. This resulted from unawareness of their rights. “The Fruits of Hypocrisy: History of Who Makes the Agriculture...Hidden”, Rome, Medici Senza Frontiere Onlus, 2005.

¹¹ See J. Achotegui, “Immigrants Living in Extreme Situation: Immigrant Syndrome with Chronic and Multiple Stress (The Ulysses Syndrome)” in *the Journal of the Spanish Association of Neuropsychiatry “Norte”*, VII(21), 2004, pp.39-53. He

In sum, persons involved in migration often enjoy a lower health status as compared to nationals as well as lower levels of access to diagnostic, treatment and preventive services. Health inequalities are a Europe-wide problem; they must be tackled at the European level if they are to be effectively addressed.

2. Is the Right to the Highest Attainable Standard of Physical and Mental Health a Privilege only for Nationals?

The Right to Health in the EU

All EU Member States have recognized the right of everyone to the “highest attainable standard of physical and mental health”¹² and the right to receive health care in the event of sickness or pregnancy¹³.

The right to health, which includes the right to health care and the right to preconditions for health, has in fact been recognized as a fundamental human right by various international instruments¹⁴ that European Countries

writes the following: “Today, the circumstances in which many immigrants come to Spain and Europe are characterised by their extreme conditions. For millions of individuals, emigration presents stress levels of such intensity that they exceed the human capacity of adaptation. These persons are, therefore, highly vulnerable to Immigrant Syndrome with Chronic and Multiple Stress, known as the Ulysses Syndrome (in reference to the Greek hero who suffered countless adversities and dangers in lands far from his loved ones). This Syndrome is an emerging health problem in our societies, making itself manifest in the current context of globalisation, in which the living conditions of a large majority of immigrants have deteriorated dramatically”.

¹² Article 12, International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966, U.N.G.A. Res. 2200 A (XXI), 993 U.N.T.S. 3.

¹³ In brief, the term right to health is commonly used at the international level and clearly underlines the importance of recognizing not only the right to health care, which is part of the right to health, but also the right to a certain number of basic preconditions for health. These include an adequate supply of safe food, nutrition and housing; access to safe and potable water and adequate sanitation; safe and healthy working conditions; a healthy environment; and access to health-related education and information, including on sexual and reproductive health. Another important aspect is the requirement of public participation in all health-related decision making at the local, national and international levels. See V. A. Leary, “The Development of the Right to Health”, in *Human Rights Tribune des droits humains*, 11(3), autumn 2005. See also R.-J. Dupuy (ed.), *The Right to Health as a Human Right*, Workshop, The Hague Academy of International Law and the United Nations University, The Netherlands, Sijthoff & Noordhoff, Alphen aan den Rijn, 1979.

¹⁴ Not only the International Covenant on Economic, Social and Cultural Rights, Article 12, but also the Universal Declaration on Human Rights, Article 25; the International Convention on the Elimination of all Forms of Racial Discrimination,

have ratified. These instruments provide for the right to health without any discrimination based on nationality or legal status¹⁵. A rights based approach to health issues must be based on fundamental human rights principles, particularly the dignity of the person and non-discrimination¹⁶.

The International Covenant on Economic, Social and Cultural Rights (ICESCR) is one of these international instruments. It has been ratified by all EU Member States and all the CoE Member States (with the exception of Andorra) and it recognizes in Article 12 the right to health. The Committee on Economic, Social and Cultural Rights (CESCR), which supervises the implementation of this Covenant has emphasized, in its General Comment¹⁷ on Article 12, that “(...) States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services (...)”.

When a country ratifies a treaty, such as the ICESCR, it assumes a legal obligation to implement the rights and obligations recognized in that treaty (e.g. the right to health). In particular, it assumes an obligation to submit regular reports to the monitoring committee set up under that treaty, like the CESCR for the ICESCR, on how the rights are being implemented¹⁸.

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families of 18 December 1990

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (MWC) is the most recent of the core human rights instruments to enter into force.¹⁹ It guarantees the right to necessary emergency medical treatment²⁰ to all migrant workers

Article 5; the Convention on the Elimination of All Forms of Discrimination against Women, Article 12; the Convention on the Rights of the Child, Article 24.

¹⁵ R. Cholewinski, *Study on Obstacles to Effective Access of Irregular Migrants to Minimum Social Rights*, Strasbourg, Council of Europe Pub, 2005, p. 42.

¹⁶ *Ibidem*.

¹⁷ CESCR General Comment No.14: The right to the highest attainable standard of health (Article 12), 2000.

¹⁸ See I. Slinckx, M. Grange, M. De Feyter, *The UN Treaty Monitoring Bodies and Migrant Workers: a Samizdat*, December 18 vzw and International Catholic Migration Commission, November 2004, p. 6.

¹⁹ On 1 July 2003.

²⁰ It is not always clear what constitutes an emergency and there are many life-threatening illnesses that might not manifest as an “emergency”. See Resolution 1509 (2006) of the Parliamentary Assembly on human rights of irregular migrants,

and members of their families, regardless of the regularity of their stay or employment. Article 28 states that “Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.”

The MWC is binding upon States that have ratified it and none of the EU Member States have done so²¹. In any event, in recognizing only necessary emergency medical treatment, the MWC fails to guarantee access to preventive medical treatment, such as early diagnosis and medical follow-up.

The only international convention, therefore, that specifically acknowledges that irregular migrants have the right to health care, which is only a part of the right to health, does so in a restrictive manner and even then it is of limited scope as no major Western receiving country has ratified it²². Article 8 of the Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live has been used to support the argumentation that human rights apply to non-nationals only as far as they are lawfully present. This article states that only aliens lawfully residing

at p. 310. See also Doc.10924, report of the Committee on Migration, Refugees and Population, in which the Rapporteur notes that “access to emergency health care is a minimum standard to be applied”. This is in line with the right to life protected under Article 2 of the European Convention on Human Rights. However, there is not a common understanding as to what urgent or emergency health care entails. However, a shift can be noted from a strict interpretation of urgent care (essential treatment, which can not reasonably be delayed) to a more flexible one evolving “necessary care” on the basis of which doctors consider regular follow-ups and vaccinations also to be part of “urgent treatment” (see Exploratory Report on the Access to Social Protection for Illegal Labour Migrants, P. Schoukens and D. Pieters, European Committee for Social Cohesion (CDCC), CDCC (2004)55, p. 12). This is in line with a more integrated concept of health care and with the conclusions of the United Nations Committee on Economic Social and Cultural Rights. The UN Committee on Economic Social and Cultural Rights has stated that “States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including ... asylum seekers and illegal immigrants, to preventive, curative and palliative health services ...” (see Ryszard Cholewinski (CDMG (2004) 29, p. 42). See R. Cholewinski, loc. cit. n. 15, at p. 46.

²¹ Four countries of the Council of Europe, namely Albania, Azerbaijan, Bosnia and Herzegovina and Turkey have ratified the MWC.

²² See E. MacDonald and R. Cholewinski, *The Migrant Workers Convention in Europe: Obstacles to the Ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; EU/EEA perspectives*, UNESCO Migration Studies 1, 2007.

in the territory of a State may enjoy the right to health protection and medical care. Nevertheless, Article 8 of the Declaration cannot supersede the interpretation of the ICESCR which affords economic and social rights to *all* persons regardless of legal status. The right to health is certainly not the sole privilege of citizens²³.

Relevant Council of Europe Instruments

The Council of Europe Convention on Human Rights and Biomedicine of 4 April 1997²⁴ aims “to ensure equitable access to health care of appropriate quality in accordance with the person’s medical needs”²⁵ and imposes an obligation on States to use their best endeavours to reach it.

Two important instruments, namely the European Convention on Social and Medical Assistance of 11 December 1953²⁶ and the European Social Charter of 1961 (and revised in 1996)²⁷, whose Article 11 recognizes the right to protection of health, explicitly require that nationals of one State Party lawfully present on the territory of another be afforded medical assistance on terms equal to those of nationals of the second State Party.

Despite this focus on lawful presence, however, the European Committee of Social Rights whose task is to monitor the application of the European Social Charter, found that “legislation or practice that denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter.”²⁸

Moreover, in the Recommendation on health services in a multicultural society²⁹, “The Committee of Ministers (...) recommends that the governments of member states: (...) promote an intersectoral and multidisciplinary approach to health problems and health care delivery in multicultural societies, taking into consideration the rights of multicultural populations; (...) embed health issues of multicultural populations in the legal framework as an integral part of the general health system”.

²³ “Vulnerable Migrants have a Right to Health” in *Lancet*, 370, 2007, pp. 827-828.

²⁴ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, Article 3, see p. 225.

²⁵ See Explanatory Report comments on the provision of Article 3 of the Convention at pp. 225-226.

²⁶ Article 1, see p. 175.

²⁷ Article 13, see p. 161.

²⁸ See Table on “Violation of Article 17 (the right of children and young persons to social, legal and economic protection)” at p. 171.

²⁹ Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society at p. 248.

Further “the [Parliamentary] Assembly considers that the right to health associated with access to health care is one of the basic universal human rights and should be equally applied to all people, including migrants, refugees and displaced persons.”³⁰ Finally the Assembly “call[s] on the member states to take as their main criterion for judging the success of health system reforms the effective access to health care for all, without discrimination, as a basic human right and, as a consequence, the improvement of the general standard of health and welfare of the entire population”³¹.

3. Competence of the European Union in Health Matters

Article 152 of the EC Treaty

The competence of the EU in the field of health is based on Article 152 of the EC Treaty³². The Treaty of Amsterdam amended and renumbered the previous Article 129 of the Treaty of Maastricht. Article 129 had introduced for the first time an explicit legal basis for a Community-wide health policy. It provided that “the Community shall contribute towards a high level of human health protection by encouraging co-operation between Member States and, if necessary, lending support to their action”. The renumbered Article 152 goes a step further, stating that a “high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities”, and removed the previous limitation on Community action in the field of public health to the prevention of diseases³³.

Limits and evolution of the EU’s influence over health issues

The competence of the EU on issues related to health is based on and limited by the subsidiarity principle. This principle is intended to ensure that all decisions are taken as close as possible to citizens, and that constant checks are made as to whether action at the Community level is justified in

³⁰ Recommendation 1503 (2001) of the Parliamentary Assembly on health conditions of migrants and refugees in Europe at p. 265.

³¹ Recommendation 1626 (2003) of the Parliamentary Assembly on the reform of health care systems in Europe: reconciling equity, quality and efficiency at p.276.

³² See pp. 59-60.

³³ Article 152 also states that “Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education”.

light of the possibilities available at the national, regional or local levels³⁴. Consequently, competence to act in the field of public health and health care services is still primarily a national matter. Further, the responsibility for ensuring access to quality health care in the EU lies with the Member States, in line with the principle of territoriality. Nevertheless, direct EU influence is increasing in this area. There have been efforts within the EU to mainstream health issues into policy areas such as social protection and employment in line with Article 152 of the EC Treaty. Furthermore, there have been attempts to extend the EU's influence over health services and social regulation in relation to the European single market and to trade issues. Additionally, the European Court of Justice has, in various cases brought before it relating to the four freedoms of the single European market (people, goods, services and capital), decided that health issues are not exclusively national matters³⁵. Lastly, Article 137 of the EC Treaty also acknowledges direct Community competence within the field of health, although it only allows for action that supports or completes action taken by Member States.

Community action in the field of health may be pursued through binding secondary legislation like directives and regulations³⁶ that influence the way national health care systems are organized, and whose legal basis is Article 39 of the EC Treaty, occasionally supported by Article 308³⁷.

4. Health System and Entitlement to Health Care

With increasing migration to and within Europe, health care systems are faced with new problems of developing accessible, appropriate, quality services for migrants and others involved in migration. Existing services have been developed primarily for native populations and are often ill-equipped for dealing with the needs of other groups. This can be contrasted with traditional countries of immigration such as Canada, Australia, and New Zealand where ethnic and cultural diversity have long had a secure place on the health-care agenda.

European countries, however, have less experience in this field. Some have built up substantial expertise, but others are only just beginning to

³⁴ R.-M. Hämäläinen, M. Koivusalo, E. Ollila, "EU Policies and Health", *Themes from Finland 1/2004*, Helsinki, Finland, STAKES, p. 6.

³⁵ *Ibidem*. See also E. Mossialos, M. McKee, *EU Law and the Social Character of Health Care*, Brussels, P.I.E. Lang, 2002.

³⁶ See "The Sources of European Community Law" at p. 46.

³⁷ V. G. Hatzopoulos, "Do the Rules on Internal Market Affect National Health Care Systems?" in *The Impact of EU Law on Health Care Systems*, M. McKee, E. Mossialos, R. Baeten (eds.), Work & Society n°39, P.I.E.-Peter Lang, 2002.

deal with these problems. It must be noted however that expertise cannot be simply imported from other continents, as populations, cultures and health care systems differ. There is therefore an urgent need for exchange and dissemination of expertise, information and good practices within and between European countries³⁸.

European Citizens Requiring Health Care within the Community

There have been a number of important recent developments in relation to **European citizens** requiring health care inside the EU.

Particularly relevant is the establishment of EU mechanisms for cross-border care. In fact, before a coordinated system of national social security was developed within the Community, anyone requiring health care abroad would have considered this to be a private matter.

Article 42 of the EC Treaty states that the Council shall adopt such measures in the field of social security as are necessary to provide freedom of movement for workers³⁹. Further, in the 1970s, the European Economic Community recognized that the principle of free movement of people has always implied that a national of a Member State should not face financial obstacles in obtaining health care in another Member State.

On 14 June 1971, Council Regulation (EEC) No. 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to members of their family moving within the Community⁴⁰ was adopted. This regulation, which has been amended on various occasions⁴¹ and which is supplemented by Regulation 574/72⁴², established a series of mechanisms by which individuals could obtain health care in other Member States and reimbursement for certain types of cross-border care. Firstly, border workers benefit from a double access to health care, both in the state of residence and in the state of work (using Form E106)⁴³. Secondly,

³⁸ David Ingleby, Professor of Intercultural Psychology, Utrecht University, Director of the European Survey on Migration Health (IMISCOE) is overseeing a group of researchers engaged in a Europe-wide survey on the state of health research and health care in Europe for migrants and ethnic minorities. The survey is being carried out in close collaboration with IOM, which in 2005 launched a call for the development of a European policy on migration health.

³⁹ EC Treaty, Article 42.

⁴⁰ See p. 106.

⁴¹ In particular it has been revised by the new EC Regulation 883/2004, OJ 2004 L200.

⁴² Council Regulation (EEC) No. 574/72 laying down the procedure for implementing Regulation (EEC) No. 1408/71, OJ 1972 L74.

⁴³ To have access to health care in the state of residence, assuming for example that the

people who go to another state for a temporary stay (for travel, studying, job search) can gain access to health care in emergency situations (after June 2004), using the European health insurance card⁴⁴ (which replaces the current paper form, in particular Form E111). Finally, patients can also obtain prior authorization for medical treatment in another Member State, which will be paid at the cost prevailing in the providing state by their competent institution in the state of insurance (using Form E112)⁴⁵.

Although the system has been designed to meet the needs of EU citizens migrating within the EU to work and people staying for a short-term period in another Member State, specific issues have arisen regarding retired persons who choose to reside or stay in another Member State⁴⁶. In fact, pre-existing chronic illness cannot prevent these pensioners from benefiting from unplanned treatment in another Member State.

Relevant rulings by the European Court of Justice (ECJ) have had important implications for the existing procedures agreed upon by the Member States. They have created an alternative basis for cover of cross-border care that is based on the principle of free movement of goods and services⁴⁷.

worker is insured in the state of work, a E106 form is issued.

⁴⁴ The European Health Insurance Card (EHIC) is part of a process started in 1998 aimed at revising and simplifying the coordination mechanism under Regulation 1408/71. The EHIC was designed to replace all existing paper forms required for occasional health treatment when in another Member State, including: E111 for temporary stay; E110 for those working in international transport; E119 for those traveling to another country to seek work; and E128 for students and workers in another Member State. See pp. 118-120.

⁴⁵ An Administrative Commission governs the application of these regulations and negotiates agreements between Member States, resolves problems of interpretation and oversees the settlement of claims and debts between Member States.

⁴⁶ See *The Internal Market and Health Services, Report of the High Level Committee on Health*, 17.12.2001, pp. 9-10. The High Level Committee on Health provides advice to the Commission services on matters related to the development of the Community's health strategy. It created the working group on the Internal Market and Health in April 1999 with a mandate to: collect information on the impact of Community provisions on health systems; collect information on cross-border health care and service arrangements; identify the nature and degree of problems arising and consider options for Community and national actions to resolve them. The report of the High Level Committee on health highlights that retired people coming from EU Member States and staying in other Member States for long periods of time do not require emergency care, because their basic disease is chronic. Moreover, in general, they do not suffer from specialized conditions which would require prior authorization. On the contrary, many of these people suffer from chronic diseases that require medical attention and follow up or that may require hospitalization due to relapse.

⁴⁷ See Articles 30, 49 and 50 of the EC Treaty. These judgments gave rise to the High Level Reflection Process on patient mobility and health care development in the

The *Kohll* and *Decker* rulings⁴⁸ of 1998 created an alternative procedure to the classic E112 procedure involving prior authorization. The *Kohll* and *Decker* procedure instituted another system for obtaining reimbursement for cross-border care, leaving patients the possibility to freely choose a provider abroad without seeking prior authorization in their home state. They can then claim reimbursement from their home health care system “as if they received the treatment there”. However, it was not clear whether the right applied to both ambulatory and hospital services.

In the *Vanbraekel*⁴⁹ case, the ECJ held that if an insured person was wrongfully refused authorization to receive hospital treatment in another Member State, he or she should be guaranteed reimbursement according to the rules applicable in the Member State in which treatment was provided, although this would not prevent the insuring state from claiming reimbursement according to its own tariffs when they would appear to be more favorable.

Further, in 2001, in the cases of *Smits-Peerbooms*⁵⁰, the ECJ confirmed that all Member States must comply with Community Law when exercising the power to organize their health care systems and that medical activities including hospital services fall within the scope of Article 50 of the EC Treaty (the freedom to provide services within the Community). The ECJ, however, acknowledged the need to maintain the financial balance of social security systems, including health care. In addition, it recognized that the preservation of a balanced medical and hospital service open to all may justify a restriction such as the one required under the system of prior authorization as long as it is based on “objective, nondiscriminatory criteria known in advance, in such a way as to circumscribe the exercise of the national authorities’ discretion, so that it is not used arbitrarily” and a decision must be made within “reasonable time” and be “capable to be challenged in judicial or quasi-judicial proceedings.” The treatment given should be regarded as “normal” in international professional circles, and must be demanded by the patient’s condition. Authorization can be refused only if the same or equally effective treatment can be obtained without

European Union.

⁴⁸ Case C-158/96, *Raymond Kohll v Union des caisses de maladie* (European Court Reports 1998, p. I-01931) and Case C-120/95, *Nicolas Decker v Caisse de maladie des employés privés* (European Court Reports 1998, p. I-01831).

⁴⁹ Case C-368/98, *Abdon Vanbraekel and Others v Alliance nationale des mutualités chrétiennes (ANMC)* (European Court Reports 2001, p. I-05363).

⁵⁰ Case C-157/99, *B.S.M. Geraets-Smits v Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v Stichting CZ Groep Zorgverzekeringen* (European Court Reports 2001, p. I-05473).

undue delay⁵¹ at an establishment having a contract with the insured person's sickness insurance fund.

Finally, in 2003 in the cases *Müller-Fauré* and *Van Riet*⁵², the ECJ examined the situation of two Dutch citizens who had obtained treatment abroad without prior authorization, in one case as an in-patient and in the other case as an outpatient receiving non-hospital care in another Member State.⁵³ The ECJ concluded that it had not been established that removal of the requirement for prior authorization would undermine the essential characteristics of the Netherlands sickness insurance scheme. The principle of freedom to provide services therefore precluded legislation such as the Netherlands legislation, which required the insured to obtain prior authorization, even under a benefit-in-kind scheme, for non-hospital care provided in another Member State by a non-contracted provider.

It is important to ensure that increasing mobility does not increase social inequalities in access to care. Wealthier and better-informed citizens are the most likely to benefit from greater access to health care abroad, so national health policy makers must ensure that developments do not undermine their commitment to solidarity⁵⁴.

Third country nationals, legally residing in the territory of a Member State, requiring health care in the EU

In 1999, the European Council, in its special summit in Tampere, stated that the European Union should ensure fair treatment of **third-country nationals** who reside legally in the territory of its Member States, grant

⁵¹ This evaluation takes into account actual medical condition (including degree of pain and nature of disability) and medical history.

⁵² Case C-385/99, *V.G. Müller-Fauré v Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA* and *E.E.M. van Riet v Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen* (European Court Reports 2003, p. I-04509).

⁵³ See also: Case C- 326/00, *Idryma Koinonikon Asfaliseon (IKA) v Vasileios Ioannidis* (European Court Reports 2003, p. I-01703); Case C-156/01, *R.P. van der Duin v Onderlinge Waarborgmaatschappij ANOZ Zorgverzekeringen UA* and *Onderlinge Waarborgmaatschappij ANOZ Zorgverzekeringen UA v T.W. van Wegberg-van Brederode* (European Court Reports 2003, p. I-07045); Case C-56/01, *Patricia Inizan v Caisse primaire d'assurance maladie des Hauts-de-Seine* (European Court Reports 2003, p. I-12403); Case C-8/02, *Ludwig Leichtle v Bundesanstalt für Arbeit* (European Court Reports 2004, p. I-02641); Case C-372/04, *The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health* (European Court Reports 2006, p. I-04325).

⁵⁴ M. McKee, L. MacLehose, E. Nolte (eds.), *Health Policy and European Union Enlargement*, Oxford, Open University Press, 2004, p. 168.

them rights and obligations comparable to those of EU citizens, enhance non-discrimination in economic, social and cultural life and approximate their legal status to that of EU nationals. Furthermore, in its Resolution of 27 October 1999⁵⁵, the European Parliament called for prompt action on promises of fair treatment for third-country nationals legally residing in the Member States and on the definition of their legal status, including uniform rights, as close as possible to those enjoyed by citizens of the European Union. The European Economic and Social Committee has also appealed for equal treatment of Community nationals and third-country nationals in the social field⁵⁶.

Hence, Council Regulation (EC) No 859/2003⁵⁷ was adopted to extend the scope of the rules coordinating national social security schemes to third-country nationals, as well as to members of their families and to their survivors, provided they are legally resident in the territory of a Member State and are in a situation which involves more than a single Member State⁵⁸.

Another European instrument that is relevant for non-nationals is the European Convention for the Protection of Human Rights and Fundamental Freedoms⁵⁹. This Convention, adopted by the Council of Europe in 1950, applies to everyone within the jurisdiction of a State Party, including non-nationals, whether they are asylum seekers, rejected asylum seekers, 1951 Convention refugees⁶⁰ and so forth. Cases brought to the European Court

⁵⁵ OJ 2000 C154, p. 63.

⁵⁶ See its opinion of 26 September 1991 on the status of migrant workers from third countries. Source: OJ 1991 C339, p. 82. In addition, the Employment and Social Policy Council, in its conclusions of 3 December 2001, argued that the coordination for social security schemes applicable to third-country nationals should grant them a set of uniform rights as near as possible to those enjoyed by EU citizens.

⁵⁷ Council Regulation (EC) No 859/2003 of 14 May 2003 extending the provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 to nationals of third countries who are not already covered by those provisions solely on the ground of their nationality, OJ 2003 L124, at p. 110.

⁵⁸ See also the Euro-Mediterranean association agreements, which have been concluded between the European Community and its partners in the Mediterranean at p. 128. See K. D. Magliveras, *Protecting the Rights of Migrant Workers in the Euro-Mediterranean Partnership*, 2004. See also U. Kulke, *Social Security Protection for Migrant Workers*, 2006, who considers the conclusion of such agreements as the best way to ensure migrant workers' social security protection.

⁵⁹ See p. 144. The ECHR forms an integral part of EU law.

⁶⁰ Convention Relating to the Status of Refugees adopted on 28 July 1951 by the United Nations Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons convened under General Assembly resolution 429 (V) of 14 December 1950.

of Human Rights⁶¹, which is responsible for the implementation of the European Convention on Human Rights, can have a health dimension that applies also to non-nationals⁶². The European Social Charter⁶³, on the contrary, only concerns nationals of a Contracting State⁶⁴.

Irregular migrants⁶⁵

Irregular migrants are those persons who have not been granted permission to enter or to stay in a given country⁶⁶. They are among the

⁶¹ Cases can be brought to the European Court of Human Rights, often referred to informally as the “Strasbourg Court”, either by other States Parties or by individuals (individuals, groups of individuals or non-governmental organisations) subject to the jurisdiction of a State Party. Information on the Court is available at: <http://www.echr.coe.int/ECHR/EN/Header/The+Court/The+Court/History+of+the+Court/>

⁶² In *D. v. United Kingdom*, as outlined at page 151, an AIDS sufferer was threatened with removal from the United Kingdom to the isle of St Kitts where no effective medical or palliative treatment for his illness was available and he would have been exposed to the risk of dying under the most distressing circumstances. The Court unanimously held that implementation of the decision to remove the applicant to St Kitts would have violated Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms.

⁶³ See p. 169.

⁶⁴ See the European Social Committee’s opinion in *FIDH v. France* http://www.coe.int/t/e/human_rights/esc/4_collective_complaints/list_of_collective_complaints/RC14_on_merits.pdf

⁶⁵ See The Platform for International Cooperation on Undocumented Migrants (PICUM)’s project “Access to Health Care for Undocumented Migrants”. This project is co-funded by the European Commission (DG Employment, Social Affairs and Equal Opportunities) within the framework of the Community Action Programme to Combat Social Exclusion. See PICUM International Conference on Access to Health Care for Undocumented Migrants in Europe, held in Brussels on 27 and 28 June 2007: see <http://www.picum.org>. See also L. Biccocchi and M. LeVoy, *Undocumented Migrants Have Rights! An Overview of the International Human Rights Framework*, PICUM, March 2007; and R. Cholewinski, “Identifying and Clarifying Concepts on ‘Irregular’ Migration”, Paper presented at the 10th Regional Conference on Migration, Migrant Forum in Asia and Singapore National Trade Union Congress, 6-7 November 2006 (<http://www.mfasia.org/mfaResources/RCholewinski-Concepts.pdf>) at p. 4.

⁶⁶ An Irregular migrant refers to an individual who, owing to irregular entry or the expiry of his/her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country’s admission rules and any other person not authorized to remain in the host country (*Glossary on Migration*, International Migration Law Series, IOM, 2004). Irregular migrants are also referred to as clandestine, illegal, undocumented migrants or migrants in an irregular situation. The term “irregular” is preferable to “illegal” as the latter carries a criminal connotation and is seen as denying migrants’ humanity. See the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Article 5. The MWC considers as “undocumented” or in an “irregular situation” those migrant

most vulnerable and, because of their lack of a legal status, are often marginalized⁶⁷.

The Council of Europe has denounced the current unclear situation that results in irregular migrants “falling outside the scope of existing health and social services”, stating that this represents “a major problem in the area of health care provision” that “requires close examination”⁶⁸.

In the EU, the European Commission has noted that “illegal immigrants are protected by universal human rights standards and should enjoy some basic rights i.e. emergency health care and school education for their children.”⁶⁹ Vork suggests⁷⁰ that the unwillingness to extend full health-care coverage to irregular migrants may stem from the fact that generous social rights are seen as a “pull factor” for future irregular migrants. This, however, runs contrary to empirical evidence showing that most irregular migrants do not make a rational choice of their destination country on the basis of a comparison between the benefits of different welfare systems⁷¹. Further, their right to health cannot be limited to a right to health care. Five factors are identified which determine health status: natural biological variation, health behaviour, social conditions, access to health care services and health related social selection⁷².

workers and members of their families who are not authorized to enter, to stay and to engage in a remunerated activity in the State of employment pursuant to the law of that State and to international agreements to which that State is a party.

⁶⁷ European network for co-operation and exchanges on social exclusion and health issues for migrants - Austria, France, Greece, Portugal, Spain (SESAME NETWORK), *Joint Report Phase I*, reporters F. Lamara and N. Djebarat, IOM Paris, 2003.

⁶⁸ Council of Europe, Parliamentary Assembly (2000) *Health conditions of migrants and refugees in Europe*. See Doc. 8650, Report of the Committee on Migration, Refugees and Demography, Rapporteur: Lord Ponsonby, Strasbourg: Council of Europe, Committee on Migration, Refugees and Demography. See also Doc. 8878, Opinion of the Social, Health and Family Affairs Committee, Rapporteur: Mr Arnau, Strasbourg: Council of Europe, Social, Health and Family Affairs Committee.

⁶⁹ European Commission (2003) *Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on Immigration, Integration and Employment* [COM (2003) 336 final of 3 June 2003].

⁷⁰ G. Vork, “Migration, Social Security and Law: some European Dilemmas” in *European Journal of Social Security*, 3(4), 2001, p. 317. See also G. Van Liemt, *Human Trafficking in Europe: an Economic Perspective*, Geneva, International Labour Organisation, June 2004.

⁷¹ R. Romero-Ortuño, *Access to Health Care for Illegal Immigrants in the EU: Should We Be Concerned?* in *European Journal of Health Law*, 11(3), 2004.

⁷² *Social Integration of Migrants in Europe: A Review of the European Literature 2000 – 2006*, COMPAS, 2006.

Romero-Ortuño⁷³ has addressed the question of whether irregular migrants should be granted full access to publicly funded health care, taking into consideration also the issue of the affordability of meeting irregular migrants' health care needs. He acknowledges the importance of containing public expenditure in the field of public health. Many countries - including EU Member States - seek to prevent collectively funded health care systems from being used by "free riders" – people who, if allowed, would benefit from the services at zero cost (i.e., without having paid taxes or other social contributions). This concept, however, does not entirely apply to irregular migrants because they are indirect tax payers; this could have significant entitlement implications in those cases in which the public health service receives a significant proportion of its funding from this kind of revenue.

Romero-Ortuño concludes that only host States are accountable for the consequences of the irregular presence of people within their borders; therefore, they have to create the legal conditions for the fulfillment of their duty to provide comprehensive health care coverage to irregular migrants, in line with the right to the highest attainable standard of health recognized as a fundamental human right by various international instruments that the Member States have ratified⁷⁴.

In practice, however, the irregular migrant is not granted a complete right to health care in EU Member States. For example, the Danish law on health care limits irregular migrants' access to the national health care system to urgent treatment. In Germany⁷⁵, in principle, irregular migrants are granted the same right to health care as asylum seekers, being entitled to emergency care, care in pain situations⁷⁶, or indispensable care in order to preserve health⁷⁷ (for example avoiding long-term aggravation or complications of diseases). The implementation of these provisions conflicts, however, with the *Aufenthaltsgesetz*⁷⁸, under which public servants have to report

⁷³ R.Romero-Ortuño, loc. cit. n.71.

⁷⁴ See footnote 14.

⁷⁵ See CommDH(2007)14, Report by the Commissioner for Human Rights, Mr Thomas Hammarberg, on his visit to Germany, 9 – 11 and 15 – 20 October 2006. See also Brochüre "10 Jahre Büro für medizinische Flüchtlingshilfe - Eine Erfolgsgeschichte?", 2006, available at: <http://www.medibuero.de/de/Materialien.html>, and J. Groß, *Möglichkeiten und Grenzen der medizinischen Versorgung von Patienten und Patientinnen ohne legalen Aufenthaltsstatus*, Berlin, April 2005.

⁷⁶ Asylbewerberleistungsgesetz (§ 4 AsylbLG) in BGBl I 1993, 1074.

⁷⁷ *Ibidem*, § 6.

⁷⁸ See, in particular, Gesetz über den Aufenthalt, die Erwerbstätigkeit und die Integration von Ausländern im Bundesgebiet (*Aufenthaltsgesetz* – § 87 AufenthG)

the details of any irregular migrant they encounter during their job, and anyone who helps an individual without a regular residence permit can be punished if assistance is provided for financial gain, or if it is done repeatedly or for the benefit of several foreigners⁷⁹.

In countries like Spain, Italy, Portugal, Belgium, the Netherlands and the UK, there are various obstacles to the implementation of national legislation guaranteeing irregular migrants' right to health care. In Spain, for example, foreigners registered in their municipality, despite their irregular status, enjoy in theory the same rights as citizens⁸⁰. The 4/2000 Aliens Act on the Right and Freedom of Foreigners universalized the right to health care and extended this right to irregular migrants through a registration procedure called *empadronamiento*. To obtain the sanitary card required to consult a doctor, the migrant has to register in the municipality. To do so she/he has to show her/his passport and a document which proves residence in that municipality, and fill in a registration form. Accessibility however is not so easy considering barriers such as fear, lack of information and administrative obstacles created by certain city councils demanding, for instance, documents the individual may not have. In fact, when migrants cannot be registered, but are either pregnant or minors, they will be entitled to the health care provided by the Social Security's Emergency Service. However, the lack of a sanitary card prevents the doctor from prescribing the drugs required for the treatment.

In Portugal, migrants⁸¹ who do not have a permanent residence permit or a work visa, which are necessary for receiving the national health card, can obtain a user's card. With this card they have access to the centers and services of the National Health Service located in the area of residence⁸².

in BGBI I 2004, 1950, and Asylbewerberleistungsgesetz (§ 4, 6).

⁷⁹ See P. Scott, "Undocumented Migrants in Germany and Britain: The Human "Rights" And "Wrongs" Regarding Access to Health Care", in *Electronic Journal of Sociology*, 2004.

⁸⁰ See M. Bernal, Part A. Identification Study Report on Spain in C. Watters, D. Ingleby (Eds.) *Final Report on Good Practices in Mental Health and Social Care Provision for Asylum Seekers and Refugees*, Bruxelles, European Refugee Fund, European Commission, 2003.

⁸¹ Despacho n. ° 25 360/2001 de 16 de Novembro de 2001 do Ministério da Saúde (document No. 25 360 of 16 November 2001 of the Ministry of health) regulates foreigners' access to the National Health Service. See *L'accès des étrangers en situation irrégulière au système de santé*, Les documents de travail du Sénat, série législation comparée, n° LC 160, Paris, Sénat, mars 2006. See also SESAME Network Joint Report, September 2003.

⁸² The user, however, has to prove that she/he has resided in Portugal for at least 90 days.

Irregular migrants pay for the services provided to them. They can, nevertheless, present a certificate issued by the social security service certifying they are facing economic difficulties. Health care justified on public health grounds is free of charge. In particular, patients affected by transmissible diseases, which have to be declared, receive free treatment including vaccinations, maternal-infantile care, and family planning. Furthermore, everyone, despite his/her nationality, lack of financial means and irregular status, has access to emergency care⁸³.

In Italy⁸⁴, migrants who do not have a permit to stay or who have a permit to stay that has expired for more than 60 days, have a right to preventive care in case of sickness or accidents⁸⁵, to necessary treatment⁸⁶, and to urgent treatment⁸⁷. Article 35, paragraph 5, of the Legislative Decree No. 286/1998⁸⁸ prohibits the Health Services from reporting to the police the irregular migrant's presence. However, despite the fact that child care is quite widespread, many of the local health offices (ASL) of the National Health Service (Servizio Sanitario Nazionale – SSN), for instance, do not allow the family to choose a doctor for the minor⁸⁹. Italy is an example of how the health professional's approach can have an impact on the enforcement of a restrictive legislation to the point of transforming it. In

⁸³ In Portugal, the police are often situated in the same building as national immigrant support centers. Consequently irregular migrants might be deterred from contacting groups giving advice and support. See PICUM Minutes of the Meeting *Access to Health Care for Undocumented Migrants with Health Care Experts*, 5 December 2005, Brussels.

⁸⁴ See S. Geraci, *Medicina delle migrazioni*, Sinnos ed., 2000; P. Bonetti e M. Pastore, "L'Assistenza Sanitaria", in *Diritto degli stranieri*, a cura di B. Nascimbene, Padova, CEDAM, 2004, pp. 973 -1013; D. Culton, "L'Assistenza Sanitaria per gli Stranieri in Italia", in *Sanità pubblica*, 2001, pp. 773 – 782.

⁸⁵ Preventive care includes treatment aiming to safeguard individual and collective health such as pregnancy and maternity care; full health care for everyone under 18; vaccinations; prophylaxis, diagnosis and treatment of infectious diseases; prevention, treatment and rehabilitation of toxic dependencies; international preventive measures.

⁸⁶ Necessary treatment includes medical assistance, medical check-ups, treatment for conditions which are non-dangerous in the immediate/short run, but that, if left untreated, will cause major harm to the health of the person or put his/her life at risk.

⁸⁷ Urgent treatment is treatment which cannot be deferred without putting into danger the patient's health or life.

⁸⁸ Legislative Decree No. 286/1998 in Official Gazette n. 191 of 18 August 1998, Ordinary Supplement n.139.

⁸⁹ This is contrary to the Convention on the Rights of the Child of 20 November 1989, which Italy has ratified (see Law No. 176 of 27 May 1991 in Official Gazette n. 135 of 11 June 1991, Ordinary Supplement).

light of this, the Italian legislation has changed⁹⁰, thanks to *contra legem* practice of greater access to health service for irregular migrants. However, migrants are not always aware of their rights, including their right to health. Therefore, changing the law does not automatically lead to improved access. Major determinants of access to health care for vulnerable migrants are appropriate legislation, strong political commitment, adequate cultural mediation, and proactive outreach programmes⁹¹.

In the United Kingdom⁹², a number of trade unions have long called on their members not to participate in the immigration checks that the 1989 regulations imposed on hospitals⁹³. Thus, many irregular migrants are *de facto* using the National Health Service for free. To put an end to the situation, however, three recent policies have been developed preventing migrants from this free access⁹⁴.

⁹⁰ G. Zincone, "Illegality, Enlightenment and Ambiguity: A Hot Italian Recipe", in Baldwin-Edwards and Joaquin Arango (eds.) *Immigrants and the Informal Economy in Southern Europe*, London and Portland, Frank Cass, 1999, pp. 43-82.

⁹¹ See Medici Senza Frontiere Onlus, loc. cit. n.10.

⁹² See S. Hargreaves, J. S. Friedland, P. Gothard, S. Saxena, H. Millington, J. Eliahoo, P. Le Feuvre and A. Holmes, "Impact on and Use of Health Services by International Migrants: Questionnaire Survey of Inner City London A&E Attenders" in *BMC Health Services Research* 2006, 6:153.

⁹³ K. Couper and U. Santamaria, "An Elusive Concept: the Changing Definition of Illegal Immigrant in the Practice of Immigration Control in the United Kingdom", in *International Migration Review*, 18(3), 1984, p. 445.

⁹⁴ These three policies are: the new amendments to the 1989 Regulations (in force since 1st April 2004), the Health and Social Care (Community Health and Standards), Bill 2003 and former Home Secretary David Blunkett's National Identity Card scheme. Prior to April 2004, people who had been in Britain for twelve (12) months and anyone who came into the country to take up permanent residence were exempt. The new regulations aim to make the rule stricter partially through the requirement of proof of legal residence. Irregular migrants are excluded from free National Health Service (NHS) hospital care, regardless of their length of stay in the country because exemption from NHS charges expressly applies only to those living lawfully in UK. See R. Romero-Ortuño, loc. cit n. 71. See P. Scott, loc. cit. n. 79. See S. Da Lomba, "Fundamental Social Rights for Irregular Migrants: The Right to Health Care in France and England" in B. Bogusz (Ed.), *Irregular Migration and Human Rights: Theoretical, European and International Perspectives. Immigration and Asylum Law and Policy in Europe*, (7), Leiden, Martinus Nijhoff Publishers, 2004, pp. 363-386. See also: "Vulnerable Migrants have a Right to Health" in *Lancet*, 370, 2007, p. 2; S. Hargreaves, A. Holmes, J. S. Friedland, "Charging Failed Asylum Seekers for Health Care in the UK" in *Lancet*, 365, 2005, pp. 732-733; "Helping Vulnerable People to Access Healthcare", London, Médecins du Monde, 2006; P. D Williams, loc. cit. n. 5.

Victims of trafficking in human beings⁹⁵

Trafficking in persons is a crime first of all directed against the individual and only secondarily against the sovereignty of a State. Trafficking does not always have a transnational character; it may involve a victim being taken to another country or being moved from one place to another within the same country. This abusive form of migration involves the exploitation of the victims in order to generate illicit profits for the traffickers.

People trafficked for sexual exploitation, for labour, for begging and delinquency, for adoption or for any other form of exploitation⁹⁶ often suffer from a multitude of physical and psychological problems⁹⁷.

Trafficked women and girls are especially vulnerable to reproductive and gender-specific health problems due to trafficking associated sexual and physical abuse, and little or no access to health services, such as lack of access to birth control, diagnostics and treatment. Sexually exploited trafficked women suffer an increased risk of sexually transmitted infections, including HIV/AIDS, and unwanted pregnancies. Further, most trafficked persons suffer severe psychological abuse and consequent mental health problems and may exhibit symptoms associated with survivors of trauma and torture⁹⁸. Other reported problems are insensitive approaches by health

⁹⁵ Trafficking is “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” (Article 3(a), UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the UN Convention Against Organized Crime, 2000). See also pertinent European instruments (i.e. EU Framework Decision and the Council of Europe Convention).

⁹⁶ Trafficking in organs is one of those forms of exploitation. See Parliamentary Assembly Recommendation 1611 (2003) Trafficking in organs in Europe, which has been adopted on 25 June 2003 (21st Sitting). See Doc. 9822, Report of the Social, Health and Family Affairs Committee, Rapporteur: Mrs Vermot-Mangold and Doc. 9845, Opinion of the Committee on Legal Affairs and Human Rights, Rapporteur: Mr Dees.

⁹⁷ See R. Surtees, *Second Annual Report on Victims of Trafficking in South-Eastern Europe*, IOM, 2005. It analyzes also the assistance and services for victims of trafficking, including mental and physical health care and assistance, in Albania, Bosnia-Herzegovina, Bulgaria, Croatia, the Province of Kosovo, the Former Yugoslav Republic of Macedonia, the Republic of Moldova, the Republic of Montenegro, Romania, and the Republic of Serbia.

⁹⁸ M. Orhant, “Trafficking in Persons: Myths, Methods, and Human Rights” in *Trafficking in Migrants*, No. 23, IOM (April 2001). See C. Zimmerman, M. Hossain,

practitioners, service providers and law enforcement, towards trafficked persons due to lack of awareness, and fear of stigmatization.

In 2004, the European Union adopted a Council Directive⁹⁹, which obligates all EU Member States, by 6 August 2006, to provide a reflection period¹⁰⁰ and residence permit to victims of trafficking under limited circumstances. According to the Directive, a reflection period, whose length can be determined under national law, should be provided to all victims of trafficking¹⁰¹. During the reflection period and while awaiting the decision of the competent authorities, the third-country nationals concerned who do not have sufficient resources should be granted standards of living capable of ensuring their subsistence and access to emergency medical treatment¹⁰². Further, EU Member States shall attend to the special needs of the most vulnerable, including, where appropriate and if provided by national law, psychological assistance¹⁰³. Thereafter, EU Member States should grant a residence permit depending upon criteria developed by the country, which could include the opportunity for the victim to assist in investigative and judicial proceedings, whether the victim has shown a clear intent to cooperate, and whether the victim has severed all ties with her exploiter/s. Article 4 of the Directive states that Member States may adopt or maintain more favourable provisions for trafficked persons; therefore, victims of trafficking can be granted a residence permit solely based upon the danger they would face if they were deported to their home country.

K. Yun, B. Roche, L. Morison, and C. Watts, *Stolen Smiles: a Summary Report on the Physical and Psychological Health Consequences of Women and Adolescents Trafficked in Europe*, London, London School of Hygiene & Tropical Medicine (LSHTM), 2006. See also *The Mental Health Aspects of Trafficking – Training Manual*, Budapest, IOM, 2004, available at: <http://www.iom.int/jahia/Jahia/cache/offonce/pid/1674?entryId=12261>

⁹⁹ Council Directive 2004/81/EC of 29 April 2004 on the residence permit issued to third-country nationals who are victims of trafficking in human beings or who have been the subject of an action to facilitate illegal immigration, who cooperate with the competent authorities, OJ 2004 L261.

¹⁰⁰ Council Directive 2004/81/EC of 29 April 2004, Article 6. It states that “Member States shall ensure that the third-country nationals concerned are granted a reflection period allowing them to recover and escape the influence of the perpetrators of the offences so that they can take an informed decision as to whether to cooperate with the competent authorities (...)”.

¹⁰¹ “While most victims’ rights groups advocate a reflection period of three months, actual reflection periods granted by countries vary greatly with respect to length of grant, and normally are for less than three months. Longer reflection periods provide a victim with the opportunity to recuperate and to make an informed decision”. R. Malpani, *Legal Aspects of Trafficking for Forced Labour Purposes in Europe*, Geneva, International Labour Office, April 2006.

¹⁰² Council Directive 2004/81/EC of 29 April 2004, Articles 6 and 7.

¹⁰³ Council Directive 2004/81/EC of 29 April 2004, Article 7.

The Experts Group on Trafficking in Human Beings of the European Commission recommended that “assistance and protection should be provided regardless of the trafficked person’s willingness or capacity to testify against their traffickers and aim at long term social inclusion”.

The Council of Europe, under the Convention on Action Against Trafficking in Human Beings¹⁰⁴, requires Member States that ratify the treaty to provide a reflection period of at least 30 days¹⁰⁵ to victims of trafficking, and, thereafter, to issue a renewable residence permit to victims of trafficking if “the competent authority considers that their stay is necessary owing to their personal situation” or “the competent authority considers that their stay is necessary for the purpose of their co-operation with the competent authorities in investigation or criminal proceedings.”¹⁰⁶ Assistance to the victims in their physical, psychological and social recovery is also contemplated by this treaty.¹⁰⁷

Italy¹⁰⁸ and Finland¹⁰⁹ represent good examples of how an approach that conforms to EU standards can be taken in order to protect and assist the victims. In these countries protection is not linked to a victim’s agreement to testify.

¹⁰⁴Council of Europe Convention on Action against Trafficking in Human Beings, Council of Europe Treaty Series - No. 197, at p. 227.

¹⁰⁵Council of Europe Convention on Action against Trafficking in Human Beings, Article 13.

¹⁰⁶Council of Europe Convention on Action against Trafficking in Human Beings, Article 14.

¹⁰⁷Council of Europe Convention on Action against Trafficking in Human Beings, Article 12.

¹⁰⁸Italy, in fact, does not always condition grant of a residence permit on a victim’s agreement to testify. Migrants in situations of abuse or severe exploitation where their safety is threatened can also receive this permit under the Legislative Decree 25 July 1998, no. 286, Article 18 (Official Gazette n. 191 of 18 August 1998, Ordinary Supplement n.139). Further, two new funds have been established, under Law No. 228 of 2003 entitled ‘Action against trafficking in human beings’, Article 12 and 13 (Official Gazette n. 195 of 23 August 2003). They provide support, including health assistance, to victims following detection and grant a residence permit.

¹⁰⁹Finland announced the creation of a residence permit in September 2005. While the intended residence permits are to be granted mainly to victims of trafficking who agree to cooperate with authorities investigating the crime, a residence permit will be granted even if there is no cooperation, if denying the permit would be unreasonable. See R. Malpani, loc. cit n. 101.

Asylum seekers, refugees, other persons in need of international protection

Asylum seekers

Asylum seekers are persons who have left their country of origin, have applied for asylum in another country, and are awaiting a decision on their application¹¹⁰. They hope to obtain refugee status or protection on other humanitarian grounds in order to benefit from the legal protection and material assistance which is an automatic part of such protection. If the application is rejected after consideration and after all possible appeals, the applicant's right to asylum is dismissed and the state usually tries to remove or deport them, sometimes after detention.

Asylum seekers constitute a particularly vulnerable section of the population due to possible pre-migration risk factors such as torture or other trauma, which may result in physical and mental problems. Documented physical problems have included tuberculosis, HIV/AIDS, hepatitis A and B, parasitic diseases, and non-specific body pains, while mental health problems include depression related to the traumatic experiences incurred prior to and during the journey. Moreover, asylum seekers often come from conflict areas, with no or little access to adequate health services.

Post-migration factors also have an impact on health. They include detention, length of asylum procedure, language barriers, and lack of knowledge about the health system in the host country.

In 2004, a comparative study was carried out on a) asylum seekers' access to medical screening upon arrival¹¹¹ and b) their access to health

¹¹⁰See the definition of "asylum seeker" in the IOM Glossary on Migration, 2004 available at <http://www.iom.int/jahia/page855.html>.

See also: http://www.unhcr.org.uk/info/briefings/basic_facts/definitions.html.

¹¹¹Medical screening could be a useful means of facilitating integration into the host community of the asylum seekers as well as refugees and migrants. Medical screening could in fact: identify the health needs of asylum seekers, refugees and migrants; introduce them to the health care system; address threats to public health; and minimize long term costs. In order to be effective, however, the screening would need to include assessment of non-infectious conditions, chronic illness, mental health and mental trauma. The effectiveness of medical screening, however, has been questioned because it cannot and does not detect diseases during their incubation period. Moreover, it can provide a false sense of security, leading to decreased public health surveillance and a narrow focus on the health problems of the migrating population. It also raises issues of ethics and discrimination and may result in stigmatization of migrants, asylum seekers and refugees in both communities of

care services in the European Union¹¹². It was based on a questionnaire sent to relevant ministries and NGOs in the then 25 EU Member States. According to this study:

a) **Medical screening** was provided to asylum seekers upon arrival in all of the 24 EU countries that responded to the questionnaire except Greece, where it was offered only to those asylum seekers who applied for a work permit. Screening programmes included HIV and tuberculosis (TB), physical and mental examinations, and other programmes such as vaccination of children, stool tests for bacteria and parasites, hepatitis B, syphilis and malaria. The content of the screening programmes varied from country to country, as did their voluntary or compulsory nature.

Regarding the manner in which the medical screening was carried out, the findings showed that in some countries, such as those in the Nordic region, medical screening was systematically offered to all new asylum seekers, while in other countries, such as Austria, France, Spain and Britain, it was only carried out in the so-called “induction” or “reception” centers. According to the respondents, regional variations in the provision of medical screening existed within some countries, such as Italy and Germany.

HIV screening was carried out in a total of 83% of the responding countries (19 out of 23), and on a compulsory basis in 26% of these (5 countries out of 19); while TB screening was carried out in 96% of countries (22 out of 23 responding states), being compulsory in 55% of these (12 countries out of 22). Screening for mental health problems was least frequent (carried out in 61% of the countries who responded to that question, or 11 out of 18).

Screening of asylum seekers was carried out by the State authorities in all countries apart from Denmark, where the Danish Red Cross was entrusted with this task.

b) Restrictions in **access to health care** were found in 10 EU Member States: Austria, Denmark, Estonia, Finland, Germany, Hungary, Luxembourg, Malta, Spain, and Sweden. In all of these countries, except Austria, asylum seekers were entitled only to emergency care at the time

origin and destination. For an in-depth analysis see the *Report of the Health and Migration Seminar*, 88th Session of the Council, 30 November-3 December 2004, Geneva.

¹¹²M. Norredam, A. Mygind, A. Krasnik, “Access to Health Care for Asylum Seekers in the European Union – a comparative study of country policies” in *European Journal of Public Health*, 16(3), 2006, pp. 286-290.

of arrival. In Austria the restriction to emergency care applied only to those asylum seekers who had left the reception centre before being assigned a residence in a federal state, and to those who traveled or moved to federal states other than those to which they had been assigned.

Restricting access to emergency care can only give rise to a number of health problems. This may lead not only to high human costs but also to significant financial costs should in-patient treatment be required at a later date.

Another means of restricting access to health care for asylum seekers is by charging for such services, while at the same time refusing permission to work for those who would avail themselves of services. It is also worth noting in this regard that most countries exclude asylum seekers with communicable diseases, such as HIV/AIDS, from treatment¹¹³.

In addition, there are a number of practical barriers in terms of access to health services for asylum seekers that must be taken into consideration. Most of these are common to the migrating population in general, and are outlined below. Nevertheless, barriers specific to asylum seekers do exist, such as waiting for months or years for paperwork that will ensure access to health care, while only having access to emergency care in the meantime (for example, in Austria and Greece, asylum seekers need certain documentation before they may access health care services, but in both countries bureaucratic delays mean that obtaining the cards could take several months); confinement in detention centers; and dispersion policies leading to disruptive and compromised care. Furthermore, the fact that asylum seekers often have to change accommodation disrupts the continuity and quality of health care available to them.

On 27 January 2003, the EU Council of Ministers adopted a Directive laying down minimum standards for the reception of asylum applicants in Member States¹¹⁴ requiring transposition in all Member States by 6 February 2005¹¹⁵. The Directive deals also with health care, and lays down

¹¹³ See *D v. UK*, footnote n. 62.

¹¹⁴ See Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers, OJ 2003 L31, at p. 98.

¹¹⁵ The Treaty establishing the European Community specifically requests the Council to adopt minimum standards on the reception of asylum-seekers in Member States. See Article 63(1) (b) of the EC Treaty. A Common European Asylum system will be introduced in the next series of asylum measures. The above mentioned Council Directive 2003/9/EC is one of the instruments of the first stage of the Common European Asylum System. It has to be noted that Denmark is not participating in this

rules for persons with special needs, minors, unaccompanied children and victims of torture.

In the context of medical screening, the Directive states that “Member States may require medical screening for applicants on public health grounds”¹¹⁶; regarding access to health care, it states that “Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illness”¹¹⁷. This latter provision clearly allows for considerable leeway and discretion in its implementation; moreover, it fails to address the key issues of complete access to health care services for asylum seekers, and of what provision must be made for those whose asylum applications fail.

Council Directive 2003/9/EC laying down minimum standards for the reception of asylum seekers together with the earlier Directive 2001/55/EC on minimum standards for giving temporary protection in the event of a mass influx of displaced persons¹¹⁸, are an important step towards providing health care for asylum seekers and persons in need of temporary protection, paying particular attention to vulnerable groups. They are nevertheless limited to the provision of emergency care and essential treatment of illness only. There is no specific provision for: access of female asylum seekers and refugees to sexual and reproductive care, such as antenatal and/or postnatal care, family planning and counselling, prevention of mother to child transmission of HIV, HIV screening and treatment, and cervical cancer screening and treatment.

Refugees

A **refugee** is defined in Article 1 of the 1951 Convention as a person who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...”¹¹⁹.

measure (according to a Protocol attached to the Treaty Denmark is not bound by the measures taken under title IV of the Treaty — Visas, asylum, immigration and other policies related to free movement of persons).

¹¹⁶See Article 9 of Council Directive 2003/9/EC.

¹¹⁷See Article 15 of Council Directive 2003/9/EC.

¹¹⁸Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (excerpt), OJ 2001 L212, p. 96.

¹¹⁹In certain regional instruments the refugee definition has been broadened to

Article 23 of the 1951 Convention states that “The Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals”. This includes, *inter alia*, relief and assistance to persons in need due to illness, age, and physical or mental impairment.

At a wider European level, the Appendix to the European Social Charter, entitled “Scope of the Social Charter in terms of Persons Protected”, imposes on Contracting States the obligation to grant refugees at least the same standards of treatment as those required by the 1951 Convention. This Appendix¹²⁰ allows refugees to take advantage of the Charter’s supervisory mechanisms in order to enforce these rights¹²¹.

In EU Member States, recognized refugees are entitled to full access to national health systems on the same basis as nationals¹²², mostly by virtue of the fact that they are granted permanent residence status and the rights that accompany this, or are granted the same rights as nationals under the asylum law of the country in question. However, newly recognized refugees are generally not legally employed either before or immediately after their successful asylum applications. This can leave refugees without any medical coverage in cases in which health insurance systems grant coverage only to the employed or formally employed persons still covered by their unemployment insurance.

In some countries, governments have taken precautions to provide medical coverage for recognized refugees who may otherwise not be eligible for it. This is the case, for example, in the Czech Republic¹²³, where, although refugees are entitled to benefit from national health care equally with

encompass other people who have fled events that pose a serious threat to their life and liberty (see the 1969 OAU - Organization of African Unity - Convention Governing Refugee Problems in Africa; and the 1984 Cartagena Declaration on Refugees, adopted by the Colloquium on the International Protection of Refugees in Central America, Mexico and Panama).

¹²⁰ See the Appendix to the European Social Charter (revised), ETS No. 163 – European Social Charter (revised) 3.V.1996, p. 169.

¹²¹ See footnote 217.

¹²² See Article 29 of Council Directive 2004/83/EC of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted, OJ 2004 L304. Extracts of this Directive, Article 29 included, are at pp. 102-103.

¹²³ See CommDH(2006)15, Follow-up Report on the Czech Republic (2003 – 2005), Assessment of the progress made in implementing the recommendations of the Council of Europe Commissioner for Human Rights.

nationals, due to a gap in the law their children - who were born in the Czech Republic and who had therefore not yet been granted refugee status and the accompanying status of permanent residence - were not covered. Hence, families had to cover the medical expenses of their children, including those associated with child birth. The Asylum Act of 2003 addresses this issue, providing that, for the purpose of medical insurance, a child born to a recognized refugee is to be considered a permanent resident until his status is adjusted and he receives refugee status¹²⁴.

Moreover, the European Parliament recognized that “a burning problem remains the access to reproductive health care¹²⁵ for refugees and in emergency contexts, as refugees, and in particular women, are highly vulnerable, and this results in higher maternal mortality and morbidity, increased (often unsafe) sexual activity with an increased risk of STI and increased infertility rates.”¹²⁶ A majority of refugee women in Europe are of reproductive age, and research findings indicate that they suffer higher maternal morbidity and mortality; experience poorer pregnancy outcomes; have less access to family planning services and counselling, with an increased likelihood of unwanted pregnancy and induced abortion; are at a higher risk of STIs, including HIV/AIDS; and run an increased risk of sexual and gender-based violence (SGBV)¹²⁷.

¹²⁴See section 88 (Medical care), paragraph 4, of the Asylum Act No 222/2003, “Coll.”, part 79, published on 31 July 2003: “For the purposes of public health insurance, a child who was born to a refugee and is staying in the Territory shall be deemed to be an alien with leave to permanently reside until a decision is made to grant asylum or on any other type of a leave to remain in the Territory under a special legal regulation.”

¹²⁵“Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to reproduction and sexually transmitted diseases”. Source: United Nations — ICPD 1994, *Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994*. UNFPA, United States of America, 1996, Article 7.2. This definition is also endorsed by the International Planned Parenthood Federation (IPPF).

¹²⁶See European Parliament resolution on the Annual Report on Human Rights in the World 2005 and the EU’s policy on the matter (2005/2203(INI)).

¹²⁷K. Janssens, M. Bosmans, M. Temmerman, *Sexual and Reproductive Health and Rights of Refugee Women in Europe, Rights, Policies, Status and Needs* (Literature Review), Ghent, Academia Press, June 2005.

Other persons in need of international protection

There are **persons in need of international protection** on grounds other than refugee status.

For example, a Council Directive of 2001 prescribes minimum standards for providing temporary protection in the event of a mass influx of displaced persons, and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof¹²⁸. Article 13 of this Directive establishes the obligations of Member States towards persons enjoying temporary protection, stating that “(...) the Member States shall make provision for persons enjoying temporary protection to receive necessary assistance in terms of social welfare and means of subsistence, if they do not have sufficient resources, as well as for medical care”, and that “the assistance necessary for medical care shall include at least emergency care and essential treatment of illness”. Moreover, it states that “the Member States shall provide necessary medical or other assistance to persons enjoying temporary protection who have special needs, such as unaccompanied minors or persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence”.

Further, the 2004 Council Directive setting minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted¹²⁹ establishes the criteria that individuals need to meet in order to qualify as refugees or as persons otherwise in need of international protection and the rights attached to that status¹³⁰.

It states that “(...) with regard to social assistance and health care, the modalities and detail of the provision of core benefits to beneficiaries

¹²⁸Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (excerpt), OJ 2001 L212, p. 96.

¹²⁹Council Directive 2004/83/EC of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted (excerpt), OJ 2004 L304, p. 102.

¹³⁰See M.-T. Gil-Bazo, “Refugee Status and Subsidiary Protection under EC Law: The Qualification Directive and the Right to Be Granted Asylum” in *Whose Freedom, Security and Justice? EU Immigration and Asylum Law and Policy*, H. Toner, E. Guild and A. Baldaccini (eds.), Hart Publishing, June 2007.

of subsidiary protection status should be determined by national law”;¹³¹ however, “the possibility of limiting the benefits for beneficiaries of subsidiary protection status to core benefits is to be understood in the sense that this notion covers at least minimum income support, assistance in case of illness, pregnancy and parental assistance, in so far as they are granted to nationals according to the legislation of the Member State concerned”¹³¹; and that “access to health care, including both physical and mental health care, should be ensured to beneficiaries of refugee or subsidiary protection status”. The health care has also to be adequate to the special needs of pregnant women, disabled people, persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence, and minors who have been victims of any form of abuse, neglect, exploitation, torture, cruel, inhumane and degrading treatment or who have suffered from armed conflict.

Outside the scope of the above mentioned Directive are persons who obtain protection through legislation of Member States in fulfillment of their international obligations¹³².

5. Barriers to Access to Health Care: Migrating Populations in General and Specific Groups

In general, a number of practical barriers have been identified in terms of access to health services for persons involved in migration in general. First, there are language barriers, particularly related to inadequate availability of competent interpreters. Secondly, there are cultural barriers, including different ways of viewing illness and the “health care provider-patient relationship”¹³³. Finally, there is a lack of awareness of available services due to the absence of information about the health care system in host countries, including a lack of awareness and training on the part of health care officials regarding migration health issues, a lack of understanding of

¹³¹ Preamble to the Directive, para. 34.

¹³² G. Gilbert, “Is Europe Living Up to Its Obligations to Refugees?” in *European Journal of International Law*, 15, 2004, p. 980.

¹³³ Research carried out in the Netherlands has demonstrated that being able to speak the national language or having the assistance of a professional translator does not guarantee that all communication problems are solved. According to Richters and Van Vliet, different social and cultural perspectives can also cause communication problems. Miscommunication stems not only from language barriers, but also from differences in social and cultural familiarity and expectations. See A. Richters and K. Van Vliet (eds.), in Çinibulak L., 2002. See also Report on Mental Health in Europe Working Group, “Migration and Mental Health in Europe (the state of mental health in Europe Working Group: Appendix 1)” in *Clinical Practice and Epidemiology in Mental Health*, 1:13, 2005, p. 11.

the specific needs and expectations of those involved in migration together with a lack of trust on the part of persons involved in migration¹³⁴.

Specific Groups

Specific group of persons involved in migration may also face barriers particular to their immigration status.

Regarding irregular migrants' access to health care in practice, Romero-Ortuño considers barriers in terms of both demand-side (irregular migrants)¹³⁵ and supply-side (health care providers)¹³⁶. On the demand side, he notes that a lack of information on the laws concerning the provision of medical care to foreigners make irregular migrants afraid of using public care services, and by the time they decide to seek medical treatment, a disease or illness may have developed to an advanced stage. Even when irregular migrants are aware of their rights, the process for obtaining regular access to health care can be too long and complicated as in, for example, Belgium and Spain¹³⁷. Thus, illiteracy, language problems and lack of time can discourage irregular migrants from starting or completing the process of seeking regular access to health services.

¹³⁴Doudová highlights the following example: “a Chinese national studying at a grammar school in a European capital, who occasionally interprets for her compatriots during medical examinations, gave an account of her own experiences. In her opinion, a major problem for her community is the lack of necessary information, which is caused by language barriers. Apart from this, foreigners sometimes have problems finding a physician; the occasional interpreter even met a physician who refused to treat a patient. She also referred to cultural differences which can cause embarrassment to Chinese women, when being treated by a male doctor”. H. Doudová, *Debate on the Access of (Il)legal Migrants to Health Insurance (Report)*, Prague, Multicultural Center Prague, 2007.

¹³⁵Braun and Würflinger, in 2001, draw attention to the following case: “An African woman was treated for fever, infection and weakness in the emergency department of a university hospital of the EU country where she was living. When she produced an unknown insurance card the hospital administration became suspicious and called the police in order to establish her residence status. The police took her to the police station and a few hours later she was again taken to a hospital emergency department, this time with a broken arm. The arm was plastered and an operation planned for the following day. However, the woman left before the operation because she feared being deported immediately afterwards”.

¹³⁶R. Romero-Ortuño, loc. cit. n. 71.

¹³⁷For Belgium, see Medisch Steunpunt Mensen Zonder Papieren (2003), Urgent Medical Care for Illegal Residents (retrieved September 8, 2003) www.medimmigrant.be. For Spain, see Médicos Sin Fronteras (2002), Socio-Sanitary Handbook for Immigrants in the Community of Madrid. Madrid: Médicos Sin Fronteras, available at: www.msf.es.

On the supply-side, he observes that health care managers and providers are also often unaware of the current legislation concerning access to health care for irregular migrants, or are faced with ambiguously or imprecisely defined entitlements, subject to incoherent and conflicting interpretations. The latter is the case in Belgium and the Netherlands¹³⁸, where new legal provisions are thwarted by implementation measures and insufficient funding. Further, administrative procedures for refunding the cost of treating an uninsured person regardless of her/his residence status can be complex, expensive and lengthy. This is the case, for example, in Belgium and Germany.

In many cases, asylum seekers have to wait months or even years for the necessary paperwork allowing access to health services, and in the meantime, may be confined to detention centers and granted only emergency health care. Moreover, asylum seeker dispersal programmes can lead to disrupted and compromised levels of care.

Finally, specific ethnic groups may face double discrimination on the basis of race/ethnicity and migratory status. Many Roma, for example, face physical, economic and information-based barriers to health care. This is the result of the complex and interrelated effects of poverty, discrimination and unfamiliarity with government institutions generally, and health services in particular. As noted by Pomykala and Holt, Roma experience discrimination in accessing health care in different ways depending on a variety of factors, including whether a community is urban or geographically isolated, or whether the Roma population is sedentary or nomadic. They may experience direct discrimination in, for example, the refusal of physicians or health care institutions to treat them¹³⁹.

¹³⁸See T. Sheldon, "Dutch Minister Warns that Illegal Immigrants Must Receive Care", in *British Medical Journal*, 318 (7193), 1999, p. 1234.

¹³⁹C. Packer, "The Health Status of Roma: Priorities for Improvements", in *Human Rights Tribune des droits humains*, 11(1), winter 2005. See also the European Union Annual Report on Human Rights 2005, available at <http://www.consilium.europa.eu/uedocs/cmsUpload/HR2005en.pdf>. It highlights, in paragraph 4.14. on persons belonging to minorities, that: "Roma, including persons describing themselves as Roma, Gypsies, Travellers, Manouches, Sinti, as well as other terms, are considered to be one of the largest ethnic minority groups within the EU. Numerous assessments of the situation of Roma in both new and old member states clearly illustrate that members of this community continue to suffer marked discrimination and social exclusion, and encounter difficulties in gaining unhindered and equal access to employment, education, social security, healthcare, housing, public services and justice. The reports of the EUMC National Focal Points confirm marginalisation of Roma in labour markets in nearly all new member states. Also in the field of housing, Roma seem to be the group facing the most discrimination, with surveys showing

6. Recommendations

The right to health, which includes the right to health care and the right to preconditions for health, is a fundamental human right applying to every human being, including migrants, whether in a regular or irregular situation, victims of trafficking, asylum seekers, refugees and other persons in need of international protection.

In the European context, instruments exist, both at the EU and Council of Europe level, recognizing the right to health as a fundamental human right and aiming at ensuring equitable access to health care of appropriate quality in accordance with the person's medical needs. They impose obligations on States to use their best endeavours to respect, protect and fulfill the right to health.

Nevertheless, health inequalities continue to exist in the region, both in terms of health status as well as access to health services of equal quality for persons involved in migration compared to nationals.

In view of the above and recognizing that:

- the specific vulnerability to physical, mental and social health problems of persons involved in migration depends on the risk factors surrounding the migration process, including pre-migration circumstances, travel conditions, the arrival or transit phase, as well as return phase;
- all medical screening should be accompanied by appropriate information and provide guarantees for consent, counselling and confidentiality, as well as follow-up and treatment;
- the health condition of an individual is not a ground for any exception to the principles and standards embodied in international migration law;
- considerations of health are also a strong argument against detention of migrants and asylum seekers, particularly children, at any stage of the migration process;
- a person's health status is not a valid reason for expulsion;

that they are the group "least wanted" as neighbours by majority populations. Roma are often affected by territorial segregation".

- persons involved in migration face barriers in terms of access to health services and equal care arising, *inter alia*, from their legal and socio economic status, lack of awareness and understanding of available services on the part of patients and lack of migration related knowledge and training on the part of health care officials, compounded in both instances by communication difficulties and linguistic and cultural barriers.

It is recommended that EU and CoE Member States take measures to:

a) Regarding persons involved in migration in general,

- ensure that the right to health is formally recognised in national laws and the practical obstacles to its enjoyment by all migrant populations, including those in an irregular situation, be eliminated;
- overcome barriers to the enjoyment of the right to health for persons involved in migration through training for health providers, policy makers, health management planners and health educators as well as other professions allied to health services delivery, on how to address health care issues associated with population mobility and disparities of health services between geographical locations. Such training should include modules on the right to health and how it applies at the national level to migrants, regular and irregular alike, victims of trafficking, asylum seekers, refugees, and other persons in need of international protection, Roma, including persons describing themselves as Roma, Gypsies, Travellers, Manouches or Sinti;
- assist persons involved in migration in gaining awareness of and confidence in the health care systems of Member States as well as realizing the importance of preventive health care;
- develop integration and prevention strategies to decrease stigmatization, discrimination and vulnerability of persons involved in migration (e.g. improve communication by language, culture and gender sensitive services) and to facilitate ethnic community participation in health services delivery, policy design, programme planning and evaluation¹⁴⁰.

¹⁴⁰ *Migrant Health for the Benefit of All*, Geneva, IOM, 2004, MC/INF/275.

b) Regarding migrants in an irregular situation,

- eliminate any requirement on health service providers to report to the authorities the presence of irregular migrants¹⁴¹;
- guarantee a holistic, equal and publicly financed health care for irregular migrants, and avoid the establishment of parallel structures for healthcare;

c) Regarding victims of trafficking in persons,

- provide a longer reflection period which gives a victim the opportunity to recover and to make an informed decision whether to cooperate with law enforcement authorities;
- guarantee health promotion, information, education and care services to victims of trafficking regardless of their willingness to cooperate in criminal proceedings against traffickers;
- guarantee health care appropriate to the needs and circumstances of individual victims with the understanding that “different stages of intervention call for different priorities in terms of health care that is offered to victims¹⁴²”.

¹⁴¹Where “social administrations providing benefits to irregular migrants would have to report this to the immigration services no irregular migrant will address himself to the social administration, annihilating his right to basic social benefits. For example where all persons are made subject to preventive care measures, this is to safeguard public health. Thus, when doctors, hospital or social officers refunding preventive care denounce irregular migrants they might put at stake the safety and health of society”. Council of Europe, Committee of Experts on Standard-Setting Instruments in the Field of Social Security (CS-CO), 6th Meeting, Limassol, 25-26 May 2004, *Exploratory Report on the Access to Social Protection for Illegal Labour Migrants*, prepared by P. Schoukens and D. Pieters, Doc. CS-CO (2004) 3rev (Strasbourg, 30 June 2004), p. 33. See also Doc.10924, *report of the Committee on Migration, Refugees and Population*, where the Rapporteur, Mr van Thijn, notes that even if access to emergency health care is generally available, it may in fact be problematic and this may be because of an obligation on health providers to report irregular migrants to the police.

¹⁴²See Budapest Declaration on Public Health and Trafficking in Human Beings, 2003. It describes, *inter alia*, the care that is needed during the initial rescue phase and during the rehabilitation phase.

d) Regarding asylum seekers, refugees and persons in need of international protection,

- ensure that host communities: provide full and non discriminatory access to health care to asylum seekers, refugees and other persons in need of international protection on the same basis as nationals; be aware of possible pre-migratory experiences or experiences during flight and the potential consequent need for specialized health services;
- address disruption of continuity and quality of care due to change of geographic location.

II. REGIONAL INSTRUMENTS

II.1 EUROPEAN COMMUNITY

The sources of European Community law are the following¹⁴³:

- primary legislation (Treaties establishing the Communities);
- secondary legislation (Regulations, Directives, General and Individual Decisions, Recommendations and Opinions);
- the EC's international agreements (agreements the Community concludes with international organizations and with non-member countries, such as association agreements, cooperation agreements and trade agreements)
- General principles of administrative law and Conventions between the Member States.

The **primary legislation** includes several **Treaties**, namely the Treaty of Rome (1957), the Single European Act (1986), the Treaty of Maastricht (1992), the Treaty of Amsterdam (1997), the Treaty of Nice (2001), the various annexes and protocols attached to them, and subsequent additions and amendments.

Concerning **secondary legislation** under the European Treaties, the EU institutions may make regulations, issue directives, take decisions, make recommendations and deliver opinions¹⁴⁴.

Regulations are binding in their entirety and are directly applicable in all Member States. Because regulations have direct effect, the individual countries do not need to pass national laws to bring them into effect, and indeed any national laws contrary to the regulation are overruled, as European Union Law prevails over the laws of the Member States. Member States therefore have to legislate in light, and consistently within the requirements, of EU Regulations.

Directives are binding upon the Member States they are addressed to as regards the objective to be achieved. However each Member State has some discretion as to how this agreed Community objective is to be incorporated into its domestic legal system. Directives also aim to harmonize legislation across the Member States by setting minimum requirements, but they allow Member States to implement higher standards if they wish.

Directives are adopted by the Council of the European Union upon a proposal submitted by the Commission to the European Parliament and

¹⁴³See The ABC of Community law by K.-D.Borchardt, pp. 58-71, available at http://europa.eu.int/eur-lex/en/about/abc_en.pdf. See also D. Phinmore and L. McGowan, A Dictionary of the European Union - 2nd edition, 2004.

¹⁴⁴See Article 249 of the EC Treaty.

the Council. The Member States are obliged to interpret and apply national law in accordance with directives.

Decisions are binding on those to whom they are addressed¹⁴⁵. Decisions come into effect when the requirement to notify them to those to whom they are addressed is complied with¹⁴⁶.

There are a variety of **soft law measures**, such as recommendations and opinions, which are mentioned in the Treaty but which do not have binding force.

Recommendations are meant to suggest a particular course of action reflecting the opinion and standpoint of the institution involved.

The Commission delivers **Opinions** primarily in the areas of employment, working conditions, vocational training and social security.

Soft law measures are also studies, reports, communications, memoranda, communiqués, codes of conduct, internal rules, impact assessments, guidelines, pilot projects and consultations.

Under the new European Constitution of 18 June 2004, not ratified and to be replaced by a “Reform Treaty”¹⁴⁷, a simpler terminology was proposed as follows:

Legislative acts are European laws, which correspond to the existing regulations, and framework laws that correspond to the existing directives. Both these legislative acts are to be adopted by the current codecision procedure, which will become the “ordinary legislative procedure” in the proposed Constitution.

Non-legislative acts are European regulations and European decisions. According to the Constitution, a regulation is a non-legislative act of general application for the implementation of legislative acts and of certain provisions of the Constitution. A decision is now defined as a non-legislative act, binding in its entirety. A decision which specifies those to whom it is addressed is binding only on them.

¹⁴⁵See Article 249 of the EC Treaty.

¹⁴⁶See Article 254 of the EC Treaty.

¹⁴⁷See p. 66. The treaty approved on 19 October 2007 (see below p. 66) partially retains this terminology.

Non-mandatory instruments are opinions and recommendations.

***Sui generis* documents** are conclusions of the European Council, Council guidelines and European Council strategic guidelines.

II.1.1 PRIMARY LEGISLATION

1. Consolidated version of the Treaty establishing the European Community (excerpt)¹⁴⁸

(...)

PART ONE

PRINCIPLES

Article 2

The Community shall have as its task, by establishing a common market and an economic and monetary union and by implementing common policies or activities referred to in Articles 3 and 4, to promote throughout the Community a harmonious, balanced and sustainable development of economic activities, a high level of employment and of social protection, equality between men and women, sustainable and non-inflationary growth, a high degree of competitiveness and convergence of economic performance, a high level of protection and improvement of the quality of the environment, the raising of the standard of living and quality of life, and economic and social cohesion and solidarity among Member States.

Article 3

1. For the purposes set out in Article 2, the activities of the Community shall include, as provided in this Treaty and in accordance with the timetable set out therein:
 - (a) the prohibition, as between Member States, of customs duties and quantitative restrictions on the import and export of goods, and of all other measures having equivalent effect;
 - (b) a common commercial policy;
 - (c) an internal market characterised by the abolition, as between Member States, of obstacles to the free movement of goods, persons, services and capital;
 - (d) measures concerning the entry and movement of persons as provided for in Title IV;
 - (e) a common policy in the sphere of agriculture and fisheries;

¹⁴⁸Source: OJ 2002 C325.

- (f) a common policy in the sphere of transport;
 - (g) a system ensuring that competition in the internal market is not distorted;
 - (h) the approximation of the laws of Member States to the extent required for the functioning of the common market;
 - (i) the promotion of coordination between employment policies of the Member States with a view to enhancing their effectiveness by developing a coordinated strategy for employment;
 - (j) a policy in the social sphere comprising a European Social Fund;
 - (k) the strengthening of economic and social cohesion;
 - (l) a policy in the sphere of the environment;
 - (m) the strengthening of the competitiveness of Community industry;
 - (n) the promotion of research and technological development;
 - (o) encouragement for the establishment and development of trans-European networks;
 - (p) a contribution to the attainment of a high level of health protection;
 - (q) a contribution to education and training of quality and to the flowering of the cultures of the Member States;
 - (r) a policy in the sphere of development cooperation;
 - (s) the association of the overseas countries and territories in order to increase trade and promote jointly economic and social development;
 - (t) a contribution to the strengthening of consumer protection;
 - (u) measures in the spheres of energy, civil protection and tourism.
2. In all the activities referred to in this Article, the Community shall aim to eliminate inequalities, and to promote equality, between men and women.

(...)

Article 12

Within the scope of application of this Treaty, and without prejudice to any special provisions contained therein, any discrimination on grounds of nationality shall be prohibited.

The Council, acting in accordance with the procedure referred to in Article 251, may adopt rules designed to prohibit such discrimination.

(...)

TITLE III

FREE MOVEMENT OF PERSONS, SERVICES AND CAPITAL

CHAPTER 1

WORKERS

Article 39

1. Freedom of movement for workers shall be secured within the Community.
2. Such freedom of movement shall entail the abolition of any discrimination based on nationality between workers of the Member States as regards employment, remuneration and other conditions of work and employment.
3. It shall entail the right, subject to limitations justified on grounds of public policy, public security or public health:
 - (a) to accept offers of employment actually made;
 - (b) to move freely within the territory of Member States for this purpose;
 - (c) to stay in a Member State for the purpose of employment in accordance with the provisions governing the employment of nationals of that State laid down by law, regulation or administrative action;

(d) to remain in the territory of a Member State after having been employed in that State, subject to conditions which shall be embodied in implementing regulations to be drawn up by the Commission.

4. The provisions of this article shall not apply to employment in the public service.

(...)

Article 42

The Council shall, acting in accordance with the procedure referred to in Article 251, adopt such measures in the field of social security as are necessary to provide freedom of movement for workers; to this end, it shall make arrangements to secure for migrant workers and their dependants:

(a) aggregation, for the purpose of acquiring and retaining the right to benefit and of calculating the amount of benefit, of all periods taken into account under the laws of the several countries;

(b) payment of benefits to persons resident in the territories of Member States.

The Council shall act unanimously throughout the procedure referred to in Article 251.

(...)

CHAPTER 3

SERVICES

Article 49

Within the framework of the provisions set out below, restrictions on freedom to provide services within the Community shall be prohibited in respect of nationals of Member States who are established in a State of the Community other than that of the person for whom the services are intended.

The Council may, acting by a qualified majority on a proposal from the Commission, extend the provisions of the Chapter to nationals of a third country who provide services and who are established within the Community.

Article 50

Services shall be considered to be ‘services’ within the meaning of this Treaty where they are normally provided for remuneration, in so far as they are not governed by the provisions relating to freedom of movement for goods, capital and persons.

‘Services’ shall in particular include:

- (a) activities of an industrial character;
- (b) activities of a commercial character;
- (c) activities of craftsmen;
- (d) activities of the professions.

Without prejudice to the provisions of the chapter relating to the right of establishment, the person providing a service may, in order to do so, temporarily pursue his activity in the State where the service is provided, under the same conditions as are imposed by that State on its own nationals.

(...)

Article 54

As long as restrictions on freedom to provide services have not been abolished, each Member State shall apply such restrictions without distinction on grounds of nationality or residence to all persons providing services within the meaning of the first paragraph of Article 49.

(...)

TITLE IV

VISAS, ASYLUM, IMMIGRATION AND OTHER POLICIES RELATED TO FREE MOVEMENT OF PERSONS

Article 61

- In order to establish progressively an area of freedom, security and justice, the Council shall adopt:

(a) within a period of five years after the entry into force of the Treaty of Amsterdam, measures aimed at ensuring the free movement of persons in accordance with Article 14, in conjunction with directly related flanking measures with respect to external border controls, asylum and immigration, in accordance with the provisions of Article 62(2) and (3) and Article 63(1)(a) and (2)(a), and measures to prevent and combat crime in accordance with the provisions of Article 31(e) of the Treaty on European Union;

(b) other measures in the fields of asylum, immigration and safeguarding the rights of nationals of third countries, in accordance with the provisions of Article 63;

(c) measures in the field of judicial cooperation in civil matters as provided for in Article 65;

(d) appropriate measures to encourage and strengthen administrative cooperation, as provided for in Article 66;

(e) measures in the field of police and judicial cooperation in criminal matters aimed at a high level of security by preventing and combating crime within the Union in accordance with the provisions of the Treaty on European Union.

(...)

Article 63

The Council, acting in accordance with the procedure referred to in Article 67, shall, within a period of five years after the entry into force of the Treaty of Amsterdam, adopt:

1. measures on asylum, in accordance with the Geneva Convention of 28 July 1951 and the Protocol of 31 January 1967 relating to the status of refugees and other relevant treaties, within the following areas:

(a) criteria and mechanisms for determining which Member State is responsible for considering an application for asylum submitted by a national of a third country in one of the Member States,

(b) minimum standards on the reception of asylum seekers in Member States,

- (c) minimum standards with respect to the qualification of nationals of third countries as refugees,
 - (d) minimum standards on procedures in Member States for granting or withdrawing refugee status;
2. measures on refugees and displaced persons within the following areas:
- (a) minimum standards for giving temporary protection to displaced persons from third countries who cannot return to their country of origin and for persons who otherwise need international protection,
 - (b) promoting a balance of effort between Member States in receiving and bearing the consequences of receiving refugees and displaced persons;
3. measures on immigration policy within the following areas:
- (a) conditions of entry and residence, and standards on procedures for the issue by Member States of long-term visas and residence permits, including those for the purpose of family reunion,
 - (b) illegal immigration and illegal residence, including repatriation of illegal residents;
4. measures defining the rights and conditions under which nationals of third countries who are legally resident in a Member State may reside in other Member States.

Measures adopted by the Council pursuant to points 3 and 4 shall not prevent any Member State from maintaining or introducing in the areas concerned national provisions which are compatible with this Treaty and with international agreements.

Measures to be adopted pursuant to points 2(b), 3(a) and 4 shall not be subject to the five-year period referred to above.

(...)

TITLE XI
SOCIAL POLICY, EDUCATION, VOCATIONAL TRAINING AND
YOUTH

CHAPTER 1

SOCIAL PROVISIONS

(...)

Article 137¹⁴⁹

1. With a view to achieving the objectives of Article 136, the Community shall support and complement the activities of the Member States in the following fields:
 - (a) improvement in particular of the working environment to protect workers' health and safety;
 - (b) working conditions;
 - (c) social security and social protection of workers;
 - (d) protection of workers where their employment contract is terminated;
 - (e) the information and consultation of workers;
 - (f) representation and collective defence of the interests of workers and employers, including co-determination, subject to paragraph 5;
 - (g) conditions of employment for third-country nationals legally residing in Community territory;
 - (h) the integration of persons excluded from the labour market, without prejudice to Article 150;
 - (i) equality between men and women with regard to labour market opportunities and treatment at work;

¹⁴⁹ Article amended by the Treaty of Nice.

(j) the combating of social exclusion;

(k) the modernisation of social protection systems without prejudice to point (c).

2. To this end, the Council:

(a) may adopt measures designed to encourage cooperation between Member States through initiatives aimed at improving knowledge, developing exchanges of information and best practices, promoting innovative approaches and evaluating experiences, excluding any harmonisation of the laws and regulations of the Member States;

(b) may adopt, in the fields referred to in paragraph 1(a) to (i), by means of directives, minimum requirements for gradual implementation, having regard to the conditions and technical rules obtaining in each of the Member States. Such directives shall avoid imposing administrative, financial and legal constraints in a way which would hold back the creation and development of small and medium-sized undertakings.

The Council shall act in accordance with the procedure referred to in Article 251 after consulting the Economic and Social Committee and the Committee of the Regions, except in the fields referred to in paragraph 1(c), (d), (f) and (g) of this article, where the Council shall act unanimously on a proposal from the Commission, after consulting the European Parliament and the said Committees. The Council, acting unanimously on a proposal from the Commission, after consulting the European Parliament, may decide to render the procedure referred to in Article 251 applicable to paragraph 1(d), (f) and (g) of this article.

3. A Member State may entrust management and labour, at their joint request, with the implementation of directives adopted pursuant to paragraph 2.

In this case, it shall ensure that, no later than the date on which a directive must be transposed in accordance with Article 249, management and labour have introduced the necessary measures by agreement, the Member State concerned being required to take any necessary measure enabling it at any time to be in a position to guarantee the results imposed by that directive.

4. The provisions adopted pursuant to this article:
 - shall not affect the right of Member States to define the fundamental principles of their social security systems and must not significantly affect the financial equilibrium thereof,
 - shall not prevent any Member State from maintaining or introducing more stringent protective measures compatible with this Treaty.
5. The provisions of this article shall not apply to pay, the right of association, the right to strike or the right to impose lock-outs.

Article 140

With a view to achieving the objectives of Article 136 and without prejudice to the other provisions of this Treaty, the Commission shall encourage cooperation between the Member States and facilitate the coordination of their action in all social policy fields under this chapter, particularly in matters relating to:

- employment,
- labour law and working conditions,
- basic and advanced vocational training,
- social security,
- prevention of occupational accidents and diseases,
- occupational hygiene,
- the right of association and collective bargaining between employers and workers.

To this end, the Commission shall act in close contact with Member States by making studies, delivering opinions and arranging consultations both on problems arising at national level and on those of concern to international organisations.

Before delivering the opinions provided for in this article, the Commission shall consult the Economic and Social Committee.

(...)

TITLE XIII

PUBLIC HEALTH

Article 152

1. A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.

Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education.

The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Community shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.

3. The Community and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.
4. The Council, acting in accordance with the procedure referred to in Article 251 and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this article through adopting:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) by way of derogation from Article 37, measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) incentive measures designed to protect and improve human health, excluding any harmonisation of the laws and regulations of the Member States.

The Council, acting by a qualified majority on a proposal from the Commission, may also adopt recommendations for the purposes set out in this article.

5. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

(...)

TITLE XIV

CONSUMER PROTECTION

Article 153

1. In order to promote the interests of consumers and to ensure a high level of consumer protection, the Community shall contribute to protecting the health, safety and economic interests of consumers, as well as to promoting their right to information, education and to organise themselves in order to safeguard their interests.
2. Consumer protection requirements shall be taken into account in defining and implementing other Community policies and activities.
3. The Community shall contribute to the attainment of the objectives referred to in paragraph 1 through:

(a) measures adopted pursuant to Article 95 in the context of the completion of the internal market;

(b) measures which support, supplement and monitor the policy pursued by the Member States.

4. The Council, acting in accordance with the procedure referred to in Article 251 and after consulting the Economic and Social Committee, shall adopt the measures referred to in paragraph 3(b).
5. Measures adopted pursuant to paragraph 4 shall not prevent any Member State from maintaining or introducing more stringent protective measures. Such measures must be compatible with this Treaty. The Commission shall be notified of them.

(...)

2. Charter of Fundamental Rights of the European Union (excerpt)¹⁵⁰

Adoption: 7 December 2000

**The text is not mandatory, but it is incorporated into the second part
of the Treaty establishing a constitution for Europe¹⁵¹**

(...)

CHAPTER I

DIGNITY

Article 1

Human dignity

Human dignity is inviolable. It must be respected and protected.

Article 2

Right to life

1. Everyone has the right to life.
2. No one shall be condemned to the death penalty, or executed.

Article 3

Right to the integrity of the person

1. Everyone has the right to respect for his or her physical and mental integrity.
2. In the fields of medicine and biology, the following must be respected in particular:

¹⁵⁰Source: OJ 2000 C364. See also document CONVENT 49 of 11 October 2000, which contains the full text of the explanations relating to the complete text of the Charter.

¹⁵¹For more information about the Charter legal status, see: http://ec.europa.eu/justice_home/unit/charte/en/about-status.html; see also p. 66.

- the free and informed consent of the person concerned, according to the procedures laid down by law,
- the prohibition of eugenic practices, in particular those aiming at the selection of persons,
- the prohibition on making the human body and its parts as such a source of financial gain,
- the prohibition of the reproductive cloning of human beings.

(...)

CHAPTER III

EQUALITY

(...)

Article 21

Non-discrimination

1. Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.
2. Within the scope of application of the Treaty establishing the European Community and of the Treaty on European Union, and without prejudice to the special provisions of those Treaties, any discrimination on grounds of nationality shall be prohibited.

(...)

CHAPTER IV

SOLIDARITY

(...)

Article 34

Social security and social assistance

1. The Union recognises and respects the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age, and in the case of loss of employment, in accordance with the rules laid down by Community law and national laws and practices.
2. Everyone residing and moving legally within the European Union is entitled to social security benefits and social advantages in accordance with Community law and national laws and practices.
3. In order to combat social exclusion and poverty, the Union recognises and respects the right to social and housing assistance so as to ensure a decent existence for all those who lack sufficient resources, in accordance with the rules laid down by Community law and national laws and practices.

Article 35¹⁵²

Health care

Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

¹⁵² “The principles set out in this Article are based on Article 152 of the EC Treaty and on Article 11 of the European Social Charter. The second sentence of the Article takes over Article 152(1)” as it is stated by the Bureau of the Convention. The latter - at its own instigation and prior to the actual adoption of the Charter – prepared explanations for each article of the Charter.

3. Treaty establishing a Constitution for Europe (excerpt)¹⁵³

Adoption: 18 June 2004

Not in force. Before it could enter into force, the Constitution for Europe should have been ratified by all the Member States of the European Union. 15 Member States have ratified the Constitution for Europe. France and the Netherlands rejected it on 29 May and 1 June 2005 respectively. In June 2007, the EU leaders agreed on a detailed mandate for a new Intergovernmental Conference whose task was to draw up a “Reform Treaty” for the EU. On 19 October 2007, the EU Member States approved in Lisbon the text of a “Treaty amending the Treaty on European Union and the Treaty establishing the European Community” to be signed on 13 December 2007 (see CIG 1/1/07 REV 1)

PART I

TITLE I

DEFINITION AND OBJECTIVES OF THE UNION

(...)

Article I-3

The Union’s objectives

1. The Union’s aim is to promote peace, its values and the well-being of its peoples.
2. The Union shall offer its citizens an area of freedom, security and justice without internal frontiers, and an internal market where competition is free and undistorted.
3. The Union shall work for the sustainable development of Europe based on balanced economic growth and price stability, a highly competitive social market economy, aiming at full employment and social progress, and a high level of protection and improvement of the quality of the environment. It shall promote scientific and technological advance.

¹⁵³Source: OJ 2004 C310, Volume 47.

It shall combat social exclusion and discrimination, and shall promote social justice and protection, equality between women and men, solidarity between generations and protection of the rights of the child.

It shall promote economic, social and territorial cohesion, and solidarity among Member States.

It shall respect its rich cultural and linguistic diversity, and shall ensure that Europe's cultural heritage is safeguarded and enhanced.

4. In its relations with the wider world, the Union shall uphold and promote its values and interests. It shall contribute to peace, security, the sustainable development of the Earth, solidarity and mutual respect among peoples, free and fair trade, eradication of poverty and the protection of human rights, in particular the rights of the child, as well as to the strict observance and the development of international law, including respect for the principles of the United Nations Charter.
5. The Union shall pursue its objectives by appropriate means commensurate with the competences which are conferred upon it in the Constitution.

(...)

PART II

THE CHARTER OF FUNDAMENTAL RIGHTS OF THE UNION

TITLE IV

SOLIDARITY

Article II-95

Health care

Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall

be ensured in the definition and implementation of all Union policies and activities.

(...)

PART III

THE POLICIES AND FUNCTIONING OF THE UNION

TITLE I

PROVISIONS OF GENERAL APPLICATION

(...)

Article III-117¹⁵⁴

In defining and implementing the policies and actions referred to in this Part, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health.

(...)

CHAPTER IV

AREA OF FREEDOM, SECURITY AND JUSTICE

(...)

¹⁵⁴This horizontal clause, designed to re-affirm certain principles for all policies, highlights that the EU shall take into consideration several requirements, including human health when implementing policies and actions.

SECTION 2

POLICIES ON BORDER CHECKS,

ASYLUM AND IMMIGRATION

(...)

Article III-267

1. The Union shall develop a common immigration policy aimed at ensuring, at all stages, the efficient management of migration flows, fair treatment of third-country nationals residing legally in Member States, and the prevention of, and enhanced measures to combat, illegal immigration and trafficking in human beings.
2. For the purposes of paragraph 1, European laws or framework laws shall establish measures in the following areas:
 - (a) the conditions of entry and residence, and standards on the issue by Member States of long-term visas and residence permits, including those for the purpose of family reunion;
 - (b) the definition of the rights of third-country nationals residing legally in a Member State, including the conditions governing freedom of movement and of residence in other Member States;
 - (c) illegal immigration and unauthorised residence, including removal and repatriation of persons residing without authorisation;
 - (d) combating trafficking in persons, in particular women and children.
3. The Union may conclude agreements with third countries for the readmission to their countries of origin or provenance of third-country

nationals who do not or who no longer fulfil the conditions for entry, presence or residence in the territory of one of the Member States.

4. European laws or framework laws may establish measures to provide incentives and support for the action of Member States with a view to promoting the integration of third-country nationals residing legally in their territories, excluding any harmonisation of the laws and regulations of the Member States.
5. This Article shall not affect the right of Member States to determine volumes of admission of third-country nationals coming from third countries to their territory in order to seek work, whether employed or self-employed.

(...)

CHAPTER V

AREAS WHERE THE UNION MAY

TAKE COORDINATING,

COMPLEMENTARY OR SUPPORTING ACTION

SECTION 1

PUBLIC HEALTH

Article III-278

1. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.

Action by the Union, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to physical and mental health¹⁵⁵. Such action shall cover:

¹⁵⁵This article, mentioning expressly physical and mental health, differs from Article 152 of the Treaty of Amsterdam which refers to human health in general. Article III-278 of the Treaty establishing a Constitution for Europe is closer to the WHO definition of health.

(a) the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education;

(b) monitoring, early warning of and combating serious cross-border threats to health.

The Union shall complement the Member States' action in reducing drug-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.
4. By way of derogation from Article I-12(5) and Article I-17(a) and in accordance with Article I-14 (2)(k), European laws or framework laws shall contribute to the achievement of the objectives referred to in this Article by establishing the following measures in order to meet common safety concerns:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) measures setting high standards of quality and safety for medicinal products and devices for medical use;

(d) measures concerning monitoring, early warning of and combating serious cross-border threats to health.

Such European laws or framework laws shall be adopted after consultation of the Committee of the Regions and the Economic and Social Committee.

5. European laws or framework laws may also establish incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, as well as measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

They shall be adopted after consultation of the Committee of the Regions and the Economic and Social Committee.

6. For the purposes of this Article, the Council, on a proposal from the Commission, may also adopt recommendations.
7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

II.1.2 SECONDARY LEGISLATION

EQUAL TREATMENT

4. Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin (excerpt)¹⁵⁶

Adoption: 29 June 2000

Entry in force: 19 July 2000

(...)

THE COUNCIL OF THE EUROPEAN UNION,

(...)

Whereas:

(...)

(12) To ensure the development of democratic and tolerant societies which allow the participation of all persons irrespective of racial or ethnic origin, specific action in the field of discrimination based on racial or ethnic origin should go beyond access to employed and self-employed activities and cover areas such as education, social protection including social security and healthcare, social advantages and access to and supply of goods and services.

(13) To this end, any direct or indirect discrimination based on racial or ethnic origin as regards the areas covered by this Directive should be prohibited throughout the Community. This prohibition of discrimination should also apply to nationals of third countries, but does not cover differences of treatment based on nationality and is without prejudice to provisions governing the entry and residence of third-country nationals and their access to employment and to occupation.

(...)

HAS ADOPTED THIS DIRECTIVE:

¹⁵⁶Source: OJ 2000 L180.

CHAPTER I

GENERAL PROVISIONS

Article 1

Purpose

The purpose of this Directive is to lay down a framework for combating discrimination on the grounds of racial or ethnic origin, with a view to putting into effect in the Member States the principle of equal treatment.

(...)

Article 3

Scope

1. Within the limits of the powers conferred upon the Community, this Directive shall apply to all persons, as regards both the public and private sectors, including public bodies, in relation to:

(a) conditions for access to employment, to self-employment and to occupation, including selection criteria and recruitment conditions, whatever the branch of activity and at all levels of the professional hierarchy, including promotion;

(b) access to all types and to all levels of vocational guidance, vocational training, advanced vocational training and retraining, including practical work experience;

(c) employment and working conditions, including dismissals and pay;

(d) membership of and involvement in an organisation of workers or employers, or any organisation whose members carry on a particular profession, including the benefits provided for by such organisations;

(e) social protection, including social security and healthcare;

(f) social advantages;

(g) education;

(h) access to and supply of goods and services which are available to the public, including housing.

2. This Directive does not cover difference of treatment based on nationality and is without prejudice to provisions and conditions relating to the entry into and residence of third-country nationals and stateless persons on the territory of Member States, and to any treatment which arises from the legal status of the third-country nationals and stateless persons concerned.

REGULAR MIGRANTS

5. Council Directive 2003/86/EC of 22 September 2003 on the right to family reunification (excerpt)¹⁵⁷

Adoption: 22 September 2003

Entry into force: 3 October 2003

(...)

CHAPTER IV

Requirements for the exercise of the right to family reunification

Article 6

1. The Member States may reject an application for entry and residence of family members on grounds of public policy, public security or public health.
2. Member States may withdraw or refuse to renew a family member's residence permit on grounds of public policy or public security or public health.

When taking the relevant decision, the Member State shall consider, besides Article 17, the severity or type of offence against public policy or public security committed by the family member, or the dangers that are emanating from such person.

3. Renewal of the residence permit may not be withheld and removal from the territory may not be ordered by the competent authority of the Member State concerned on the sole ground of illness or disability suffered after the issue of the residence permit.

Article 7

1. When the application for family reunification is submitted, the Member State concerned may require the person who has submitted the application to provide evidence that the sponsor has:

¹⁵⁷Source: OJ 2003 L251.

(a) accommodation regarded as normal for a comparable family in the same region and which meets the general health and safety standards in force in the Member State concerned;

(b) sickness insurance in respect of all risks normally covered for its own nationals in the Member State concerned for himself/herself and the members of his/her family;

(c) stable and regular resources which are sufficient to maintain himself/herself and the members of his/her family, without recourse to the social assistance system of the Member State concerned. Member States shall evaluate these resources by reference to their nature and regularity and may take into account the level of minimum national wages and pensions as well as the number of family members.

2. Member States may require third country nationals to comply with integration measures, in accordance with national law.

With regard to the refugees and/or family members of refugees referred to in Article 12 the integration measures referred to in the first subparagraph may only be applied once the persons concerned have been granted family reunification.

6. Council Directive 2003/109/EC of 25 November 2003 concerning the status of third-country nationals who are long-term residents (excerpt)¹⁵⁸

Adoption: 23 January 2004

Entry into force: 25 November 2003

(...)

Article 11

Equal treatment

1. Long-term residents shall enjoy equal treatment with nationals as regards:

(d) social security, social assistance and social protection as defined by national law;

(...)

(f) access to goods and services and the supply of goods and services made available to the public and to procedures for obtaining housing;

(...)

4. Member States may limit equal treatment in respect of social assistance and social protection to core benefits.

(...)

¹⁵⁸Source: OJ 2004 L16.

CHAPTER III

RESIDENCE IN THE OTHER MEMBER STATES

Article 15

Conditions for residence in a second Member State

(...)

2. Member States may require the persons concerned to provide evidence that they have:

(...)

(b) sickness insurance covering all risks in the second Member State normally covered for its own nationals in the Member State concerned.

(...)

Article 16

Family members

1. When the long-term resident exercises his/her right of residence in a second Member State and when the family was already constituted in the first Member State, the members of his/her family, who fulfil the conditions referred to in Article 4(1) of Directive 2003/86/EC shall be authorised to accompany or to join the long-term resident.

(...)

4. The second Member State may require the family members concerned to present with their application for a residence permit:

(...)

(c) evidence that they have stable and regular resources which are sufficient to maintain themselves without recourse to the social assistance of the Member State concerned or that the long-term resident has such resources and insurance for them, as well as sickness insurance covering all risks in the second Member State. Member States shall evaluate these resources by reference to their nature and regularity and may take into account the level of minimum wages and pensions.

(...)

Article 18

Public health

1. Member States may refuse applications for residence from long-term residents or their family members where the person concerned constitutes a threat to public health.
2. The only diseases that may justify a refusal to allow entry or the right of residence in the territory of the second Member State shall be the diseases as defined by the relevant applicable instruments of the World Health Organisation's and such other infectious or contagious parasite-based diseases as are the subject of protective provisions in relation to nationals in the host country. Member States shall not introduce new more restrictive provisions or practices.
3. Diseases contracted after the first residence permit was issued in the second Member State shall not justify a refusal to renew the permit or expulsion from the territory.
4. A Member State may require a medical examination, for persons to whom this Directive applies, in order to certify that they do not suffer from any of the diseases referred to in paragraph 2. Such medical examinations, which may be free of charge, shall not be performed on a systematic basis.

7. Council Directive 2004/114/EC of 13 December 2004 on the conditions of admission of third-country nationals for the purposes of studies, pupil exchange, unremunerated training or voluntary service (excerpt)¹⁵⁹

Adoption: 13 December 2004

Entry into force: 12 January 2005

(...)

(5) The Member States should give effect to the provisions of this Directive without discrimination on the basis of sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinions, membership of a national minority, property, birth, disability, age or sexual orientation.

(...)

CHAPTER II

CONDITIONS OF ADMISSION

(...)

Article 6

General conditions

1. A third-country national who applies to be admitted for the purposes set out in Articles 7 to 11¹⁶⁰ shall:

(...)

(c) have sickness insurance in respect of all risks normally covered for its own nationals in the Member State concerned;

¹⁵⁹Source: OJ 2004 L375.

¹⁶⁰Article 7, Specific conditions for students; Article 8, Mobility of students; Article 9, Specific conditions for school pupils; Article 10, Specific conditions for unremunerated trainees.

(d) not be regarded as a threat to public policy, public security or public health;

(...)

Article 11

Specific conditions for volunteers

Subject to Article 3, a third-country national who applies to be admitted to a voluntary service scheme shall, in addition to the general conditions stipulated in Article 6:

(...)

(c) provide evidence that the organisation responsible for the voluntary service scheme in which he/she is participating has subscribed a third-party insurance policy and accepts full responsibility for him/her throughout his/her stay, in particular as regards his/her subsistence, healthcare and return travel costs;

(...)

Article 16

Withdrawal or non-renewal of residence permits

1. Member States may withdraw or refuse to renew a residence permit issued on the basis of this Directive when it has been fraudulently acquired or wherever it appears that the holder did not meet or no longer meets the conditions for entry and residence laid down in Article 6 and in whichever of Articles 7 to 11 applies to the relevant category.
2. Member States may withdraw or refuse to renew a residence permit on grounds of public policy, public security or public health.

8. Council Directive 2005/71/EC of 12 October 2005 on a specific procedure for admitting third-country nationals for the purposes of scientific research¹⁶¹

Adoption: 12 October 2005

Entry into force: 23 November 2005

**CHAPTER I
GENERAL PROVISIONS**

Article 1

Purpose

This Directive lays down the conditions for the admission of third-country researchers to the Member States for more than three months for the purposes of carrying out a research project under hosting agreements with research organisations.

(...)

**CHAPTER II
RESEARCH ORGANISATIONS**

(...)

Article 6

Hosting agreement

1. A research organisation wishing to host a researcher shall sign a hosting agreement with the latter whereby the researcher undertakes to complete the research project and the organisation undertakes to host the researcher for that purpose without prejudice to Article 7.
2. Research organisations may sign hosting agreements only if the following conditions are met:

(...)

¹⁶¹Source: OJ 2005 L289.

(c) during his/her stay the researcher has sickness insurance for all the risks normally covered for nationals of the Member State concerned;

(...)

CHAPTER III

ADMISSION OF RESEARCHERS

Article 7

Conditions for admission

1. A third-country national who applies to be admitted for the purposes set out in this Directive shall:

(...)

(b) present a hosting agreement signed with a research organisation in accordance with Article 6(2);

(...)

(d) not be considered to pose a threat to public policy, public security or public health.

Member States shall check that all the conditions referred to in points (a), (b), (c) and (d) are met.

2. Member States may also check the terms upon which the hosting agreement has been based and concluded.

3. Once the checks referred to in paragraphs 1 and 2 have been positively concluded, researchers shall be admitted on the territory of the Member States to carry out the hosting agreement.

Article 12

Equal treatment

Holders of a residence permit shall be entitled to equal treatment with nationals as regards:

- (a) recognition of diplomas, certificates and other professional qualifications in accordance with the relevant national procedures;
- (b) working conditions, including pay and dismissal;
- (c) branches of social security as defined in Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community (1). The special provisions in the Annex to Council Regulation (EC) No 859/2003 of 14 May 2003 extending the provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 to nationals of third countries who are not already covered by these provisions solely on the ground of their nationality (2) shall apply accordingly;
- (d) tax benefits;
- (e) access to goods and services and the supply of goods and services made available to the public.

*SMUGGLED MIGRANTS AND VICTIMS
OF TRAFFICKING IN HUMAN BEINGS*

9. Council Directive 2004/81/EC of 29 April 2004 on the residence permit issued to third-country nationals who are victims of trafficking in human beings or who have been the subject of an action to facilitate illegal immigration, who cooperate with the competent authorities (excerpt)¹⁶²

Adoption: 6 August 2004

Entry into force: 29 April 2004

(...)

(4) This Directive is without prejudice to the protection granted to refugees, to beneficiaries of subsidiary protection and persons seeking international protection under international refugee law and without prejudice to other human rights instruments.

(...)

(7) Member States should give effect to the provision of this Directive without discrimination on the basis of sex, race, colour, ethnic or social origin, genetic characteristics, language, religion or belief, political or other opinions, membership of a national minority, fortune, birth, disabilities, age or sexual orientation.

(...)

(12) Given their vulnerability, the third-country nationals concerned should be granted the assistance provided by this Directive. This

¹⁶²Source: OJ 2004 L261. See “The European Legal Framework to Fight Trafficking in Human Being”, in *Awareness-raising of judicial authorities concerning trafficking in human being, Handbook, Volume II*, IOM, 2005, p.p. 269-270. See the *European Union Annual Report on Human Rights 2005*. In its paragraph 4.11. on Asylum, Migration, Refugees and Displaced Persons, the Report refers to the Council Directive 2004/81/EC, as follows: “On 29 April 2004, the Council adopted Directive 2004/81/EC on the residence permit issued to third-country nationals who are victims of trafficking, or who have been the subject of an action to facilitate illegal immigration, and who co-operate with the competent authorities. This Directive grants certain rights, including legal stay and medical and psychological treatment, to victims of human trafficking. It balances the need to fight against illegal immigration and the need to guarantee respect for the human rights of victims of illegal immigration. The Directive will have to be transposed into national law by all member states by August 2006”. See R. Malpani, loc. cit n. 101.

assistance should allow them to recover and escape the influence of the perpetrators of the offences. The medical treatment to be provided to the third-country nationals covered by this Directive also includes, where appropriate, psychotherapeutical care.

(...)

CHAPTER II

PROCEDURE FOR ISSUING THE RESIDENCE PERMIT

Article 6

Reflection period

1. Member States shall ensure that the third-country nationals concerned are granted a reflection period allowing them to recover and escape the influence of the perpetrators of the offences so that they can take an informed decision as to whether to cooperate with the competent authorities.

The duration and starting point of the period referred to in the first subparagraph shall be determined according to national law.

2. During the reflection period and while awaiting the decision of the competent authorities, the third-country nationals concerned shall have access to the treatment referred to in Article 7 and it shall not be possible to enforce any expulsion order against them.

(...)

Article 7

Treatment granted before the issue of the residence permit

1. Member States shall ensure that the third-country nationals concerned who do not have sufficient resources are granted standards of living capable of ensuring their subsistence and access to emergency medical treatment. They shall attend to the special needs of the most vulnerable, including, where appropriate and if provided by national law, psychological assistance.

2. Member States shall take due account of the safety and protection needs of the third-country nationals concerned when applying this Directive, in accordance with national law.

(...)

CHAPTER III

TREATMENT OF HOLDERS OF THE RESIDENCE PERMIT

Article 9

Treatment granted after the issue of the residence permit

1. Member States shall ensure that holders of a residence permit who do not have sufficient resources are granted at least the same treatment provided for in Article 7.
2. Member States shall provide necessary medical or other assistance to the third-country nationals concerned, who do not have sufficient resources and have special needs, such as pregnant women, the disabled or victims of sexual violence or other forms of violence and, if Member States have recourse to the option provided for in Article 3(3), minors.

*ASYLUM SEEKERS, REFUGEES
AND OTHER PERSONS IN NEED OF
INTERNATIONAL PROTECTION*

10. Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (excerpt)¹⁶³

Adoption: 20 July 2001

Entry in force: 7 August 2001

(...)

CHAPTER III

Obligations of the Member States towards persons enjoying temporary protection

(...)

Article 13

1. The Member States shall ensure that persons enjoying temporary protection have access to suitable accommodation or, if necessary, receive the means to obtain housing.
2. The Member States shall make provision for persons enjoying temporary protection to receive necessary assistance in terms of social welfare and means of subsistence, if they do not have sufficient resources, as well as for medical care.

Without prejudice to paragraph 4, the assistance necessary for medical care shall include at least emergency care and essential treatment of illness.

3. Where persons enjoying temporary protection are engaged in employed or self-employed activities, account shall be taken, when fixing the proposed level of aid, of their ability to meet their own needs.

¹⁶³Source: OJ 2001 L212.

4. The Member States shall provide necessary medical or other assistance to persons enjoying temporary protection who have special needs, such as unaccompanied minors or persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence.

CHAPTER V

Return and measures after temporary protection has ended

(...)

Article 23

1. The Member States shall take the necessary measures concerning the conditions of residence of persons who have enjoyed temporary protection and who cannot, in view of their state of health, reasonably be expected to travel; where for example they would suffer serious negative effects if their treatment was interrupted. They shall not be expelled so long as that situation continues.
2. The Member States may allow families whose children are minors and attend school in a Member State to benefit from residence conditions allowing the children concerned to complete the current school period.

11. Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers (excerpt)¹⁶⁴

Adoption: 27 January 2003

Entry into force: 6 February 2003

(...)

CHAPTER II

GENERAL PROVISIONS ON RECEPTION CONDITIONS

Article 5

Information

1. Member States shall inform asylum seekers, within a reasonable time not exceeding fifteen days after they have lodged their application for asylum with the competent authority, of at least any established benefits and of the obligations with which they must comply relating to reception conditions.

Member States shall ensure that applicants are provided with information on organisations or groups of persons that provide specific legal assistance and organisations that might be able to help or inform them concerning the available reception conditions, including health care.

(...)

Article 9

Medical screening

Member States may require medical screening for applicants on public health grounds.

(...)

¹⁶⁴Source: OJ 2003 L31.

Article 13

General rules on material reception conditions and health care

1. Member States shall ensure that material reception conditions are available to applicants when they make their application for asylum.
2. Member States shall make provisions on material reception conditions to ensure a standard of living adequate for the health of applicants and capable of ensuring their subsistence.

Member States shall ensure that that standard of living is met in the specific situation of persons who have special needs, in accordance with Article 17, as well as in relation to the situation of persons who are in detention.

3. Member States may make the provision of all or some of the material reception conditions and health care subject to the condition that applicants do not have sufficient means to have a standard of living adequate for their health and to enable their subsistence.
4. Member States may require applicants to cover or contribute to the cost of the material reception conditions and of the health care provided for in this Directive, pursuant to the provision of paragraph 3, if the applicants have sufficient resources, for example if they have been working for a reasonable period of time.

If it transpires that an applicant had sufficient means to cover material reception conditions and health care at the time when these basic needs were being covered, Member States may ask the asylum seeker for a refund.

5. Material reception conditions may be provided in kind, or in the form of financial allowances or vouchers or in a combination of these provisions.

Where Member States provide material reception conditions in the form of financial allowances or vouchers, the amount thereof shall be determined in accordance with the principles set out in this Article.

(...)

Article 15

Health care

1. Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illness.
2. Member States shall provide necessary medical or other assistance to applicants who have special needs.

CHAPTER III

REDUCTION OR WITHDRAWAL OF RECEPTION CONDITIONS

Article 16

Reduction or withdrawal of reception conditions

1. Member States may reduce or withdraw reception conditions in the following cases:

(...)

(b) where an applicant has concealed financial resources and has therefore unduly benefited from material reception conditions.

If it transpires that an applicant had sufficient means to cover material reception conditions and health care at the time when these basic needs were being covered, Member States may ask the asylum seeker for a refund.

(...)

CHAPTER IV

PROVISIONS FOR PERSONS WITH SPECIAL NEEDS

Article 17

General principle

1. Member States shall take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, in the national legislation implementing the provisions of Chapter II relating to material reception conditions and health care.
2. Paragraph 1 shall apply only to persons found to have special needs after an individual evaluation of their situation.

Article 18

Minors

1. The best interests of the child shall be a primary consideration for Member States when implementing the provisions of this Directive that involve minors.
2. Member States shall ensure access to rehabilitation services for minors who have been victims of any form of abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts, and ensure that appropriate mental health care is developed and qualified counselling is provided when needed.

(...)

12. Council Directive 2004/83/EC of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted (excerpt)¹⁶⁵

Adoption: 29 April 2004

Entry into force: 20 December 2004

(...)

(34) With regard to social assistance and health care, the modalities and detail of the provision of core benefits to beneficiaries of subsidiary protection status should be determined by national law. The possibility of limiting the benefits for beneficiaries of subsidiary protection status to core benefits is to be understood in the sense that this notion covers at least minimum income support, assistance in case of illness, pregnancy and parental assistance, in so far as they are granted to nationals according to the legislation of the Member State concerned.

(35) Access to health care, including both physical and mental health care, should be ensured to beneficiaries of refugee or subsidiary protection status.

Article 29

Health care

1. Member States shall ensure that beneficiaries of refugee or subsidiary protection status have access to health care under the same eligibility conditions as nationals of the Member State that has granted such statuses.
2. By exception to the general rule laid down in paragraph 1, Member States may limit health care granted to beneficiaries of subsidiary protection to core benefits which will then be provided at the same levels and under the same eligibility conditions as nationals.

¹⁶⁵Source: OJ 2004 L304.

3. Member States shall provide, under the same eligibility conditions as nationals of the Member State that has granted the status, adequate health care to beneficiaries of refugee or subsidiary protection status who have special needs, such as pregnant women, disabled people, persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence or minors who have been victims of any form of abuse, neglect, exploitation, torture, cruel, inhuman and degrading treatment or who have suffered from armed conflict.

(...)

*SOCIAL SECURITY AND PATIENTS
MOBILITY*

13. Council Regulation (EEC) No. 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community (excerpt)¹⁶⁶

Adoption: 14 June 1971

Entry into force: 1 October 1972

(...)

TITLE I

GENERAL PROVISIONS

(...)

Article 2¹⁶⁷

Persons covered

1. This Regulation shall apply to employed or self-employed persons and to students who are or have been subject to the legislation of one or more Member States and who are nationals of one of the Member States or who are stateless persons or refugees residing within the territory of one of the Member States, as well as to the members of their families and their survivors.
2. This Regulation shall apply to the survivors of employed or self-employed persons and of students who have been subject to the legislation of one or more Member States, irrespective of the nationality of such persons, where their survivors are nationals of one of the Member States, or stateless persons or refugees residing within the territory of one of the Member States.

(...)

¹⁶⁶Source: OJ 1971 L149. Regulation (EEC) No. 547/72 lays down the application rules. See in particular its articles 21-24 on implementation of Article 22 of the Regulation (EEC) No. 1408/71.

¹⁶⁷Article 2 substituted by Article 1(2) of Reg. 307/99 as from 1 May 1999.

TITLE III
SPECIAL PROVISIONS RELATING TO THE VARIOUS
CATEGORIES OF BENEFITS
CHAPTER 1
SICKNESS AND MATERNITY

(...)

Section 2

Employed or self-employed persons and members of their families

Article 22

**Stay outside the competent State – Return to or transfer of residence
to another Member State during sickness or maternity – Need to go
to another Member State in order to receive appropriate treatment**

1. An employed or self-employed person who satisfies the conditions of the legislation of the competent State for entitlement to benefits, taking account where appropriate of the provisions of Article 18, and:
 - (a) whose condition requires benefits in kind which become necessary on medical grounds during a stay in the territory of another Member State, taking into account the nature of the benefits and the expected length of the stay¹⁶⁸;
 - (b) who, having become entitled to benefits chargeable to the competent institution, is authorized by that institution to return to the territory of the Member State where he resides, or to transfer his residence to the territory of another Member State; or
 - (c) who is authorized by the competent institution to go to the territory of another Member State to receive there the treatment appropriate to his condition, shall be entitled:

¹⁶⁸Point (a) substituted in Article 22.1 by Article 1.1(a) of Reg. 631/2004 as from 1 June 2004.

(i) to benefits in kind provided on behalf of the competent institution by the institution of the place of stay or residence in accordance with the provisions of the legislation which it administers, as though he were insured with it; the length of the period during which benefits are provided shall be governed, however, by the legislation of the competent State;

(ii) to cash benefits provided by the competent institution in accordance with the provisions of the legislation which it administers. However, by agreement between the competent institution and the institution of the place of stay or residence, such benefits may be provided by the latter institution on behalf of the former, in accordance with the provisions of the legislation of the competent State.

1a. The Administrative Commission shall establish a list of benefits in kind which, in order to be provided during a stay in another Member State, require, for practical reasons, a prior agreement between the person concerned and the institution providing the care¹⁶⁹;

2. The authorization required under paragraph 1(b) may be refused only if it is established that movement of the person concerned would be prejudicial to his state of health or the receipt of medical treatment.

The authorization required under paragraph 1(c) may not be refused where the treatment in question is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resides and where he cannot be given such treatment within the time normally necessary for obtaining the treatment in question in the Member State of residence taking account of his current state of health and the probable course of the disease.

3. Paragraphs 1, 1a and 2 shall apply by analogy to members of the family of an employed or self-employed person¹⁷⁰.

However, for the purpose of applying paragraph 1(a) and (c)(i) to the members of the family referred to in Article 19(2) who reside in the territory of a Member State other than the one in whose territory the employed or self-employed person resides:

¹⁶⁹ Paragraph 1a. inserted by Article 1.1(b) of Reg. 631/2004 as from 1 June 2004.

¹⁷⁰ (a) Words in paragraph 3 of Article 22 and Article 22a substituted by Articles 1.1(c) and 2 of Reg. 631/2004 as from 1 June 2004.

(a) benefits in kind shall be provided on behalf of the institution of the Member State in whose territory the members of the family are residing by the institution of the place of stay in accordance with the provisions of the legislation which it administers as if the employed or self-employed person were insured there. The period during which benefits are provided shall, however, be that laid down under the legislation of the Member State in whose territory the members of the family are residing;

(b) the authorization required under paragraph 1(c) shall be issued by the institution of the Member State in whose territory the members of the family are residing.

(Application of article 22(3) to Greenland referred to in article 3 of reg. 1661/85.)

4. The fact that the provisions of paragraph 1 apply to an employed or self-employed person shall not affect the right to benefit of members of his family.

Article 22a

Special rules for certain categories of persons

Notwithstanding Article 2, Article 22(1)(a) and (c) and (1a) shall also apply to persons who are nationals of one of the Member States and who are insured under the legislation of a Member State and to the members of their families residing with them.

(...)

14. Council Regulation (EC) No. 859/2003 of 14 May 2003 extending the provisions of Regulation (EEC) No. 1408/71 and Regulation (EEC) No. 574/72 to nationals of third countries who are not already covered by those provisions solely on the ground of their nationality¹⁷¹

Adoption: 14 May 2003

Entry into force: 1 June 2003

THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community and in particular Article 63, point 4 thereof,

Having regard to the proposal from the Commission¹⁷²,

Having regard to the opinion of the European Parliament¹⁷³,

Whereas:

(1) As its special meeting in Tampere on 15 and 16 October 1999, the European Council proclaimed that the European Union should ensure fair treatment of third-country nationals who reside legally in the territory of its Member States, grant them rights and obligations comparable to those of EU citizens, enhance non-discrimination in economic, social and cultural life and approximate their legal status to that of Member States' nationals.

(2) In its resolution of 27 October 1999¹⁷⁴, the European Parliament called for prompt action on promises of fair treatment for third-country nationals legally resident in the Member States and on the definition of their legal status, including uniform rights as close as possible to those enjoyed by the citizens of the European Union.

¹⁷¹Source: OJ 2003 L124. Third-country nationals and their family members and survivors can benefit from the European provisions on the coordination of social security schemes as long as they are legally resident in a Member State and in situations which involve more than a single Member State. Specific provisions on family benefits apply in the case of Austria and Germany.

¹⁷²OJ 2002 C126 E, p. 388.

¹⁷³Opinion of 21 November 2002, (not yet published in the Official Journal).

¹⁷⁴OJ 2000 C154, p. 63.

(3) The European Economic and Social Committee has also appealed for equal treatment of Community nationals and third-country nationals in the social field, notably in its opinion of 26 September 1991 on the status of migrant workers from third countries¹⁷⁵.

(4) Article 6(2) of the Treaty on European Union provides that the Union shall respect fundamental rights, as guaranteed by the European Convention on the Protection of Human Rights and Fundamental Freedoms signed in Rome on 4 November 1950 and as they result from the constitutional traditions common to the Member States, as general principles of Community law.

(5) This Regulation respects the fundamental rights and observes the principles recognised in particular by the Charter of Fundamental Rights of the European Union, in particular the spirit of its Article 34(2).

(6) The promotion of a high level of social protection and the raising of the standard of living and quality of life in the Member States are objectives of the Community.

(7) As regards the conditions of social protection of third-country nationals, and in particular the social security scheme applicable to them, the Employment and Social Policy Council argued in its conclusions of 3 December 2001 that the coordination applicable to third-country nationals should grant them a set of uniform rights as near as possible to those enjoyed by EU citizens.

(8) Currently, Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community¹⁷⁶, which is the basis for the coordination of the social security schemes of the different Member States, and Council Regulation (EEC) No 574/72 of 21 March 1972, laying down the procedure for implementing Regulation (EEC) No 1408/71¹⁷⁷, apply only to certain third-country nationals. The number and diversity of legal instruments used in an effort to resolve problems in connection with the coordination of the Member States' social security schemes encountered by nationals of third countries who are in the same situation as Community nationals give rise to legal and administrative complexities. They create

¹⁷⁵OJ 1991 C339, p. 82.

¹⁷⁶OJ 1971 L149, p. 2; Regulation last amended by Regulation (EC) No. 1386/2001 of the European Parliament and of the Council (OJ 2001 L187, p. 1).

¹⁷⁷OJ 1972 L74, p. 1; Regulation last amended by Commission Regulation (EC) No. 410/2002 (OJ 2002 L62, p. 17).

major difficulties for the individuals concerned, their employers, and the competent national social security bodies.

(9) Hence, it is necessary to provide for the application of the coordination rules of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 to third-country nationals legally resident in the Community who are not currently covered by the provisions of these Regulations on grounds of their nationality and who satisfy the other conditions provided for in this Regulation; such an extension is in particular important with a view to the forthcoming enlargement of the European Union.

(10) The application of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 to these persons does not give them any entitlement to enter, to stay or to reside in a Member State or to have access to its labour market.

(11) The provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 are, by virtue of this Regulation, applicable only in so far as the person concerned is already legally resident in the territory of a Member State. Being legally resident is therefore a prerequisite for the application of these provisions.

(12) The provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 are not applicable in a situation which is confined in all respects within a single Member State. This concerns, *inter alia*, the situation of a third country national who has links only with a third country and a single Member State.

(13) The continued right to unemployment benefit, as laid down in Article 69 of Regulation (EEC) No 1408/71, is subject to the condition of registering as a job-seeker with the employment services of each Member State entered. Those provisions may therefore apply to a third-country national only provided he/she has the right, where appropriate pursuant to his/her residence permit, to register as a job-seeker with the employment services of the Member State entered and the right to work there legally.

(14) Transitional provisions should be adopted to protect the persons covered by this Regulation and to ensure that they do not lose rights as a result of its entry into force.

(15) To achieve these objectives it is necessary and appropriate to extend the scope of the rules coordinating the national social security schemes by adopting a Community legal instrument which is binding and directly

applicable in every Member State which takes part in the adoption of this Regulation.

(16) This Regulation is without prejudice to rights and obligations arising from international agreements with third countries to which the Community is a party and which afford advantages in terms of social security.

(17) Since the objectives of the proposed action cannot be sufficiently achieved by the Member States and can therefore, by reason of the scale or effects of the proposed action, be better achieved at Community level, the Community may take measures in accordance with the principle of subsidiarity enshrined in Article 5 of the Treaty. In compliance with the principle of proportionality as set out in that Article, this Regulation does not go beyond what is necessary to achieve these objectives.

(18) In accordance with Article 3 of the Protocol on the position of the United Kingdom and Ireland annexed to the Treaty on the European Union and to the Treaty establishing the European Community, Ireland and the United Kingdom gave notice, by letters of 19 and 23 April 2002, of their wish to take part in the adoption and application of this Regulation.

(19) In accordance with Articles 1 and 2 of the Protocol on the position of Denmark annexed to the Treaty on the European Union and to the Treaty establishing the European Community, Denmark is not taking part in the adoption of this Regulation and is not therefore bound by or subject to it,

HAS ADOPTED THIS REGULATION:

Article 1

Subject to the provisions of the Annex to this Regulation, the provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 shall apply to nationals of third countries who are not already covered by those provisions solely on the ground of their nationality, as well as to members of their families and to their survivors, provided they are legally resident in the territory of a Member State and are in a situation which is not confined in all respects within a single Member State.

Article 2

1. This Regulation shall not create any rights in respect of the period before 1 June 2003.
2. Any period of insurance and, where appropriate, any period of employment, self-employment or residence completed under the legislation of a Member State before 1 June 2003 shall be taken into account for the determination of rights acquired in accordance with the provisions of this Regulation.
3. Subject to the provisions of paragraph 1, a right shall be acquired under this Regulation even if it relates to a contingency arising prior to 1 June 2003.
4. Any benefit that has not been awarded or that has been suspended on account of the nationality or the residence of the person concerned shall, at the latter's request, be awarded or resumed from 1 June 2003, provided that the rights for which benefits were previously awarded did not give rise to a lumpsum payment.
5. The rights of persons who prior to 1 June 2003, obtained the award of a pension may be reviewed at their request, account being taken of the provisions of this Regulation.
6. If the request referred to in paragraph 4 or paragraph 5 is lodged within two years from 1 June 2003, rights deriving from this Regulation shall be acquired from that date and the provisions of the legislation of any Member State on the forfeiture or lapse of rights may not be applied to the persons concerned.
7. If the request referred to in paragraph 4 or paragraph 5 is lodged after expiry of the deadline referred to in paragraph 6, rights not forfeited or lapsed shall be acquired from the date of such request, subject to any more favourable provisions of the legislation of any Member State.

Article 3

This Regulation shall enter into force on the first day of the month following its publication in the *Official Journal of the European Union*.

15. Decision No. 189 of 18 June 2003 aimed at introducing a European health insurance card to replace the forms necessary for the application of Council Regulations (EEC) No. 1408/71 and (EEC) No. 574/72 as regards access to health care during a temporary stay in a Member State other than the competent State or the State of residence¹⁷⁸ (Text with relevance for the EEA and for the EU/Switzerland Agreement)

Adoption: 18 June 2003

THE ADMINISTRATIVE COMMISSION,

Having regard to Article 81(a) of Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community¹⁷⁹ (1), under which it is the duty of the Administrative Commission on Social Security for Migrant Workers to deal with all administrative questions arising from Regulation (EEC) No 1408/71 and subsequent regulations,

Having regard to Article 2(1) of Council Regulation (EEC) No 574/72 of 21 March 1972 fixing the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons and their families moving within the Community¹⁸⁰, under which the Administrative Commission is required to draw up models of certificates, certified statements, declarations, claims and other documents necessary for the application of the regulations,

Having regard to Article 117 of Regulation (EEC) No 574/72, under which the Administrative Commission is required to adapt to the new data-processing techniques the models of certificates, certified statements, declarations, claims and other documents together with the operations and methods of transmission of the data provided for the implementation of the regulations,

Whereas:

¹⁷⁸Source: OJ 2003 L276, p. 1.

¹⁷⁹OJ 1971 L149, p. 2 (English special edition: Series-I 71(II), p. 416). Regulation as last amended by Regulation (EC) No. 1386/2001 of the European Parliament and of the Council (OJ 2001 L187, p. 1).

¹⁸⁰OJ 1972 L74, p. 1 (English special edition: Series I Chapter 1972(I) p. 159). Regulation as last amended by Commission Regulation (EC) No. 410/2002 of the European Parliament and of the Council (OJ 2002 L62, p. 17).

(1) In accordance with Regulation (EEC) No 1408/71, the current forms entitle persons covered by the Regulation to reimbursement of health care costs during a temporary stay in a Member State other than the competent State or, for recipients of a retirement or other pension and family members who do not reside in the same Member State as the worker, in a Member State other than the State of residence.

(2) The Barcelona European Council, held on 15 and 16 March 2002, decided: 'that a European health insurance card will replace the current paper forms needed for health treatment in another Member State. The Commission will present a proposal to that effect before the spring European Council in 2003. Such a card will simplify procedures, but will not change existing rights and obligations' (point 34).

(3) Given that the use of health or social insurance cards differs widely from one country to another, the European health insurance card (hereinafter referred to as the 'European card') should be introduced initially in a format in which the data necessary for the provision of health care and reimbursement of the costs can be read with the naked eye. This information may additionally be incorporated in an electronic medium. The use of an electronic medium will furthermore become generalised at a later stage in the introduction of the European card.

(4) The European card must conform to a single model defined by the Administrative Commission, which should both help facilitate access to health care and help to prevent irregular, abusive or fraudulent use of the card.

(5) The institutions in the Member States should determine the period of validity of the European cards they issue. In particular, the period of validity of the card should take account of the presumed duration of the insured person's entitlement.

(6) When exceptional circumstances prevent the person concerned from producing the European card, a provisional replacement certificate of limited validity should be issued. 'Exceptional circumstances' may be the theft or loss of the European card or departure at notice too short for a European card to be obtained.

(7) The Administrative Commission recommends that decisions of the EEA Joint Committee and of the EU-Switzerland Joint Committee be prepared from the point of view of the implications of the European card replacing the forms necessary for the application of Regulations (EEC) No 1408/71

and (EEC) No 574/72 as regards access to care during a temporary stay in a Member State other than the competent State or the State of residence,

HAS DECIDED AS FOLLOWS:

Article 1

The European health insurance card (hereinafter referred to as the 'European card') shall progressively replace the forms provided for by Regulations (EEC) No 1408/71 and (EEC) No 574/72 giving entitlement to reimbursement of health care costs during a temporary stay in a Member State other than the competent State or the State of residence. The different stages in replacing these forms shall be the subject of subsequent decisions of the Administrative Commission on Social Security for Migrant Workers.

Article 2

1. The period of validity of the European card shall be determined by the issuing institution.
2. The institution at the place of stay shall be reimbursed for the cost of health care provided on the basis of a valid card, in accordance with the provisions in force.

Article 3

The European card may be issued either in the form of a specific card or as the reverse side of the health insurance card(s) existing in the Member States.

Article 4

The European card shall be an individual card made out in the name of the holder.

Article 5

When exceptional circumstances prevent an insured person from producing the European card, a provisional replacement certificate of limited validity shall be issued.

Article 6

1. The European card and the provisional replacement certificate shall conform to a single model meeting the characteristics and specifications

laid down by decision of the Administrative Commission on Social Security for Migrant Workers.

2. The European card shall contain the following data:
 - surname and forename of the card holder,
 - personal identification number of the card holder or, when no such number exists, the number of the insured person from whom the rights of the card holder derive,
 - date of birth of the card holder,
 - expiry date of the card,
 - ISO code of the Member State issuing the card,
 - identification number and acronym of the competent institution,
 - logical number of the card.

Article 7

This decision shall be published in the *Official Journal of the European Union*. It shall be applicable from the first day of the month following its publication.

The European Health Insurance Card¹⁸¹

The establishment of the European Health Insurance Card (EHIC) is one element of a process of modernization, launched in 1998, to revise and simplify the coordination of mechanisms specified under Council Regulation (EEC) No. 1408/71.

The EHIC came into being as a project launched by the Commission, with the support of the Barcelona European Council¹⁸² in March 2002, to promote occupational mobility in the context of the Lisbon agenda¹⁸³ and to demonstrate the

¹⁸¹ See <http://europa.eu/scadplus/leg/en/cha/c10123.htm>. For more detailed information, consult the website of the Directorate-General for Employment and Social Affairs at the European Commission (http://ec.europa.eu/employment_social/healthcard/links_en.htm).

¹⁸² The European Council met in Barcelona on 15 and 16 March 2002 for its second annual Spring meeting on the economic, social, environmental situation in the Union.

¹⁸³ The Lisbon Agenda put in place an overall strategy for the Union aimed at promoting economic growth, fostering competitiveness and job creation, and advancing structural and regulatory reform, while ensuring social cohesion and environmental sustainability as defined by the Göteborg European Council.

benefits of Europe to its citizens.

The EHIC was designed for EU citizens to replace all existing paper forms required for occasional health treatment when in another Member State, including: E111 for temporary stay; E110 for those working in international transport; E119 for those traveling to another country to seek work; and E128 for students and workers in another member state. The card is intended to simplify procedures for patients, providers and administrations.

The Decisions, which had to be adopted by the Administrative Commission on Social Security for Migrant Workers (CASSTM) in order to implement the EHIC, included:

- Decision No 190 of 18 June 2003 concerning the technical specifications of the European health insurance card (Text with relevance for the EEA and for the EU/Switzerland Agreement), its Annex 1 on technical provisions concerning the design of the European health insurance card, and its Annex 2 on model of the provisional certificate replacing the European health insurance card in OJ 2003 L276;
- Decision No 191 of 18 June 2003 concerning the replacement of forms E 111 and E 111 B by the European health insurance card (Text with relevance for the EEA and for the EU/Switzerland Agreement) in OJ2003 L276;
- Decision No 196 of 23 March 2004 pursuant to Article 22(1a) (Text with relevance to the EEA and to the EU/Switzerland Agreement) and its Annex on the illustrative list of vital treatments requiring, during a temporary stay in another Member State, the prior agreement of the unit providing such treatment in OJ 2004 L160;
- Decision No 197 of 23 March 2004 on the transitional periods for the introduction of the European Health Insurance Card in accordance with Article 5 of Decision No 191 (Text of relevance to the EEA and to the EU/Switzerland Agreement) and its Annexes I, II and III in OJ 2004 L343;

- Decision No 198 of 23 March 2004 concerning the replacement and discontinuance of the model forms necessary for the application of Regulations (EEC) No 1408/71 and (EEC) No 574/72 of the Council (E 110, E 111, E 111 B, E 113, E 114, E 119, E 128 and E 128 B) in OJ 2004 L259.

See also the European Observatory on Health Systems and Policies' *Policy Brief on Cross-Border Health Care in Europe*, published in 2005 and available at: <http://www.euro.who.int/observatory>.

16. Regulation (EC) No. 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems (Text with relevance for the EEA and for Switzerland) (excerpt)¹⁸⁴

Adoption: 29 April 2004

Entry into force: 20 May 2004

(...)

TITLE III

SPECIAL PROVISIONS CONCERNING THE VARIOUS

CATEGORIES OF BENEFITS

CHAPTER 1

Sickness, maternity and equivalent paternity benefits

Section 1

Insured persons and members of their families, except pensioners and members of their families

(...)

Article 19

Stay outside the competent Member State

1. Unless otherwise provided for by paragraph 2, an insured person and the members of his/her family staying in a Member State other than the competent Member State shall be entitled to the benefits in kind which become necessary on medical grounds during their stay, taking into account the nature of the benefits and the expected length of the stay.

¹⁸⁴Source: OJ 2004 L166. See Corrigendum to Regulation (EC) No. 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, OJ 2004 L200.

These benefits shall be provided on behalf of the competent institution by the institution of the place of stay, in accordance with the provisions of the legislation it applies, as though the persons concerned were insured under the said legislation.

2. The Administrative Commission shall establish a list of benefits in kind which, in order to be provided during a stay in another Member State, require for practical reasons a prior agreement between the person concerned and the institution providing the care.

Article 20

Travel with the purpose of receiving benefits in kind — authorisation to receive appropriate treatment outside the Member State of residence

1. Unless otherwise provided for by this Regulation, an insured person travelling to another Member State with the purpose of receiving benefits in kind during the stay shall seek authorization from the competent institution.
2. An insured person who is authorised by the competent institution to go to another Member State with the purpose of receiving the treatment appropriate to his/her condition shall receive the benefits in kind provided, on behalf of the competent institution, by the institution of the place of stay, in accordance with the provisions of the legislation it applies, as though he/she were insured under the said legislation. The authorisation shall be accorded where the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned resides and where he/she cannot be given such treatment within a time limit which is medically justifiable, taking into account his/her current state of health and the probable course of his/her illness.
3. Paragraphs 1 and 2 shall apply *mutatis mutandis* to the members of the family of an insured person.
4. If the members of the family of an insured person reside in a Member State other than the Member State in which the insured person resides, and this Member State has opted for reimbursement on the basis of fixed amounts, the cost of the benefits in kind referred to in paragraph 2 shall be borne by the institution of the place of residence of the

members of the family. In this case, for the purposes of paragraph 1, the institution of the place of residence of the members of the family shall be considered to be the competent institution.

*SEXUAL AND REPRODUCTIVE HEALTH
AND RIGHTS*

17. European Parliament resolution on sexual and reproductive health and rights (extracts)¹⁸⁵

Adoption: 3 July 2002

The European Parliament,

(...)

As regards contraception

(...)

4. Urges the governments of the Member States and the candidate countries to strive to provide contraceptives and sexual and reproductive health services free of charge, or at low cost, for underserved groups, such as young people, ethnic minorities and the socially excluded;

(...)

As regards unwanted pregnancies and abortion

(...)

11. Calls upon the governments of the Member States and the candidate countries to provide specialised sexual and reproductive health services which include high quality and professional advice and counselling adapted to the needs of specific groups (e.g. immigrants), provided by a trained, multidisciplinary staff; underlines that advice and counselling must be confidential and non-judgmental and that in the event of legitimate conscientious objection of the provider, referral to other service providers must take place; where advice on abortion is provided, attention must be drawn to the physical and psychological health risks associated with abortion, and alternative solutions (adoption, availability of support in the event of a decision to keep the child) must be discussed;

¹⁸⁵Source: (2001/2128 (INI)) P5_TA(2002)0359. On 3 July 2002, the European Parliament adopted a report on sexual and reproductive health and rights in Europe drafted by Ms Anne Van Lancker for the Women's Rights Committee (Report on sexual and reproductive health and rights (2001/2128 (INI)), Committee on Women's Rights and Equal Opportunities, Rapporteur: Anne E.M. Van Lancker)

II.1.3 EURO-MEDITERRANEAN ASSOCIATION AGREEMENTS

Euro-Mediterranean association agreements¹⁸⁶, which have been concluded between the European Community and its partners in the Mediterranean, cover the three main areas included in the Barcelona Declaration¹⁸⁷: political dialogue; establishment of a free trade area; and economic, financial, social and cultural cooperation. They replace the cooperation agreements concluded in the 1970s.

All association agreements also include clauses dealing with social and cultural cooperation, as well as a clause defining respect for democratic principles and fundamental human rights, as “an essential element” of the agreement.

The European Community concluded with Turkey a first generation association agreement in March 1995. This agreement entered into force on 31 December 1995. Second generation association agreements have been signed between the EU and other partners in the Mediterranean. Association agreements are in force with Tunisia since 11 March 1998, with Israel since 1 June 2000, with Morocco since 1 March 2000, with Jordan since 1 May 2002, with Egypt since 1 June 2004, and with Algeria since 1 September 2005. An interim agreement was also concluded with the Palestine Liberation Organization (P.L.O.), and it entered into force on 1 June 1997. The agreement signed with Lebanon is not yet in force, however an interim agreement was concluded and it entered into force on 1 March 2003. The negotiations for an agreement with Syria were concluded in October 2004, but the agreement has yet to be signed.

Below are relevant extracts of the two Euro-Mediterranean association agreements establishing an association between the European Community and its member states, and the Republic of Tunisia and the Kingdom of Morocco respectively.

¹⁸⁶See: <http://www.ladocumentationfrancaise.fr/dossiers/europe-mediterranee/chronologie.shtml>.

¹⁸⁷The Barcelona Declaration was adopted at the Euro-Mediterranean Conference of 27 and 28 November 1995. In this Declaration the then 27 Euro-Mediterranean Partners agreed on the establishment of a Euro-Mediterranean Free Trade Area by 2010 through Association Agreements, negotiated and concluded with the European Union, together with free trade agreements between themselves.

TUNISIA

18. Euro-Mediterranean association agreements establishing an association between the European Communities and their Member States, of the one part, and the Republic of Tunisia, of the other part (excerpt)¹⁸⁸

Adoption: 17 July 1995

Entry into force: 1 March 1998

(...)

TITLE VI

COOPERATION IN SOCIAL AND CULTURAL MATTERS

CHAPTER I

WORKERS

Article 64

1. The treatment accorded by each Member State to workers of Tunisian nationality employed in its territory shall be free from any discrimination based on nationality, as regards working conditions, remuneration and dismissal, relative to its own nationals.
2. All Tunisian workers allowed to undertake paid employment in the territory of a Member State on a temporary basis shall be covered by the provisions of paragraph 1 with regard to working conditions and remuneration.
3. Tunisia shall accord the same treatment to workers who are nationals of a Member State and employed in its territory.

Article 65

1. Subject to the provisions of the following paragraphs, workers of Tunisian nationality and any members of their families living with them shall enjoy, in the field of social security, treatment free from any

¹⁸⁸Source: OJ 1998 L97.

discrimination based on nationality relative to nationals of the Member States in which they are employed.

The concept of social security shall cover the branches of social security dealing with sickness and maternity benefits, invalidity, old-age and survivors' benefits, industrial accident and occupational disease benefits and death, unemployment and family benefits.

These provisions shall not, however, cause the other coordination rules provided for in Community legislation based on Article 51 of the EC Treaty to apply, except under the conditions set out in Article 67 of this Agreement.

2. All periods of insurance, employment or residence completed by such workers in the various Member States shall be added together for the purpose of pensions and annuities in respect of old age, invalidity and survivors' benefits and family, sickness and maternity benefits and also for that of medical care for the workers and for members of their families resident in the Community.
3. The workers in question shall receive family allowances for members of their families who are resident in the Community.
4. The workers in question shall be able to transfer freely to Tunisia, at the rates applied by virtue of the legislation of the debtor Member State or States, any pensions or annuities in respect of old age, survivor status, industrial accident or occupational disease, or of invalidity resulting from industrial accident or occupational disease, except in the case of special non-contributory benefits.
5. Tunisia shall accord to workers who are nationals of a Member State and employed in its territory, and to the members of their families, treatment similar to that specified in paragraphs 1, 3 and 4.

Article 66

The provisions of this Chapter shall not apply to nationals of the Parties residing or working illegally in the territory of their host countries.

Article 67

1. Before the end of the first year following the entry into force of this Agreement, the Association Council shall adopt provisions to implement the principles set out in Article 65.
2. The Association Council shall adopt detailed rules for administrative cooperation providing the necessary management and monitoring guarantees for the application of the provisions referred to in paragraph 1.

Article 68

The provisions adopted by the Association Council in accordance with Article 67 shall not affect any rights or obligations arising from bilateral agreements linking Tunisia and the Member States where those agreements provide for more favourable treatment of nationals of Tunisia or of the Member States.

CHAPTER II

DIALOGUE IN SOCIAL MATTERS

Article 69

1. The Parties shall conduct regular dialogue on any social matter which is of interest to them.
2. Such dialogue shall be used to find ways to achieve progress in the field of movement of workers and equal treatment and social integration for Tunisian and Community nationals residing legally in the territories of their host countries.
3. Dialogue shall cover in particular all issues connected with:
 - (a) the living and working conditions of the migrant communities;
 - (b) migration;
 - (c) illegal immigration and the conditions governing the return of individuals who are in breach of the legislation dealing with the right to stay and the right of establishment in their host countries;

(d) schemes and programmes to encourage equal treatment between Tunisian and Community nationals, mutual knowledge of cultures and civilizations, the furthering of tolerance and the removal of discrimination.

Article 70

Dialogue on social matters shall be conducted at the same levels and in accordance with the same procedures as provided for in Title I of this Agreement, which can itself provide a framework for that dialogue.

CHAPTER III

COOPERATION IN THE SOCIAL FIELD

Article 71

With a view to consolidating cooperation between the Parties in the social field, projects and programmes shall be carried out in any area of interest to them.

Priority will be afforded to:

- (a) reducing migratory pressure, in particular by creating jobs and developing training in areas from which emigrants come;
- (b) resettling those repatriated because of their illegal status under the legislation of the state in question;
- (c) promoting the role of women in the economic and social development process through education and the media in step with Tunisian policy on the matter;
- (d) bolstering and developing Tunisia's family planning and mother and child protection programmes;
- (e) improving the social protection system;
- (f) enhancing the health cover system;
- (g) improving living conditions in poor, densely populated areas;

(h) implementing and financing exchange and leisure programmes for mixed groups of Tunisian and European young people residing in the Member States, with a view to promoting mutual knowledge of their respective cultures and fostering tolerance.

Article 72

Cooperation schemes may be carried out in coordination with Member States and relevant international organisations.

Article 73

A working party shall be set up by the Association Council by the end of the first year following the entry into force of this Agreement. It shall be responsible for the continuous and regular evaluation of the implementation of Chapters 1 to 3.

MOROCCO

19. Euro-Mediterranean association agreements establishing an association between the European Communities and their Member States, of the one part, and the Kingdom of Morocco, of the other part (excerpt)¹⁸⁹

Adoption: 26 February 1996

Entry into force: 1 March 2000

(...)

TITLE VI

COOPERATION IN SOCIAL AND CULTURAL MATTERS

CHAPTER I

WORKERS

Article 64

1. The treatment accorded by each Member State to workers of Moroccan nationality employed in its territory shall be free from any discrimination based on nationality, as regards working conditions, remuneration and dismissal, relative to its own nationals.
2. All Moroccan workers allowed to undertake paid employment in the territory of a Member State on a temporary basis shall be covered by the provisions of paragraph 1 with regard to working conditions and remuneration.
3. Morocco shall accord the same treatment to workers who are nationals of a Member State and employed in its territory.

Article 65

1. Subject to the provisions of the following paragraphs, workers of Moroccan nationality and any members of their families living with

¹⁸⁹Source: OJ 2000 L 70.

them shall enjoy, in the field of social security, treatment free from any discrimination based on nationality relative to nationals of the Member States in which they are employed.

The concept of social security shall cover the branches of social security dealing with sickness and maternity benefits, invalidity, old-age and survivors' benefits, industrial accident and occupational disease benefits and death, unemployment and family benefits.

These provisions shall not, however, cause the other coordination rules provided for in Community legislation based on Article 51 of the EC Treaty to apply, except under the conditions set out in Article 67 of this Agreement.

2. All periods of insurance, employment or residence completed by such workers in the various Member States shall be added together for the purpose of pensions and annuities in respect of old-age, invalidity and survivors' benefits and family, sickness and maternity benefits and also for that of medical care for the workers and for members of their families resident in the Community.
3. The workers in question shall receive family allowances for members of their families who are resident in the Community.
4. The workers in question shall be able to transfer freely to Morocco, at the rates applied by virtue of the legislation of the debtor Member State or States, any pensions or annuities in respect of old age, survivor status, industrial accident or occupational disease, or of invalidity resulting from industrial accident or occupational disease, except in the case of special non-contributory benefits.
5. Morocco shall accord to workers who are nationals of a Member State and employed in its territory, and to the members of their families, treatment similar to that specified in paragraphs 1, 3 and 4.

Article 66

The provisions of this chapter shall not apply to nationals of the Parties residing or working illegally in the territory of their host countries.

Article 67

1. Before the end of the first year following the entry into force of this Agreement, the Association Council shall adopt provisions to implement the principles set out in Article 65.
2. The Association Council shall adopt detailed rules for administrative cooperation providing the necessary management and monitoring guarantees for the application of the provisions referred to in paragraph 1.

Article 68

The provisions adopted by the Association Council in accordance with Article 67 shall not affect any rights or obligations arising from bilateral agreements linking Morocco and the Member States where those agreements provide for more favourable treatment of nationals of Morocco or of the Member States.

CHAPTER II

DIALOGUE IN SOCIAL MATTERS

Article 69

1. The Parties shall conduct regular dialogue on any social matter which is of interest to them.
2. Such dialogue shall be used to find ways to achieve progress in the field of movement of workers and equal treatment and social integration for Moroccan and Community nationals residing legally in the territories of their host countries.
3. Dialogue shall cover in particular all issues connected with:
 - (a) the living and working conditions of the migrant communities;
 - (b) migration;
 - (c) illegal immigration and the conditions governing the return of individuals who are in breach of the legislation dealing with the right to stay and the right of establishment in their host countries;

(d) schemes and programmes to encourage equal treatment between Moroccan and Community nationals, mutual knowledge of cultures and civilisations, the furthering of tolerance and the removal of discrimination.

Article 70

Dialogue on social matters shall be conducted at the same levels and in accordance with the same procedures as provided for in Title I of this Agreement, which can itself provide a framework for that dialogue.

CHAPTER III

COOPERATION IN THE SOCIAL FIELD

Article 71

1. With a view to consolidating cooperation between the Parties in the social field, projects and programmes shall be carried out in any area of interest to them.

Priority will be afforded to the following projects:

- (a) reducing migratory pressure, in particular by improving living conditions, creating jobs and developing training in areas from which emigrants come;
- (b) resettling those repatriated because of their illegal status under the legislation of the state in question;
- (c) promoting the role of women in the economic and social development process through education and the media in step with Moroccan policy on the matter;
- (d) bolstering and developing Morocco's family planning and mother and child protection programmes;
- (e) improving the social protection system;
- (f) enhancing the health cover system;
- (g) implementing and financing exchange and leisure programmes for

mixed groups of Moroccan and European young people residing in the Member States, with a view to promoting mutual knowledge of their respective cultures and fostering tolerance.

Article 72

Cooperation schemes may be carried out in coordination with Member States and relevant international organisations.

Article 73

A working party shall be set up by the Association Council by the end of the first year following the entry into force of this Agreement. It shall be responsible for the continuous and regular evaluation of the implementation of Chapters I to III.

II.2 COUNCIL OF EUROPE

Sources of Council of Europe Law are¹⁹⁰:

Treaties: agreements and conventions

The term **treaty** is used only in the title of collections of the Council of Europe Conventions. The Council of Europe treaties include “conventions”, “agreements”¹⁹¹, the French “arrangements”¹⁹², “codes”, and “outline or framework conventions”, but despite the title chosen their legal character and the legal regime which applies to them is the same.

Under Article 1 of its Statute, the Council of Europe and its statutory bodies aim to achieve greater unity between its member states for the purpose of safeguarding and realizing the ideals and principles that are their common heritage and facilitating their economic and social progress.

In particular, the Council of Europe pursues the above mentioned goal “by agreements ... in economic, social, cultural, scientific, legal administrative matters and in the maintenance and further realization of human rights and fundamental freedoms”. Member states are expected to accede to the conventions adopted by the Committee of Ministers, which Article 13 of the Statute defines as the organ that acts on behalf of the Council of Europe.

Council of Europe **agreements and conventions** are governed by the Vienna Convention on the Law of Treaties of 23 May 1969. This convention is not binding on all the Member States, but most of its provisions codify existing customary rules and are applied as such. On the other hand, rules specific to the Council override the convention. These rules are laid down in the Council Statute, the Statutory

¹⁹⁰See F. Benoît-Rohmer, H. Klebes, *Council of Europe Law - Towards a Pan-European Legal Area*, Council of Europe, June 2005, available in both English and French.

¹⁹¹The term agreement is often used as synonym of treaty or convention, but its meaning is more general. Agreement, in fact, is an expression of assent by two or more parties to the same object, not necessarily in order to produce legal effects. The Council of Europe no longer concludes agreements, consequently the distinction between agreement and convention has ceased to be valid. However, this distinction was based on forms of consent: states acceded to conventions by depositing an instrument of ratification, acceptance or approval; whilst signing was often enough for agreements. At present, some conventions can also be signed without requiring ratification, acceptance or approval.

¹⁹²The agreements mostly known in French as arrangements are usually concerned with implementing some other text.

Resolutions adopted in 1951 and 1993, and the Rules of Procedure applying to meetings of the Committee Ministers and the Ministers' Deputies.

In principle, Council of Europe conventions are multilateral as they apply between more than two states.

Recommendations and Resolutions

Recommendations are non-binding instruments that aim to harmonize laws in a more flexible way, compared to conventions. They take instant effect once adopted and are addressed to all member states. As mentioned above, they are more flexible than conventions since their implementation is a matter for states and they can be modified more rapidly. However they reflect a measure of agreement between all the member governments on the subject they cover.

The Committee of Ministers can use recommendations to lay down guidelines for the member states' policies and laws. Moreover, member states can use them to propose joint solutions to new problems. The Committee of Ministers may recommend that states adopt laws inspired by joint regulations set out in recommendations, or model codes appended to them.

Recommendations can also supplement conventions, and they are open to being monitored. In fact, under Article 15 of the Statute of the Council of Europe, the Committee of Ministers may ask governments to inform it on the action they take on its recommendations. Thus, the Committee of Ministers instructs the steering or *ad hoc* committees to monitor the recommendations' implementation and to report on the conclusions reached. On the basis of such conclusions the Committee of Ministers may decide to focus on the difficulties involved in implementing particular recommendations.

Moreover, Committee of Ministers' recommendations, as well as Parliamentary Assembly recommendations, constitute "soft law" and may produce direct effect in public international law.

Assembly recommendations have also been cited by constitutional courts in support of their arguments, producing an indirect legal effect.

Indirect legal effects also result from Committee of Ministers **resolutions** that are adopted with the view of enforcing judgments of the European Court of Human Rights.

Furthermore, the Committee of Ministers can also adopt **interim resolutions** noting progress made with execution, or expressing concern or making suggestions on this issue. These resolutions are non-binding instruments, but they can be used to put pressure on governments when information supplied by the latter indicates failure to execute a judgment.

Lastly, the Court has sporadically used Assembly resolutions to support its own arguments.

II.2.1 CONVENTIONS

20. Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocol No. 11 (excerpt)¹⁹³

Adoption: 4 November 1950

Entry into force: 3 September 1953

(...)

SECTION I. RIGHTS AND FREEDOMS

Article 2. Right to life

1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
 - (a) in defence of any person from unlawful violence;
 - (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
 - (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

Article 3. Prohibition of torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

(...)

¹⁹³Source: European Treaty Series - No. 5.

Article 5. Right to liberty and security

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
 - (a) the lawful detention of a person after conviction by a competent court;
 - (b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
 - (c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
 - (d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
 - (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
 - (f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.
2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.
3. Everyone arrested or detained in accordance with the provisions of paragraph 1.c of this article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial.

Release may be conditioned by guarantees to appear for trial.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.
5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation.

(...)

Article 8. Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

(...)

Article 14. Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

21. Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocol No. 11 (excerpt)¹⁹⁴

Adoption: 20 March 1952

Entry into force: 18 May 1954

(...)

Article 1. Protection of property

Every natural or legal person is entitled to the peaceful enjoyment of his possessions. No one shall be deprived of his possessions except in the public interest and subject to the conditions provided for by law and by the general principles of international law.

The preceding provisions shall not, however, in any way impair the right of a State to enforce such laws as it deems necessary to control the use of property in accordance with the general interest or to secure the payment of taxes or other contributions or penalties.

(...)

¹⁹⁴Source: ETS No. 9.

22. Protocol No. 4 to the Convention for the Protection of Human Rights and Fundamental Freedoms securing certain rights and freedoms other than those already included in the Convention and in the first Protocol thereto (excerpt)¹⁹⁵

Adoption: 16 September 1963

Entry into force: 2 May 1968

(...)

Article 2. Freedom of movement

1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.
2. Everyone shall be free to leave any country, including his own.
3. No restrictions shall be placed on the exercise of these rights other than such as are in accordance with law and are necessary in a democratic society in the interests of national security or public safety, for the maintenance of ordre public, for the prevention of crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.
4. The rights set forth in paragraph 1 may also be subject, in particular areas, to restrictions imposed in accordance with law and justified by the public interest in a democratic society.

(...)

¹⁹⁵Source: ETS No. 46.

23. Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms (excerpt)¹⁹⁶

Adoption: 4 November 2000

Entry into force: 1 April 2005

The member States of the Council of Europe signatory hereto,

Having regard to the fundamental principle according to which all persons are equal before the law and are entitled to the equal protection of the law;

Being resolved to take further steps to promote the equality of all persons through the collective enforcement of a general prohibition of discrimination by means of the Convention for the Protection of Human Rights and Fundamental Freedoms signed at Rome on 4 November 1950 (hereinafter referred to as the Convention);

Reaffirming that the principle of non-discrimination does not prevent States Parties from taking measures in order to promote full and effective equality, provided that there is an objective and reasonable justification for those measures,

Have agreed as follows:

Article 1. General prohibition of discrimination¹⁹⁷

1. The enjoyment of any right set forth by law shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.
2. No one shall be discriminated against by any public authority on any ground such as those mentioned in paragraph 1.

(...)

¹⁹⁶Source: ETS No. 177.

¹⁹⁷Protocol No. 12 to the European Convention on Human Rights goes a step further than the Convention, and specifically its Article 14. In fact, Article 1 of the Protocol contains a general prohibition of discrimination, which is not limited to the enjoyment of rights and freedoms laid down in the Convention. See K. Janssens, M. Bosmans, M. Temmerman, loc. cit n. 127, p. 49.

Selected jurisprudence

Lack of necessary health care as a violation of Article 3 (prohibition of torture)

For what concerns the types of “treatment” which fall within the scope of **Article 3 (prohibition of torture)** of the Convention, the European Court of Human Rights, in the case *Pretty v. United Kingdom* (judgment of 29 April 2002, Application No. 2346/02, paragraph 52), stated that:

“(...) the Court’s case-law refers to “ill-treatment” that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering (...). Where treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual’s moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3 (...). The suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible (...).”

Cholewinski¹⁹⁸ highlights that even if the threshold for breaching the right to be free from inhumane and degrading treatment is set very high, as it is outlined in the judgment mentioned above, the denial of health care to irregular migrants may also amount to an infringement of this right. Moreover, he quotes Da Lomba, who, referring to the judgment of the English Court of Appeal in *R (on the application of Q and Others) v. Secretary of State for the Home Department*¹⁹⁹, argues, on the basis of English case law, that the threshold for breaching the right to be free from degrading and inhumane treatment may be reached when “irregular migrants cannot afford health care and do not

¹⁹⁸ See R. Cholewinski, loc. cit. 15, at p. 45

¹⁹⁹ *R (on the application of Q and Others) v. Secretary of State for the Home Department* [2003] EWCA Civ 364.

benefit from other sources of support”, and, consequently, “the state’s refusal to provide free health care could engage Article 3 where the consequences for the irregular migrants’ health, dignity and/or feelings satisfy the level of severity set out in *Pretty*”²⁰⁰.

Article 3 has also been invoked to prevent migrants who are ill from being expelled to countries of origin or third countries with inadequate health care facilities, as in the case of *D. v. the United Kingdom* (1997)²⁰¹. In this case an AIDS sufferer was threatened with removal from the United Kingdom to the isle of St Kitts where no effective medical or palliative treatment for his illness was available and he would have been exposed to the risk of dying under the most distressing circumstances. The court unanimously held that the implementation of the decision to remove the applicant to St Kitts would have violated Article 3 of the Convention.

Although the European Court of Human Rights did not decide in the case *B.B. v. France* (1998)²⁰² because the Government in the end did not deport the applicant, it noted that the deportation of a national of the Democratic Republic of Congo suffering from AIDS to his country of origin where there was no access to adequate medical care would have constituted a violation of Article 3 of the Convention. The court, in the case of *B.B v. France*, referred expressly to the case *D. v. United Kingdom*.

On the other hand, looking at the most recent jurisprudence of the European Court of Human Rights, this principle seems to apply only exceptionally.

See, in fact, the case *Arcila Henao v. The Netherlands*²⁰³, which was declared *inadmissible* under Article 3. In this case, although the situation of the applicant - a Colombian national found HIV-positive whilst serving a two-year prison

²⁰⁰See Da Lomba S., “Fundamental Social Rights for Irregular Migrants: The Right to Health Care in France and England” in Bogusz B. et al., (eds), *Irregular Migration and Human Rights: Theoretical, European and International Perspectives*, 2004.

²⁰¹*D. v. United Kingdom* [1997] 24 EHRR 423.

²⁰²*B.B v. France* [1998] ECHR 84.

²⁰³*Arcila Henao v. The Netherlands*, Application N° 13669/03.

sentence for drugs related offences in The Netherlands - would have been less favorable in Colombia, his condition did not appear to have reached an advanced or terminal stage, and treatment was in principle available in Colombia. The circumstances were not of such an exceptional nature that the applicant's expulsion would have amounted to inhuman treatment under Article 3.

Violation of Article 2 (the right to life) and Article 8 (the right to respect for private and family life)

It appears from the European Court of Human Rights' case law that a state's failure to provide effective access to health care for irregular migrants could also potentially result in a violation of Articles 2 and/or 8. Naturally, the threshold for an infringement of the rights protected in these Articles is set at a high level. In fact, there must be a "real and immediate" threat to life of which the authorities were or ought to have been aware for a state's responsibility to be engaged in case of inaction and for a violation of Article 2 to be found. In this respect, see the case *Osman v. United Kingdom* (1998)²⁰⁴ in which it is stated that:

"For the Court, and having regard to the nature of the right protected by Article 2, a right fundamental in the scheme of the Convention, it is sufficient for an applicant to show that the authorities did not do all that could be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge. This is a question that can only be answered in the light of all the circumstances of any particular case."

For a violation of Article 8 of the Convention, the person's private life has to be infringed so that there are "sufficiently adverse effects on his or her physical and moral integrity". See *Bensaid v. United Kingdom* (2001)²⁰⁵ in which the court stated:

"Not every act or measure which adversely affects moral or physical integrity will interfere with the right to respect of

²⁰⁴ *Osman v. United Kingdom* [1998] 2626 EHRR 357, paragraph 116.

²⁰⁵ *Bensaid v. United Kingdom* [2001] 33 EHRR 205, paragraph 46.

private life guaranteed by Article 8. However, the Court's case law does not exclude that treatment which does not reach the severity of Article 3 treatment may nonetheless breach Article 8 in its private-life aspect where there are sufficiently adverse effects on physical and moral integrity.”

Cholewinski²⁰⁶ recalls that the second paragraph of Article 8 of the Convention, unlike Articles 2 and 3, enables contracting parties to justify restrictions on these two rights.

Breach of Article 14 (prohibition of discrimination) of the Convention in conjunction with Article 1 (enjoyment of property) of Protocol No. 1

The European Court of Human Rights held that there was a violation of Article 14 in conjunction with Article 1 of the First Protocol in the cases *Gaygusuz v. Austria* (1996)²⁰⁷ and *Koua Poirrez v. France* (2003)²⁰⁸.

In the first case, the applicant was a Turkish national who lived and worked in Austria with interruptions and who was not granted a right to social security benefits prescribed by law on the sole basis of nationality and in absence of any reasonable justification.

In the second case, the applicant was a national of Ivory Coast, born and living in the Paris area, who had suffered from a severe physical handicap since the age of seven. The court came to the conclusion that the refusal of the French authorities to grant him a disabled adult's allowance constituted a violation of Article 14 of the Convention combined with Article 1 of Protocol No. 1.

²⁰⁶R. Cholewinski, loc. cit. 15, at p. 45.

²⁰⁷*Gaygusuz v. Austria* [1996] 23 EHRR 364.

²⁰⁸*Koua Poirrez v. France* [2003] 40 EHRR 34.

24. European Social Charter (revised) (excerpt)²⁰⁹

Adoption: 3 May 1996

Entry into force: 1 July 1999

(...)

Part I

The Parties accept as the aim of their policy, to be pursued by all appropriate means both national and international in character, the attainment of conditions in which the following rights and principles may be effectively realised:

1. Everyone shall have the opportunity to earn his living in an occupation freely entered upon.
2. All workers have the right to just conditions of work.
3. All workers have the right to safe and healthy working conditions.
4. All workers have the right to a fair remuneration sufficient for a decent standard of living for themselves and their families.
5. All workers and employers have the right to freedom of association in national or international organisations for the protection of their economic and social interests.
6. All workers and employers have the right to bargain collectively.
7. Children and young persons have the right to a special protection against the physical and moral hazards to which they are exposed.

²⁰⁹Source: ETS No. 163 – European Social Charter (revised) 3.V.1996. See also the Explanatory Report to the European Social Charter (revised). The European Social Charter is a general human rights treaty, which guarantees social and economic rights. It was adopted, by the Members of the Council of Europe in Turin, on 18 October 1961, and revised in Strasbourg in 1996. The European Committee of Social Rights (ECSR) is the body responsible for monitoring compliance of the States Parties with the Charter. The revised European Social Charter is designed to take the place progressively of the European Social Charter, incorporating the rights guaranteed by the Charter as amended and the Additional Protocol No. 14 to the European Convention on Human Rights. See the 1961 European Social Charter.

8. Employed women, in case of maternity, have the right to a special protection.
9. Everyone has the right to appropriate facilities for vocational guidance with a view to helping him choose an occupation suited to his personal aptitude and interests.
10. Everyone has the right to appropriate facilities for vocational training.
11. Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable.
12. All workers and their dependents have the right to social security.
13. Anyone without adequate resources has the right to social and medical assistance.
14. Everyone has the right to benefit from social welfare services.
15. Disabled persons have the right to independence, social integration and participation in the life of the community.
16. The family as a fundamental unit of society has the right to appropriate social, legal and economic protection to ensure its full development.
17. Children and young persons have the right to appropriate social, legal and economic protection.
18. The nationals of any one of the Parties have the right to engage in any gainful occupation in the territory of any one of the others on a footing of equality with the nationals of the latter, subject to restrictions based on cogent economic or social reasons.
19. Migrant workers who are nationals of a Party and their families have the right to protection and assistance in the territory of any other Party.
20. All workers have the right to equal opportunities and equal treatment in matters of employment and occupation without discrimination on the grounds of sex.

21. Workers have the right to be informed and to be consulted within the undertaking.
22. Workers have the right to take part in the determination and improvement of the working conditions and working environment in the undertaking.
23. Every elderly person has the right to social protection.
24. All workers have the right to protection in cases of termination of employment.
25. All workers have the right to protection of their claims in the event of the insolvency of their employer.
26. All workers have the right to dignity at work.
27. All persons with family responsibilities and who are engaged or wish to engage in employment have a right to do so without being subject to discrimination and as far as possible without conflict between their employment and family responsibilities.
28. Workers' representatives in undertakings have the right to protection against acts prejudicial to them and should be afforded appropriate facilities to carry out their functions.
29. All workers have the right to be informed and consulted in collective redundancy procedures.
30. Everyone has the right to protection against poverty and social exclusion.
31. Everyone has the right to housing.

(...)

Article 2 – The right to just conditions of work

With a view to ensuring the effective exercise of the right to just conditions of work, the Parties undertake:

1. to provide for reasonable daily and weekly working hours, the working week to be progressively reduced to the extent that the increase of productivity and other relevant factors permit;

2. to provide for public holidays with pay;
3. to provide for a minimum of four weeks' annual holiday with pay;
4. to eliminate risks in inherently dangerous or unhealthy occupations, and where it has not yet been possible to eliminate or reduce sufficiently these risks, to provide for either a reduction of working hours or additional paid holidays for workers engaged in such occupations;
5. to ensure a weekly rest period which shall, as far as possible, coincide with the day recognised by tradition or custom in the country or region concerned as a day of rest;
6. to ensure that workers are informed in written form, as soon as possible, and in any event not later than two months after the date of commencing their employment, of the essential aspects of the contract or employment relationship;
7. to ensure that workers performing night work benefit from measures which take account of the special nature of the work.

Article 3 – The right to safe and healthy working conditions

With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:

1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;
2. to issue safety and health regulations;
3. to provide for the enforcement of such regulations by measures of supervision;

4. to promote the progressive development of occupational health services for **all workers** with essentially preventive and advisory functions.

(...)

Article 11 – The right to protection of health²¹⁰

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

European Committee of Social Rights' observations on Article 11²¹¹

In the General Introduction to the Committee's Conclusions 2005, the European Committee of Social Rights, which decide whether law and practice of states is in conformity with the Social Charter, made the following observation regarding Article 11 of the Charter:

²¹⁰See the decision of the European Committee of Social Rights in *Marangopoulos v. Greece*, Collective Complaint No. 30/2005. The complaint was lodged by the Marangopoulos Foundation for Human Rights (MFHR) *versus* Greece's failure to comply with Article 11 of the European Social Charter. MFHR claimed that in the main areas where lignite is mined Greece had not taken sufficient account of the environmental effects or developed an appropriate strategy to prevent and combat public health risks. In this decision, the European Committee of Social Rights considered the link between the protection of health and a healthy environment and interpreted Article 11 as including the right to a healthy environment. Under Article 11 everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable. Further, measures should be designed, in light of current knowledge, to remove the causes of ill-health resulting from environmental threats such as pollution. The Committee, in the above mentioned decision, held there had been a violation of Article 11 as well as of Articles 3§2 and 2§4 of the European Social Charter. See: http://www.coe.int/t/e/human_rights/esc/4_collective_complaints/list_of_collective_complaints/MeritsRC30_en.pdf.

²¹¹See European Social Charter (revised) - Conclusions 2005, Volume I, ISBN 92-871-5832-0, Council of Europe, September 2005, p.p. 10-11

“The Committee notes that the right to protection of health guaranteed in Article 11 of the Charter complements Articles 2 and 3 of the European Convention on Human Rights - as interpreted by the European Court of Human Rights - by imposing a range of positive obligations designed to secure its effective exercise. This normative partnership between the two instruments is underscored by the Committee’s emphasis on human dignity. In *Collective Complaint FIDH v. France* (No. 14/2003) it stated that “human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention of Human Rights and [that] health care is a prerequisite for the preservation of human dignity”.

In assessing whether the right to protection of health can be effectively exercised, the Committee pays particular attention to the situation of disadvantaged and vulnerable groups. Hence, it considers that any Conclusions 2005 – General Introduction 11 restrictions on this right must not be interpreted in such a way as to impede the effective exercise by these groups of the right to protection of health. This interpretation imposes itself because of the non discrimination requirement (Articles E of the Revised Charter and Preamble of the 1961 Charter) in conjunction with the substantive rights of the Charter. The Committee therefore assesses the conditions under which the whole population has access to health care, taking into account also the Council of Europe Parliamentary Assembly Recommendation 1626 (2003) on “reform of health care systems in Europe: reconciling equity, quality and efficiency”, which invites member states to take as their main criterion for judging the success of health system reforms effective access to health care for all, without discrimination, as a basic human right. In this respect, the Committee henceforth focuses on issues relating to emergency situations and to disparities between urban and rural areas.

The Committee notes that this approach calls for an exacting interpretation of the way the personal scope of the Charter is applied in conjunction with Article 11 on the right to

protection of health, particularly with its first paragraph on access to health care. In this respect, it recalls that it clarified the application of the Charter's personal scope in its general introduction to Conclusions XVII-1 and 2004 (pp. 9-10; see also the general introduction to Conclusions XVI-1 and 2002).

Furthermore, the Committee henceforth pays attention to preventive policies regarding mental health taking into account also the recent Declaration of the WHO ministerial conference in Helsinki (12-15 January 2005). It focuses particularly on conditions in psychiatric institutions (including those for young persons) in accordance with the requirements of Articles 14 and 17 of the Charter and also in the light of Articles 3 and 5 of the European Convention on Human Rights as well as the Council of Europe Committee of Ministers Recommendation (2004) 10 concerning the protection of the human rights and dignity of persons with mental disorder.

Finally, the management of waiting lists and waiting times in health care, which the Committee examines by paying particular attention to the issues of discrimination and emergency situations and in the light of the Council of Europe Committee of Ministers Recommendation No. R (99) 21 on criteria for the management for waiting lists and waiting times in health care, and health education in schools are crucial for assessing the conformity of national situations with Articles 11§1 and 11§2 respectively”.

Article 12 – The right to social security

With a view to ensuring the effective exercise of the right to social security, the Parties undertake:

1. to establish or maintain a system of social security;
2. to maintain the social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security;
3. to endeavour to raise progressively the system of social security to a higher level;
4. to take steps, by the conclusion of appropriate bilateral and multilateral agreements or by other means, and subject to the conditions laid down in such agreements, in order to ensure:

(a) equal treatment with their own nationals of the nationals of other Parties in respect of social security rights, including the retention of benefits arising out of social security legislation, whatever movements the persons protected may undertake between the territories of the Parties;

(b) the granting, maintenance and resumption of social security rights by such means as the accumulation of insurance or employment periods completed under the legislation of each of the Parties.

Article 13 – The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

As regards Article 13 §1 and repatriation²¹²

“The Committee considers that according to the terms of the appendix, this provision requires that nationals of Contracting Parties working regularly or residing legally in the territory of another Contracting Party must be entitled to social and medical assistance as of right on an equal basis with nationals in accordance with Article 13 para. 1 (...). This implies that no length of residence requirement may be demanded and that repatriation on the sole ground that those nationals are asking for social or medical assistance is excluded as long as their regular work or lawful residence on the territory of the Contracting Party concerned lasts.”

(...)

Article 17 – The right of children and young persons to social, legal and economic protection

With a view to ensuring the effective exercise of the right of children and young persons to grow up in an environment which encourages the full development of their personality and of their physical and mental capacities, the Parties undertake, either directly or in co-operation with public and private organisations, to take all appropriate and necessary measures designed:

²¹²European Committee of Social Rights, statement of interpretation, Conclusions XIII-4, pp. 54-57 (Excerpt).

1. to ensure that children and young persons, taking account of the rights and duties of their parents, have the care, the assistance, the education and the training they need, in particular by providing for the establishment or maintenance of institutions and services sufficient and adequate for this purpose;
2. to protect children and young persons against negligence, violence or exploitation;
3. to provide protection and special aid from the state for children and young persons temporarily or definitively deprived of their family's support;
3. to provide to children and young persons a free primary and secondary education as well as to encourage regular attendance at schools.

(...)

Article 19 – The right of migrant workers and their families to protection and assistance

With a view to ensuring the effective exercise of the right of migrant workers and their families to protection and assistance in the territory of any other Party, the Parties undertake:

1. to maintain or to satisfy themselves that there are maintained adequate and free services to assist such workers, particularly in obtaining accurate information, and to take all appropriate steps, so far as national laws and regulations permit, against misleading propaganda relating to emigration and immigration;
2. to adopt appropriate measures within their own jurisdiction to facilitate the departure, journey and reception of such workers and their families, and to provide, within their own jurisdiction, appropriate services for health, medical attention and good hygienic conditions during the journey;
3. to promote co-operation, as appropriate, between social services, public and private, in emigration and immigration countries;
4. to secure for such workers lawfully within their territories, insofar as such matters are regulated by law or regulations or are subject to

the control of administrative authorities, treatment not less favourable than that of their own nationals in respect of the following matters:

- (a) remuneration and other employment and working conditions;
 - (b) membership of trade unions and enjoyment of the benefits of collective bargaining;
 - (c) accommodation;
5. to secure for such workers lawfully within their territories treatment not less favourable than that of their own nationals with regard to employment taxes, dues or contributions payable in respect of employed persons;
 6. to facilitate as far as possible the reunion of the family of a foreign worker permitted to establish himself in the territory;
 7. to secure for such workers lawfully within their territories treatment not less favourable than that of their own nationals in respect of legal proceedings relating to matters referred to in this article;
 8. to secure that such workers lawfully residing within their territories are not expelled unless they endanger national security or offend against public interest or morality;
 9. to permit, within legal limits, the transfer of such parts of the earnings and savings of such workers as they may desire;
 10. to extend the protection and assistance provided for in this article to self-employed migrants insofar as such measures apply;
 11. to promote and facilitate the teaching of the national language of the receiving state or, if there are several, one of these languages, to migrant workers and members of their families;
 12. to promote and facilitate, as far as practicable, the teaching of the migrant worker's mother tongue to the children of the migrant worker.

As regards Article 19§6

Conditions of and restrictions on family reunion:

a) Refusal on health grounds

A state may not deny entry to its territory for the purpose of family reunion to a family member of a migrant worker for health reasons. A refusal on this ground may only be admitted for specific illnesses which are so serious as to endanger public health²¹³. These are the diseases requiring quarantine which are stipulated in the World Health Organisation's International Health Regulations of 1969, or other serious contagious or infectious diseases such as tuberculosis or syphilis. Very serious drug addiction or mental illness may justify refusal of family reunion, but only where the authorities establish, on a case-by-case basis, that the illness or condition constitutes a threat to public order or security²¹⁴.

As regards Article 19§8

This paragraph obliges States to prohibit by law the expulsion of migrants lawfully residing in their territory, except where they are a threat to national security, or offend against public interest or morality²¹⁵.

Expulsion for offences against public order or morality can only be in conformity with the Charter if they constitutes a penalty for a criminal act, imposed by a court or a judicial authority, and are not solely based on the existence of a criminal conviction but on all aspects of the non-nationals' behaviour, as well as the circumstances and the length of time of his/her presence in the territory of the State.

Risks to public health are not in themselves risks to public order and cannot constitute a ground for expulsion, unless the person refuses to undergo suitable treatment²¹⁶.

²¹³European Committee of Social Rights, Conclusions XVI-1, Greece, p. 316.

²¹⁴European Committee of Social Rights, Conclusions XVI-1, Finland, pp. 227-228.

²¹⁵European Committee of Social Rights, Conclusions VI, p. 126.

²¹⁶European Committee of Social Rights, Conclusions V, p. 138.

(...)

Article 23 – The right of elderly persons to social protection

With a view to ensuring the effective exercise of the right of elderly persons to social protection, the Parties undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:

- to enable elderly persons to remain full members of society for as long as possible, by means of:

- (a) adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;

- (b) provision of information about services and facilities available for elderly persons and their opportunities to make use of them;

- to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:

- (a) provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;

- (b) the health care and the services necessitated by their state;

- to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.

(...)

Part V

Article E – Non-discrimination

The enjoyment of the rights set forth in this Charter shall be secured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, birth or other status.

The Explanatory Report’s observations on the provision of Article E of the revised Charter state

“135. This new Article of the Revised Charter confirms the case law of the Committee of Independent Experts in respect of the Charter that is that the non-discrimination clause in the preamble to the Charter applies to all the provisions of the Charter. Accordingly, the Revised Charter does not allow discrimination on any of the grounds listed in this Article in respect of any of the rights contained in the instrument.

136. The Article has been based on Article 14 of the European Convention on Human Rights which contains a more extensive enumeration of grounds than the preamble to the Charter. The grounds enumerated in the Article are the same as those contained in the preamble to the Charter, with the addition of some grounds mentioned in the Convention. However, with respect to some of these latter grounds, the Committee of Independent Experts has already indicated in its case law that they apply to the rights guaranteed under the Charter. The words “such as” contained in the provision indicate that the list of grounds on which discrimination is not permitted is not exhaustive. It is understood that this provision prohibits, inter alia, the refusal to employ women on grounds of pregnancy. It also provides for non-discrimination in access to health care. These are merely two examples. The appendix to the new Article provides that differential treatment based on an objective and reasonable justification shall not be deemed to be discriminatory. An objective and reasonable justification may be such as the requirement of a certain age or a certain capacity for access

to some forms of education. Whereas national extraction is not an acceptable ground for discrimination, the requirement of a specific citizenship might be acceptable under certain circumstances, for example for the right to employment in the defence forces or in the civil service.

137. In addition, it is understood that this provision must not be interpreted so as to extend the scope *ratione personae* of the Revised Charter which is defined in the appendix to the instrument and which includes foreigners only in so far as they are nationals of other parties lawfully resident or working regularly within the territory of the Party concerned”.

(...)

Article G – Restrictions

1. The rights and principles set forth in Part I when effectively realised, and their effective exercise as provided for in Part II, shall not be subject to any restrictions or limitations not specified in those parts, except such as are prescribed by law and are necessary in a democratic society for the protection of the rights and freedoms of others or for the protection of public interest, national security, public health, or morals.
2. The restrictions permitted under this Charter to the rights and obligations set forth herein shall not be applied for any purpose other than that for which they have been prescribed.

Article H – Relations between the Charter and domestic law or international agreements

The provisions of this Charter shall not prejudice the provisions of domestic law or of any bilateral or multilateral treaties, conventions or agreements which are already in force, or may come into force, under which more favourable treatment would be accorded to the persons protected.

Appendix to the Revised European Social Charter

Scope of the Revised European Social Charter in terms of persons protected

1. Without prejudice to Article 12, paragraph 4, and Article 13, paragraph 4, the persons covered by Articles 1 to 17 and 20 to 31 include foreigners only in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned, subject to the understanding that these articles are to be interpreted in the light of the provisions of Articles 18 and 19²¹⁷.

This interpretation would not prejudice the extension of similar facilities to other persons by any of the Parties.

2. Each Party will grant to refugees as defined in the Convention relating to the Status of Refugees, signed in Geneva on 28 July 1951 and in the Protocol of 31 January 1967, and lawfully staying in its territory, treatment as favourable as possible, and in any case not less favourable than under the obligations accepted by the Party under the said convention and under any other existing international instruments applicable to those refugees.
3. Each Party will grant to stateless persons as defined in the Convention on the Status of Stateless Persons done in New York on 28 September 1954 and lawfully staying in its territory, treatment as favourable as possible and in any case not less favourable than under the obligations accepted by the Party under the said instrument and under any other existing international instruments applicable to those stateless persons.

²¹⁷See D. Harris, *The European Social Charter* (1984), who criticizes the restrictive scope *ratione personae* of the European Social Charter. At p. 283, he writes: "The more restrictive rule in the Charter is particularly open to criticism because the Charter does not limit a state's power to control entry into its territory. If a contracting party allows an alien to take up residence or work within its territory, it is difficult to justify excluding that person from the rights guaranteed in the Charter solely on the basis of his nationality."

With respect to the scope of the Scope of the Revised European Social Charter in terms of persons protected²¹⁸

“Personal Scope of the Charter

The personal scope of the Charter is defined in the Appendix. It covers:

- i. nationals of other Parties lawfully resident or working regularly within their territory;
- ii. refugees and stateless persons lawfully staying in their territory.

The Committee recalls that States Parties to the Charter can extend its scope beyond the minimum laid down in the Appendix.

The Committee notes that the Parties to the Charter (in its 1961 and revised 1996 versions) have guaranteed to foreigners not covered by the Charter rights identical to or inseparable from those of the Charter by ratifying human rights treaties – in particular the European Convention of Human Rights – or by adopting domestic rules whether constitutional, legislative or otherwise without distinguishing between persons referred to explicitly in the Appendix and other non-nationals. In so doing, the Parties have undertaken these obligations.

Whereas these obligations do not in principle fall within the ambit of its supervisory functions, the Committee does not exclude that the implementation of certain provisions of the Charter could in certain specific situations require complete equality of treatment between nationals and foreigners, whether or not they are nationals of member States, Party to the Charter.”

²¹⁸European Committee of Social Rights, statement of interpretation, Conclusions 2004, pp. 9-10.

Violation of Article 17 (the right of children and young persons to social, legal and economic protection)

The Committee of Ministers adopted resolution (2005)6, reproduced below, at the 925th meeting of the Ministers' Deputies on 4 May 2005.

This resolution originates from the *Collective Complaint No. 14/2003 International Federation of Human Rights Leagues (FIDH) v. France*²¹⁹.

The complaint, lodged on 3 March 2003, relates to Articles 13 (the right to social and medical assistance), 17 (the right of children and young persons to social, legal and economic protection) as well as Article E of the Revised European Social Charter (prohibition of all forms of discrimination in the application of the rights guaranteed by the treaty). It is alleged that recent reforms of the «Aide médicale de l'Etat» (State medical assistance) and to the «Couverture maladie universelle» (Universal sickness cover) deprive a large number of adults and children with insufficient resources of the right to medical assistance.

Collective Complaint No. 14/2003 (Extracts)

“i. On the interpretation of the Appendix to the Charter

26. *The present complaint raises issues of primary importance in the interpretation of the Charter. In this respect, the Committee makes it clear that, when it has to interpret the Charter, it does so on the basis of the 1969 Vienna Convention on the Law of Treaties. Article 31§1 of the said Convention states:*

“A treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose.”

²¹⁹The text of the collective complaint is available at: http://www.coe.int/T/E/Human_Rights/Esc/4_Collective_complaints/List_of_collective_complaints/

27. *The Charter was envisaged as a human rights instrument to complement the European Convention on Human Rights. It is a living instrument dedicated to certain values which inspired it: dignity, autonomy, equality and solidarity. The rights guaranteed are not ends in themselves but they complete the rights enshrined in the European Convention of Human Rights.*
28. *Indeed, according to the Vienna Declaration of 1993, all human rights are “universal, indivisible and interdependent and interrelated” (para. 5). The Committee is therefore mindful of the complex interaction between both sets of rights.*
29. *Thus, the Charter must be interpreted so as to give life and meaning to fundamental social rights. It follows inter alia that restrictions on rights are to be read restrictively, i. e. understood in such a manner as to preserve intact the essence of the right and to achieve the overall purpose of the Charter.*
30. *As concerns the present complaint, the Committee has to decide how the restriction in the Appendix ought to be read given the primary purpose of the Charter as defined above. The restriction attaches to a wide variety of social rights in Articles 1-17 and impacts on them differently. In the circumstances of this particular case, it treads on a right of fundamental importance to the individual since it is connected to the right to life itself and goes to the very dignity of the human being. Furthermore, the restriction in this instance impacts adversely on children who are exposed to the risk of no medical treatment.*
31. *Human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention of Human Rights and health care is a prerequisite for the preservation of human dignity.*

32. *The Committee holds that legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter.”*

The European Committee of Social Rights declared the complaint admissible on 16 May 2003, it subsequently concluded that there was a violation of Article 17 and transmitted its decision on the merits of the complaint to the Parties and to the Committee of Ministers on 3 November 2004. The Committee of Ministers adopted Resolution ResChS(2005)6 on 4 May 2005.

This is a controversial decision. Four committee members disagreed with the majority’s narrow interpretation of the appendix to the (revised) Charter. However the decision is in line with the recognition of the provision of health care as a fundamental human rights in general international human rights law and it is significant in terms of the (revised) Charter’s future application²²⁰.

Resolution ResChS(2005)6. Collective complaint No. 14/2003 by the International Federation of Human Rights Leagues (FIDH) against France

The Committee of Ministers,

Having regard to Article 9 of the Additional Protocol to the European Social Charter providing for a system of collective complaints;

Taking into consideration the complaint lodged on 3 March 2003 by FIDH against France;

Having regard to the report transmitted by the European Committee of Social Rights, in which the situation in France as regards the right of children in an illegal situation to benefit from medical assistance constitutes a violation of Article 17 of the Revised Charter for the following reasons:

²²⁰See R. Cholewinski, loc. cit. n. 15.

“35. With respect to Article 17, the Committee recalls that several provisions of the Revised Charter guarantee the Rights of Children and young persons. The text of Part I provides that:

“The Parties accept as the aim of their policy, to be pursued by all appropriate means both national and international in character, the attainment of conditions in which the following rights and principles may be effectively realised:

(...)

7. Children and young persons have the right to a special protection against the physical and moral hazards to which they are exposed

(...)

17. Children and young persons have the right to appropriate social, legal and economic protection. (...)”

36. Article 17 of the Revised Charter is further directly inspired by the United Nations Convention on the Rights of the Child. It protects in a general manner the right of children and young persons, including unaccompanied minors, to care and assistance. Yet, the Committee notes that:

a) medical assistance to the above target group in France is limited to situations that involve an immediate threat to life;

b) children of illegal immigrants are only admitted to the medical assistance scheme after a certain time.

37. For these reasons, the Committee considers that the situation is not in conformity with Article 17.”

Having regard to the information communicated by the French delegation during the 913th and 917th meetings (2 February and 2 March 2005) of the Ministers’ Deputies,

Takes note of the circular DHOS/DSS/DGAS No. 141 of 16 March 2005 on the implementation of urgent care delivered to foreigners resident in France in an illegal manner and non beneficiaries of State Medical Assistance.

25. European Convention on Social and Medical Assistance (excerpt)²²¹

Adoption: 11 December 1953

Entry into force: 1 July 1954

Article 1²²²

Each of the Contracting Parties undertakes to ensure that nationals of the other Contracting Parties who are lawfully present in any part of its territory to which this Convention applies, and who are without sufficient resources, shall be entitled equally with its own nationals and on the same conditions to social and medical assistance (hereinafter referred to as “assistance”) provided by the legislation in force from time to time in that part of its territory.

(...)

Article 3

Proof of the nationality of the person concerned shall be provided in accordance with the regulations governing such matters under the legislation of the country of origin.

Article 4

The cost of assistance to a national of any of the Contracting Parties shall be borne by the Contracting Party which has granted the assistance.

Article 5

The Contracting Parties undertake, so far as their laws and regulations permit, to help each other to recover the full cost of assistance as far as possible

²²¹Source: ETS No. 14. See also Annex II to the European Convention on Social and Medical Assistance (Reservations formulated by the Contracting Parties); Annex III to the European Convention on Social and Medical Assistance (List of documents recognised as affording proof of residence, referred to in Article 11 of the Convention); Annex IV to the European Convention on Social and Medical Assistance (Interpretation of the terms “nationals” and “territory”).

²²²See also Annex I to the European Convention on Social and Medical Assistance - Legislative measures regarding assistance referred to in Article 1 of the Convention.

either from third parties under financial obligation to the assisted person or from persons who are liable to contribute to the cost of maintenance of the person concerned.

Section II – Repatriation

Article 6

- (a) A Contracting Party in whose territory a national of another Contracting Party is lawfully resident shall not repatriate that national on the sole ground that he is in need of assistance.
- (b) Nothing in this Convention shall prejudice the right to deport on any ground other than the sole ground mentioned in the previous paragraph.

Article 7

- (a) The provisions of Article 6.a notwithstanding, a Contracting Party may repatriate a national of another Contracting Party resident in its territory on the sole ground mentioned in Article 6.a if the following conditions are fulfilled:
 - i. the person concerned has not been continuously resident in the territory of that Contracting Party for at least five years if he entered it before attaining the age of 55 years, or for at least ten years if he entered it after attaining that age;
 - ii. he is in a fit state of health to be transported; and
 - iii. has no close ties in the territory in which he is resident.
- (b) The Contracting Parties agree not to have recourse to repatriation except in the greatest moderation and then only where there is no objection on humanitarian grounds.
- (c) In the same spirit, the Contracting Parties agree that, if they repatriate an assisted person, facilities should be offered to the spouse and children, if any, to accompany the person concerned.

(...)

Section III – Residence

Article 11

- (a) Residence by an alien in the territory of any of the Contracting Parties shall be considered lawful within the meaning of this Convention so long as there is in force in his case a permit or such other permission as is required by the laws and regulations of the country concerned to reside therein. Failure to renew any such permit, if due solely to the inadvertence of the person concerned shall not cause him to cease to be entitled to assistance.
- (b) Lawful residence shall become unlawful from the date of any deportation order made out against the person concerned, unless a stay of execution is granted²²³.

²²³Article 11 b of the European Convention on Social and Medical Assistance suggests that until the date lawful residence becomes unlawful following a deportation order, a person may qualify for the benefit of the Convention. Thus, it accepts that at least some irregular migrants can be entitled to social protection as long as they are tolerated on the national territory. See Council of Europe, Committee of Experts on Standard-Setting Instruments in the Field of Social Security (CS-CO), 6th Meeting, Limassol, 25-26 May 2004, *Exploratory Report on the Access to Social Protection for Illegal Labour Migrants*, prepared by P. Schoukens and D. Pieters, Doc. CS-CO (2004) 3rev (Strasbourg, 30 June 2004), p. 26.

26. Protocol to the European Convention on Social and Medical Assistance (excerpt)²²⁴

(...)

Article 3

1. The provisions of Section II of the Assistance Convention shall not apply to refugees.
2. In the case of a person who has ceased to qualify for the benefits of the Geneva Convention in accordance with the provisions of paragraph C of Article 1 thereof, the period for repatriation laid down in Article 7. a.i of the Assistance Convention shall begin from the date when he has thus ceased to qualify.

²²⁴Source: ETS No. 14 – Social and Medical Assistance, 11.XII.1953.

27. European Convention on the Legal Status of Migrant Workers (excerpt)²²⁵

Adoption: 24 November 1977

Entry into force: 1 May 1983

(...)

Article 3 – Medical examinations and vocational test

1. Recruitment of prospective migrant workers may be preceded by a medical examination and a vocational test.
2. The medical examination and the vocational test are intended to establish whether the prospective migrant worker is physically and mentally fit and technically qualified for the job offered to him and to make certain that his state of health does not endanger public health.
3. Arrangements for the reimbursement of expenses connected with medical examination and vocational test shall be laid down when appropriate by bilateral agreements, so as to ensure that such expenses do not fall upon the prospective migrant worker.
4. A migrant worker to whom an individual offer of employment is made shall not be required, otherwise than on grounds of fraud, to undergo a vocational test except at the employer's request.

(...)

Article 19 – Social and Medical Assistance

Each Contracting Party undertakes to grant within its territory, to migrant workers and members of their families who are lawfully present in its territory, social and medical assistance on the same basis as nationals in accordance with the obligations it has assumed by virtue of other international agreements and in particular of the European Convention on Social and Medical Assistance of 1953.

²²⁵Source: ETS No. 93. This Convention only protects lawfully resident migrant workers.

**Article 20 – Industrial accidents and occupational diseases –
Industrial hygiene**

1. With regard to the prevention of industrial accidents and occupational diseases and to industrial hygiene, migrant workers shall enjoy the same rights and protection as national workers, in application of the laws of a Contracting Party and collective agreements and having regard to their particular situation.
2. A migrant worker who is victim of an industrial accident or who has contracted an occupational disease in the territory of the receiving State shall benefit from occupational rehabilitation on the same basis as national workers.

28. European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (excerpt) ²²⁶

Adoption: 26 November 1987

Entry into force: 1 February 1989

The member States of the Council of Europe, signatory hereto,

Having regard to the provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms,

Recalling that, under Article 3 of the same Convention, “no one shall be subjected to torture or to inhuman or degrading treatment or punishment”;

Noting that the machinery provided for in that Convention operates in relation to persons who allege that they are victims of violations of Article 3;

Convinced that the protection of persons deprived of their liberty against torture and inhuman or degrading treatment or punishment could be strengthened by non-judicial means of a preventive character based on visits,

Have agreed as follows:

Chapter I

Article 1

There shall be established a European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as “the Committee”). The Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment.

²²⁶Source: ETS No. 126. Text amended according to the provisions of Protocols No. 1 (ETS No. 151) and No. 2 (ETS No. 152), which entered into force on 1 March 2002. See the Explanatory Report prepared by the Steering Committee of Human Rights and submitted to the Committee of Ministers of the Council of Europe.

The Explanatory Report's observations on the provision of article 1 of the Convention

23. This article establishes the body which is to carry out the visits, and the purpose of the visits. In this way it describes the principal functions of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.
24. The notion of “deprivation of liberty” for the purposes of the present Convention is to be understood within the meaning of Article 5 of the European Convention on Human Rights, as elucidated by the case-law of the European Court and Commission of Human Rights. However, the distinction between “lawful” and “unlawful” deprivation of liberty arising in connection with Article 5 is immaterial in relation to the committee’s competence.
25. As already pointed out in paragraph 17, the committee shall not perform any judicial functions: its members will not have to be lawyers, its recommendations will not bind the State concerned and the committee shall not express any view on the interpretation of legal terms. Its task is a purely preventive one. It will carry out fact-finding visits and, if necessary, on the basis of information obtained through them, make recommendations with a view to strengthening the protection of persons deprived of their liberty from torture and from inhuman or degrading treatment or punishment.
26. The prohibition of torture and inhuman or degrading treatment or punishment is a general international standard which, albeit differently formulated, is found in various international instruments, such as Article 3 of the European Convention on Human Rights.
27. The case-law of the European Court and Commission of Human Rights on Article 3 provides a source of guidance for the committee. However, the committee’s activities are aimed at future prevention rather than

the application of legal requirements to existing circumstances. The committee should not seek to interfere in the interpretation and application of Article 3.

Article 2

Each Party shall permit visits, in accordance with this Convention, to any place within its jurisdiction where persons are deprived of their liberty by a public authority.

(...)

The Explanatory Report's observations on the provision of article 2 of the Convention

28. By this provision, Parties to the Convention agree to permit visits to any place within their jurisdiction where one or more persons are deprived of their liberty by a public authority. It is immaterial whether the deprivation is based on a formal decision or not.

29. Visits may take place in any circumstances. The Convention applies not only in peacetime, but also during war or any other public emergency. The committee's competence is, however, limited as regards the places it may visit by the provisions of Article 17, paragraph 3 (see *infra*, paragraph 93).

30. Visits may be organised in all kinds of places where persons are deprived of their liberty, whatever the reasons may be. The Convention is therefore applicable, for example, to places where persons are held in custody, are imprisoned as a result of conviction for an offence, are held in administrative detention, or are interned for medical reasons or where minors are detained by a public authority. Detention by military authorities is also covered by the Convention.

The CPT's mandate thus extends beyond prisons and police stations to encompass, for example, psychiatric institutions, detention areas at military barracks, holding centres for asylum seekers or other categories of foreigners, and places in which young persons may be deprived of their liberty by judicial or administrative order (see The CPT standards, page 5).

31. Visits to places where persons are deprived of their liberty because of their mental condition will require careful preparation and handling, for example as regards the qualifications and experience of those chosen for the visit and the manner in which the visit is conducted. In carrying out its visits, moreover, the committee will no doubt wish to have regard to any relevant recommendation adopted by the Committee of Ministers.
32. Visits may be carried out in private as well as public institutions. The criterion is whether the deprivation of liberty is the result of action by a public authority. Accordingly, the committee may carry out visits only in relation to persons who are deprived of their liberty by a public authority, and not voluntary patients. However, in the latter case, it should be possible for the committee to satisfy itself that this was indeed the wish of the patient concerned.

The Committee for the Prevention of Torture

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, usually referred to as the “Committee for the Prevention of Torture” (CPT), was established in accordance with Article 1 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

As its name implies, the CPT’s mandate involves the prevention of torture and inhuman or degrading treatment or punishment. Its work is an integral part of the Council of Europe’s system for the protection of human rights. In fact, the CPT is essentially a non-judicial machinery with a preventive character that supplements a judicial system receiving complaints from individuals or from states to the European Court of Human Rights alleging that human rights violations have taken place.

Through country visits to sites where persons are – or may be – deprived of their liberty by a public authority of a State bound by the Convention, the CPT assesses the conditions of detention and obtains information on current procedures and practices.

Places of detention include such places as immigration holding centers, psychiatric hospitals and homes for elderly or disabled persons, prisons, juvenile detention centers and police stations.

Visits by the CPT may be: *periodic* – the Committee visits States parties to the Convention according to schedules determined on an annual basis - or *ad hoc* – conducted in States whenever the Committee deems such visits “to be required in the circumstances”.

The CPT’s findings from visits are set out in confidential reports sent to the governments concerned. These reports, together with the responses of the governments, may be published with the latter’s agreement.

The Committee's function is therefore to cooperate with States and, through its recommendations, encourage improvements in the protection of persons deprived of their liberty.

With a view to guaranteeing a multidisciplinary approach to the CPT's work, the Committee's members, who are elected for a four-year term by the Committee of Ministers and can be re-elected twice, belong to a variety of backgrounds: lawyers, medical doctors, psychologists, specialists in prison and police matters, etc.

The CPT draws up each year a General Report on its activities. Some of the substantive issues the Committee pursues during its visits to places of deprivation of liberty are set out in these General Reports.

See below extracts from a document which collects substantive sessions of CPT's General Reports referring to the right to health in places of detention

29. The Committee for the Prevention of Torture Standards - “substantive” sections of the Committee for the Prevention of Torture’s General Reports (extracts)²²⁷

(...)

I. Police custody

Extract from the 2nd General Report [CPT/Inf (92) 3]

36. The CPT attaches particular importance to three rights for persons detained by the police: the right of the person concerned to have the fact of his detention notified to a third party of his choice (family member, friend, consulate), the right of access to a lawyer, and the right to request a medical examination by a doctor of his choice (in addition to any medical examination carried out by a doctor called by the police authorities)²²⁸ They are, in the CPT’s opinion, three fundamental safeguards against the ill-treatment of detained persons which should apply as from the very outset of deprivation of liberty, regardless of how it may be described under the legal system concerned (apprehension, arrest, etc).
37. Persons taken into police custody should be expressly informed without delay of all their rights, including those referred to in paragraph 36.

(...)

Extract from the 12th General Report [CPT/Inf (2002) 15]

(...)

42. Persons in police custody should have a formally recognised right of **access to a doctor**. In other words, a doctor should always be called without delay if a person requests a medical examination; police officers should not seek to filter such requests. Further, the right of access to a doctor should include the right of a person in custody to be

²²⁷Source: CPT/Inf/E (2002) 1, Rev. 2006. The document is available at: <http://www.cpt.coe.int/EN/docsstandards.htm>.

²²⁸This right has subsequently been reformulated as follows: the right of access to a doctor, including the right to be examined, if the person detained so wishes, by a doctor of his own choice (in addition to any medical examination carried out by a doctor called by the police authorities), *CPT standards*, p. 5.

examined, if the person concerned so wishes, by a doctor of his/her own choice (in addition to any medical examination carried out by a doctor called by the police).

All medical examinations of persons in police custody must be conducted out of the hearing of law enforcement officials and, unless the doctor concerned requests otherwise in a particular case, out of the sight of such officials.

It is also important that persons who are released from police custody without being brought before a judge have the right to directly request a medical examination/certificate from a recognised forensic doctor.

(...)

II. Imprisonment

(...)

Extract from the 11th General Report [CPT/Inf (2001) 16]

(...)

Prison overcrowding

28. The phenomenon of prison overcrowding continues to blight penitentiary systems across Europe and seriously undermines attempts to improve conditions of detention. (...)

(...)

Large capacity dormitories

29. In a number of countries visited by the CPT, particularly in central and eastern Europe, inmate accommodation often consists of large capacity dormitories which contain all or most of the facilities used by prisoners on a daily basis, such as sleeping and living areas as well as sanitary facilities. The CPT has objections to the very principle of such accommodation arrangements in closed prisons and those objections are reinforced when, as is frequently the case, the dormitories in question are found to hold prisoners under extremely cramped and insalubrious conditions. No doubt, various factors - including those

of a cultural nature - can make it preferable in certain countries to provide multi-occupancy accommodation for prisoners rather than individual cells. However, there is little to be said in favour of - and a lot to be said against - arrangements under which tens of prisoners live and sleep together in the same dormitory.

(...)

With such accommodation, the appropriate allocation of individual prisoners, based on a case by case risk and needs assessment, also becomes an almost impossible exercise. All these problems are exacerbated when the numbers held go beyond a reasonable occupancy level; further, in such a situation the excessive burden on communal facilities such as washbasins or lavatories and the insufficient ventilation for so many persons will often lead to deplorable conditions.

(...)

Access to natural light and fresh air

30. The CPT frequently encounters devices, such as metal shutters, slats, or plates fitted to cell windows, which deprive prisoners of access to natural light and prevent fresh air from entering the accommodation. They are a particularly common feature of establishments holding pre-trial prisoners. The CPT fully accepts that specific security measures designed to prevent the risk of collusion and/or criminal activities may well be required in respect of certain prisoners. However, the imposition of measures of this kind should be the exception rather than the rule. This implies that the relevant authorities must examine the case of each prisoner in order to ascertain whether specific security measures are really justified in his/her case. Further, even when such measures are required, they should never involve depriving the prisoners concerned of natural light and fresh air. The latter are basic elements of life which every prisoner is entitled to enjoy; moreover, the absence of these elements generates conditions favourable to the spread of diseases and in particular tuberculosis.

(...)

Transmissible diseases

31. The spread of transmissible diseases and, in particular, of tuberculosis, hepatitis and HIV/AIDS has become a major public health concern in a number of European countries. Although affecting the population at large, these diseases have emerged as a dramatic problem in certain prison systems. In this connection the CPT has, on a number of occasions, been obliged to express serious concerns about the inadequacy of the measures taken to tackle this problem. Further, material conditions under which prisoners are held have often been found to be such that they can only favour the spread of these diseases.

The CPT is aware that in periods of economic difficulties - such as those encountered today in many countries visited by the CPT - sacrifices have to be made, including in penitentiary establishments. However, regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment. Compliance with this duty by public authorities is all the more important when it is a question of care required to treat life-threatening diseases.

The use of up-to date methods for screening, the regular supply of medication and related materials, the availability of staff ensuring that prisoners take the prescribed medicines in the right doses and at the right intervals, and the provision when appropriate of special diets, constitute essential elements of an effective strategy to combat the above-mentioned diseases and to provide appropriate care to the prisoners concerned. Similarly, material conditions in accommodation for prisoners with transmissible diseases must be conducive to the improvement of their health; in addition to natural light and good ventilation, there must be satisfactory hygiene as well as an absence of overcrowding.

Further, the prisoners concerned should not be segregated from the rest of the prison population unless this is strictly necessary on medical or other grounds. In this connection, the CPT wishes to stress in particular that there is no medical justification for the segregation of prisoners solely on the grounds that they are HIV-positive.

In order to dispel misconceptions on these matters, it is incumbent on national authorities to ensure that there is a full educational programme about transmissible diseases for both prisoners and prison staff. Such a programme should address methods of transmission and means of protection as well as the application of adequate preventive measures. More particularly, the risks of HIV or hepatitis B/C infection through sexual contacts and intravenous drug use should be highlighted and the role of body fluids as the carriers of HIV and hepatitis viruses explained.

It must also be stressed that appropriate information and counselling should be provided before and - in the case of a positive result - after any screening test. Further, it is axiomatic that patient-related information should be protected by medical confidentiality. As a matter of principle, any interventions in this area should be based on the informed consent of the persons concerned.

Moreover, for control of the above-mentioned diseases to be effective, all the ministries and agencies working in this field in a given country must ensure that they co-ordinate their efforts in the best possible way. In this respect the CPT wishes to stress that the continuation of treatment after release from prison must be guaranteed²²⁹.

(...)

Life-sentenced and other long-term prisoners

33.(...)

Long-term imprisonment can have a number of desocialising effects upon inmates. In addition to becoming institutionalised, long-term prisoners may experience a range of psychological problems (including loss of self-esteem and impairment of social skills) and have a tendency to become increasingly detached from society; to which almost all of them will eventually return. In the view of the CPT, the regimes which are offered to prisoners serving long sentences should seek to compensate for these effects in a positive and proactive way.

(...)

²²⁹See also “Health care services in prisons”, section “transmittable diseases”.

III. Health care services in prisons

Extract from the 3rd General Report [CPT/Inf (93) 12]

30. Health care services for persons deprived of their liberty is a subject of direct relevance to the CPT's mandate²³⁰. An inadequate level of health care can lead rapidly to situations falling within the scope of the term "inhuman and degrading treatment". Further, the health care service in a given establishment can potentially play an important role in combatting the infliction of ill-treatment, both in that establishment and elsewhere (in particular in police establishments). Moreover, it is well placed to make a positive impact on the overall quality of life in the establishment within which it operates.
31. In the following paragraphs, some of the main issues pursued by CPT delegations when examining health care services within prisons are described. However, at the outset the CPT wishes to make clear the importance which it attaches to the general principle - already recognised in most, if not all, of the countries visited by the Committee to date - that prisoners are entitled to the same level of medical care as persons living in the community at large. This principle is inherent in the fundamental rights of the individual.
32. The considerations which have guided the CPT during its visits to prison health care services can be set out under the following headings:
 - a. Access to a doctor
 - b. Equivalence of care
 - c. Patient's consent and confidentiality
 - d. Preventive health care
 - e. Humanitarian assistance
 - f. Professional independence
 - g. Professional competence.

²³⁰Reference should also be made to Recommendation No. R (98) 7 concerning the ethical and organisational aspects of health care in prison, adopted by the Committee of Ministers of the Council of Europe on 8 April 1998.

a. Access to a doctor

33. When entering prison, all prisoners should without delay be seen by a member of the establishment's health care service. In its reports to date the CPT has recommended that every newly arrived prisoner be properly interviewed and, if necessary, physically examined by a medical doctor as soon as possible after his admission. It should be added that in some countries, medical screening on arrival is carried out by a fully qualified nurse, who reports to a doctor. This latter approach could be considered as a more efficient use of available resources²³¹.

It is also desirable that a leaflet or booklet be handed to prisoners on their arrival, informing them of the existence and operation of the health care service and reminding them of basic measures of hygiene.

34. While in custody, prisoners should be able to have access to a doctor at any time, irrespective of their detention regime (as regards more particularly access to a doctor for prisoners held in solitary confinement, see paragraph 56 of the CPT's 2nd General Report: CPT/Inf (92) 3). The health care service should be so organised as to enable requests to consult a doctor to be met without undue delay.

Prisoners should be able to approach the health care service on a confidential basis, for example, by means of a message in a sealed envelope. Further, prison officers should not seek to screen requests to consult a doctor.

35. A prison's health care service should at least be able to provide regular out-patient consultations and emergency treatment (of course, in addition there may often be a hospital-type unit with beds). The services of a qualified dentist should be available to every prisoner. Further, prison doctors should be able to call upon the services of specialists.

As regards emergency treatment, a doctor should always be on call. Further, someone competent to provide first aid should always be present on prison premises, preferably someone with a recognised nursing qualification.

²³¹This requirement has subsequently been reformulated as follows: every newly-arrived prisoner should be properly interviewed and physically examined by a medical doctor as soon as possible after his admission; save for in exceptional circumstances, that interview/examination should be carried out on the day of admission, especially insofar as remand establishments are concerned. Such medical screening on admission could also be performed by a fully qualified nurse reporting to a doctor.

Out-patient treatment should be supervised, as appropriate, by health care staff; in many cases it is not sufficient for the provision of follow-up care to depend upon the initiative being taken by the prisoner.

36. The direct support of a fully-equipped hospital service should be available, in either a civil or prison hospital.

If recourse is had to a civil hospital, the question of security arrangements will arise. In this respect, the CPT wishes to stress that prisoners sent to hospital to receive treatment should not be physically attached to their hospital beds or other items of furniture for custodial reasons. Other means of meeting security needs satisfactorily can and should be found; the creation of a custodial unit in such hospitals is one possible solution.

37. Whenever prisoners need to be hospitalised or examined by a specialist in a hospital, they should be transported with the promptness and in the manner required by their state of health.

b. Equivalence of care

i) general medicine

38. A prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community. Provision in terms of medical, nursing and technical staff, as well as premises, installations and equipment, should be geared accordingly.

There should be appropriate supervision of the pharmacy and of the distribution of medicines. Further, the preparation of medicines should always be entrusted to qualified staff (pharmacist/nurse, etc.).

39. A medical file should be compiled for each patient, containing diagnostic information as well as an ongoing record of the patient's evolution and of any special examinations he has undergone. In the event of a transfer, the file should be forwarded to the doctors in the receiving establishment.

Further, daily registers should be kept by health care teams, in which particular incidents relating to the patients should be mentioned. Such registers are useful in that they provide an overall view of the health

care situation in the prison, at the same time as highlighting specific problems which may arise.

40. The smooth operation of a health care service presupposes that doctors and nursing staff are able to meet regularly and to form a working team under the authority of a senior doctor in charge of the service.

ii) psychiatric care

41. In comparison with the general population, there is a high incidence of psychiatric symptoms among prisoners. Consequently, a doctor qualified in psychiatry should be attached to the health care service of each prison, and some of the nurses employed there should have had training in this field.

The provision of medical and nursing staff, as well as the layout of prisons, should be such as to enable regular pharmacological, psychotherapeutic and occupational therapy programmes to be carried out.

42. The CPT wishes to stress the role to be played by prison management in the early detection of prisoners suffering from a psychiatric ailment (e.g. depression, reactive state, etc.), with a view to enabling appropriate adjustments to be made to their environment. This activity can be encouraged by the provision of appropriate health training for certain members of the custodial staff.
43. A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system.

On the one hand, it is often advanced that, from an ethical standpoint, it is appropriate for mentally ill prisoners to be hospitalised outside the prison system, in institutions for which the public health service is responsible. On the other hand, it can be argued that the provision of psychiatric facilities within the prison system enables care to be administered in optimum conditions of security, and the activities of medical and social services intensified within that system.

Whichever course is chosen, the accommodation capacity of the psychiatric facility in question should be adequate; too often there is a prolonged waiting period before a necessary transfer is effected.

The transfer of the person concerned to a psychiatric facility should be treated as a matter of the highest priority.

44. A mentally disturbed and violent patient should be treated through close supervision and nursing support, combined, if considered appropriate, with sedatives. Resort to instruments of physical restraint shall only very rarely be justified and must always be either expressly ordered by a medical doctor or immediately brought to the attention of such a doctor with a view to seeking his approval. Instruments of physical restraint should be removed at the earliest possible opportunity. They should never be applied, or their application prolonged, as a punishment.

In the event of resort being had to instruments of physical restraint, an entry should be made in both the patient's file and an appropriate register, with an indication of the times at which the measure began and ended, as well as of the circumstances of the case and the reasons for resorting to such means.

c. Patient's consent and confidentiality

45. Freedom of consent and respect for confidentiality are fundamental rights of the individual. They are also essential to the atmosphere of trust which is a necessary part of the doctor/patient relationship, especially in prisons, where a prisoner cannot freely choose his own doctor.

i) patient's consent

46. Patients should be provided with all relevant information (if necessary in the form of a medical report) concerning their condition, the course of their treatment and the medication prescribed for them. Preferably, patients should have the right to consult the contents of their prison medical files, unless this is inadvisable from a therapeutic standpoint.

They should be able to ask for this information to be communicated to their families and lawyers or to an outside doctor.

47. Every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and

strictly defined exceptional circumstances which are applicable to the population as a whole.

A classically difficult situation arises when the patient's decision conflicts with the general duty of care incumbent on the doctor. This might happen when the patient is influenced by personal beliefs (eg. refusal of a blood transfusion) or when he is intent on using his body, or even mutilating himself, in order to press his demands, protest against an authority or demonstrate his support for a cause.

In the event of a hunger strike, public authorities or professional organisations in some countries will require the doctor to intervene to prevent death as soon as the patient's consciousness becomes seriously impaired. In other countries, the rule is to leave clinical decisions to the doctor in charge, after he has sought advice and weighed up all the relevant facts.

48. As regards the issue of medical research with prisoners, it is clear that a very cautious approach must be followed, given the risk of prisoners' agreement to participate being influenced by their penal situation. Safeguards should exist to ensure that any prisoner concerned has given his free and informed consent.

The rules applied should be those prevailing in the community, with the intervention of a board of ethics. The CPT would add that it favours research concerning custodial pathology or epidemiology or other aspects specific to the condition of prisoners.

49. The involvement of prisoners in the teaching programmes of students should require the prisoners' consent.

ii) confidentiality

50. Medical secrecy should be observed in prisons in the same way as in the community. Keeping patients' files should be the doctor's responsibility.
51. All medical examinations of prisoners (whether on arrival or at a later stage) should be conducted out of the hearing and - unless the doctor concerned requests otherwise - out of the sight of prison officers. Further, prisoners should be examined on an individual basis, not in groups.

d. Preventive health care

52. The task of prison health care services should not be limited to treating sick patients. They should also be entrusted with responsibility for social and preventive medicine.

i) hygiene

53. It lies with prison health care services - as appropriate acting in conjunction with other authorities - to supervise catering arrangements (quantity, quality, preparation and distribution of food) and conditions of hygiene (cleanliness of clothing and bedding; access to running water; sanitary installations) as well as the heating, lighting and ventilation of cells. Work and outdoor exercise arrangements should also be taken into consideration.

Insalubrity, overcrowding, prolonged isolation and inactivity may necessitate either medical assistance for an individual prisoner or general medical action vis-à-vis the responsible authority.

ii) transmittable diseases²³²

54. A prison health care service should ensure that information about transmittable diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to prisoners and to prison staff. Where appropriate, medical control of those with whom a particular prisoner has regular contact (fellow prisoners, prison staff, frequent visitors) should be carried out.

55. As regards more particularly AIDS, appropriate counselling should be provided both before and, if necessary, after any screening test. Prison staff should be provided with ongoing training in the preventive measures to be taken and the attitudes to be adopted regarding HIV-positivity and given appropriate instructions concerning non-discrimination and confidentiality.

56. The CPT wishes to emphasise that there is no medical justification for the segregation of an HIV+ prisoner who is well²³³.

²³²See also "Imprisonment", section "transmissible diseases".

²³³Subsequently reformulated as follows: there is no medical justification for the segregation of a prisoner solely on the grounds that he is HIV positive.

iii) suicide prevention

57. Suicide prevention is another matter falling within the purview of a prison's health care service. It should ensure that there is an adequate awareness of this subject throughout the establishment, and that appropriate procedures are in place.
58. Medical screening on arrival, and the reception process as a whole, has an important role to play in this context; performed properly, it could identify at least certain of those at risk and relieve some of the anxiety experienced by all newly-arrived prisoners.

Further, prison staff, whatever their particular job, should be made aware of (which implies being trained in recognising) indications of suicidal risk. In this connection it should be noted that the periods immediately before and after trial and, in some cases, the pre-release period, involve an increased risk of suicide.

59. A person identified as a suicide risk should, for as long as necessary, be kept under a special observation scheme. Further, such persons should not have easy access to means of killing themselves (cell window bars, broken glass, belts or ties, etc).

Steps should also be taken to ensure a proper flow of information - both within a given establishment and, as appropriate, between establishments (and more specifically between their respective health care services) - about persons who have been identified as potentially at risk.

iv) prevention of violence

60. Prison health care services can contribute to the prevention of violence against detained persons, through the systematic recording of injuries and, if appropriate, the provision of general information to the relevant authorities. Information could also be forwarded on specific cases, though as a rule such action should only be undertaken with the consent of the prisoners concerned.
61. Any signs of violence observed when a prisoner is medically screened on his admission to the establishment should be fully recorded, together with any relevant statements by the prisoner and the doctor's conclusions. Further, this information should be made available to the prisoner.

The same approach should be followed whenever a prisoner is medically examined following a violent episode within the prison (see also paragraph 53 of the CPT's 2nd General report: CPT/Inf (92) 3) or on his readmission to prison after having been temporarily returned to police custody for the purposes of an investigation.

62. The health care service could compile periodic statistics concerning injuries observed, for the attention of prison management, the Ministry of Justice, etc.

v) social and family ties

63. The health care service may also help to limit the disruption of social and family ties which usually goes hand in hand with imprisonment. It should support - in association with the relevant social services - measures that foster prisoners' contacts with the outside world, such as properly-equipped visiting areas, family or spouse/partner visits under appropriate conditions, and leaves in family, occupational, educational and socio-cultural contexts.

According to the circumstances, a prison doctor may take action in order to obtain the grant or continued payment of social insurance benefits to prisoners and their families.

e. Humanitarian assistance

64. Certain specific categories of particularly vulnerable prisoners can be identified. Prison health care services should pay especial attention to their needs.

i) mother and child

65. It is a generally accepted principle that children should not be born in prison, and the CPT's experience is that this principle is respected.
66. A mother and child should be allowed to stay together for at least a certain period of time. If the mother and child are together in prison, they should be placed in conditions providing them with the equivalent of a creche and the support of staff specialised in post-natal care and nursery nursing.

Long-term arrangements, in particular the transfer of the child to the community, involving its separation from its mother, should be

decided on in each individual case in the light of pedo-psychiatric and medico-social opinions.

ii) adolescents

67. Adolescence is a period marked by a certain reorganisation of the personality, requiring a special effort to reduce the risks of long-term social maladjustment.

While in custody, adolescents should be allowed to stay in a fixed place, surrounded by personal objects and in socially favourable groups. The regime applied to them should be based on intensive activity, including socio-educational meetings, sport, education, vocational training, escorted outings and the availability of appropriate optional activities.

iii) prisoners with personality disorders

68. Among the patients of a prison health care service there is always a certain proportion of unbalanced, marginal individuals who have a history of family traumas, long-standing drug addiction, conflicts with authority or other social misfortunes. They may be violent, suicidal or characterised by unacceptable sexual behaviour, and are for most of the time incapable of controlling or caring for themselves.
69. The needs of these prisoners are not truly medical, but the prison doctor can promote the development of socio-therapeutic programmes for them, in prison units which are organised along community lines and carefully supervised.

Such units can reduce the prisoners' humiliation, self-contempt and hatred, give them a sense of responsibility and prepare them for reintegration. Another direct advantage of programmes of this type is that they involve the active participation and commitment of the prison staff.

iv) prisoners unsuited for continued detention

70. Typical examples of this kind of prisoner are those who are the subject of a short-term fatal prognosis, who are suffering from a serious disease which cannot be properly treated in prison conditions, who are severely handicapped or of advanced age. The continued detention

of such persons in a prison environment can create an intolerable situation. In cases of this type, it lies with the prison doctor to draw up a report for the responsible authority, with a view to suitable alternative arrangements being made.

f. Professional independence

71. The health-care staff in any prison is potentially a staff at risk. Their duty to care for their patients (sick prisoners) may often enter into conflict with considerations of prison management and security. This can give rise to difficult ethical questions and choices. In order to guarantee their independence in health-care matters, the CPT considers it important that such personnel should be aligned as closely as possible with the mainstream of health-care provision in the community at large.
72. Whatever the formal position under which a prison doctor carries on his activity, his clinical decisions should be governed only by medical criteria.

The quality and the effectiveness of medical work should be assessed by a qualified medical authority. Likewise, the available resources should be managed by such an authority, not by bodies responsible for security or administration.

73. A prison doctor acts as a patient's personal doctor. Consequently, in the interests of safeguarding the doctor/patient relationship, he should not be asked to certify that a prisoner is fit to undergo punishment. Nor should he carry out any body searches or examinations requested by an authority, except in an emergency when no other doctor can be called in.
74. It should also be noted that a prison doctor's professional freedom is limited by the prison situation itself: he cannot freely choose his patients, as the prisoners have no other medical option at their disposal. His professional duty still exists even if the patient breaks the medical rules or resorts to threats or violence.

g. Professional competence

75. Prison doctors and nurses should possess specialist knowledge enabling them to deal with the particular forms of prison pathology and adapt their treatment methods to the conditions imposed by detention.

In particular, professional attitudes designed to prevent violence - and, where appropriate, control it - should be developed.

76. To ensure the presence of an adequate number of staff, nurses are frequently assisted by medical orderlies, some of whom are recruited from among the prison officers. At the various levels, the necessary experience should be passed on by the qualified staff and periodically updated.

Sometimes prisoners themselves are allowed to act as medical orderlies. No doubt, such an approach can have the advantage of providing a certain number of prisoners with a useful job. Nevertheless, it should be seen as a last resort. Further, prisoners should never be involved in the distribution of medicines.

77. Finally, the CPT would suggest that the specific features of the provision of health care in a prison environment may justify the introduction of a recognised professional speciality, both for doctors and for nurses, on the basis of postgraduate training and regular in-service training.

IV. Foreign nationals detained under aliens legislation

Extract from the 7th General Report [CPT/Inf (97) 10]

A. Preliminary remarks

24. CPT visiting delegations frequently encounter foreign nationals deprived of their liberty under aliens legislation (hereafter “immigration detainees”): persons refused entry to the country concerned; persons who have entered the country illegally and have subsequently been identified by the authorities; persons whose authorisation to stay in the country has expired; asylum-seekers whose detention is considered necessary by the authorities; etc.

In the following paragraphs, some of the main issues pursued by the CPT in relation to such persons are described. The CPT hopes in this way to give a clear advance indication to national authorities of its views concerning the treatment of immigration detainees and, more generally, to stimulate discussion in relation to this category of persons deprived of their liberty. The Committee would welcome comments on this section of its General Report.

B. Detention facilities

25. CPT visiting delegations have met immigration detainees in a variety of custodial settings, ranging from holding facilities at points of entry to police stations, prisons and specialised detention centres. As regards more particularly transit and “international” zones at airports, the precise legal position of persons refused entry to a country and placed in such zones has been the subject of some controversy. On more than one occasion, the CPT has been confronted with the argument that such persons are not “deprived of their liberty” as they are free to leave the zone at any moment by taking any international flight of their choice.

For its part, the CPT has always maintained that a stay in a transit or “international” zone can, depending on the circumstances, amount to a deprivation of liberty within the meaning of Article 5 (1)(f) of the European Convention on Human Rights, and that consequently such zones fall within the Committee’s mandate. The judgement delivered on 25 June 1996 by the European Court of Human Rights in the case of *Amuur against France*²³⁴ can be considered as vindicating this view. In that case, which concerned four asylum seekers held in the transit zone at Paris-Orly Airport for 20 days, the Court stated that “The mere fact that it is possible for asylum seekers to leave voluntarily the country where they wish to take refuge cannot exclude a restriction (“atteinte”) on liberty” and held that “holding the applicants in the transit zone was equivalent in practice, in view of the restrictions suffered, to a deprivation of liberty”.

26. **Point of entry holding facilities** have often been found to be inadequate, in particular for extended stays. More specifically, CPT delegations have on several occasions met persons held for days under makeshift conditions in airport lounges. It is axiomatic that such persons should be provided with suitable means for sleeping, granted access to their luggage and to suitably-equipped sanitary and washing facilities, and allowed to exercise in the open air on a daily basis. Further, access to food and, if necessary, medical care should be guaranteed.

²³⁴Case of *Amuur v France* is available at the European Court of Human Rights Portal: <http://cmiskp.echr.coe.int/tkp197/portal.asp?sessionId=7751826&skin=hudoc-en&action=request>. A summary of this case is available at: <http://sim.law.uu.nl/SIM/CaseLaw/hof.nsf/0/0485002b3f14cb33c1256640004c2f74?OpenDocument>.

27. In certain countries, CPT delegations have found immigration detainees held in **police stations** for prolonged periods (for weeks and, in certain cases, months), subject to mediocre material conditions of detention, deprived of any form of activity and on occasion obliged to share cells with criminal suspects. Such a situation is indefensible.

The CPT recognises that, in the very nature of things, immigration detainees may have to spend some time in an ordinary police detention facility. However, conditions in police stations will frequently - if not invariably - be inadequate for prolonged periods of detention. Consequently, the period of time spent by immigration detainees in such establishments should be kept to the absolute minimum.

28. On occasion, CPT delegations have found immigration detainees held in **prisons**. Even if the actual conditions of detention for these persons in the establishments concerned are adequate -which has not always been the case - the CPT considers such an approach to be fundamentally flawed. A prison is by definition not a suitable place in which to detain someone who is neither convicted nor suspected of a criminal offence.

Admittedly, in certain exceptional cases, it might be appropriate to hold an immigration detainee in a prison, because of a known potential for violence. Further, an immigration detainee in need of in-patient treatment might have to be accommodated temporarily in a prison health-care facility, in the event of no other secure hospital facility being available. However, such detainees should be held quite separately from prisoners, whether on remand or convicted.

29. In the view of the CPT, in those cases where it is deemed necessary to deprive persons of their liberty for an extended period under aliens legislation, they should be accommodated **in centres specifically designed for that purpose**, offering material conditions and a regime appropriate to their legal situation and staffed by suitably-qualified personnel. The Committee is pleased to note that such an approach is increasingly being followed in Parties to the Convention.

Obviously, such centres should provide accommodation which is adequately-furnished, clean and in a good state of repair, and which offers sufficient living space for the numbers involved. Further, care should be taken in the design and layout of the premises to avoid as far as possible any impression of a carceral environment. As regards regime activities, they should include outdoor exercise, access to a

day room and to radio/television and newspapers/magazines, as well as other appropriate means of recreation (e.g. board games, table tennis). The longer the period for which persons are detained, the more developed should be the activities which are offered to them.

The staff of centres for immigration detainees have a particularly onerous task. Firstly, there will inevitably be communication difficulties caused by language barriers. Secondly, many detained persons will find the fact that they have been deprived of their liberty when they are not suspected of any criminal offence difficult to accept. Thirdly, there is a risk of tension between detainees of different nationalities or ethnic groups. Consequently, the CPT places a premium upon the supervisory staff in such centres being carefully selected and receiving appropriate training. As well as possessing well-developed qualities in the field of interpersonal communication, the staff concerned should be familiarised with the different cultures of the detainees and at least some of them should have relevant language skills. Further, they should be taught to recognise possible symptoms of stress reactions displayed by detained persons (whether post-traumatic or induced by socio-cultural changes) and to take appropriate action.

C. Safeguards during detention

30. Immigration detainees should - in the same way as other categories of persons deprived of their liberty - be entitled, as from the outset of their detention, to inform a person of their choice of their situation and to have access to a lawyer and a doctor. Further, they should be expressly informed, without delay and in a language they understand, of all their rights and of the procedure applicable to them.

The CPT has observed that these requirements are met in some countries, but not in others. In particular, visiting delegations have on many occasions met immigration detainees who manifestly had not been fully informed in a language they understood of their legal position. In order to overcome such difficulties, immigration detainees should be systematically provided with a document explaining the procedure applicable to them and setting out their rights. This document should be available in the languages most commonly spoken by those concerned and, if necessary, recourse should be had to the services of an interpreter.

31. The right of access to a lawyer should apply throughout the detention period and include both the right to speak with the lawyer in private and to have him present during interviews with the authorities concerned.

All detention facilities for immigration detainees should provide access to medical care. Particular attention should be paid to the physical and psychological state of asylum seekers, some of whom may have been tortured or otherwise ill-treated in the countries from which they have come. The right of access to a doctor should include the right - if a detainee so wishes - to be examined by a doctor of his choice; however, the detainee might be expected to cover the cost of such a second examination.

More generally, immigration detainees should be entitled to maintain contact with the outside world during their detention, and in particular to have access to a telephone and to receive visits from relatives and representatives of relevant organisations.

D. Risk of ill-treatment after expulsion

32. The prohibition of torture and inhuman or degrading treatment or punishment englobes the obligation not to send a person to a country where there are substantial grounds for believing that he would run a real risk of being subjected to torture or ill-treatment. Whether Parties to the Convention are fulfilling this obligation is obviously a matter of considerable interest to the CPT. What is the precise role that the Committee should seek to play in relation to that question?
33. Any communications addressed to the CPT in Strasbourg by persons alleging that they are to be sent to a country where they run a risk of being subjected to torture or ill-treatment are immediately brought to the attention of the European Commission of Human Rights²³⁵. The Commission is better placed than the CPT to examine such allegations and, if appropriate, take preventive action.

If an immigration detainee (or any other person deprived of his liberty) interviewed in the course of a visit alleges that he is to be sent to a country where he runs a risk of being subjected to torture or ill-treatment, the CPT's visiting delegation will verify that this assertion has been brought to the attention of the relevant national authorities and is being given due consideration. Depending on the circumstances, the

²³⁵Since 1 November 1998: "European Court of Human Rights".

delegation might request to be kept informed of the detainee's position and/or inform the detainee of the possibility of raising the issue with the European Commission of Human Rights (and, in the latter case, verify that he is in a position to submit a petition to the Commission).

34. However, in view of the CPT's essentially preventive function, the Committee is inclined to focus its attention on the question of whether the decision-making process as a whole offers suitable guarantees against persons being sent to countries where they run a risk of torture or ill-treatment. In this connection, the CPT will wish to explore whether the applicable procedure offers the persons concerned a real opportunity to present their cases, and whether officials entrusted with handling such cases have been provided with appropriate training and have access to objective and independent information about the human rights situation in other countries. Further, in view of the potential gravity of the interests at stake, the Committee considers that a decision involving the removal of a person from a State's territory should be appealable before another body of an independent nature prior to its implementation.

E. Means of coercion in the context of expulsion procedures

35. Finally, the CPT must point out that it has received disturbing reports from several countries about the means of coercion employed in the course of expelling immigration detainees. Those reports have contained in particular allegations of beating, binding and gagging, and the administration of tranquillizers against the will of the persons concerned.
36. The CPT recognises that it will often be a difficult task to enforce an expulsion order in respect of a foreign national who is determined to stay on a State's territory. Law enforcement officials may on occasion have to use force in order to effect such a removal. However, the force used should be no more than is reasonably necessary. It would, in particular, be entirely unacceptable for persons subject to an expulsion order to be physically assaulted as a form of persuasion to board a means of transport or as punishment for not having done so. Further, the Committee must emphasise that to gag a person is a highly dangerous measure.

The CPT also wishes to stress that any provision of medication to persons subject to an expulsion order must only be done on the basis of a medical decision and in accordance with medical ethics.

Deportation of foreign nationals by air

Extract from the 13th General Report [CPT/Inf (2003) 35]

(...)

34. The question of the use of force and means of restraint arises from the moment the detainee concerned is taken out of the cell in which he/she is being held pending deportation (whether that cell is located on airport premises, in a holding facility, in a prison or a police station). The techniques used by escort personnel to immobilise the person to whom means of physical restraint – such as steel handcuffs or plastic strips – are to be applied deserve special attention. In most cases, the detainee will be in full possession of his/her physical faculties and able to resist handcuffing violently. In cases where resistance is encountered, escort staff usually immobilise the detainee completely on the ground, face down, in order to put on the handcuffs. Keeping a detainee in such a position, in particular with escort staff putting their weight on various parts of the body (pressure on the ribcage, knees on the back, immobilisation of the neck) when the person concerned puts up a struggle, entails a risk of positional asphyxia²³⁶.

There is a similar risk when a deportee, having been placed on a seat in the aircraft, struggles and the escort staff, by applying force, oblige him/her to bend forward, head between the knees, thus strongly compressing the ribcage. In some countries, the use of force to make the person concerned bend double in this way in the passenger seat is, as a rule, prohibited, this method of immobilisation being permitted only if it is absolutely indispensable in order to carry out a specific, brief, authorised operation, such as putting on, checking or taking off handcuffs, and only for the duration strictly necessary for this purpose.

The CPT has made it clear that **the use of force and/or means of restraint capable of causing positional asphyxia should be avoided whenever possible and that any such use in exceptional circumstances must be the subject of guidelines designed to reduce to a minimum the risks to the health of the person concerned.**

²³⁶See, in particular, *Positional Asphyxia – Sudden Death*, US Department of Justice, June 1995, and the proceedings of the Safer Restraint Conference held in London in April 2002 under the aegis of the UK Police Complaints Authority (cf. www.pca.gov.uk).

35. The CPT has noted with interest the directives in force in certain countries, according to which means of restraint must be removed during the flight (as soon as take-off has been completed). If, exceptionally, the means of restraint had to be left in place, because the deportee continued to act aggressively, the escort staff were instructed to cover the foreigner's limbs with a blanket (such as that normally issued to passengers), so as to conceal the means of restraint from other passengers.

On the other hand, instructions such as those followed until recently in one of the countries visited in connection with the most problematic deportation operations, whereby the persons concerned were made to wear nappies and prevented from using the toilet throughout the flight on account of their presumed dangerousness, can only lead to a degrading situation.

36. In addition to the avoidance of the risks of positional asphyxia referred to above, the CPT has systematically recommended **an absolute ban on the use of means likely to obstruct the airways (nose and/or mouth) partially or wholly**. Serious incidents that have occurred in various countries over the last ten years in the course of deportations have highlighted the considerable risk to the lives of the persons concerned of using these methods (gagging the mouth and/or nose with adhesive tape, putting a cushion or padded glove on the face, pushing the face against the back of the seat in front, etc.). The CPT drew the attention of States Parties to the Convention to the dangers of methods of this kind as far back as 1997, in its 7th General Report. It notes that this practice is now expressly prohibited in many States Parties and **invites States which have not already done so to introduce binding provisions in this respect without further delay**.
37. It is essential that, in the event of a flight emergency while the plane is airborne, the rescue of the person being deported is not impeded. Consequently, **it must be possible to remove immediately any means restricting the freedom of movement of the deportee, upon an order from the crew**.

Account should also be taken of the health risks connected with the so-called "economy-class syndrome" in the case of persons who are confined to their seats for long periods²³⁷.

²³⁷See, in particular, "Frequency and prevention of symptomless deep-vein thrombosis

38. Two particular points were of concern to the CPT after visits to certain countries: the wearing of masks by deportation escorts and the use, by the latter, of incapacitating or irritant gases to remove immigration detainees from their cells in order to transfer them to the aircraft.

In the CPT's opinion, **security considerations can never serve to justify escort staff wearing masks during deportation operations.** This practice is highly undesirable, since it could make it very difficult to ascertain who is responsible in the event of allegations of ill-treatment.

The CPT also has very serious reservations about the use of incapacitating or irritant gases to bring recalcitrant detainees under control in order to remove them from their cells and transfer them to the aircraft. The use of such gases in very confined spaces, such as cells, entails manifest risks to the health of both the detainee and the staff concerned. Staff should be trained in other control techniques (for instance, manual control techniques or the use of shields) to immobilise a recalcitrant detainee.

39. Certain incidents that have occurred during deportation operations have highlighted **the importance of allowing immigration detainees to undergo a medical examination before the decision to deport them is implemented.** This precaution is particularly necessary when the use of force and/or special measures is envisaged.

Similarly, **all persons who have been the subject of an abortive deportation operation must undergo a medical examination as soon as they are returned to detention** (whether in a police station, a prison or a holding facility specially designed for foreigners). In this way it will be possible to verify the state of health of the person concerned and, if necessary, establish a certificate attesting to any injuries. Such a measure could also protect escort staff against unfounded allegations.

40. During many visits, the CPT has heard allegations that immigration detainees had been injected with medication having a tranquillising or sedative effect, in order to ensure that their deportation proceeded without difficulty. On the other hand, it also noted in certain countries that instructions prohibited the administration, against the will of

in long-haul flights: a randomised trial", in J. Scurr *et al.*, *The Lancet*, 357, 12 May 2001.

the person concerned, of tranquillisers or other medication designed to bring him or her under control. **The CPT considers that the administration of medication to persons subject to a deportation order must always be carried out on the basis of a medical decision taken in respect of each particular case. Save for clearly and strictly defined exceptional circumstances, medication should only be administered with the informed consent of the person concerned.**

41. **Operations involving the deportation of immigration detainees must be preceded by measures to help the persons concerned organise their return, particularly on the family, work and psychological fronts.** It is essential that immigration detainees be informed sufficiently far in advance of their prospective deportation, so that they can begin to come to terms with the situation psychologically and are able to inform the people they need to let know and to retrieve their personal belongings. The CPT has observed that a constant threat of forcible deportation hanging over detainees who have received no prior information about the date of their deportation can bring about a condition of anxiety that comes to a head during deportation and may often turn into a violent agitated state. In this connection, the CPT has noted that, in some of the countries visited, there was a psycho-social service attached to the units responsible for deportation operations, staffed by psychologists and social workers who were responsible, in particular, for preparing immigration detainees for their deportation (through ongoing dialogue, contacts with the family in the country of destination, etc.). Needless to say, **the CPT welcomes these initiatives and invites those States which have not already done so to set up such services.**

(...)

V. Involuntary placement in psychiatric establishments

Extract from the 8th General Report [CPT/Inf (98) 12]

(...)

C. Patients' living conditions and treatment

32. The CPT closely examines patients' living conditions and treatment; inadequacies in these areas can rapidly lead to situations falling

within the scope of the term “inhuman and degrading treatment”. The aim should be to offer material conditions which are conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment. This is of importance not only for patients but also for staff working in psychiatric establishments. Further, adequate treatment and care, both psychiatric and somatic, must be provided to patients; having regard to the principle of the equivalence of care, the medical treatment and nursing care received by persons who are placed involuntarily in a psychiatric establishment should be comparable to that enjoyed by voluntary psychiatric patients.

33. The quality of patients’ living conditions and treatment inevitably depends to a considerable extent on available resources. The CPT recognises that in times of grave economic difficulties, sacrifices may have to be made, including in health establishments. However, in the light of the facts found during some visits, the Committee wishes to stress that the provision of certain basic necessities of life must always be guaranteed in institutions where the State has persons under its care and/or custody. These include adequate food, heating and clothing as well as - in health establishments - appropriate medication.

living conditions

34. Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hospital hygiene requirements.

Particular attention should be given to the decoration of both patients’ rooms and recreation areas, in order to give patients visual stimulation. The provision of bedside tables and wardrobes is highly desirable, and patients should be allowed to keep certain personal belongings (photographs, books, etc). The importance of providing patients with lockable space in which they can keep their belongings should also be underlined; the failure to provide such a facility can impinge upon a patient’s sense of security and autonomy.

Sanitary facilities should allow patients some privacy. Further, the needs of elderly and/or handicapped patients in this respect should be given due consideration; for example, lavatories of a design which do not allow the user to sit are not suitable for such patients. Similarly, basic hospital equipment enabling staff to provide adequate care (including personal hygiene) to bedridden patients must be

made available; the absence of such equipment can lead to wretched conditions.

It should also be noted that the practice observed in some psychiatric establishments of continuously dressing patients in pyjamas/nightgowns is not conducive to strengthening personal identity and self-esteem; individualisation of clothing should form part of the therapeutic process.

35. Patients' food is another aspect of their living conditions which is of particular concern to the CPT. Food must be not only adequate from the standpoints of quantity and quality, but also provided to patients under satisfactory conditions. The necessary equipment should exist enabling food to be served at the correct temperature. Further, eating arrangements should be decent; in this regard it should be stressed that enabling patients to accomplish acts of daily life - such as eating with proper utensils whilst seated at a table - represents an integral part of programmes for the psycho-social rehabilitation of patients. Similarly, food presentation is a factor which should not be overlooked.

The particular needs of disabled persons in relation to catering arrangements should also be taken into account.

36. The CPT also wishes to make clear its support for the trend observed in several countries towards the closure of large-capacity dormitories in psychiatric establishments; such facilities are scarcely compatible with the norms of modern psychiatry. Provision of accommodation structures based on small groups is a crucial factor in preserving/restoring patients' dignity, and also a key element of any policy for the psychological and social rehabilitation of patients. Structures of this type also facilitate the allocation of patients to relevant categories for therapeutic purposes.

Similarly, the CPT favours the approach increasingly being adopted of allowing patients who so wish to have access to their room during the day, rather than being obliged to remain assembled together with other patients in communal areas.

treatment

37. Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient. It

should involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports. Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis; it is also desirable for them to be offered education and suitable work.

The CPT all too often finds that these fundamental components of effective psycho-social rehabilitative treatment are underdeveloped or even totally lacking, and that the treatment provided to patients consists essentially of pharmacotherapy. This situation can be the result of the absence of suitably qualified staff and appropriate facilities or of a lingering philosophy based on the custody of patients.

38. Of course, psychopharmacologic medication often forms a necessary part of the treatment given to patients with mental disorders. Procedures must be in place to ensure that medication prescribed is in fact provided, and that a regular supply of appropriate medicines is guaranteed. The CPT will also be on the look-out for any indications of the misuse of medication.
39. Electroconvulsive therapy (ECT) is a recognised form of treatment for psychiatric patients suffering from some particular disorders. However, care should be taken that ECT fits into the patient's treatment plan, and its administration must be accompanied by appropriate safeguards.

The CPT is particularly concerned when it encounters the administration of ECT in its unmodified form (i.e. without anaesthetic and muscle relaxants); this method can no longer be considered as acceptable in modern psychiatric practice. Apart from the risk of fractures and other untoward medical consequences, the process as such is degrading for both the patients and the staff concerned. Consequently, ECT should always be administered in a modified form.

ECT must be administered out of the view of other patients (preferably in a room which has been set aside and equipped for this purpose), by staff who have been specifically trained to provide this treatment. Further, recourse to ECT should be recorded in detail in a specific register. It is only in this way that any undesirable practices can be clearly identified by hospital management and discussed with staff.

40. Regular reviews of a patient's state of health and of any medication prescribed is another basic requirement. This will inter alia enable informed decisions to be taken as regards a possible dehospitalisation or transfer to a less restrictive environment.

A personal and confidential medical file should be opened for each patient. The file should contain diagnostic information (including the results of any special examinations which the patient has undergone) as well as an ongoing record of the patient's mental and somatic state of health and of his treatment. The patient should be able to consult his file, unless this is unadvisable from a therapeutic standpoint, and to request that the information it contains be made available to his family or lawyer. Further, in the event of a transfer, the file should be forwarded to the doctors in the receiving establishment; in the event of discharge, the file should be forwarded - with the patient's consent - to a treating doctor in the outside community.

41. Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.

Of course, consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the patient's condition and the treatment proposed; to describe ECT as "sleep therapy" is an example of less than full and accurate information about the treatment concerned. Consequently, all patients should be provided systematically with relevant information about their condition and the treatment which it is proposed to prescribe for them. Relevant information (results, etc.) should also be provided following treatment.

(...)

Means of restraint in psychiatric establishments for adults

Extract from the 16th General Report [CPT/Inf (2006) 35]

How restraint should be used

47.(...)

For the staff of a psychiatric hospital, it should be of the utmost concern that the conditions and circumstances surrounding the use of restraint do not aggravate the mental and physical health of the restrained patient. This implies, inter alia, that previously prescribed therapeutic treatment should, as far as possible, not be interrupted and that substance-dependent patients should receive adequate treatment for withdrawal symptoms. Whether these symptoms are caused by deprivation of illegal drugs, nicotine or other substances should not make any difference.

48. In general, the place where a patient is restrained should be specially designed for that specific purpose. It should be safe (e.g. without broken glass or tiles), and enjoy appropriate light and adequate heating, thereby promoting a calming environment for the patient.

(...)

When recourse is had to restraint, the means should be applied with skill and care in order not to endanger the health of the patient or cause pain. Vital functions of the patient, such as respiration, and the ability to communicate, eat and drink must not be hampered. If a patient has a tendency to bite, suck or spit, potential damage should be averted in a manner other than by covering the mouth.

(...)

VI. Juveniles deprived of their liberty

Extract from the 9th General Report [CPT/Inf (99) 12]

Preliminary remarks

20. In certain of its previous general reports, the CPT has set out the criteria which guide its work in a variety of places of detention, including police stations, prisons, holding centres for immigration detainees and psychiatric establishments.

The Committee applies the above-mentioned criteria, to the extent to which they are appropriate, in respect of juveniles (i.e. persons under the age of 18) deprived of their liberty. However - regardless of the reason for which they may have been deprived of their liberty - juveniles are inherently more vulnerable than adults. In consequence, particular vigilance is required to ensure that their physical and mental well-being is adequately protected. In order to highlight the importance which it attaches to the prevention of ill-treatment of juveniles deprived of their liberty, the CPT has chosen to devote this chapter of its 9th General Report to describing some of the specific issues which it pursues in this area.

(...)

Safeguards against the ill-treatment of juveniles

22. Given its mandate, the CPT's first priority during visits to places where juveniles are deprived of their liberty is to seek to establish whether they are being subjected to deliberate ill-treatment. The Committee's findings to date would suggest that, in most of the establishments which it visits, this is a comparatively rare occurrence.
23. However, as is the case for adults, it would appear that juveniles run a higher risk of being deliberately ill-treated in police establishments than in other places of detention. Indeed, on more than one occasion, CPT delegations have gathered credible evidence that juveniles have featured amongst the persons tortured or otherwise ill-treated by police officers.

In this context, the CPT has stressed that it is during the period immediately following deprivation of liberty that the risk of torture and ill-treatment is at its greatest. It follows that it is essential that all

persons deprived of their liberty (including juveniles) enjoy, as from the moment when they are first obliged to remain with the police, the rights to notify a relative or another third party of the fact of their detention, the right of access to a lawyer and the right of access to a doctor.

(...)

Detention centres for juveniles

1. introduction

28. In the view of the CPT, all juveniles deprived of their liberty because they are accused or convicted of criminal offences ought to be held in detention centres specifically designed for persons of this age, offering regimes tailored to their needs and staffed by persons trained in dealing with the young.

Moreover, the care of juveniles in custody requires special efforts to reduce the risks of long-term social maladjustment. This calls for a multidisciplinary approach, drawing upon the skills of a range of professionals (including teachers, trainers and psychologists), in order to respond to the individual needs of juveniles within a secure educative and socio-therapeutic environment.

2. material conditions of detention

29. A well-designed juvenile detention centre will provide positive and personalised conditions of detention for young persons deprived of their liberty. In addition to being of an adequate size, well lit and ventilated, juveniles' sleeping and living areas should be properly furnished, well-decorated and offer appropriate visual stimuli. Unless there are compelling security reasons to the contrary, juveniles should be allowed to keep a reasonable quantity of personal items.
30. The CPT would add that, in certain establishments, it has observed a tendency to overlook the personal hygiene needs of female detainees, including juvenile girls. For this population in custody, ready access to sanitary and washing facilities as well as provision of hygiene items, such as sanitary towels, is of particular importance. The failure to provide such basic necessities can amount, in itself, to degrading treatment.

(...)

8. medical issues

37. When examining the issue of health-care services in prisons in its 3rd General Report (cf. CPT/Inf (93) 12, paragraphs 30 to 77), the CPT identified a number of general criteria which have guided its work (access to a doctor; equivalence of care; patient's consent and confidentiality; preventive health care; professional independence and professional competence). Those criteria apply with equal force to detention centres for juveniles.
38. Of course, the CPT pays special attention to the specific medical needs of juveniles deprived of their liberty.

It is particularly important that the health care service offered to juveniles constitutes an integrated part of a multidisciplinary (medico-psycho-social) programme of care. This implies *inter alia* that there should be close co-ordination between the work of an establishment's health care team (doctors, nurses, psychologists, etc.) and that of other professionals (including social workers and teachers) who have regular contact with inmates. The goal should be to ensure that the health care delivered to juveniles deprived of their liberty forms part of a seamless web of support and therapy.

It is also desirable that the content of a detention centre's programme of care be set out in writing and made available to all members of staff who may be called upon to participate in it.

39. All juveniles deprived of their liberty should be properly interviewed and physically examined by a medical doctor as soon as possible after their admission to the detention centre; save for in exceptional circumstances, the interview/examination should be carried out on the day of admission. However, a newly-arrived juvenile's first point of contact with the health care service could be a fully-qualified nurse who reports to a doctor.

If properly performed, such medical screening on admission should enable the establishment's health care service to identify young persons with potential health problems (e.g. drug addiction, suicidal tendencies). The identification of such problems at a sufficiently early stage will facilitate the taking of effective preventive action within the framework of the establishment's medico-psycho-social programme of care.

40. Further, it is axiomatic that all juveniles deprived of their liberty should be able to have confidential access to a doctor at any time, regardless of the regime (including disciplinary confinement) to which they may be subjected. Appropriate access to a range of specialist medical care, including dentistry, should also be guaranteed.
41. The task of the health care service in any place of detention should not be limited to treating sick patients; it should also be entrusted with responsibility for social and preventive medicine. In this connection, the CPT wishes to highlight two aspects of particular concern as regards juveniles deprived of their liberty, namely, inmates' nutrition and the provision of health education.

Health care staff should play an active part in monitoring the quality of the food which is being provided to inmates. This is particularly important for juveniles, who may not have reached their full growth potential. In such cases, the consequences of inadequate nutrition may become evident more rapidly - and be more serious - than for those who have reached full physical maturity.

It is also widely recognised that juveniles deprived of their liberty have a tendency to engage in risk-taking behaviour, especially with respect to drugs (including alcohol) and sex. In consequence, the provision of health education relevant to young persons is an important element of a preventive health care programme. Such a programme should, in particular, include the provision of information about the risks of drug abuse and about transmittable diseases.

VII. Women deprived of their liberty

Extract from the 10th General Report [CPT/Inf (2000) 13]

(...)

Ante natal and post natal care

26. Every effort should be made to meet the specific dietary needs of pregnant women prisoners, who should be offered a high protein diet, rich in fresh fruit and vegetables.
27. It is axiomatic that babies should not be born in prison, and the usual practice in Council of Europe member States seems to be, at an

appropriate moment, to transfer pregnant women prisoners to outside hospitals.

Nevertheless, from time to time, the CPT encounters examples of pregnant women being shackled or otherwise restrained to beds or other items of furniture during gynaecological examinations and/or delivery. Such an approach is completely unacceptable, and could certainly be qualified as inhuman and degrading treatment. Other means of meeting security needs can and should be found.

28. Many women in prison are primary carers for children or others, whose welfare may be adversely affected by their imprisonment²³⁸.

One particularly problematic issue in this context is whether - and, if so, for how long - it should be possible for babies and young children to remain in prison with their mothers. This is a difficult question to answer given that, on the one hand, prisons clearly do not provide an appropriate environment for babies and young children while, on the other hand, the forcible separation of mothers and infants is highly undesirable.

29. In the view of the CPT, the governing principle in all cases must be the welfare of the child. This implies in particular that any ante and post natal care provided in custody should be equivalent to that available in the outside community. Where babies and young children are held in custodial settings, their treatment should be supervised by specialists in social work and child development. The goal should be to produce a child-centred environment, free from the visible trappings of incarceration, such as uniforms and jangling keys.

Arrangements should also be made to ensure that the movement and cognitive skills of babies held in prison develop normally. In particular, they should have adequate play and exercise facilities within the prison and, wherever possible, the opportunity to leave the establishment and experience ordinary life outside its walls.

Facilitating child-minding by family members outside the establishment can also help to ensure that the burden of child-rearing is shared (for example, by the child's father). Where this is not possible, consideration should be given to providing access to creche-

²³⁸ Cf. also Recommendation 1469 (2000) of the Parliamentary Assembly of the Council of Europe on the subject of mothers and babies in prison.

type facilities. Such arrangements can enable women prisoners to participate in work and other activities inside the prison to a greater extent than might otherwise be possible.

Hygiene and health issues

30. The Committee also wishes to call attention to a number of hygiene and health issues in respect of which the needs of women deprived of their liberty differ significantly from those of men.
31. The specific **hygiene** needs of women should be addressed in an adequate manner. Ready access to sanitary and washing facilities, safe disposal arrangements for blood-stained articles, as well as provision of hygiene items, such as sanitary towels and tampons, are of particular importance. The failure to provide such basic necessities can amount, in itself, to degrading treatment.
32. It is also essential that the **health care** provided to persons deprived of their liberty be of a standard equivalent to that enjoyed by patients in the outside community.

Insofar as women deprived of their liberty are concerned, ensuring that this principle of equivalence of care is respected will require that health care is provided by medical practitioners and nurses who have specific training in women's health issues, including in gynaecology.

Moreover, to the extent that preventive health care measures of particular relevance to women, such as screening for breast and cervical cancer, are available in the outside community, they should also be offered to women deprived of their liberty.

Equivalence of care also requires that a woman's right to bodily integrity should be respected in places of detention as in the outside community. Thus, where the so-called "morning after" pill and/or other forms of abortion at later stages of a pregnancy are available to women who are free, they should be available under the same conditions to women deprived of their liberty.

33. As a matter of principle, prisoners who have begun a course of treatment before being incarcerated should be able to continue it once detained. In this context, efforts should be made to ensure that adequate supplies of specialist medication required by women are available in places of detention.

As regards, more particularly, the contraceptive pill, it should be recalled that this medication may be prescribed for medical reasons other than preventing conception (e.g. to alleviate painful menstruation). The fact that a woman's incarceration may - in itself - greatly diminish the likelihood of conception while detained is not a sufficient reason to withhold such medication.

30. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (excerpt)²³⁹

Adoption: 4 April 1997

Entry into force: 1 December 1999

(...)

Chapter I – General provisions

Article 1 – Purpose and object

Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine.

Each Party shall take in its internal law the necessary measures to give effect to the provisions of this Convention.

Article 2 – Primacy of the human being

The interests and welfare of the human being shall prevail over the sole interest of society or science.

Article 3 – Equitable access to health care

Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.

The Explanatory Report of the Secretary General of the Council of Europe comments on the provision of Article 3 of the Convention

23. This article defines an aim and imposes an obligation on States to use their best endeavours to reach it.

²³⁹ Source: ETS No. 164. See also the Explanatory Report in ETS No. 164.

24. The aim is to ensure equitable access to health care in accordance with the person's medical needs. "Health care" means the services offering diagnostic, preventive, therapeutic and rehabilitative interventions, designed to maintain or improve a person's state of health or alleviate a person's suffering. This care must be of a fitting standard in the light of scientific progress and be subject to a continuous quality assessment.
25. Access to health care must be equitable. In this context, "equitable" means first and foremost the absence of unjustified discrimination. Although not synonymous with absolute equality, equitable access implies effectively obtaining a satisfactory degree of care.
26. The Parties to the Convention are required to take appropriate steps to achieve this aim as far as the available resources permit. The purpose of this provision is not to create an individual right on which each person may rely in legal proceedings against the State, but rather to prompt the latter to adopt the requisite measures as part of its social policy in order to ensure equitable access to health care.
27. Although States are now making substantial efforts to ensure a satisfactory level of health care, the scale of this effort largely depends on the volume of available resources. Moreover, State measures to ensure equitable access may take many different forms and a wide variety of methods may be employed to this end.

31. Council of Europe Convention on Action against Trafficking in Human Beings (excerpt)²⁴⁰

Adoption: 16 May 2005

On 24 October 2007, the 10 ratifications, acceptances or approvals, including 8 Member States of the Council of Europe, required for its entry into force were reached. It will enter into force on 1 February 2008, namely on the first day of the third month following the deposit of the tenth instrument of ratification

(...)

Chapter III – Measures to protect and promote the rights of victims, guaranteeing gender equality

Article 12 – Assistance to victims

1. Each Party shall adopt such legislative or other measures as may be necessary to assist victims in their physical, psychological and social recovery. Such assistance shall include at least:
 - (a) standards of living capable of ensuring their subsistence, through such measures as: appropriate and secure accommodation, psychological and material assistance;
 - (b) access to emergency medical treatment;
 - (c) translation and interpretation services, when appropriate;
 - (d) counselling and information, in particular as regards their legal rights and the services available to them, in a language that they can understand;
 - (e) assistance to enable their rights and interests to be presented and considered at appropriate stages of criminal proceedings against offenders;
 - (f) access to education for children.

²⁴⁰ Source: ETS No. 197. See loc. cit. n. 164.

2. Each Party shall take due account of the victim's safety and protection needs.
3. In addition, each Party shall provide necessary medical or other assistance to victims lawfully resident within its territory who do not have adequate resources and need such help.
4. Each Party shall adopt the rules under which victims lawfully resident within its territory shall be authorised to have access to the labour market, to vocational training and education.
5. Each Party shall take measures, where appropriate and under the conditions provided for by its internal law, to co-operate with non-governmental organisations, other relevant organisations or other elements of civil society engaged in assistance to victims.
6. Each Party shall adopt such legislative or other measures as may be necessary to ensure that assistance to a victim is not made conditional on his or her willingness to act as a witness.
7. For the implementation of the provisions set out in this article, each Party shall ensure that services are provided on a consensual and informed basis, taking due account of the special needs of persons in a vulnerable position and the rights of children in terms of accommodation, education and appropriate health care.

The Explanatory Report comments on the provision of Article 12 of the Convention

“157. Sub-paragraph b. provides for emergency medical treatment to be available to victims.

Article 13 of the Revised European Social Charter [ETS No.163] also recognizes the right of any person who is without adequate resources to social and medical assistance. Medical assistance is often necessary for victims of trafficking who have been exploited or have suffered violence. The assistance may also allow evidence to be kept of the violence so that, if they wish, the victims can take legal action. Full medical assistance is only for victims lawfully resident in the Party's territory under Article 12(3).

(...)

171. Paragraph 7 indicates that the services provided to victims should be carried out on an informed and consensual basis. It is indeed essential that victims agree to the services provided to them. Thus, for instance, victims must be able to agree to the detection of illness such as HIV/AIDS for them to be licit. In addition, the services provided must take into account the specific needs of persons in a vulnerable position and the rights of children concerning accommodation, education and health”.

II.2.2 RECOMMENDATIONS, RESOLUTIONS AND GUIDELINES

*HEALTH CONDITIONS,
HEALTH CARE PROVIDERS*

32. Recommendation Rec(2001)12 of the Committee of Ministers to member states on the adaptation of health care services to the demand for health care and health care services of people in marginal situations²⁴¹

Adoption: 10 October 2001

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members and that this aim may be pursued, *inter alia*, in particular by the adoption of common rules in the health field;

Noting that the number of persons living in marginal situations is constantly increasing in the member states;

Considering that problems specific to persons living in marginal situations have serious consequences on their health and that this becomes a public health problem of growing importance and a serious and costly burden for the individual, the family, the community and the state;

Recognising that due to the growth of inequalities in health in the European countries, any relevant and effective health policy should not only consider the health problems of the persons living in marginal situations but also those of the persons living in insecure conditions, health promotion being one of the key components of such a policy;

Noting that it is now largely documented that psychological stress experienced by persons living in such insecure conditions has an effect on their physical and mental health;

Recognising the need for policies designed to prevent health problems of persons living in marginal situations, while taking into account the need for protection of privacy of all persons concerned, and the respect of confidentiality;

Recognising the right of persons living in insecure situations to live in conditions favourable to their proper development free from physical and

²⁴¹Text available at: <http://www.coe.int/>.

psychological overload, social isolation, psychosomatic symptoms related to stress and other forms of handicap;

Recalling Article 11 of the European Social Charter on the right to health protection and Article 3 of the Convention on Human Rights and Biomedicine on the equitable access to health care;

Referring to the 1994 Ljubljana Charter on Health reforms and the Copenhagen Declaration on Reducing the Social Inequalities in Health of September 2000;

Having regard to the recommendations of the Committee of Ministers to Member States, No. R (2000) 5 on the development of structures for citizen and patient participation in the decision-making process affecting health care, Recommendation No. R (97) 4 on securing and promoting the health of single parent families and Recommendation No. R (98) 7 concerning the ethical and organisational aspects of health care in prison;

Aware that measures aimed at reducing the incidence of health problems of persons living in insecure conditions at primary level depend largely on situations outside the normal sphere of health and social services activities;

Considering that the aim and duty of the state and society is to influence broad social and economic prerequisites to health, which finally determine the poorer health of persons living in marginal situations;

Considering that it is also the responsibility of the state to ensure that policies affecting health are developed in a coherent way to increase the potential for health gain and to avoid adverse effects on health;

Aware of the Council of Europe Project on Human Dignity and Social Exclusion and the proposals for action adopted at the 1998 Helsinki Conference;

Aware of the WHO initiative on Partnership in Health and Poverty and aware of the communication of the European Commission on “Building an Inclusive Europe” and the programme of Community action to encourage co-operation between member states of the European Union to combat social exclusion;

Aware of the Charter of Fundamental Rights of the European Union,

Recommends the governments of member states to:

- i. develop a coherent and comprehensive policy framework that:
 - secures and promotes the health of persons living in insecure conditions;
 - protects human dignity and prevents social exclusion and discrimination;
 - ensures supportive environments for the social integration of persons living in marginal situations or in insecure conditions;
- ii. strengthen and implement their legislation in order to ensure human rights protection, social solidarity and equity;
- iii. improve multisectoral co-operation to increase the ability of their social systems to participate in preventing health problems for persons living in insecure conditions. This approach should clearly specify the role, responsibilities and co-ordination of the various agencies and social institutions involved in order to prevent these persons from falling into marginal situations;
- iv. develop comprehensive, effective and efficient health systems for a timely and adequate response to health needs in order to ensure equity and equal access to health care services, taking into account health needs and available resources, and to be able to identify, assess and treat health problems of persons living in marginal situations;
- v. take to this end, whenever feasible, the measures presented in the appendix to this recommendation.

Appendix to Recommendation Rec(2001)12

I. Principles

Governments are encouraged to develop a social/health policy in the framework of the principles adopted by the World Health Organisation at the 1986 Ottawa Conference in order to prevent insecure conditions and therefore limit the risks of falling into marginal situations.

When adapting the health care services to the needs of persons living in marginal situations or in insecure conditions, governments of member states should consider a certain number of principles:

1. The policy should be based on values propounded by the Council of Europe: human rights and patient's rights, human dignity, social cohesion, democracy, equity, solidarity, equal gender opportunity, participation, freedom of choice – balanced by the obligation to help strengthen one's own health.

To be efficient, any health policy, especially if oriented towards the needs of persons living in marginal situations, should be based on an integrated approach and begin with social protection measures. A minimal regular income should be given to these persons.

2. One of the best policies (apart from raising the standard of living) for improving their health and to prevent them from falling into marginal situations is to ensure equal access to social and health systems for everybody whatever his/her economic and legal status. It should take into account the fact that new groups and individuals may at any time find themselves in a marginal situation.
3. Social and economic prevention of the risk of falling into marginal situations should become a priority for governments and societies.
4. Long-term policies to improve social and health conditions for persons living in marginal situations or in insecure conditions cannot be implemented without their participation and agreement. They should, therefore, be considered as responsible persons, able to assume their own responsibilities and as much as possible involved in the decision process.
5. To ensure non-stigmatisation, member states, working in a long-term perspective, should endeavour to meet the needs of persons living in marginal situations within the existing health system. They should ensure an equal access for everybody to the national health resources, which may require positive discrimination in the form of well targeted outreach measures, limited in time and scope and fully integrated into the normal health services.
6. There is no specific disease of the poor. Persons living in marginal situations suffer from the same diseases as the rest of the population but in a disproportionate way.
7. The social and health policies need to be grounded on aims to prevent impoverishment and ill-health, where other than merely health and

social sectors matter. All policies need to be assessed and evaluated in terms of their impacts on social cohesion, social exclusion and health. This implies intersectoral action and accountability of all policies, including economic and trade policies, in terms of their implications for social well-being, health, equity and marginalisation of people.

8. The health systems have to be based on equity guaranteeing access to care according to need and financing of care regardless of the ability to pay.
9. Prevention, health promotion and health care measures for persons living in marginal situations or in insecure conditions should be an integral and integrated dimension of national and local social/health policy.
10. Children are particularly vulnerable in deprived conditions, governments should pay particular attention to them in ensuring that they will benefit from specific social/health preventive policies.
11. Governments should identify critical gaps and barriers in access to health care services: legal, social, economic, cultural, administrative and/or physical barriers. Initiatives and programmes should be implemented in order to reduce these obstacles, which often increase inequalities.
12. Appropriate policies should be developed to adapt the health system to the needs of persons living in marginal situations or in insecure conditions. Further elaboration and implementation of these policies should take into account the decisive role of civil society and NGOs in tackling social inequalities.

II. Development of an integrated and coherent social/ health policy

Developing an integrated social/health policy in the framework of the Ottawa Charter includes measures which are obviously beyond the capacity of the health sector alone. (“The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Health promotion action means: build a healthy public policy, create supportive environments, strengthen community action, develop personal skills, reorient health services”). These measures should depend on national and regional conditions and may include, among others:

- compulsory education, including health education from early childhood;
- an environment which provides suitable jobs and professional activities;
- decent housing; and
- other measures which ensure a satisfactory social protection.

Those issues are currently under study by the Social Cohesion Committee in order to develop a comprehensive recommendation on access to social goods and services.

In health care, the priority aim should be to ensure that health services are available and financially accessible to everyone.

The health policy should be formulated and implemented in order to improve the primary health care system so as to better respond to the needs of various social and cultural groups. It should also provide services of appropriate quality to everybody, including health promotion ones.

A special effort should be made to develop a specific preventive health policy for the most vulnerable persons including unemployed persons and their families, young single parent households, disabled, refugees, migrants and prisoners. Special attention should be paid to mental health problems, which often affect people in conditions of socio-economic vulnerability, poverty and exclusion.

Programmes for health promotion should reach people in marginal situations and should be planned in co-operation with them and be acceptable to them.

While all age groups should be considered for targeted action, special emphasis should be placed on the very early period in life, between conception and school age.

All children should be offered a complete programme of immunisation and equal access to paediatric health services and all women should receive antenatal, birth and postnatal care in appropriate health facilities.

Screening and rehabilitation should be offered to anyone regardless of his/her economic, social and cultural status. Physical access to all facilities for the disabled should be secured.

Each person should have an equal access to curative services including secondary and tertiary hospital care, where most people in marginal situations usually end up due to emergencies.

III. Development of specific measures to guarantee a better equity

When deciding on and implementing specific measures to improve access to health services to persons living in marginal situations or in insecure conditions, governments should pay particular attention to the risk of stigmatisation of these people. In addition, and because the objective is that everyone should have an equal access to health services, positive discrimination measures may be proposed for a limited period of time and be integrated into the normal health system.

1. Accessibility to preventive, promotional and curative health services and programmes

- Regional/local systems for identifying people living in marginal situations should be developed.
- Emphasis should be put on the primary health care network for providing affordable health services to persons living in marginal situations.
- Health promotion and preventive services should be organised at local level with particular emphasis on outreach activities toward people living in marginal situations.
- Provision and delivery of emergency health services should not depend on advance payment but be guaranteed irrespective of the ability to pay for it.
- Innovative organisational approaches should be encouraged, aimed at increasing flexibility of health care provision (adjusted opening hours, telephone booking system, etc.).
- Specific measures should be taken for financing basic health care services to persons living in illegal situations.
- Persons living in marginal situations or in insecure conditions are often poorly informed. Communication should be improved for informing them about existing programmes and services and how to reach them.

- Health professionals should act as advocates for persons living in marginal situations who generally have a low access to health services. This role could include lobbying authorities, politicians, and international organisations for improving access to health services for these persons.
- Health care of people living in illegal situations should be provided, with respect for their anonymity.

2. Specific population groups

Health services should be offered to everyone but special attention should be paid to persons living in insecure conditions, avoiding stigmatisation.

- Women living in insecure conditions have a higher rate of premature birth and perinatal morbidity, so they should benefit from special social/health surveillance during pregnancy and the perinatal period.
- Children with social/family risk factors should receive special attention from social/health services.
- Families with economic and/or social difficulties should receive support in educating their children, with an emphasis on measures directly benefiting the recipient children (educational vouchers, food stamps, etc.).
- Specific social/health services should be implemented at local level for young people having family/social risks factors with special emphasis on information on family planning, STD, HIV/Aids, traffic accidents, suicide, drug abuse, alcohol, etc. Their general physical and psychosocial well-being should be regularly assessed.
- Social/health services should pay particular attention to the needs of disabled persons whatever the origin of the handicap.
- Special attention should be paid to the needs of persons living in marginal situations with chronic diseases as well as with metabolic or neurological pathologies.
- Occupational health should be developed in particularly exposed working places.

- People living in prison and their children living in collective institutions should benefit from health services of equally good quality as outside prison.
- For underprivileged groups of population including **refugees, recent migrants**, etc., special attention should be paid to the specific cultural dimension of health. Some key social/health services should include professionals coming from such populations.
- Health care for elderly persons living in insecure conditions should be developed within the community by specially trained social/health workers.
- Specialised services should be available for alcohol and drug abusers.

IV. Improvement of knowledge on the health of persons living in insecure conditions

Governments should pay particular attention to the improvement of knowledge on the health of persons living in insecure conditions and their specific health needs. There is a need for the routine collection of standardised and comparable data based on common definitions. Health and social indicators should be linked together. A monitoring and surveillance system should be developed, resulting in regular, if possible annual, reports at country and European levels. The following measures are recommended:

1. Information system

- An observatory of social/health development should be set up at national/regional level to collect, process and disseminate reliable information on social/health status of persons living in insecure conditions.
- Data collected on a routine basis should include social and economic indicators as well as indicators of accessibility to health services.
- In order to avoid discrimination and to ensure individual protection, anonymity of data should be fully respected.
- Periodic and regular surveys should be conducted to better assess the use of services for specific problems.

- Regional/local health conferences should be organised to collect and disseminate information.
- Information should be made available to both social/health professionals and to the public.
- Existing networks in the community should be identified in order to create supportive environments.

2. Research

Research programmes should address the following issues:

- Cost/utility, cost/benefit and cost/effectiveness evaluation of different health policies and programmes for improving access to health services for persons living in insecure conditions.
- Selection of relevant indicators for monitoring and evaluation of policies, programmes and activities.
- Health status and needs of people at risk and those living in marginal situations.
- Qualitative surveys on health perception and obstacles to access to health care.
- Longitudinal analysis of individual histories of how people get into marginal situations and of the strategies used to leave them.
- Health status and needs of young adults should receive particular attention.
- Differences in values, social support networks, positive and negative experiences with health care services.
- Social distance between various groups and health care professionals.
- The role and impact of NGOs interventions.
- Ways in which health facilities are modified to meet the needs of groups in marginal situations.

V. Change of behaviour of the administration and of health/ social professionals at the central and local level

The following action areas are recommended to help the administration and health/social professionals at the national and local level to adapt their response to the health needs of persons living in insecure conditions:

1. Policies

- A policy paper on health protection and health promotion for persons living in marginal situations should be published. The formulation of such a policy should be based on a large consensus among all potential partners and when feasible with the community concerned.
- Policy implementation should be based on a multisectoral approach and its impact systematically monitored and evaluated.
- Re-assessment of the interface between health authorities and social services is encouraged.
- NGOs experience and capacity should be used to implement policies at local level.
- Instruments should be experimented with and developed with a view to involving people living in insecure conditions in the decision making process to design and organise health services.

2. Professional practices

- Regular meetings should be organised at local level between administration staff, social/health professionals and NGOs to organise responses to health needs of groups/persons living in marginal situations.
- New social professions should be created for young adults in marginal situations to prepare them for working in their own community.

3. Training

- Disciplines like public health, epidemiology (in particular of non-communicable diseases), health promotion, social sciences, and health economy should be reinforced in the undergraduate curriculum of health professionals and social workers and, particularly, future physicians.
- National postgraduate programmes should be implemented with an emphasis on specific approaches to vulnerable social groups and individuals, preventive actions, outreach strategies and non-discriminatory identification methods of the health needs at community level.
- Training programmes should be organised for both health and education personnel for an early detection of health problems at school.
- Special programmes should be prepared for social/health/education staff for drawing their attention to the specific needs of the poor, unemployed people, refugees, etc.
- Professionals working at grassroots level and NGOs should be encouraged to play an important role in such training programmes.

33. Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society²⁴²

Adoption: 8 November 2006

The Committee of Ministers, under the terms of Article 15.*b* of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members and that this aim may be pursued in particular by the adoption of common rules in the public health field;

Recalling Article 11 of the European Social Charter (ETS No. 35) on the right to protection of health, and recalling Article 3 of the Council of Europe's Convention on Human Rights and Biomedicine (ETS No. 164) on equitable access to health care of appropriate quality;

Noting, in this context, that inequalities with regard to health care affecting ethnic groups are linked to problems of access, the lack of culture competence in health care providers, lack of essential provisions (such as interpreter services or translated health education material), all of which may be structural barriers to quality care;

Recognising that, in an increasingly diverse and multicultural Europe, understanding and addressing the needs of a multicultural population is becoming a growing challenge;

Considering that respect for human rights and the dignity of the individual requires that this diversity is taken into account in the equitable delivery of health services;

Recognising that socio-economic factors, such as poverty, unemployment, unhealthy living conditions and occupational hazards are unevenly distributed within the population and may very well account for most of the health disparities;

Aware, in this context, that ethnic minorities seem to be most vulnerable to health problems within every socio-economic class;

²⁴²Text available at: <http://www.coe.int/>.

Recognising that a general diversity-based approach – that is, one that takes into account all sources of diversity that may be relevant to health and health care issues – is preferable to an approach that is limited to dealing with minority-linked cultural diversity;

Recognising that the reduction of health inequalities in multicultural societies requires the development of a diversity-based policy examining ideas, policies, programmes and research to assess their potentially different impact on specific gender and age groups;

Aware that the issue of diversity and its management is not exclusively related to the presence of ethnic minorities in present-day Europe but should rather be viewed as a feature of the European population as a whole;

Adopting a broad definition of culture that recognises cultural subcategories based on shared attributes (such as gender) or shared life experiences (such as education, occupation, socio-economic status, trauma, homelessness, being without ID papers);

Aware that cultural factors are often used as a universal and unique explanation when no other factors can be called into account for observed health disparities between different ethnic groups;

Concerned that a narrow focus on cultural issues denies the importance of class or socio-economic status, age, sexual orientation, gender, religion, geographic location, physical and mental ability that may all distinctly affect any group's health needs, interests and concerns;

Noting that migration factors related to the migratory experience have been shown to be linked with health problems of ethnic groups;

Having regard to Recommendation No. R (2000) 5 of the Committee of Ministers to member states on the development of structures for citizen and patient participation in the decision-making process affecting health care;

Concerned in this context that patients' rights cannot be respected nor protected when health care providers and patients cannot communicate effectively;

Convinced that the development of culture competence or cultural responsiveness would add to the effectiveness of health care provision not only for ethnic minorities but also for the public at large;

Aware that the development of an integrated social and health policy should go beyond the adaptation of health care services to cultural diversity;

Having regard to the Charter of Fundamental Rights of the European Union,

Recommends that the governments of member states:

- i. consider issues related to the improvement of access and quality of health care services in multicultural societies as one of the priority areas of action in health care policy;
- ii. develop coherent and comprehensive policies and strategies addressing health care needs in multicultural societies, including prevention;
- iii. promote an intersectoral and multidisciplinary approach to health problems and health care delivery in multicultural societies, taking into consideration the rights of multicultural populations;
- iv. promote the involvement and participation of all parties concerned (researchers, policy makers, local health authorities, health professionals, representatives of ethnic minority groups and non-governmental organisations) in the planning, implementation and monitoring of health policies for multicultural populations;
- v. embed health issues of multicultural populations in the legal framework as an integral part of the general health system;
- vi. develop a knowledge base on the health of multicultural populations through systematic data collection and research;
- vii. promote the inclusion of ethnic minority groups in culturally appropriate/adapted programmes promoting health and prevention, and in research and quality management;
- viii. provide further support to the exchange of experience and good practice between member states and promote international networking between organisations, research institutions and other agencies active in the field of the health of multicultural populations;
- ix. produce regular reports on actions taken in the country to improve the health of multicultural populations;

- x. to this end, whenever feasible, carry out the measures presented in the appendix to this recommendation;
- xi. support an active, targeted dissemination of this recommendation and its explanatory memorandum, accompanied where appropriate, by a translation into the local languages.

Appendix to Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society

A. General considerations

1. When adapting the health care services to the needs of multicultural populations, governments of member states should base their policies on values propounded by the Council of Europe – human rights and patient’s rights, human dignity, social cohesion, democracy, equity, solidarity, equal gender opportunity, participation, freedom of choice – balanced by the obligation to help individuals look after their own health.

Member states should apply a systematic approach to issues related to responding to cultural diversity. Guidelines and standards for the provision of good services in multicultural populations should be developed.

Developing coherent and comprehensive policies and strategies addressing health care needs in multicultural societies, including prevention, should include:

- protecting human dignity and preventing social exclusion and discrimination;
- promoting delivery of high quality, linguistically appropriate, culturally sensitive, equitable and appropriate health care services;
- promoting changes in the conduct of health authorities at the national and local level and of health and social professionals to adapt their response to the health needs of multicultural populations;
- developing cultural competence in health care providers (meant as the ability to provide effective health care services taking into consideration the individual’s gender, sexual orientation, disability, age and religious, spiritual and cultural beliefs).

2. Health disparities in multicultural societies may have different causes, including external ones. These include cultural and socio-economic factors, migrant status and discrimination. Member states should pay attention to those factors in the appropriate policy settings as part of a comprehensive, coherent overall policy approach that focuses on eliminating the external causes of disparities in the health field.

2.1. Biological/genetic factors.

2.2. Cultural factors. Explaining health differences between ethnic groups using cultural factors bears a risk of blaming the “victim”, reification and gross oversimplification. Cultural factors seem to be used when no other factors can be called into account for observed health disparities between different ethnic groups.

2.3. Material factors. Socio-economic factors may very well account for most of the health disparities concerning ethnic groups, ethnic minorities being the most vulnerable to health problems within every socio-economic class.

2.4. Migration factors may influence the health of migrants.

2.5. Racism. The experience of racism and discrimination may have a direct and negative impact on health.

2.6. Selective impact and quality of health care: inadequate handling of cultural differences may affect the quality of care; the development of culture competence or cultural sensitivity would add to the efficiency of health care provision to ethnic minorities.

3. The reduction of ethnic (and other) inequalities in health requires the development of a diversity-based analysis policy to assess their potentially different impact on specific gender and age groups.

B. Strategies for improvement of health and health care for multicultural populations – Non-discrimination in access to health care

1. Promoting non-discrimination and respect for patient/human rights

1.1. Governments should develop and implement anti-discrimination policies and practices that effectively prevent (in)direct discrimination in access to health care services of good quality.

1.2. Governments should entrust an independent body with the assessment of the accessibility of the health care system for multicultural populations.

2. Access to health care

2.1. Equitable access to health care services of appropriate quality should be promoted and monitored. In order to achieve the objective of equal access to health care, member states should develop strategies for eliminating practical barriers for multicultural populations to access health care, including linguistic and cultural hurdles.

2.2. Governments should increase awareness of policy makers, health care providers and the general public of possible health care disparities between ethnic groups.

3. Improving quality of communication – Language barriers

3.1. Removing barriers to communication is one of the most urgent, evident and straightforward areas in which interventions are needed; a general policy that facilitates the learning of the language of the host country for ethnic minority members and immigrants should also be developed.

3.2. Professional interpreters should be made available and used on a regular basis for ethnic minority patients who need them, whenever appropriate.

3.3. Linguistic diversity should be taken into account, including appropriate legal measures.

3.4. Health care professionals should be made aware that linguistic barriers have negative effects on the quality of health care. They should be trained to work together with interpreters in an effective way.

3.5. Training programmes are needed for interpreters working within the field of health care. Besides basic interpreting skills, these should include medical terminology, courses on the structure of the health care system, ethical interpreting practice, culture competence and culture brokerage. Interpreters working in mental health care settings ought to be specially trained to perform their tasks in the context of psychotherapeutic or psychiatric interventions. Public health authorities should be encouraged to monitor the quality of medical interpreter services for ethnic minorities.

4. Sensitivity to health and socio-cultural needs of multicultural populations

4.1. Adequate assessment and analysis of the health problems of ethnic minorities is needed.

4.2. Member states should find appropriate answers to the objectively demonstrated added value of health care services that are specifically adapted to particular health (care) needs of a multicultural population. Ideally, all health care institutions should be equipped to treat health problems of all citizens; however, for very specific health problems it may be necessary to temporarily or even permanently create specialised services that respond to particular health care needs.

4.3. Measures should be taken that make it possible for the health care system to respond to the cultural diversity of the population.

5. Patient education, empowerment and participation

5.1. Patient training programmes should be developed and implemented to increase their participation in the decision-making process regarding treatment and to improve outcomes of care in multicultural populations.

5.2. Culturally appropriate health promotion and disease prevention programmes have to be developed and implemented as they are indispensable to improve health literacy in ethnic minority groups in terms of health care.

5.3. Ethnic minority groups should be encouraged to participate actively in the planning of health care services (assessment of ethnic minorities' health needs, programme development), their implementation and evaluation.

6. Implications for health facilities and health care providers

6.1. Effective strategies should be developed to increase (ethnic) diversity among health professionals and social workers. Therefore, member states should ensure that ethnic minorities get access to the social and medical professions. Adequate measures have to be taken to make it possible for ethnic minority health professionals who have been trained abroad to get the qualifications needed to exercise their profession in the host country.

6.2. Multidisciplinary team approaches should be encouraged to reduce health and health care disparities between multicultural populations. Collaboration between social workers and social services on the one hand, and medical professionals on the other should be more widely implemented.

6.3. Member states should encourage the development of intercultural mediation programmes:

- adequate training and supervision programmes have to be developed for intercultural mediators;
- research on the effects of intercultural mediation programmes, preferably within the framework of international collaboration, should be encouraged and member states should engage in the development of standards of good practice for intercultural mediators.

6.4. A population diversity perspective should be incorporated into the basic training curriculum of all health care professionals and social workers, as well as in the continuing education of these professionals. It is important that such courses do not only focus on knowledge, but also on attitudes (cultural sensitivity, influence of prejudices, (subconscious) rejection of ethnic minority patients), and cross-cultural skills, in order to avoid stereotyping of ethnic minorities. Intercultural communication training has to be included in all culture competence training programmes.

Inclusion of programmes dedicated to this subject in the training of health professionals has to be carefully thought about to be efficient, and should be offered in schools but also as continuing education throughout their careers, after having acquired some hands-on experience in the field and the ability to approach the topic more in depth. Enquiries should be done at the health professionals' level too, in order to assess their needs, perceptions and problems with patients of different ethnic backgrounds.

6.5. Health professionals should be made aware of possible structural discrimination and racist practices in the health care system and their effects. They should be taught how to detect and address these issues within the health care system. In addition, they ought to be made aware of the effects of discrimination and racism experienced by ethnic minorities in society at large on the interaction of these groups with the health care system.

6.6. Exchange programmes with the countries of origin of the migrants should be encouraged, focusing on new migrants and refugees, following the experience of countries of southern Europe and their southern neighbours (Barcelona Declaration).

7. Development of a knowledge base on the health needs of multicultural populations and the health care they receive

Identifying ethnic minorities in research and administrative health data

7.1. Member states should develop strategies that allow for appropriate data collection on the health needs, health determinants and the health care received by multicultural populations.

7.2. Relevant data should be analysed and reported to influence policy and service designers, service evaluation and to allow for the development of strategies for the improvement of the quality of health care services in multicultural societies.

7.3. Strategies ought to be developed to avoid the abuse of data collected on ethnic minorities and their stigmatisation, and thus guarantee their safety.

Inclusion and proportional representation of ethnic minorities in research

7.4. Whenever relevant, member states should develop legislation which foster a true representation of ethnic minorities in clinical and health services research. In the case of research financed through public funds, researchers should be asked to provide an adequate scientific explanation whenever ethnic minorities are excluded.

7.5. Research data have to be analysed with the possible effects of (cultural) diversity kept in mind. In the presentation of the results, attention should be drawn to diversity issues that are relevant for the organisation of health care services.

7.6. Further research is needed to determine how and why ethnic health patterns and health care disparities occur, and to develop intervention strategies and to assess their impact. Where no adequate systems of monitoring of ethnic groups in the fields of health and health care exist, research will have to be conducted to provide information on the health status of ethnic minorities, their access to care and the existing health care disparities.

7.7. Further research is needed to fully exploit the potential role of civil society and to develop methods of preparatory training for interested citizens. University students should be encouraged to study these issues in their final study dissertation.

34. Recommendation Rec(2006)10 of the Committee of Ministers to member states on better access to health care for Roma and Travellers in Europe²⁴³

Adoption: 12 July 2006

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve greater unity between its members and that this aim may be pursued, in particular, through common action and adoption of common rules in the health field;

Noting that many Roma and Travellers are living in marginal situations in member states and experience widespread discrimination in all areas of life;

Aware that as a result of poor living conditions, *inter alia*, many Roma and Traveller communities have a poorer health status than that experienced by the general population;

Bearing in mind Article 25.1 of the Universal Declaration of Human Rights, Articles 2 and 24 of the United Nations Convention on the Rights of the Child, the Convention on Human Rights and Fundamental Freedoms (ETS No. 5), and its Protocol No. 12 (ETS No. 55), the Framework Convention for the Protection of National Minorities (ETS No. 157), Article 11 of the European Social Charter (ETS No. 35) on the right to health protection and Article 3 of the Convention on Human Rights and Biomedicine (ETS No. 164) on the equitable access to health care;

Bearing in mind Council of Europe Recommendations No. R (2000) 4 on the education of Roma/Gypsy children in Europe, No. R (2000) 5 on the development of structures for citizen and patient participation in the decision-making process affecting health care, Rec(2001)12 on the adaptation of health services to the demand for health care and health care services of people in marginal situations, Rec(2001)17 on improving the economic and employment situation of Roma/Gypsies and Travellers in Europe, Rec(2004)14 on the movement and encampment of Travellers in

²⁴³Text available at: <http://www.coe.int/>.

Europe and Rec(2005)4 on improving the housing conditions of Roma and Travellers in Europe;

Recalling Recommendations 563 (1969), 1203 (1993) and 1557 (2002) of the Parliamentary Assembly of the Council of Europe, in which mention is made of the living conditions of Roma in Europe, and Resolutions 125 (1981), 16 (1995), 249 (1993) and 44 (1997) and Recommendation 11 (1995) of the Congress of Local and Regional Authorities of the Council of Europe on the situation of Roma/Gypsies in Europe;

Bearing in mind General Policy Recommendation No. 3 of the European Commission against Racism and Intolerance on combating racism and discrimination against Roma/Gypsies; and European Union Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin and the Article 152 of the Treaty on European Union and Article 35 of the European Union Charter of Fundamental Rights;

Having in mind the Guiding Principles for improving the situation of the Roma adopted by the European Union (COEEN Group) at the Tampere Summit in December 1999;

Noting the relevance of the World Health Organisation's Health 21 programme for the European region and of its policy documents on patients' rights and citizens' participation;

Referring to the Copenhagen Declaration on Reducing the Social Inequalities in Health of September 2000;

Aware of the OSCE Action Plan for the Improvement of the Situation of the Roma and Sinti;

Confirming its commitment towards achieving the Millennium Development Goals and the targets of the Decade of Roma Inclusion;

Bearing in mind that the constitutional structures, legal traditions, and the domestic repartition of responsibilities differ in Council of Europe member states, which may lead to various ways of implementing the present recommendation;

Recommends the governments of member states to follow the principles and implement the provisions set out in the appendix hereafter.

Appendix to Recommendation Rec(2006)10 on better access to health care for Roma and Travellers in Europe

I. Definition

The term “Roma and Travellers” used in the present text refers to Roma, Sinti, Kalé, Travellers, and related groups in Europe, and aims to cover the wide diversity of groups concerned. In the context of the United Kingdom “Roma and Travellers” also refers to self-proclaimed “Gypsies”.

II. General principles

Member states should ensure the development of coherent, integrated and appropriate policies and strategies in the light of the following principles:

- i. protection of human rights, human dignity and autonomy;
- ii. respect of patients’ rights, including protection of confidentiality and privacy;
- iii. respect in the patient/health staff relationship;
- iv. respect of the principle of informed consent;
- v. freedom of choice of the doctor/provider, whenever the health system allows for that;
- vi. participation of the patient in his/her treatment: freedom to choose the treatment which the patient feels most adapted to his/her needs, including the freedom to refuse the treatment offered except in cases of emergency or for persons requiring a special protection;
- vii. equal access to appropriate, quality treatment and care for all groups and categories of the population;
- viii. respect of cultural traditions in the delivery of health care services in so far as they do not endanger the health of the person;
- ix. participation of the community in the elaboration of health care policies and strategies.

III. Legal framework for preventing and combating discrimination in health care

To ensure equal access to health care and treatment for Roma and Travellers on a non-discriminatory and culturally sensitive basis, in so far as the health of the person is not thereby endangered, governments of member states should:

- i. adopt comprehensive anti-discrimination legislation that includes the express prohibition of direct and indirect discrimination in access to health care and related public services;
- ii. allocate adequate authority and resources to guarantee the proper implementation and enforcement of this legislation through appropriate mechanisms, particularly at the local level;
- iii. ensure:
 - that national bodies concerned with combating discrimination give consistent attention to the field of health care for Roma and Travellers in their monitoring and recommendations;
 - that effective remedies for victims of discrimination are made available through implementation and publication of complaint mechanisms and provision of legal assistance to those in economic need.

IV. Framework for health policies

1. Effective access

Governments of member states should ensure:

- i. physical access to health care including emergency care, through the provision of adequate roads, communication, ambulances and services for Roma and Traveller communities of the same standard as for the general population;
- ii. access to health care for persons involved in migration, with consideration for portability of client-held records under the same conditions as for the general population;

- iii. geographically accessible and affordable health care;
- iv. access to health services for Roma and Travellers lacking documentation to access mainstream services;
- v. access to health care for Roma and Travellers who are refugees or asylum seekers in accordance with binding international conventions.

2. Planning

Roma and Travellers shall receive in every country the same medical care as the general population, or, if they are not nationals of the member state concerned, as any other persons with the same type of residence status.

Governments of member states should:

- i. make the improvement of conditions of Roma and Travellers' health a priority area for action and develop the necessary comprehensive health policies and strategies;
- ii. provide mechanisms to ensure the consideration of a broad range of Roma and Traveller health interests and needs in the policy-making process, for example children/adolescents/women/elderly, sedentary/nomadic;
- iii. stress the importance of an inter-sectoral approach, taking into consideration the rights to acquire citizenship, identification documentation, social benefits, social insurance, education, employment, decent living conditions, housing, and other factors affecting health status and access to care;
- iv. mainstream the policies responding to the health needs of Roma and Travellers into national health strategies and services;
- v. consider introducing the collection of census data on a strictly voluntary basis so that individuals from Roma and Traveller communities may be included in the planning of health services to these communities. National and local health bodies should be encouraged to do research and build up a knowledge base of information on the health needs of Roma and Traveller

communities and the effectiveness of services to them and how to best meet those needs;

- vi. promote the involvement and participation of all parties concerned (policy makers, local health authorities, health professionals, researchers, representatives of Roma and Travellers and non-governmental organisations) in the planning, implementation and monitoring of health policies;
- vii. take appropriate measures to make the wider population aware of the need of effective special measures intended to reach equal access to health care for Roma and Travellers;
- viii. provide for adequate authority and resources for the co-ordination and supervision of all the measures taken at national and local level;
- ix. identify and address research needs;
- x. provide where necessary for outreach measures fully integrated into the normal health service;
- xi. earmark specific funding for the improvement of the health situation of Roma and Travellers in all countries where Roma and Travellers are reported to face problems in accessing the healthcare system;
- xii. ensure that family planning is gender sensitive;
- xiii. take into consideration good practices on disseminating information about Romani culture and about prejudices existing among both health care professionals and Roma and Travellers;
- xiv. take into account the range of good practices existing in other member states and/or regions (for example Roma and Traveller health units, Roma and Traveller health mediators, training on primary health care, guidebooks).

3. Prevention

a. Health education

Member states should ensure access to health information and education through awareness raising campaigns for Roma and Travellers by health care and social workers, authorities and NGOs. Where desired, information on reproductive and sexual health and gender equality should be given as part of the health education.

Special attention should be paid to the education of the general population and to the elimination of existing anti-Roma and Traveller prejudices, which seriously hinder normal access to health care of Roma and Travellers.

b. Housing and health

Recognising that decent housing and a satisfactory sanitation infrastructure is a sine qua non for improvement of the health status of Roma and Traveller communities, governments of member states should ensure:

- i. that Roma and Traveller settlements and encampment sites are located in decent places in a healthy environment, with own toilet and water facilities, electricity, paved roads, rubbish containers, sewage, etc., under the same conditions as the general population of the region concerned;
- ii. that members of mobile populations without access to legal caravan sites have access to health care and other public services;
- iii. that local health bodies should work with local housing and other agencies to address these wider issues. When doing so they should ensure that Roma and Traveller communities are engaged effectively in these processes.

c. Sexual and reproductive health

Governments of member states should pay particular attention to the health situation of Roma and Traveller women, by ensuring comprehensive sexual and reproductive health (SRH) services and

information, particularly family planning. Such services should also be made accessible for Roma and Travellers adolescent and adult men.

d. Children and health

Health policies should give special attention to the health of **children** through a wide range of preventive measures including vaccination and prenatal and postnatal care. Special attention should be given to underage female children.

4. Participation of Roma and Travellers

- i. Wherever appropriate local health services should ensure that they have in place specific services such as gender equality advisors and health mediators to meet the health needs of these communities. Members of Roma and Traveller communities, where applicable, should be involved in developing those services and, where possible, health professionals should be recruited from their communities.
- ii. Where applicable training should be undertaken to improve Roma and Travellers' skills in policy making and health public administration.
- iii. Adequate resources should be provided for capacity-building training to enable representatives of the Roma and Traveller communities to engage effectively in the consultation process when drawing up strategies and policies affecting their health.
- iv. The actual focus of training programmes for Roma and Travellers in the field of health should be expanded from health mediators – whose role is to mediate between Romani patients and health professionals, provide basic health education and assist Roma communities in obtaining necessary insurance and documents – to include more ambitious targets.
- v. Roma and Travellers, if they so wish, should be encouraged to take up professions such as those of nurses and doctors at all levels of the health system.

5. Staff training

Governments of member states should support education of health care workers and authorities about diverse Romani and Traveller traditions, cultures, living conditions and mobility patterns and how this may affect Roma and Traveller health needs.

35. Recommendation 1503 (2001) of the Parliamentary Assembly on health conditions of migrants and refugees in Europe²⁴⁴

Adoption: 14 March 2001

1. The growing scope of migratory movements all over the world raises specific health questions in both sending and receiving countries.
2. Migrants cannot be considered exclusively as providers of labour, but also as entitled to rights, and especially to the right of equal treatment, above all in connection with health conditions.
3. Migrants are particularly vulnerable to health problems. Many migrants and refugees, in particular those moving from a poor socioeconomic environment to Europe, suffer from communicable diseases, such as tuberculosis or hepatitis, as well as respiratory diseases associated with poor nutrition, the cold, overcrowding, and inadequate sanitation, water supply and housing, compounded by limited access to health care.
4. Moreover, due to their vulnerable situation and to cultural obstacles in host countries, migrants and refugees appear to be more exposed than the rest of the population to other types of health problems, such as reproductive, occupational and mental health problems.
5. Given the inevitable interdependence between the health of migrants and their host countries populations, this issue is of general concern and should be given high importance. In particular
6. The Assembly considers that the right to health associated with access to health care is one of the basic universal human rights and should be equally applied to all people, including migrants, refugees and displaced persons.
7. The Assembly is greatly concerned that in many European countries there are migrants who fall outside the scope of existing health and social services.

²⁴⁴Text available at: <http://www.coe.int/>. See Doc. 8650, report of the Committee on Migration, Refugees and Demography, Rapporteur: Lord Ponsonby and Doc. 8878, opinion of the Social, Health and Family Affairs Committee, Rapporteur: Mr. Arnau.

8. The Assembly also expresses serious concern that few countries have developed comprehensive health policies concerning migrants and refugees. In general, migrants and refugees are not provided with health services that are socially and culturally adjusted to their needs.
9. Health care provision in the context of clandestine migration is another serious problem which requires further examination.
10. Consequently, the Assembly recommends that the Committee of Ministers:
 - i. examine national laws and policies in regard to the health of migrants and refugees with a view to developing a comprehensive, harmonised approach in all member states;
 - ii. organise exchanges of experience and information on the subject between the member states, with the participation of the appropriate governmental agencies and non-governmental organisations, including migrants and refugees associations;
 - iii. instruct the appropriate committee to develop, in consultation with the relevant governmental and non-governmental organisations, guidelines to be addressed to the member states on the health conditions of migrants and refugees in Europe;
 - iv. foster the standardisation of health screening and the criteria of its application to migrants and refugees;
 - v. review policies for the protection of migrants in the face of occupational risks;
 - vi. foster the setting up of a European system for the systematic collection and sharing of health care statistics concerning migrants and refugees;
 - vii. encourage the member states:
 - a. to sign and ratify relevant Council of Europe legal instruments, notably the revised European Social Charter, the European Convention on Social Security and its Protocol, the European Code of Social Security and its Protocols, the European Interim

Agreement on Social Security Schemes related to Old Age, Invalidity and Survivors and the European Convention on the Legal Status of Migrant Workers;

- b. to sign and ratify the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families and the two conventions on migrant workers of the International Labour Organization (ILO): the Migration for Employment Convention (revised) (C97) (1949), and the Migrant Workers? Convention (supplementary provisions) (C143) (1975);
- c. to develop specific information programmes for migrants and refugees covering their rights in the field of health care and education in prevention;
- d. to help associations of migrants and refugees to promote health education by financing the provision of educational documentation and through the training of staff recruited from migrant and refugee communities;
- e. to encourage migrants and refugees to get involved in routine national and local health care and disease prevention programmes;
- f. to examine more closely the problem of cultural obstacles preventing access to health care, including the question of translation/interpretation;
- g. to establish programmes designed to train health care providers to be more sensitive to the needs and backgrounds of migrants and refugees;
- h. to foster specialised training of civil servants in the public administration, so that they can deal with the needs created by the migration phenomenon;
- i. to request the support of non-governmental organisations operating with refugees and displaced persons, as well as their advice, in matters affecting these groups of people.

Report of the Committee on Migration, Refugees and Demography²⁴⁵

In the explanatory memorandum of the report, dated 9 February 2000, the following issues are considered: the nature and scale of the problem (which is health conditions of migrants and refugees in Europe); pre-migration health conditions (in particular poverty and health as well as health related behavior); the impact of uprooting and displacement on health (specifically considering disruption of family life, psychological and physical health, psychiatric illness, schizophrenia, suicide among children, psychiatric morbidity and children, substance abuse, gender-related psychosocial health); characteristics of resettlement and their impact on health (especially occupational health and safety and other accidents); and policies and practices concerning the health of migrants and refugees.

In particular, analyzing policies and practices concerning the health of migrants and refugees, the explanatory memorandum highlights:

“From the specific perspective of health, few countries have seen fit to ensure migrants with the type of socially and culturally tailored services they need, and in many parts of Europe there are migrants who are falling outside the scope of existing health and social services. This is especially true of undocumented migrants, who in many countries are increasing in number. Even such basic amenities as interpretation/translation for migrants requiring health care are lacking in most countries and there have been few programmes to train health care providers to the unique needs and contexts of migrants. Nor do there appear to have been many policies designed to ensure that migrants are accorded healthy housing and protection from occupational hazards. The data nevertheless indicate that because of economic and legal reasons, the housing and occupational environment of migrants often places them at a risk of communicable and non-communicable health problems.”

²⁴⁵Doc. 8650, Report of the Committee on Migration, Refugees and Demography, Rapporteur: Lord Ponsonby.

In view of the growing nature of migration, and given the symbiosis that is inevitably created between the health of migrants and their host populations, this is an area that calls for much greater attention than it has been given to date. More will probably need to be done, for example, to systematically gather and share health and health care statistics concerning migrants and would-be migrants. More is also called for with respect to standardising definitions of migration, health screening and the reasons for it. Everywhere there is also an urgent need to involve migrants in routine national and local health care and disease prevention programmes”.

Opinion of the Social, Health and Family Affairs Committee²⁴⁶

The Social, Health and Family Affairs Committee, in the explanatory memorandum, underlines that “*Immigrant workers must be considered not only as a source of labour but as people with rights, for example the right to equal treatment without discrimination of any kind, particularly in the field of health*”.

Moreover, it emphasizes that “*the right to health, which is a universal right, cannot be secured if the right of everyone to have access to health care services is not recognised. However, the problem of non-recognition of the right to medical care is one that affects undocumented or illegal migrants, especially as regards access to emergency services*”.

The opinion of the Social, Health and Family Affairs Committee expressed in this second document also takes into consideration common problems of migrants and refugees in Europe, highlighting that:

“Illegal migrants and refugees in the process of legalising their situation represent a major problem in the area of health-care provision.

Different European countries deal with the problem of resident aliens’ access to health services in different ways.

²⁴⁶ Doc. 8878, Opinion of the Social, Health and Family Affairs Committee, Rapporteur: Mr. Arnau.

There are different practices, even within one and the same country, but the highest degree of protection is afforded to children, pregnant women, people suffering from infectious diseases and people requiring emergency medical care”.

Lastly, the document mentions the “Solidarity Card” introduced by the Autonomous Community of Valencia (Spain).

This card “enables illegal immigrants living in this region to receive the same medical care as other citizens. This solution ensures that all resident citizens have access to public health services, irrespective of their legal status. Immigrants’ personal details are registered on a file which is available to all public health centres.

The solution found in Valencia for providing medical care to all those in need of it reflected in the very name of the Card points to one possible way of guaranteeing one of the fundamental human rights”.

Reply to the Parliamentary Assembly Recommendation 1503 (2001) on the health conditions of migrants and refugees in Europe²⁴⁷

(...)

The Deputies adopted the following reply to Parliamentary Assembly Recommendation 1503 (2001):

“The Committee of Ministers has examined Parliamentary Assembly Recommendation 1503 (2001) on the health conditions of migrants and refugees in Europe.

The Committee of Ministers attaches great importance to promoting health equity and improving the health status of vulnerable sectors of the population. It draws the Assembly’s attention to its recent Recommendation

²⁴⁷Source: (REC_1503 (2001), CM (2001)161 Appendix II), available at <http://www.hri.ca/forthereCord2001/euro2001/documentation/comminister/rec15032001.htm>. At their 778th meeting (778/6.1) the Committee of Ministers adopted a reply to the Parliamentary Assembly’s recommendation 1503 on the health conditions of migrants and refugees in Europe.

Rec(2001)12 on the adaptation of health care services to the demand for health care and health care services of people in marginal situations, which has enhanced the series of recommendations on vulnerable populations. The definition of persons living in insecure conditions and in marginal situations is applicable to migrants and refugees. Many of the measures put forward by the Assembly in its recommendation are compatible with the policy guidelines set out in Recommendation Rec(2001)12²⁴⁸.

It recommends the introduction of a coherent and comprehensive policy framework based on the principles of equity, human dignity and participation. In order to protect and improve the health of people in marginal situations, this recommendation proposes a multi-sectoral approach for carrying out preventative work, ensuring a favourable context for social reintegration, avoiding stigmatisation and improving knowledge of this field. The measures adopted to facilitate access to health care for vulnerable persons are also of benefit to the population as a whole, and help to avoid the pitfall of “second-class medicine for the poor”.

As the Council of Europe has noted whilst carrying out the activities on access to social rights for vulnerable persons (i.e.: access to social protection, access to housing and access to employment), measures aimed at facilitating access to health care for persons in marginal situations should not on any account be disassociated from the design and implementation of integrated approaches aimed at improving effective access to social rights.

The activities on access to social protection, access to housing and access to employment, have lead to the adoption, in 2001, of guidelines for the improvement of access to these respective rights. The Group on access to social rights will carry forward the results of these activities and, by following an integrated approach which will take account of the health and education aspects, will draw up in 2002 a comprehensive report on access to social rights.

The Assembly’s attention is also drawn to the activities of Working Table II of the Stability Pact as part of the “Initiative for Social Cohesion” Working Group. The health component is called “South-East Europe Strategic Review on Social Cohesion - Health Network” and focuses on a survey to improve access to health care for vulnerable and marginalized persons.

²⁴⁸Text available at: <http://www.hri.ca/forthereCord2001/euro2001/documentation/comminister/rec15032001.htm>.

This work was used to prepare the Health Ministers' Forum in Dubrovnik, which was a particularly important event in developing regional co-operation for health development in South-East Europe, promoting access to health and reducing vulnerability. Amongst the achievements of the Forum was the adoption and signing by the Ministers of a commitment to meet the health needs of vulnerable populations in South-East Europe - "the Dubrovnik Pledge". The Health Network will continue its work throughout 2002 in order to identify priority issues in policy development and offer practical solutions, including projects of a regional dimension.

This activity is a response to the concern expressed by the Health Ministers of the Council of Europe member States in 1999 at their 6th Conference with regard to the impact of the crisis in South-East Europe on the life and health of refugees, displaced persons and all persons living in the area, as well as on health and social services in countries directly affected.

The Committee of Ministers has carefully studied the Assembly's suggestion that it examine national laws and policies in regard to the health of migrants and refugees with a view to developing a comprehensive, harmonised approach in all member states. It is true that, at the present time, equal access to health care in the majority of member states is only guaranteed to legal immigrants and refugees, whilst other migrants receive only emergency health care.

As regards developing new policy guidelines on the health conditions of migrants and refugees in Europe, the Committee of Ministers is examining the possibility of launching a joint activity by the European Committee on Migration (CDMG) and the European Health Committee (CDSP). In particular, the second committee's work could focus on examining the organisation of health care in a multicultural society.

The CDMG's work could draw on the conclusions of the report on "Diversity and Cohesion: new challenges for the integration of immigrants and minorities", in which the issue of access to health services was considered at length. Equal treatment is an aspect of integration policy and community relations. Another facet of the CDMG's activity could focus on reviewing policies to protect migrants against occupational hazards. The Convention on the Legal Status of Migrant Workers could serve as the basis of this work.

The Committee of Ministers has brought Recommendation 1503 (2001) to the attention of the governments of its member states, with a view to informing them of the various measures recommended by the Assembly. It welcomes the renewed invitation to member states to sign and ratify

the relevant legal instruments, and is pleased to note the willingness, expressed by the Parliamentary Assembly, the Congress of Local and Regional Authorities and the European Committee on Migration, at the Conference on “Irregular Migration and Dignity of Migrants: co-operation in the Mediterranean region” held in Athens on 3 and 4 October 2001, to pursue a joint campaign to encourage signature and ratification of the Council of Europe’s relevant legal instruments.”

36. Recommendation 1626(2003) of the Parliamentary Assembly on the reform of health care systems in Europe: reconciling equity, quality and efficiency²⁴⁹.

Adoption: 1 October 2003

1. The Parliamentary Assembly recalls the pledge made in 1996 by the health ministers of the European member states of the World Health Organisation (WHO), all of whom are member states of the Council of Europe, to promote the principles outlined in the Ljubljana Charter on Reforming Health Care in Europe. According to these principles the reform of European health care systems should be driven by the values of human dignity, equity, solidarity and professional ethics; be aimed at the improvement of health; respond to the needs and expectations of citizens sharing responsibility for their own health; be focused on the improvement of quality and cost-effectiveness, based on sound financing in order to allow universal coverage and equitable access; and be oriented towards primary health care.
2. Seven years on, the Parliamentary Assembly notes that the reform of health care systems in the member states of the Council of Europe has been a virtually continuous process which seeks to reconcile the often contradictory aims of maximising quality, efficiency and equality of access whilst guaranteeing the viability of the system, against a background of limited government resources and rapid demographic and technological change. This process has led to a certain convergence between the “Bismarck” systems, which are contribution-based and managed by the social partners, and the “Beveridge” systems, which are universal, revenue-financed and state-controlled.
3. The countries of central and eastern Europe have faced the particularly difficult challenge of achieving equitable, balanced and sustainable systems in the context of transition to a mixed economy.
4. The Assembly considers that, in line with the objective of greater social cohesion and solidarity set by the 2nd Summit of Heads of State and Government of the Council of Europe in 1997, the main criterion for judging the success of health system reforms should be effective access to health care for all without discrimination, which is a basic human

²⁴⁹Text available at: <http://www.coe.int/>. See Doc. 9903, report of the Social, Health and Family Affairs Committee, Rapporteur: Mr Brînzan.

right. This also has the consequence of improving the general standard of health and welfare of the entire population.

5. In order to counter the financial pressure involved in providing universal health coverage and the increasing costs associated with secondary care, greater emphasis must be placed on prevention and primary care. Moreover, measures to raise additional revenue and contain costs must be sought without affecting equality of access. The effects of co-payments and private insurance should be studied in this regard and best practice identified.
6. The Parliamentary Assembly welcomes the considerable recent achievements of the Committee of Ministers in the health field, and notably Recommendation No. R (97) 17 on the development and implementation of quality improvement systems (QIS) in health care; Recommendation No. R (98) 7 concerning ethical and organisational aspects of health care in prison; Recommendation No. R (99) 21 on criteria for managing waiting lists and waiting times in health care; Recommendation No. R (2000) 5 on the development of structures for citizen and patient participation in the decision-making process affecting health care; Recommendation Rec(2001)12 on the adaptation of health care services to the demand for health care and health care services of people in marginal situations; and Recommendation Rec(2001)13 on developing a methodology for drawing up guidelines on best medical practices.
7. The Parliamentary Assembly emphasises the need to systematically promote the implementation by the member states of these and other recommendations of the Committee of Ministers in the health field, as well as those of the conferences of European health ministers, the latest of which was held in Oslo on 12 and 13 June 2003 and was entitled Health, Dignity and Human Rights.
8. The Parliamentary Assembly welcomes the work done in the health field by the Organisation for Economic Co-operation and Development (OECD) and looks forward in particular to the results of its current health project (2001-2004) designed to measure and analyse the performance of health care systems in its member countries and factors affecting performance, such as waiting times for elective surgery.
9. Given the increasingly international nature of threats to health, for example through epidemics, and demands on health care systems, such as “health tourism”, recruitment of medical staff or bio-terrorism, the

Parliamentary Assembly considers that health policies should be made part of European Union/European Community competence in the draft treaty of the European Union establishing a constitution for Europe.

10. The Parliamentary Assembly therefore recommends that the Committee of Ministers:

- i. reaffirm the role of the state in regulating health care systems;
- ii. step up its assistance programmes in the health field with a view to strengthening the implementation of its recommendations to the governments of member states;
- iii. instruct the appropriate committee to pursue its work on the revision of Articles 11 and 13 of the European Social Charter with a view to widening their scope;
- iv. study the trends in member states' health policies that may have the effect of reducing equality of access to health care, for example increasing patients' contributions ("co-payments"), promoting the expansion of private insurance or concentrating resources excessively on flagship hospitals;
- v. call on the member states to take as their main criterion for judging the success of health system reforms the effective access to health care for all, without discrimination, as a basic human right and, as a consequence, the improvement of the general standard of health and welfare of the entire population;
- vi. call on the member states to consider prevention as an independent "fourth pillar" in addition to acute care, long-term care and rehabilitation;
- vii. call on the member states to give greater priority to primary care and the role of general practitioners in order to reduce costs and improve the general health and welfare of the population;
- viii. call on the member states to strengthen respect for patients' rights;
and

- ix. call on the member states to support the role of citizens and patients in health care systems, to preserve and consolidate the patient's right to free choice of physician, health facility and health insurance, encourage greater access to information for patients and reinforce the patient's capacity to make decisions and take responsibility for them.

*MIGRANT STUDENTS
AND YOUNG MIGRANTS*

37. Recommendation Rec(2006)9 of the Committee of Ministers to member states on the admission, rights and obligations of migrant students and co-operation with countries of origin (excerpt)²⁵⁰

Adoption: 12 July 2006

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members;

Recalling the 1950 Convention for the Protection of Human Rights and Fundamental Freedoms and its Protocols, and, in particular, its Article 8, which guarantees the right to respect for private and family life, its Article 14, which sets forth the principle of non-discrimination with regard to the rights granted, Article 2 of Protocol No. 11, which stipulates that no person shall be denied the right to education, Article 2 of Protocol No. 4, which guarantees freedom of movement, Article 1 of Protocol No. 12, which prohibits discrimination, as well as the relevant case law of the European Court of Human Rights;

Recalling the 1997 Convention on the Recognition of Qualifications concerning Higher Education in the European Region, which aims to facilitate the recognition in one state of qualifications granted in another state;

Taking note of the Council Directive of the European Union 2004/114/EC of 13 December 2004 on the conditions of admission of third-country nationals for the purposes of studies, pupil exchange, unremunerated training or voluntary service²⁵¹;

Recognising that the right to education is a fundamental principle of human rights, and that higher education, which is instrumental in the pursuit and advancement of knowledge, constitutes an exceptionally rich cultural and scientific asset for both individuals and society;

²⁵⁰Text available at: <http://www.coe.int/>.

²⁵¹See the Council Directive of the European Union 2004/114/EC at p. 85.

Considering that for countries of origin and, in particular, for developing countries human capital is an important resource that can contribute to their sustainable development and social and economic progress;

Considering that the mobility of migrant students contributes to peace, mutual understanding and tolerance, and creates mutual confidence among peoples and nations;

Recognising that the mobility of migrant students aims to increase their professional qualifications and skills;

Affirming the need to improve the legal status of migrant students and to facilitate their access to educational institutions and educational resources and to social and economic rights in the member states on conditions similar to those of national students;

Taking into account Recommendation No. R (84) 13 of the Committee of Ministers to member states concerning the situation of foreign students;

Recalling that at the 7th Conference of European Ministers responsible for Migration Affairs of the Council of Europe, the Ministers recommended to the Committee of Ministers to strengthen the dialogue and partnership between member states and, when relevant, with non-member states on migration issues;

Recommends that the governments of member states apply the principles set out below in their legislation and administrative practice.

Recalls that this recommendation does not prevent a member state granting a more favourable legal status to foreign nationals who apply for admission or have already been admitted for study purposes.

Recommends member states to bring the principles of this recommendation to the attention of the relevant bodies in their respective countries through the appropriate channels.

Encourages member states not having yet done so to ratify the European Convention on Social and Medical Assistance and its Protocol (1953), the European Convention on Establishment (1955), the European Convention on the Legal Status of Migrant Workers (1977), the Convention on the Participation of Foreigners in Public Life at Local Level (1992), the European Convention on the Exercise of Children's Rights (1996), the

revised European Social Charter (1996) and the European Convention on Nationality (1997).

Appendix to Recommendation Rec(2006)9 on the admission, rights and obligations of migrant students and co-operation with countries of origin

I. Scope of application

1. This recommendation applies to migrant students²⁵² wishing to pursue studies in an institution of higher education in a member state of the Council of Europe.
2. For the purposes of this recommendation, the term “migrant student” covers any foreign national, including those originating from developing countries and stateless persons where:
 - he has been admitted to an institution of higher education in a member state in order to pursue, as his main activity, a course of full-time study; and
 - he will pursue or is pursuing a course of study that will lead to the award of a qualification recognised in accordance with the legislation and/or administrative practice of the member state concerned or a preparatory programme for studies of this type; and
 - he is requesting admission to the territory of the member state concerned in order to pursue the course of study or has already been so admitted.
3. For the purposes of this recommendation, the expression “institution of higher education” refers to a public or private institution which is recognised, or whose curriculum is recognised by a member state and which is considered to be of higher education level, in accordance with the legislation and/or administrative practice of the member state concerned.
4. Member states may, by adjusting its content accordingly and with due regard to its principles, extend this recommendation to persons seeking admission to their territory, or who are already so

²⁵²For the purpose of clarity the masculine gender is used to refer to both male and female migrant students throughout the text.

admitted, for the purposes of studies other than those mentioned above, including unpaid vocational training aimed at improving their skills.

II. Conditions of admission

1. A migrant student should be admitted to the territory of a member state if he satisfies the conditions set out below.

(...)

- e. He possesses health insurance covering all the risks, including maternity and invalidity, usually covered by the social security system of the member state concerned, unless he is covered by such insurance in his capacity as a student.

2. The entry and/or stay of a migrant student whose presence would constitute a threat to public order, public security or public health may be refused.

(...)

VI. Access to rights

1. Migrant students lawfully present on the territory of a member state and/or to whom a residence permit has been issued should be entitled to enter and exit the state.

Member states should facilitate the freedom of movement of migrant students, as provided by national legislation, by establishing, wherever possible, a fast-track procedure with regard to entry, exit and transit visas.

2. During their stay, migrant students should have access to health care.

Member states should allow migrant students to contract health insurance covering all risks (including maternity and invalidity).

Migrant students temporarily without sufficient resources should have access to social and medical assistance as provided by national legislation and international agreements in force.

3. Migrant students should have access, under conditions provided by the national legislation in the host country, to student university accommodation or, if none is available, to social housing.
4. Migrant students admitted to a member state should have the possibility to pursue part of their course of study in an institution of higher education situated in another member state or to take part in an exchange programme in accordance with the national legislation of the member states concerned.

(...)

38. Recommendation 1596 (2003) of the Parliamentary Assembly on the situation of young migrants in Europe²⁵³

Adoption: 31 January 2003

1. Young migrants represent a varied and heterogeneous group. They include children, young women and young men who have fallen prey to human traffickers or who have been smuggled into a country in the hope of escaping poverty, persecution or a situation of generalised violence; young people who have entered European countries through legal channels for study, work or family reunion; and second-generation migrants who are born in the host country. Many of them come from non-European countries; but many others are Europeans who move, legally or illegally, from one member state to another. They are immigrants for some states and emigrants, or returning emigrants, for others.
2. Bearing in mind the activities of the Council of Europe in the field of migration, as well as the numerous activities addressing the situation of youth in Europe, and namely those conducted by the Directorate for Youth and Sport, the Parliamentary Assembly recalls the works of the Hearing on the Specific Situation of Young Migrants (held at the European Youth Centre in Budapest, on 15 and 16 November 2001), where thirty young people from twenty-seven European countries shared their experience of migration with members of the Sub-Committee on Migration of the Committee on Migration, Refugees and Demography, and voiced their unease and concern at current policies, or absence of policies, applying to their situation.
3. The Assembly is convinced that the situation of young migrants in Europe requires urgent action on the part of the Council of Europe, in co-operation with the relevant international organisations, to address the reasons why young people want to, or are forced to, emigrate, their rights and living conditions as immigrants, and finally their rights and needs when, and if, they return to their countries of origin.
4. The Assembly therefore recommends that the Committee of Ministers:

²⁵³Text available at: <http://www.coe.int/>. See Doc. 9645, report of the Committee on Migration, Refugees and Demography, Rapporteur: Mr Yáñez-Barnuevo.

- i. in consultation with relevant international agencies such as Unicef, the International Organisation for Migration (IOM) and the Office of the United Nations High Commissioner for Refugees (UNHCR) – and in compliance with the mandate of these agencies – initiate a long-term multidisciplinary programme for young migrants in Europe, with the aim of fostering social cohesion and the participation of young migrants through the improvement of their legal status, the support of appropriate integration and reintegration projects, the development of educational materials and programmes and the organisation of various initiatives designed to meet the needs of young migrants and highlighting their positive contribution to the strengthening of democratic society;
- ii. include in the work programme of the General Directorate on Education, Culture and Heritage, Youth and Sport regular meetings – in the form of seminars, hearings, conferences and others – on the topic of young migrants, with the participation of young migrants;
- iii. encourage member states to submit projects to the Council of Europe Development Bank, with a view to funding or co-funding integration projects for young migrants in host countries, as well as reintegration projects for young migrants returning to their countries of origin, in particular young victims of trafficking;
- iv. initiate a study to review the implementation of Committee of Ministers Recommendation Rec(2000)15 of the concerning the security of residence of long-term migrants and Recommendation Rec(2002)4 on the legal status of persons admitted for family reunification, with special regard to protection against expulsion of migrants who were born or raised in Council of Europe member states or who are minors;
- v. with reference to the current preparation of a report on conditions for the acquisition and loss of nationality by its Committee of Experts on Nationality (CJ-NA), ask its relevant committees to initiate a study on the use of nationality law as an instrument to foster social cohesion and the integration of young migrants and include this issue among those to be addressed during the next European Conference on Nationality;
- vi. initiate a feasibility study on the harmonisation of national laws on legal guardianship of separated children, as defined in subparagraph 7.iv of the present recommendation, with a view to the

elaboration of an international binding instrument including the following guidelines:

- a. all Council of Europe member states should adopt a legal framework for the appointment of a legal guardian for separated children who are under their jurisdiction, irrespective of whether they apply for asylum or not;
 - b. the legal guardian should look after the child individually, and be chosen among people or institutions of proven reliability, and have an understanding of the special and cultural needs of separated children as well as of the institutions of the host country;
 - c. the appointment of the legal guardian should take place as a matter of urgency, and in any case within two weeks of the presence of the child on national territory coming to the knowledge of the authorities;
 - d. the legal guardian should ensure that all decisions affecting the child are taken in his or her best interests, that the child has suitable legal representation to deal with his or her legal status and that she or he receives suitable care, accommodation, education, language support and health care;
 - e. the legal guardian should also act as a link between the child and various service providers and advocate on behalf of the child where necessary.
5. Furthermore, with a view to fostering participation and social cohesion, the Assembly recommends that the Committee of Minister elaborate measures aiming to assist member states to:
- i. grant the right to vote and stand in local elections to migrants having settled legally on their territories and having resided there for at least three years;
 - ii. adopt appropriate legislation to facilitate the acquisition of nationality for migrants having resided legally in the country on a long-term basis;
 - iii. facilitate the acquisition of nationality for children born on their territories to legally residing foreign parents;

- iv. establish, or promote the establishment of, integration programmes according to, the following guidelines:
 - a. states should use all the available instruments at their disposal to fund, or support the funding of, integration programmes, and in particular the loans of the Council of Europe Development Bank and other international agencies;
 - b. states and local authorities should:
 - mobilise resources to employ sufficient staff for the implementation of integration programmes and provide them with adequate training;
 - monitor the implementation of integration programmes and conduct periodical evaluation studies;
 - ensure the participation of migrants in the elaboration, implementation and evaluation of integration programmes;
 - establish special integration programmes addressed to young migrants, not only those who have newly arrived;
 - c. participation in integration programmes should be voluntary, but states and local authorities could provide financial inducements to ensure wider attendance;
 - d. integration programmes should include language tuition and vocational guidance and/or training;
 - e. integration programmes should be based on an assessment of the integration needs of each beneficiary;
 - f. in the absence of specific integration programmes devoted to them, young migrants with dependants, especially women, should have priority of access to ordinary integration programmes;
 - g. integration programmes should aim at the personal development of beneficiaries, providing them with instruments to participate in all aspects of society, while preserving their language, culture and national identity, in accordance with the European Convention on Human Rights.

6. With a view to using education effectively as an instrument to foster equality, multiculturalism and mutual understanding, the Assembly also recommends that the Committee of Ministers elaborate measures addressed to member states, and aiming at:
 - i. ensuring unimpeded access to compulsory education for migrant children, irrespective of their own or their parents' legal status;
 - ii. ensuring access to compulsory education for migrants aged under 18 and who have not completed compulsory education in other countries, irrespective of their legal status or the legal status of their parents;
 - iii. responding to the special needs of migrant students integrating the ordinary curriculum with additional classes, focusing on tuition in the language of the host country and the study of its society and culture;
 - iv. investing additional resources in the employment in educational institutions of specialised staff, such as psychologists, pedagogues, social workers and cultural mediators and provide them, as well as teachers, with appropriate training to deal with young migrants;
 - v. ensuring that the content of school programmes and textbooks does not contain any national or ethnic prejudices and does not convey any discriminatory or racist interpretation of the history, culture and society of foreign countries or communities;
 - vi. funding and supporting extracurricular activities aimed at highlighting the value of the culture and civilisation of migrants' communities and their countries of origin;
 - vii. supporting initiatives taken at local level to foster contacts between immigrant parents, the school and the community.
7. The Assembly further recommends that the Committee of Ministers include in its working programme activities aimed at assisting member states to:
 - i. introduce in all domestic laws or policy measures affecting children a specific mention of the situation of migrant children;

- ii. give primacy and binding character to the principle of the best interests of the child, making this explicit in all laws, regulations or administrative guidelines concerning migration and/or asylum;
- iii. refrain from detaining minors exclusively on immigration grounds, and consequently provide for alternative and adequate accommodation;
- iv. introduce in domestic law and policy the definition of “separated children” as “children under 18 years of age who are outside their country of origin and separated from both parents or their legal/customary primary caregivers”, and afford them an effective system of care and protection, consistent with the present recommendation as well as the recommendations of the Separated Children in Europe Programme established by the UNHCR and members of the International Save the Children Alliance;
- v. ensure that the definition of separated children, and the special care and protection to which they are entitled, are interpreted and applied in a uniform manner throughout their territories, even when the competence in this matter falls within the remit of federate, regional or local authorities;
- vi. introduce legal provisions to allow the placement of separated children, including those who do not apply for asylum, in reception centres or care institutions appropriate to their needs, invest in the creation of such centres and institutions where necessary and ensure that separated children benefit from the same level of assistance and protection as is available for children with the nationality of the host country;
- vii. facilitate the family reunification of separated children with their parents in other member states, even when parents do not have permanent residence status or are asylum seekers, in compliance with the principle of the best interests of the child;
- viii. consider favourably requests for family reunification between separated children and family members other than parents who have a legal title to reside in a member state, are over 18 years of age and are willing and able to support them;
- ix. facilitate the family reunification of separated young people with mental or physical disabilities, including those who are over 18

years of age, with their parents or other adult family members upon whom they were dependant in the country of origin or the country of habitual residence and who are legally residing in another member state;

- x. in any ordinary or accelerated procedure implying the return of separated children to their countries of origin or any other country, including procedures of non-admission at the border, comply with the following guidelines:
 - a. states should make sure that return is not in breach of their international obligations under the 1951 Geneva Convention relating to the Status of Refugees and its 1967 Protocol, or the European Convention on Human Rights and other relevant instruments;
 - b. return should not be possible before a legal guardian for the child has been appointed;
 - c. before taking the decision to return a separated child, states should demand and take into consideration the opinion of the child's legal guardian as to whether return would be in the best interests of the child;
 - d. return should be conditional upon the findings of a careful assessment of the family situation that the child would find upon return, and of whether the child's family would be able to provide appropriate care. In the absence of parents or other family members, the suitability of childcare agencies in the country of return should be investigated. The assessment should be conducted by a professional and independent organisation or person and should be objective, non-political and aimed at ensuring the respect of the principle of the best interests of the child;
 - e. prior to return, states should obtain an explicit and formal undertaking from the child's parents, relatives, other adult carer or any existing childcare agency in the country of return that they will provide immediate and long-term care upon the child's arrival;

- f. the decision to return a separated child should be reasoned and notified to the child and his/her legal guardian in writing, together with information on how to appeal against it;
 - g. the child and/or his or her legal guardian should have the right to lodge an appeal before a court against the decision to return. Such an appeal should have suspensive effect and be extended to the lawfulness and the merits of the decision;
 - h. during return, the child should be accompanied and treated in a manner in keeping with his or her age;
 - i. the well-being of the child following return should be monitored by appropriate authorities or agencies on the spot, who should liaise with, and report to, the authorities of the country from which the child has been returned;
 - j. migrants who arrived in a host country as separated children but who have reached the age of 18 at the time of return should be treated as vulnerable cases and consulted on the conditions required for successful reintegration into their country of origin.
8. As regards the issue of trafficking in children and young people, the Assembly recommends that the Committee of Ministers include in its working programme activities aimed at assisting member states:
- i. to sign and ratify the United Nations instruments applicable to this matter, and in particular the Additional Protocol to the Convention against Transnational Organised Crime to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, and International Labour Organization Convention No. 182 concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour;
 - ii. to establish effective protection regimes for children and young people who are victims of trafficking, and ensure the availability of psychological counselling and assistance upon demand of the victims, their legal guardians or care institutions;

- iii. to devise and implement appropriate programmes to meet the care and assistance needs of traumatised children and young people who are victims of trafficking in host countries;
 - iv. to devise and implement appropriate reintegration programmes for young victims of trafficking returning to their countries of origin;
 - v. to allocate additional financial resources to the prevention of trafficking in children and young people in the countries of origin and support or conduct information campaigns in schools and other places of socialisation or care, including orphanages, especially in areas at risk;
 - vi. support the initiatives of the IOM, the UNHCR and other agencies – within the limits of their mandates – to train police officers, border police and immigration officials on the international legal framework applying to trafficking, with particular attention to the assistance and protection needs of children and young people who are victims.
9. Finally, also recalling Assembly Recommendation 1547 (2002) on expulsion procedures in conformity with human rights and enforced with respect for safety and dignity, the Assembly asks the Commissioner for Human Rights to conduct an investigation on the situation of separated children in Council of Europe member states and report to the Assembly and the Committee of Ministers.

IRREGULAR MIGRANTS

39. Recommendation No. R (2000) 3 of the Committee of Ministers to member states on the Right to the Satisfaction of Basic Material Needs of Persons in Situations of Extreme Hardship²⁵⁴

Adoption: 19 January 2000

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is the achievement of greater unity between its members for the purpose of safeguarding and realising the ideals and principles which are their common heritage;

Bearing in mind the European Convention for the Protection of Human Rights and Fundamental Freedoms;

Concerned by the individual situations of extreme hardship which exist, sometimes on a very large scale, in all the member States;

Aware that the satisfaction of basic human material needs (as a minimum: food, clothing, shelter and basic medical care) is a requirement intrinsic to the dignity of every human being and constitutes the condition for the existence of all human beings and their well-being;

Further aware that the satisfaction of these needs corresponds to a duty of society in terms of humanity;

Further considering that the recognition of an individual, universal and enforceable right, for persons in situations of extreme hardship, to the satisfaction of those needs is a condition for the exercise of other fundamental rights and an indispensable element in a democratic state based on the rule of law;

Referring to the conclusions of the Conference on Human Dignity and Social Exclusion (Helsinki, 18-20 May 1998), to Resolution 1999/26 of the United Nations' Commission on Human Rights on human rights and extreme poverty, to Recommendation 1196 (1992) of the Parliamentary Assembly of the Council of Europe on severe poverty and social exclusion: towards guaranteed minimum levels of resources, as well as to the Committee of Ministers' Recommendation No R (93) 1 to member States on effective access to the law and to justice for the very poor;

²⁵⁴Text available at: <http://www.coe.int/>.

Noting that certain member states already recognise, in their internal law and practice, the existence of an individual, universal and enforceable right to the satisfaction of basic human material needs;

Considering that the law and practice of all member states should recognise such a right;

RECOMMENDS the governments of the member states to put into practice the principles in the Annex to this Recommendation in order to recognise, at national level, an individual universal and enforceable right to the satisfaction of basic material needs (as a minimum : food, clothing, shelter and basic medical care) for persons in situations of extreme hardship.

Appendix to Recommendation No. R (2000) 3

Principle 1

Member states should recognise, in their law and practice, a right to the satisfaction of basic material needs of any person in a situation of extreme hardship.

Principle 2

The right to the satisfaction of basic human material needs should contain as a minimum the right to food, clothing, shelter and basic medical care.

Principle 3

The right to the satisfaction of basic human material needs should be enforceable, every person in a situation of extreme hardship being able to invoke it directly before the authorities and, if need be, before the courts.

Principle 4

The exercise of this right should be open to all citizens and foreigners, whatever the latter's position under national rules on the status of foreigners, and in the manner determined by national authorities.

Principle 5

The member states should ensure that the information available on the existence of this right is sufficient.

40. Twenty guidelines of the Committee of Ministers of Europe on forced return²⁵⁵

Adoption: 4 May 2005

The Committee of Ministers,

Recalling that, in accordance with Article 1 of the European Convention on Human Rights, member states shall secure to everyone within their jurisdiction the rights and freedoms defined in Section I of the Convention;

Recalling that everyone shall have the right to freedom of movement in accordance with Article 2 of Protocol No. 4 to the Convention;

Recalling that member states have the right, as a matter of well-established international law and subject to their treaty obligations, to control the entry and residence of aliens on their territory;

Considering that, in exercising this right, member states may find it necessary to forcibly return illegal residents within their territory;

Concerned about the risk of violations of fundamental rights and freedoms which may arise in the context of forced return;

Believing that guidelines not only bringing together the Council of Europe's standards and guiding principles applicable in this context, but also identifying best possible practices, could serve as a practical tool for use by both governments in the drafting of national laws and regulations on the subject and all those directly or indirectly involved in forced return operations;

Recalling that every person seeking international protection has the right for his or her application to be treated in a fair procedure in line with international law, which includes access to an effective remedy before a decision on the removal order is issued or is executed,

²⁵⁵Source: CM(2005)40 final 9 May 2005. When adopting this Decision, the Permanent Representative of the United Kingdom indicated that, in accordance with Article 10.2c of the Rules of Procedure for the meetings of the Ministers' Deputies, he reserved the right of his Government to comply or not with Guidelines 2, 4, 6, 7, 8, 11 and 16.

1. Adopts the attached guidelines and invites member states to ensure that they are widely disseminated amongst the national authorities responsible for the return of aliens.
2. Considers that in applying or referring to those guidelines the following elements must receive due consideration:
 - a.* none of the guidelines imply any new obligations for Council of Europe member states. When the guidelines make use of the verb “shall” this indicates only that the obligatory character of the norms corresponds to already existing obligations of member states. In certain cases however, the guidelines go beyond the simple reiteration of existing binding norms. This is indicated by the use of the verb “should” to indicate where the guidelines constitute recommendations addressed to the member states. The guidelines also identify certain good practices, which appear to represent innovative and promising ways to reconcile a return policy with full respect for human rights. States are then “encouraged” to seek inspiration from these practices, which have been considered by the Committee of Ministers to be desirable;
 - b.* nothing in the guidelines shall affect any provisions in national or international law which are more conducive to the protection of human rights. In particular, in so far as these guidelines refer to rights which are contained in the European Convention on Human Rights, their interpretation must comply with the case-law of the European Court of Human Rights;
 - c.* the guidelines are without prejudice to member states’ reservations to international instruments.

The Guidelines on Forced Return

The origin of these Guidelines lie in Parliamentary Assembly Recommendation 1547(2002) on expulsion procedures in conformity with human rights and enforced with respect for safety and dignity. In its reply to Recommendation 1547(2002), the Committee of Ministers of the Council of Europe expressed its support for the idea of the Parliamentary Assembly to draw up a code of good conduct for expulsion procedures.

In its Decision No. CM/859/09092003, the Committee of Ministers requested that the ad hoc Committee of Experts on Legal Aspects of Territorial Asylum, Refugees and Stateless Persons (CAHAR) prepare a draft set of non-binding guidelines on expulsion procedures. A Working Party composed of six experts appointed by the CAHAR, two experts appointed by the Steering Committee for Human Rights (CDDH), and two experts appointed by the European Committee on Migration (CDMG) assisted in the preparation of these guidelines and held four meetings.

The draft guidelines were discussed at the 55th Meeting of CAHAR of 20-22 October 2004, where it was decided to forward the draft guidelines to the Committee of Ministers for adoption. The Committee of Ministers subsequently adopted the guidelines at the 925th Meeting of the Ministers' Deputies on 4 May 2005.

During this last meeting, the Committee of Ministers of the Council of Europe adopted the twenty guidelines on forced return and also took note of the comments on these guidelines drafted by the CAHAR.

(...)

Chapter III – Detention pending removal

(...)

Guideline 10. Conditions of detention pending removal

1. Persons detained pending removal should normally be accommodated within the shortest possible time in facilities specifically designated for that purpose, offering material conditions and a regime appropriate to their legal situation and staffed by suitably qualified personnel.
2. Such facilities should provide accommodation which is adequately furnished, clean and in a good state of repair, and which offers sufficient living space for the numbers involved. In addition, care should be taken in the design and layout of the premises to avoid, as far as possible, any impression of a “carceral” environment. Organised activities should include outdoor exercise, access to a day room and to radio/television and newspapers/magazines, as well as other appropriate means of recreation.
3. Staff in such facilities should be carefully selected and receive appropriate training. Member states are encouraged to provide the staff concerned, as far as possible, with training that would not only equip them with interpersonal communication skills but also familiarise them with the different cultures of the detainees. Preferably, some of the staff should have relevant language skills and should be able to recognise possible symptoms of stress reactions displayed by detained persons and take appropriate action. When necessary, staff should also be able to draw on outside support, in particular medical and social support.
4. Persons detained pending their removal from the territory should not normally be held together with ordinary prisoners, whether convicted or on remand. Men and women should be separated from the opposite sex if they so wish; however, the principle of the unity of the family should be respected and families should therefore be accommodated accordingly.
5. National authorities should ensure that the persons detained in these facilities have access to lawyers, doctors, non-governmental organisations, members of their families, and the UNHCR, and that they are able to communicate with the outside world, in accordance with the relevant national regulations. Moreover, the functioning of

these facilities should be regularly monitored, including by recognized independent monitors.

6. Detainees shall have the right to file complaints for alleged instances of ill-treatment or for failure to protect them from violence by other detainees. Complainants and witnesses shall be protected against any ill-treatment or intimidation arising as a result of their complaint or of the evidence given to support it.
7. Detainees should be systematically provided with information which explains the rules applied in the facility and the procedure applicable to them and sets out their rights and obligations. This information should be available in the languages most commonly used by those concerned and, if necessary, recourse should be made to the services of an interpreter. Detainees should be informed of their entitlement to contact a lawyer of their choice, the competent diplomatic representation of their country, international organizations such as the UNHCR and the International Organization for Migration (IOM), and non-governmental organisations. Assistance should be provided in this regard.

Comments drafted by the CAHAR on guideline 10

1. The wording used in the first three paragraphs of this Guideline was inspired from the 7th General Report of the CPT (CPT/Inf(97)10, para. 29). These paragraphs also build upon the Recommendation (CommDH/Rec(2001)1) of the Commissioner for Human Rights concerning the rights of aliens wishing to enter a Council of Europe member state and the enforcement of removal orders (19 September 2001), especially paragraphs 7, 9 and 10 and upon Parliamentary Assembly Recommendation 1547(2002) on expulsion procedures in conformity with human rights and enforced with respect for safety and dignity, especially para. 13, v, d).
2. In the above mentioned report, the CPT expressed the view that “in those cases where it is deemed necessary to deprive persons of their liberty for an extended period under aliens legislation, they should be accommodated in centres specifically designed for that purpose, offering material conditions and a regime appropriate to their legal situation and staffed by suitably-qualified personnel” (7th General Report (CPT/Inf(97)10), para. 29).

(...)

See also The CPT STANDARDS – “SUBSTANTIVE” SECTIONS OF THE CPT’S GENERAL REPORTS, CPT/Inf/E (2002) 1 - Rev. 2004.

Guideline 11. Children and families

1. Children shall only be detained as a measure of last resort and for the shortest appropriate period of time.
2. Families detained pending removal should be provided with separate accommodation guaranteeing adequate privacy.
3. Children, whether in detention facilities or not, have a right to education and a right to leisure, including a right to engage in play and recreational activities appropriate to their age. The provision of education could be subject to the length of their stay.
4. Separated children should be provided with accommodation in institutions provided with the personnel and facilities which take into account the needs of persons of their age.
5. The best interest of the child shall be a primary consideration in the context of the detention of children pending removal.

(...)

Chapter V – Forced removals

(...)

Guideline 16. Fitness for travel and medical examination

1. Persons shall not be removed as long as they are medically unfit to travel.
2. Member states are encouraged to perform a medical examination prior to removal on all returnees either where they have a known medical disposition or where medical treatment is required, or where the use of restraint techniques is foreseen.
3. A medical examination should be offered to persons who have been the subject of a removal operation which has been interrupted due to their resistance in cases where force had to be used by the escorts.
4. Host states are encouraged to have “fit-to-fly” declarations issued in cases of removal by air.

Comments drafted by the CAHAR on guideline 16.

1. The first paragraph of this Guideline derives from rights guaranteed under Articles 2 and 3 ECHR. The Guideline 16 takes into account the recommendations made by the CPT that has emphasised the “importance of allowing immigration detainees to undergo a medical examination before the decision to deport them is implemented” (13th General Report (CPT/Inf(2003)35), para. 39).
2. Medical examination and transfer of medical information should only be carried out in accordance with human rights and relevant personal data protection legislation.
3. With respect to medical examination to be offered to persons who have been the subject of an abortive deportation operation, the CPT has found that: “In this way it will be possible to verify the state of health of the person concerned and, if necessary, establish a certificate attesting to any injuries. Such a measure could also protect escort staff against unfounded allegations” (13th General Report (CPT/Inf(2003)35), para. 39).
4. Without stating this as an obligation, this Guideline also encourages states to have “fit-to-fly” declarations systematically delivered before a removal by air.

(...)

Guideline 19. Means of restraint

1. The only forms of restraint which are acceptable are those constituting responses that are strictly proportionate responses to the actual or reasonably anticipated resistance of the returnee with a view to controlling him/her.
2. Restraint techniques and coercive measures likely to obstruct the airways partially or wholly, or forcing the returnee into positions where he/she risks asphyxia, shall not be used.

3. Members of the escort team should have training which defines the means of restraint which may be used, and in which circumstances; the members of the escort should be informed of the risks linked to the use of each technique, as part of their specialised training. If training is not offered, as a minimum regulations or Guidelines should define the means of restraint, the circumstances under which they may be used, and the risks linked to their use.
4. Medication shall only be administered to persons during their removal on the basis of a medical decision taken in respect of each particular case.

Comments drafted by the CAHAR on guideline 19.

1. This Guideline signifies that the escort may use coercive measures on individuals who refuse or resist the removal only if they are proportionate and do not exceed reasonable force. This requirement of proportionality is expressed by the European Court of Human Rights under Article 3 ECHR, with respect to which it noted that “In respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3”, but that the use of force may be made necessary, provided it was not excessive, by the conduct of the person against whom force is used (Eur. Ct. HR (4th Sect.), *Berlinski v. Poland* judgment of 20 June 2002 (Appl. No. 27715/95 and No. 30209/96), para. 59-65).
2. The requirement to administer medication only “on the basis of a medical decision” sets out in paragraph 4 of the Guideline is also a requirement of Article 5 of the Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Medicine, signed in Oviedo on 4 April 1997 (ETS No. 164). Medicine should also be provided if there is a case of medical need on the part of the returnee.

Finally, this Guideline was inspired from the 13th General Report of the CPT (CPT/Inf(2003)35).

41. Recommendation 1577 (2002) of the Parliamentary Assembly on the creation of a charter of intent on clandestine migration (excerpt)²⁵⁶

Adoption: 23 September 2002

1. The Parliamentary Assembly is deeply concerned by the increasing number of migrants who lose their lives while attempting to enter the territory of the member states illegally, or who live in extremely dangerous and inhuman conditions before, during and after their illegal entry into Europe. Recourse to clandestine migration also represents an infringement of the right of each state to regulate the entry of foreign nationals into their territory and the circumvention of the immigration rules that are enshrined in law, a phenomenon which is of major political, social and economic significance.

(...)

11. The Assembly therefore recommends that the Committee of Ministers elaborate an international instrument on clandestine migration to be open for signature and ratification by member states, taking into account the recommendations of the Commissioner for Human Rights, mandated international and regional organisations as well as the European Union, incorporating the following principles:

- i. the legitimate goal of combating clandestine migration should not be pursued in such a manner that it undermines the obligation of member states to protect those genuinely in need of international protection;

(...)

- vi. clandestine migrants should not be deprived of their rights, including the right to welfare for children, and particularly for vulnerable individuals, the right to emergency health care and the right not to be held in slavery or servitude;

²⁵⁶Text available at: <http://www.coe.int/>. See Doc. 9522, report of the Committee on Migration, Refugees and Demography, Rapporteur: Mr Wilkinson. While underlining the “rights and living conditions of clandestine migrants in Europe”, the report stresses that one of the main areas of concern is access to health care.

42. Recommendation 1618 (2003) of the Parliamentary Assembly on migrants in irregular employment in the agricultural sector of southern European countries (excerpt)²⁵⁷

Adoption: 8 September 2003

1. The Parliamentary Assembly notes that reliance on migrant labour has become a characteristic feature of Mediterranean agriculture, especially for seasonal activities where a large workforce may be needed at short notice and for brief periods. The work of many of these migrants is undeclared. As a result, they have no right to receive minimum wages or make social security contributions and are often subjected to abuse and exploitation. In some cases the concentration in rural areas of migrants with no homes or work, waiting to be recruited, creates unease in the local population, and even racist or violent outbreaks.

(...)

3. The Assembly is concerned about the work and living conditions of migrants working irregularly in the agricultural sector, and about the extent to which the employment of migrants has grown in Council of Europe member states, and especially in southern European countries.

6. The Assembly therefore recommends that the Committee of Ministers:

(...)

iii. call on member states to:

(...)

c. grant seasonal or temporary migrant workers accepted under the above-mentioned procedures work permits giving, amongst other rights, full access to social security in the host country. Residence permits could be renewable or issued for multiple entries, and should not be bound to a single employer. The repeated issuing of seasonal or temporary

²⁵⁷The text, available at: <http://www.coe.int/>, was adopted by the Standing Committee, acting on behalf of the Parliamentary Assembly, on 8 September 2003. See Doc. 9883, Report of the Committee on Migration, Refugees and Demography, Rapporteur: Ms de Zulueta.

work permits should lead to the progressive acquisition of rights for the beneficiary, including the right to longer-term residence, the right to family reunion and the right to vote and stand in local elections;

43. Resolution 1509 (2006) of the Parliamentary Assembly on human rights of irregular migrants²⁵⁸

Adoption: 27 June 2006

1. The Parliamentary Assembly is deeply concerned by the ever growing number of irregular migrants in Europe.
2. It is the right of each Council of Europe member state to regulate the entry of foreign nationals and to return irregular migrants to their country of origin in accordance with international human rights law.
3. A large number of irregular migrants lose their life when seeking to enter Europe. For those that make it, many live in dangerous and inhumane conditions. A great number are subjected to exploitation and many live in fear of apprehension and being sent back to their country of origin.
4. It must be recognised that there will always be a number of irregular migrants present in Europe, no matter the policies adopted by Governments to prevent their entry or to return them speedily.
5. The Assembly considers that as a starting point, international human rights instruments are applicable to all persons regardless of their nationality or status. Irregular migrants, as they are often in a vulnerable situation, have a particular need for the protection of their human rights, including basic civil and political rights and social and economic rights.
6. The Assembly considers that there is an urgent need to provide clarity on the issue of the rights of irregular migrants notwithstanding that it is both a difficult and sensitive issue for member states of the Council of Europe.
7. The Assembly prefers to use the term “irregular migrant” to other terms such as “illegal migrant” or “migrant without papers”. This term is more neutral and does not carry, for example, the stigmatisation of the term “illegal”. It is also the term increasingly favoured by international organisations working on migration issues.

²⁵⁸Text available at: <http://www.coe.int/>. See Doc.10924, loc. cit. 20.

8. There is no single instrument which deals with the rights of irregular migrants. The most relevant international instrument is the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990). This has, however, only been ratified by three member states of the Council of Europe, namely Azerbaijan, Bosnia and Herzegovina and Turkey.
9. The Assembly notes that there are many other international and European instruments that have provisions which can be used to guarantee minimum rights of irregular migrants. Some of these include the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (1966), the International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Rights of the Child (1989), the International Convention on the Elimination of All Forms of Racial Discrimination (1965), ILO Convention 143 on Migrant Workers (1975), the European Convention on Human Rights (1950), the European Social Charter (1961), the Revised Social Charter (1996) and the Council of Europe Convention on Action against Trafficking in Human Beings (2005).
10. The Assembly notes, however, that the large number of disparate instruments and the varying degree of signatures and ratifications leave a web of uncertainty as to the minimum rights to be applied to irregular migrants.
11. It should be possible to extract a number of minimum civil and political and economic and social and economic rights to be applied by member states of the Council of Europe in favour of irregular migrants.
12. In terms of civil and political rights, the Assembly considers that the European Convention on Human Rights provides a minimum safeguard and notes that the Convention requires that its Contracting Parties take measures for the effective prevention of human rights violations against vulnerable persons such as irregular migrants. The following minimum rights merit highlighting:
 - 12.1. the right to life should be enjoyed and respected. Unreasonable force should not be used to prevent the entry of non-nationals into a country and a duty exists on the authorities to endeavour to rescue those whose life may be in danger in seeking to enter a country;
 - 12.2. irregular migrants should be protected from torture, inhuman or degrading treatment or punishment. The return process of irregular

migrants should be carried out respecting fully the right of dignity of the returnee, taking into account, *inter alia*, the age, sex, health and disability of the returnee. Coercive measures during expulsion should be kept to an absolute minimum;

12.3. irregular migrants should be protected from slavery and forced labour and victims of trafficking should be granted specific rights in line with the Council of Europe Convention on Action against Trafficking in Human Beings (ETS 197);

12.4. detention of irregular migrants should be used only as a last resort and not for an excessive period of time. Where necessary, irregular migrants should be held in special detention facilities and not with convicted prisoners. Children should only be detained as a measure of last resort and then for the shortest appropriate period of time. Detention or holding of other vulnerable persons (pregnant women, mothers with young children, elderly, people with disabilities) should be avoided wherever possible. Suitable accommodation should be available to lodge families together but otherwise men and women should be housed separately. Detainees should have the right to contact anyone of their choice (lawyers, family members, NGOs, UNHCR, etc.), have access to adequate medical care and access to an interpreter and free legal aid where appropriate;

12.5. detention of irregular migrants must be judicially authorised. Independent judicial scrutiny of the legality and need for continued detention should be available. Those detained should be expressly informed, without delay and in a language they understand of their rights and procedures applicable to them. They should be entitled to take proceedings before a court to challenge speedily the lawfulness of their detention;

12.6. irregular migrants in detention also have the right to communicate with the consular posts of their country of origin and to be informed, by the authorities of the State where they are detained, of their rights under the 1963 Vienna Convention on Consular Relations;

12.7. those whose right of entry to a country is disputed should have the right to a hearing with the assistance of an interpreter in order to explain the reasons for entering the country and should be able to lodge an application for asylum if appropriate;

12.8. the right to asylum and *non-refoulement* should be respected;

12.9. an irregular migrant being removed from the country should be entitled to an effective remedy before a competent independent and impartial authority. The remedy should have a suspensive effect when the returnee has an arguable claim that, if returned, he or she would be subjected to treatment contrary to his or her human rights. Interpretation and legal aid should be available;

12.10. an irregular migrant being removed from the country has the right to an effective access to the European Court of Human Rights by lodging an individual application with the Court under Article 34 of the European Convention on Human Rights;

12.11. collective expulsion of aliens, including irregular migrants, is prohibited;

12.12. the right to respect for private and family life should be observed. Removal should not take place when the irregular person concerned has particularly strong family or social ties with the country seeking to remove him or her and that the removal is likely to lead to the conclusion that expulsion would violate the right to private and/or family life of the person concerned;

12.13. the right to confidential treatment of information concerning irregular migrants should be respected. Information, for example relating to an asylum application, should not be made available by the host country to the authorities of the country of origin;

12.14. while certain restrictions can be placed on the political activities of aliens, the restriction on the rights to freedom of assembly, association and expression should not extend beyond what is reasonably necessary;

12.15. irregular migrants have the right to marry and total barriers should not be put in place preventing them from marrying;

12.16. irregular migrants should be entitled to the protection of their property. They should be able to manage or dispose of it, including through banking facilities allowing for the transfer of earnings and savings;

12.17. irregular migrants should not be discriminated against in accordance with Article 14 of the European Convention on Human Rights and under Protocol No. 12 to the Convention;

12.18. there should be no discrimination on grounds of race or ethnicity in granting or refusing admission, in authorising a stay or an expulsion of an irregular migrant.

13. In terms of economic and social rights, the Assembly considers that the following minimum rights should, *inter alia*, apply:

13.1. adequate housing and shelter guaranteeing human dignity should be afforded to irregular migrants;

13.2. emergency healthcare should be available to irregular migrants and States should seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly;

13.3. social protection through social security should not be denied to irregular migrants where it is necessary to alleviate poverty and preserve human dignity. Children are in a particularly vulnerable situation and they should be entitled to social protection which they should enjoy on the same footing as national children;

13.4. irregular migrants who have made social security contributions should be able to benefit from these contributions or be reimbursed, for example if expelled from the country;

13.5. in relation to irregular migrants in work, they should be entitled to fair wages, reasonable working conditions, compensation for accidents, access to the courts to defend their rights and also freedom to form and to join a trade union. Any employer failing to comply with these terms should be rigorously pursued by the relevant authorities in member states;

13.6. all children have a right to education extending to primary school level and also to secondary school level in those countries where such schooling is compulsory. Education should reflect their culture and language and they should be entitled to recognition, including through certification, of the standards achieved;

13.7. all children, but also other vulnerable groups such as the elderly, single mothers and more generally single girls and women, should be given particular protection and attention.

14. Consequently, the Parliamentary Assembly invites the governments of member states of the Council of Europe to:

14.1. sign and ratify, where not already done, and implement the relevant human rights instruments contributing to the protection of the rights of irregular migrants, including, *inter alia*, the UN International Convention on the Rights of All Migrant Workers and Members of their Families (1990), the International Covenant on Civil and Political Rights (1966), the International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Rights of the Child (1989), the International Convention on the Elimination of All Forms of Racial Discrimination (1965), ILO Convention 143 on Migrant Workers (1975), the European Convention on Human Rights (1950), the European Social Charter (1961), including its additional Protocol providing for a System of Collective Complaints (1995), and Revised Social Charter (1996) and the Council of Europe Convention on Action against Trafficking in Human Beings (2005).

15. On the basis of the principles contained in the international human rights instruments relevant to irregular migrants, the Assembly invites the governments of member states of the Council of Europe to guarantee the minimum civil and political and social and economic rights outlined in this Resolution.

16. The Parliamentary Assembly also invites the governments of member states of the Council of Europe to assure that irregular migrants are able to enjoy their minimum rights in practice, including by:

16.1. raising awareness of the rights of irregular migrants;

16.2. raising awareness of the situation in which irregular migrants live and the difficulties and exploitation they face;

16.3. refraining from criminalising humanitarian assistance for irregular migrants by civil society actors;

16.4. dispensing with the duty of certain authorities (for example school authorities, doctors and medical authorities) to inform on the

illegal status of migrants so as to avoid the situation where irregular migrants do not claim their rights through fear of identification as irregular migrants and fear of expulsion;

16.5. considering all relevant means for regularising the situation of irregular migrants where there are reasons why irregular migrants can not or should not be returned to their country of origin;

16.6. supporting voluntary return programmes for irregular migrants and carrying out forcible returns only as a last resort and in accordance with the 20 guidelines on Forced Return adopted by the Committee of Ministers in May 2005;

16.7. ensuring the availability of non-judicial human rights protection, including by national or local ombudsmen, or other such authorities, alongside judicial protection.

17. The Assembly also invites member states of the Council of Europe to support the United Nations Special Rapporteur on the human rights of migrants in his work.

18. The Assembly furthermore invites the Council of Europe Commissioner for Human Rights to take up the issue of rights of irregular migrants in his contacts with states and with national ombudsmen, and invites him to give priority to the rights of irregular migrants in both his individual country reports and thematic reports.

44. Recommendation 1755 (2006) of the Parliamentary Assembly on human rights of irregular migrants²⁵⁹

Adoption: 27 June 2006

1. The Parliamentary Assembly refers to its Resolution 1509 (2006) on human rights of irregular migrants.
2. The Assembly is convinced that there is a need to clarify the minimum rights applying to irregular migrants. The Assembly recognises that a legal instrument specifically devoted to the rights of irregular migrants is unlikely to receive support from member states of the Council of Europe but notes that there are other ways in which to codify and clarify the minimum rights of irregular migrants.
3. Therefore, the Assembly recommends that the Committee of Ministers:
 - 3.1. instruct the relevant intergovernmental committees to establish a list of minimum rights for irregular migrants, including civil and political and social and economic rights, with a view to preparing a recommendation or guiding principles for adoption by the Committee of Ministers. These minimum rights should use as a starting point those rights identified in the above mentioned Resolution 1509 (2006) on human rights of irregular migrants;
 - 3.2. instruct the European Committee on Migration (CDMG) to hold a round table discussion on the state of ratifications of member states of the Council of Europe of the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, with a view to analysing the obstacles faced by member states in ratifying this treaty;
 - 3.3. keep under review the effectiveness of the human rights instruments relevant to the protection of the rights of irregular migrants, in particular the European Social Charter and Revised Social Charter, with a view to examining whether there is a need to strengthen the human rights instruments in order to protect more effectively the rights of irregular migrants.

²⁵⁹Text available at: <http://www.coe.int/>. See Doc.10924, report of the Committee on Migration, Refugees and Population, Rapporteur: Mr van Thijn.

*VICTIMS OF TRAFFICKING
IN HUMAN BEINGS*

45. Recommendation No. R (2000) 11 of the Committee of Ministers to member states on action against trafficking in human beings for the purpose of sexual exploitation²⁶⁰

Adoption: 19 May 2000

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Bearing in mind that Europe has recently experienced a considerable growth of activities connected with trafficking in human beings for the purpose of sexual exploitation, which is often linked to organised crime in as much as such lucrative practices are used by organised criminal groups as a basis for financing and expanding their other activities, such as drugs and arms trafficking and money laundering;

Considering that trafficking in human beings for the purpose of sexual exploitation extends well beyond national borders, and that it is therefore necessary to establish a pan-European strategy to combat this phenomenon and protect its victims, while ensuring that the relevant legislation of the Council of Europe's member states is harmonised and uniformly and effectively applied;

Recalling the Declaration adopted at the Second Summit of the Council of Europe (October 1997), in which the heads of state and government of the member states of the Council of Europe decided "to seek common responses to the challenges posed by the growth (...) in organised crime (...) throughout Europe" and affirmed their determination "to combat violence against women and all forms of sexual exploitation of women";

Bearing in mind the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and its protocols;

Bearing in mind the European Social Charter (1961), the Revised European Social Charter (1996) and the Additional Protocol to the European Social Charter providing for a System of Collective Complaints;

²⁶⁰Text available at: <http://www.coe.int/>. See also the following website: http://www.coe.int/t/dg2/trafficking/campaign/Docs/COERefTxt/CMtxts_en.asp. The latter includes Recommendations of the Committee of Ministers as well as of the Parliamentary Assembly of the Council of Europe, related to the fight against trafficking.

Bearing in mind the following recommendations of the Committee of Ministers to member states of the Council of Europe: Recommendation No. R (91) 11 on sexual exploitation, pornography and prostitution of, and trafficking in, children and young adults; Recommendation No. R (96) 8 on crime policy in Europe in a time of change, and Recommendation No. R (97) 13 concerning intimidation of witnesses and the rights of the defence;

Bearing in mind the following texts of the Parliamentary Assembly of the Council of Europe: Recommendation 1065 (1987) on the traffic in children and other forms of child exploitation, Recommendation 1211 (1993) on clandestine migration: traffickers and employers of clandestine migrants, Resolution 1099 (1996) on the sexual exploitation of children and Recommendation 1325 (1997) of the Council of Europe on trafficking in women and forced prostitution in Council of Europe member states;

Recalling also the Convention on the Elimination of all forms of Discrimination against Women (1979) and other international conventions such as the United Nations Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others (1949);

Considering that trafficking in human beings for the purpose of sexual exploitation, which mainly concerns women and young persons, may result in slavery for the victims;

Condemns trafficking in human beings for the purpose of sexual exploitation, which constitutes a violation of human rights and an offence to the dignity and the integrity of the human being,

Recommends that the governments of member states:

1. review their legislation and practice with a view to introducing, where necessary, and applying the measures described in the appendix to this recommendation;
2. ensure that this recommendation is brought to the attention of all relevant public and private bodies, in particular police and judicial authorities, diplomatic missions, migration authorities, professionals in the social, medical and education fields and non-governmental organisations.

Appendix to Recommendation No. R 11

I. Basic principles and notions

1. The basic notions should be as follows: trafficking in human beings for the purpose of sexual exploitation includes the procurement by one or more natural or legal persons and/or the organisation of the exploitation and/or transport or migration – legal or illegal – of persons, even with their consent, for the purpose of their sexual exploitation, *inter alia* by means of coercion, in particular violence or threats, deceit, abuse of authority or of a position of vulnerability.

On this basis, the governments of member States are invited to consider the following measures:

II. General measures

2. Take appropriate legislative and practical measures to ensure the protection of the rights and the interests of the victims of trafficking, in particular the most vulnerable and most affected groups: women, adolescents and children.
3. Give absolute priority to assisting the victims of trafficking through rehabilitation programmes, where applicable, and to protecting them from traffickers.
4. Take action to apprehend, prosecute and punish all those responsible for trafficking, and to prevent sex tourism and all activities which might lead to forms of trafficking.
5. Consider trafficking in human beings for the purposes of sexual exploitation as falling within the scope of international organised crime, and therefore calls for co-ordinated action adapted to realities both at national and international levels.

III. Basis for action and methods

6. Take co-ordinated action using a multidisciplinary approach involving the relevant social, judicial, administrative, customs, law

enforcement and immigration authorities and non-governmental organisations (NGOs).

7. Encourage co-operation, involving both national authorities and NGOs, between countries of origin, transit and destination of the victims of trafficking, by means of bilateral and multilateral agreements.
8. In order to ensure that these actions have a firm and reliable basis, encourage national and international research concerning, in particular:
 - the influence of the media, and above all new information and communication techniques on trafficking in human beings for the purpose of sexual exploitation;
 - the clients of the sex trade: trends in demand and their consequences for trafficking in human beings for the purpose of sexual exploitation;
 - the origin of the phenomenon of trafficking and the methods used by traffickers.
9. Consider the establishment of research units specialising in trafficking in human beings for the purpose of sexual exploitation.
10. Take steps to develop, both at national and international level, data and statistics that will help to shed more light on the phenomenon of trafficking in human beings for the purpose of sexual exploitation and, if possible, compare the way the phenomenon is developing in the Council of Europe's different member States.

IV. Prevention

i. Awareness-raising and information

11. Organise information campaigns with a gender perspective in order to increase public awareness of the hazardous situations that may lead to trafficking and the negative effects of such trafficking and, in particular, discredit the notion that there are easy gains to be made from prostitution; these campaigns should be directed at all parties

concerned, particularly female immigration applicants and women refugees.

12. Organise information campaigns intended to discredit sex tourism and discourage potential participants from joining in such activities.
13. Provide appropriate information, such as documentation, videos and leaflets on trafficking in and the sexual exploitation of women, children and young persons to diplomatic representatives, public authorities, the media, humanitarian NGOs and other public and private bodies working in the countries of origin of potential victims.
14. Disseminate widely, in every country, information on the health risks associated with sexual exploitation.
15. Encourage and organise activities to make media professionals more aware of issues relating to trafficking in human beings for the purpose of sexual exploitation and the influence the media can have in this field.

ii. Education

16. Introduce or step up sex education programmes in schools, with particular emphasis on equality between women and men and on respect for human rights and individual dignity, taking into account the rights of the child as well as the rights of his or her parents, legal guardians and other individuals legally responsible for him or her.
17. Ensure that school curricula include information on the risks of exploitation, sexual abuse and trafficking that children and young people could face and ways of protecting themselves; this information should also be circulated to young people outside the education system and to parents.
18. Provide both boys and girls with an education that avoids gender stereotypes and ensures that all teachers and others involved in education are trained in such a way as to incorporate a gender dimension into their teaching.

iii. Training

19. Organise special training for social workers, as well as for medical, teaching, diplomatic, consular, judicial, customs and police personnel to enable them to identify cases of trafficking for the purpose of sexual exploitation and respond appropriately.
20. Introduce and/or develop training programmes to enable police personnel to acquire specialised skills in this field.
21. In particular, set up specific training programmes and exchanges of experiences in order to improve co-operation between the police and the NGOs specialising in victim protection.
22. Also introduce training programmes for immigration officials and frontier police so that they can contribute to prevention by making sure that persons travelling abroad, particularly young persons not accompanied by a parent or guardian, are not involved in trafficking.

iv. Long-term action

23. Combat the long-term causes of trafficking, which are often linked to the inequalities between economically developed countries and those that are less developed, particularly by improving the social status as well as the economic condition of women in the latter.
24. Take into account in economic, social, migration or other policies, the need to improve women's condition and prevent trafficking in human beings and sex tourism.
25. Disseminate information on the possibilities of legal migration in order to make women aware of the conditions and procedures for obtaining visas and residence permits.

V. Assistance to and protection of victims

i. Victim support

26. Encourage the establishment or development of reception centres or other facilities where the victims of human trafficking can benefit

from information on their rights, as well as psychological, medical, social and administrative support with a view to their reintegration into their country of origin or the host country.

27. In particular, ensure that the victims have the opportunity, for example through the reception centres or other facilities, to benefit from legal assistance in their own language.

ii. Legal action

28. Provide, where possible, victims of trafficking, particularly children and witnesses, with special (audio or video) facilities to report and file complaints, and which are designed to protect their private lives and their dignity and reduce the number of official procedures and their traumatising effects.
29. If necessary, and particularly in the case of criminal networks, take steps to protect victims, witnesses and their families to avoid acts of intimidation and reprisals.
30. Establish victim protection systems which offer effective means to combat intimidation as well as real threats to the physical security of the victims and their families both in countries of destination and countries of origin.
31. Provide protection when needed in the country of origin for the families of victims of trafficking when the latter bring legal proceedings in the country of destination.
32. Extend, where appropriate, this protection to members of associations or organisations assisting the victims during civil and penal proceedings.
33. Enable the relevant courts to order offenders to pay compensation to victims.
34. Grant victims, if necessary, and in accordance with national legislation, a temporary residence status in the country of destination, in order to enable them to act as witnesses during judicial proceedings against offenders; during this time, it is essential to ensure that victims have access to social and medical assistance.

35. Consider providing, if necessary, a temporary residence status on humanitarian grounds.

iii. Social measures for victims of trafficking in countries of origin

36. Encourage and support the establishment of a network of NGOs involved in assistance to victims of trafficking.
37. Promote co-operation between reception facilities and NGOs in countries of origin to assist the return and reintegration of victims.

iv. Right of return and rehabilitation

38. Grant victims the right to return to their countries of origin, by taking all necessary steps, including through co-operation agreements between the countries of origin and countries of destination of the victims.
39. Establish, through bilateral agreements, a system of financing the return of victims and a contribution towards their reintegration.
40. Organise a system of social support for returnees to ensure that victims are assisted by the medical and social services and/or by their families.
41. Introduce special measures concerned with victims' occupational reintegration.

VI. Penal legislation and judicial co-operation

42. Enact or strengthen legislation on trafficking in human beings for the purpose of sexual exploitation and introduce, where necessary, a specific offence.
43. Introduce or increase penal sanctions that are in proportion to the gravity of the offences, including dissuasive custodial sentences, and allow for effective judicial co-operation and the extradition of the persons charged or convicted.

44. Take such steps as are necessary to order, without prejudice to the rights of third parties in good faith, the seizure and confiscation of the instruments of, and proceeds from, trafficking.
45. Facilitate police investigation and monitoring of establishments in which victims of trafficking are exploited and organise their closure if necessary.
46. Provide for rules governing the liability of legal persons, with specific penalties.
47. Provide for traffickers to be extradited in accordance with applicable international standards, if possible, to the country where evidence of offences can be uncovered.
48. Establish rules governing extra-territorial jurisdiction to permit and facilitate the prosecution and conviction of persons who have committed offences relating to trafficking in human beings for the purpose of sexual exploitation, irrespective of the country where the offences were committed, and including cases where the offences took place in more than one country.
49. In accordance with national laws concerning the protection of personal data, as well as with the provisions of the Council of Europe Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, set up and maintain information systems which could be useful for the investigation and prosecution of trafficking offences.

VII. Measures for co-ordination and co-operation

i. *At national level*

50. Set up a co-ordinating mechanism responsible for drawing up the national policy on combating trafficking and organising a multidisciplinary approach to the issue.
51. Use this mechanism to encourage the exchange of information, the compilation of statistics and the assessment of practical findings obtained in the field, trends in trafficking and the results of national policy.

52. Use this mechanism to liaise with mechanisms of other countries and international organisations in order to co-ordinate activities, and to monitor, review and implement national and international strategies aimed at combating trafficking;

ii. At international level

53. As far as possible, make use of all the available international instruments and mechanisms applicable to trafficking, particularly regarding the seizure and confiscation of profits earned from trafficking.
54. Set up an international body to co-ordinate the fight against trafficking, with particular responsibility for establishing a European file of missing persons, in accordance with national laws concerning the protection of personal data.
55. Increase and improve exchanges of information and co-operation between countries at bilateral level as well as through international organisations involved in combating trafficking.
56. Governments are invited to consider signing and ratifying, if they have not already done so, the Council of Europe's Convention on Laundering, Search, Seizure and Confiscation of the Proceeds from Crime (1990), the Revised European Social Charter (1996) and the Additional Protocol to the European Social Charter providing for a System of Collective Complaints (1995), the European Convention on the Exercise of Children's Rights (1996), the Convention on the Elimination of all forms of discrimination against Women (1979) and its Optional Protocol (1999), as well as the United Nations Convention on the Rights of the Child (1989) and/or to consider withdrawing existing reservations to these instruments.
57. Governments are invited to incorporate into their national systems all the measures necessary to apply the principles and standards laid down in the Action Programme adopted at the 4th World Conference on Women (Beijing, 4-15 September 1995), and in particular Part IV.D, and the agreed conclusions adopted at the 42nd session of the United Nations Commission on the Status of Women, the resolution adopted regularly by the General Assembly of the United Nations on the Traffic in Women and Girls, the declaration adopted at the Ministerial Conference containing European Guidelines for

Measures to Prevent and Combat Trafficking in Women for the Purpose of Sexual Exploitation (The Hague, 24-26 April 1997), as well as in the following recommendations of the Committee of Ministers to the member states of the Council of Europe: Recommendation No. R (80) 10 on measures against the transfer and the safekeeping of funds of criminal origin, Recommendation No. R (85) 11 on the position of the victim in the framework of criminal law and procedure and Recommendation No. R (87) 21 on assistance to victims and the prevention of victimisation.

46. Recommendation Rec (2001)18 of the Committee of Ministers to member states on subsidiary protection²⁶¹

Adoption: 27 November 2001

The Committee of Ministers, under the terms of Article 15. *b* of the Statute of the Council of Europe,

Recalling the 1950 Convention on the Protection of Human Rights and Fundamental Freedoms, the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol and other relevant international instruments, namely the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the United Nations Convention on the Rights of the Child, the Universal Declaration of Human Rights, the International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights;

Affirming that persons in need of international protection must be able to seek and enjoy such protection with full respect to their fundamental human rights and dignity;

Considering that not all persons with international protection needs are covered by a full application of the 1951 Convention and its 1967 Protocol and that such persons should be given adequate treatment:

Stressing that protection measures, subsidiary to those enshrined in the 1951 Convention and its 1967 Protocol, should be implemented in such a manner that these measures do not undermine but complement the existing refugee protection regime;

Underlining that the availability of subsidiary protection must not prejudice the right of persons to apply for refugee status and that nothing in this recommendation shall be interpreted as restricting or adversely affecting the rights of persons as recognised by international law, in particular by the 1951 Convention, its 1967 Protocol and by national legislation and practice;

Bearing in mind the functions of the Office of the United Nations High Commissioner for Refugees (UNHCR) under Article 35 of the 1951 Convention Relating to the Status of Refugees and its extended mandate

²⁶¹Text available at: <http://www.coe.int/>.

stipulated by various resolutions of the United Nations General Assembly;

Considering that subsidiary protection is a category of individual protection as opposed to the concept of temporary protection which, as defined by Recommendation No. R (2000) 9 of the Committee of Ministers, is an exceptional practical measure, limited in time, applicable as such in situations of massive and sudden influx;

Calling on member states, in which legislative and administrative mechanisms do not exist for granting subsidiary protection to persons in need of international protection but who are not covered by the 1951 Convention and its 1967 Protocol, to introduce such mechanisms, either by legislation or practice,

Adopts the following recommendations:

1. Subsidiary protection should be granted by member states to a person who, on the basis of a decision taken individually by the competent authorities, does not fulfill the criteria for refugee status under the 1951 Convention and its 1967 Protocol but is found to be in need of international protection:
 - because that person faces a risk of torture or inhuman or degrading treatment or punishment in his/her country of origin; or
 - because that person has been forced to flee or remain outside his/her country of origin as a result of a threat to his/her life, security or liberty, for reasons of indiscriminate violence, arising from situations such as armed conflict; or
 - for other reasons recognised by the legislation or practice of the member state and therefore cannot be returned to the country of origin.

Procedures

2. All possible protection grounds should preferably be considered in a single procedure. If there is an application for refugee status, that should be examined first.
3. When considering the cessation of, and exclusion from, subsidiary protection, member states should be fully aware of the absolute

character of Article 3 of the European Convention on Human Rights and other relevant human rights instruments. Such cases should be decided individually in an objective and non-arbitrary manner.

4. Provisions incorporated in Recommendation No. R (81) 16 of the Committee of Ministers on the harmonisation of national procedures relating to asylum and in Conclusion 8 (XXVIII) of the Executive Committee of the UNHCR (EXCOM) on the determination of refugee status, should, as far as possible, be applied by member states when deciding on the granting of subsidiary protection.

Minimum standards of treatment

5. Host member states should ensure that beneficiaries of subsidiary protection enjoy a legal status and that therefore, in particular, they:
 - are issued with documents certifying their legal status;
 - are issued, in conformity with national law, with a travel document if the beneficiary has no access to such a document issued by the authorities of the country of origin;
 - enjoy freedom of movement within the territory of the host state, restricted only by -interests of national security or public order;
 - have access to courts and administrative authorities;
 - enjoy basic social and economic rights, in particular, access to housing, legal means of subsistence (access to social benefits or to the labour market), basic healthcare and, as appropriate, education or training.
6. For family reunion of beneficiaries of subsidiary protection, the provisions of Recommendation No. R (99) 23 of the Committee of Ministers on family reunion for refugees and other persons in need of international protection apply.
7. If the stay of beneficiaries of subsidiary protection in the host country is prolonged due to the continuation of conditions on which subsidiary protection is based under paragraph 1, member states should consider the granting of a long-term residence permit to such beneficiaries, in particular when their stay exceeds five years.

*ASYLUM SEEKERS, REFUGEES
AND OTHER PERSONS IN NEED OF
INTERNATIONAL PROTECTION*

47. Recommendation No. R (2000)9 of the Committee of Ministers to member states on temporary protection (excerpt)²⁶²

Adoption: 3 May 2000

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

(...)

Adopts the following recommendations

(...)

3. Persons benefiting from temporary protection should have access, at least, to:
 - adequate means of subsistence, including accommodation,
 - appropriate health care,
 - education for their children,
 - the labour market in conformity with national legislation.

²⁶²Text available at: <http://www.coe.int/>. See the Explanatory Memorandum: <http://www.legislationline.org/legislation.php?tid=129&lid=5320&less=false>. See also Council of Europe, Committee of Experts on Standard-Setting Instruments in the Field of Social Security (CS-CO), 6th Meeting, Limassol, 25-26 May 2004, Exploratory Report on the Access to Social Protection for Illegal Labour Migrants, prepared by P. Schoukens and D. Pieters, Doc. CS-CO (2004) 3rev (Strasbourg, 30 June 2004), pp. 25-26.

48. Recommendation Rec(2006)6 of the Committee of Ministers to member states on internally displaced persons²⁶³

Adoption: 5 April 2006

The Committee of Ministers, under the terms of Article 15.*b* of the Statute of the Council of Europe,

Recalling that one of the core objectives of the Council of Europe is to preserve and to promote human rights to the benefit of everyone in Europe;

Considering that a large number of citizens of the Council of Europe member states can not fully benefit from their human rights as a consequence of the fact that they have been forced or obliged to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or man-made disasters, without crossing an internationally recognised state border;

Recalling the existence of the United Nations Guiding Principles on Internal Displacement (hereinafter the “UN guiding principles”), which address all phases of internal displacement and which have gained international recognition and authority;

Stressing its commitment to the spirit and provisions of the United Nations guiding principles and its willingness to implement them in the member states’ national legislation and policy;

Anxious to promote the United Nations guiding principles in a European context and to develop some of these principles further on the basis of the existing standards of the Council of Europe;

Recognising that internally displaced persons have specific needs by virtue of their displacement;

Bearing in mind that, while internally displaced persons, despite being displaced, remain citizens of their country entitled to the full enjoyment of human rights and guarantees of international humanitarian law, international law does not provide for any specific binding instrument defining their rights;

²⁶³Text available at: <http://www.coe.int/>.

Considering that the national authorities of the member states on the territory of which internal displacement is taking place are primarily responsible for the protection and assistance of the internally displaced persons, notwithstanding the rights and obligations of other states or appropriate international organisations under international law;

Affirming that member states affected by internal displacement should refrain from instrumental use of displaced persons for political aims;

Recalling that the arbitrary displacement of persons from their homes or place of habitual residence is prohibited, as can be inferred from the European Convention on Human Rights, which is an integral part of member states' domestic law;

Aware that mismanagement of internal displacement may not only lead to human rights violations but also feed into international migration and refugee movements across the continent;

Considering that neither this recommendation nor the United Nations guiding principles should prevent Council of Europe member states from introducing or maintaining more favourable standards for internally displaced persons,

Recommends that governments of member states be guided, when formulating their internal legislation and practice, and when faced with internal displacement, by the following principles:

1. The United Nations guiding principles and other relevant international instruments of human rights or humanitarian law apply to all internally displaced persons, including persons displaced from their homes or places of habitual residence due to natural or man-made disasters;
2. Internally displaced persons shall not be discriminated against because of their displacement. Member states should take adequate and effective measures to ensure equal treatment among internally displaced persons and between them and other citizens. This may entail the obligation to consider specific treatment tailored to meet internally displaced persons' needs;
3. Particular attention shall be paid to the protection of persons belonging to national minorities and to the protection and assistance requirements of the most vulnerable groups in accordance with relevant international law standards;

4. Protecting internally displaced persons and their rights as well as providing humanitarian assistance to them is a primary responsibility of the state concerned;

Such responsibility entails requesting aid from other states or international organisations if the state concerned is not in a position to provide protection and assistance to its internally displaced persons;

This responsibility also entails not to arbitrarily refuse offers from other states or international organisations to provide such aid;

5. Member states shall, in accordance with their obligations under Articles 2, 3 and 5 of the European Convention on Human Rights, take appropriate measures, on the one hand, to prevent acts that may violate internally displaced persons' right to life, to physical integrity and to liberty and security and, on the other, to effectively investigate alleged violations of these rights. This is of particular relevance in the organisation and maintenance of camps for internally displaced persons: in this regard, appropriate measures include those safeguarding the civilian nature of camps;

Internally displaced persons shall not be sent back to areas where they would face a real risk of being subjected to treatment contrary to Articles 2 and 3 of the European Convention on Human Rights;

6. Member states shall, in accordance with Article 8 of the European Convention on Human Rights, take appropriate measures to facilitate the reunification of families which are separated by internal displacement. Such measures may include locating missing family members, notably those that have been taken hostage. Competent authorities should convey to relatives of an internally displaced person, upon their request, any information they may have on his/her whereabouts;
7. Internally displaced persons shall be provided with all documents necessary for the effective exercise of their rights as soon as possible following their displacement and without unreasonable conditions being imposed;
8. Internally displaced persons are entitled to the enjoyment of their property and possessions in accordance with human rights law. In particular, internally displaced persons have the right to repossess the property left behind following their displacement. If internally

displaced persons are deprived of their property, such deprivation should give rise to adequate compensation;

9. Member states should take appropriate legal and practical measures to enable internally displaced persons to effectively exercise their right to vote in national, regional or local elections and to ensure that this right is not infringed by obstacles of a practical nature;
10. With a view to limiting the adverse consequences of internal displacement, member states should develop preventive measures such as strategic action plans, to be implemented in the event of crises which could lead to internal displacement;
11. Internally displaced persons should be properly informed, but also consulted to the extent possible, in respect of any decision affecting their situation prior to, during or after their displacement;
12. Internally displaced persons have the right to return voluntarily, in safety and in dignity, to their homes or places of habitual residence, or to resettle in another part of the country in accordance with the European Convention on Human Rights;

Conditions for proper and sustainable integration of internally displaced persons following their displacement should be ensured;

13. In order to address existing gaps in international law as far as the treatment of internally displaced persons is concerned, member states should consider the elaboration of additional international instruments.

49. Recommendation 1327 (1997) of the Parliamentary Assembly on the protection and reinforcement of the human rights of refugees and asylum-seekers in Europe (excerpt)²⁶⁴

Adoption: 24 April 1997

(...)

8. The Parliamentary Assembly recommends that the Committee of Ministers:

(...)

vii. urge the member states:

(...)

r. to review their policies in the field of social rights and assistance in order to ensure that each asylum-seeker's case is treated on its merits, in particular to ensure that there is no discrimination against certain categories of asylum-seekers, such as so-called "late applicants";

(...)

²⁶⁴Text available at: <http://www.coe.int/>. See Doc. 7783, report of the Committee on Migration, Refugees and Demography, Rapporteur: Mrs Brasseur.

50. Recommendation 1374 (1998) of the Parliamentary Assembly on the situation of refugee women in Europe²⁶⁵

Adoption: 26 May 1998

1. The Assembly recalls and reaffirms its Resolution 1018 (1994) and its Recommendation 1229 (1994) on equality of rights between men and women, Recommendation 1236 (1994) on the right of asylum, Recommendation 1261 (1995) on the situation of immigrant women in Europe, Recommendation 1309 (1996) on the training of officials receiving asylum seekers at border points, and Recommendation 1327 (1997) on the protection and reinforcement of the human rights of refugees and asylum seekers in Europe. The Assembly also recalls the declaration on equality of women and men adopted by the Committee of Ministers on 16 November 1988.
2. While regretting that no reliable information and statistics about refugee women are collected in a systematic way by Council of Europe member states, the Assembly considers this group of refugees to be particularly vulnerable and subject to specific, gender-related problems and discrimination.
3. Increased dependency and the traditional socio-cultural and economic role of refugee women in their countries of origin often lead to lack of motivation, confidence and self-esteem, thus putting them at a distinct disadvantage compared to their male counterparts from the moment they arrive in a host country. Therefore the Assembly acknowledges the need for the creation of specific conditions which would enable refugee women to overcome these difficulties.
4. The Assembly is particularly concerned by certain practices applied to refugee women during and after the status determination procedure in host countries, which may result in violation of their human rights.
5. The Assembly considers that the member states of the Council of Europe should eliminate all gender-related discrimination among refugees, and adapt the treatment of women refugees to their specific situation and requirements.

²⁶⁵The text, available at: <http://www.coe.int/>, was adopted by the Standing Committee, acting on behalf of the Assembly, on 26 May 1998. See Doc. 8066, report of the Committee on Migration, Refugees and Demography, Rapporteur: Mrs Johansson.

6. Consequently, the Assembly recommends that the Committee of Ministers:
 - i. instruct its appropriate committees:
 - a. to hold exchanges of views and experience on this subject;
 - b. to examine the question of the recognition of gender-related persecution as a basis for refugee status;
 - c. to implement Recommendation 1371 adopted on 23 April 1998 by the Assembly aimed at prohibiting and punishing sexual mutilations of women;
 - ii. ensure the financing of a widespread information campaign among health personnel, as well as refugee groups in the host countries most concerned, about the harmful consequences of female genital mutilation on the health, physical integrity and dignity of women and to their right to personal fulfilment;
 - iii. initiate the setting-up of a European system for data collection and needs assessment in regard to refugee women;
 - iv. encourage the development of programmes aiming at the integration and re-integration of refugee women, including support training, vocational training and income-generating programmes;
 - v. organise and actively support refugee women's training in human rights and related subjects as part of their preparation for possible return;
 - vi. urge the member states:
 - a. to adopt measures to guarantee the physical safety of women in refugee centres consonant with the Office of the United Nations High Commissioner for Refugees (UNHCR) Guidelines on the Protection of Refugee Women;
 - b. to recognise as refugees women whose claim to refugee status is based upon well founded fear of persecution for reasons enumerated in the 1951 Convention and 1967 Protocol relating to the status of

- refugees, including persecution through sexual violence or gender-related persecution;
- c. to ensure that the authorities responsible for refugee status determination procedure are well informed about the overall situation in the countries of origin of applicants, in particular concerning the situation of women, possible gender-related persecution and its consequences;
 - d. to review the staffing and recruitment policies of such authorities in order to ensure that there is a sufficient number of female staff, and that in cases of claims to refugee status based on gender-related persecution, a member of the female staff is available;
 - e. to re-examine refugee status determination procedure and policies with a view to ensuring that women who have an independent claim for refugee status have access to an individual consideration of such claim, even if they are accompanied by a male partner;
 - f. to review their policies in the field of social rights and assistance in order to ensure that refugee women are not forced into prostitution, and in particular are offered reorientation programmes and counselling as well as realistic alternatives to earn their living;
 - g. to organise the prohibition of forced marriages, particularly of young girls who are minors, including such marriages when celebrated outside the territory of the member states, depriving such unions of all legal effect, except to the advantage of the young girl forced into such a union and of any children born thereof (right to maintenance for herself and any children), classifying as rape any sexual intercourse imposed without her consent, declaring the forced union to be an absolute ground of divorce, constituting a fault on the part of the so-called husband, and finally, establishing the criminal and civil liability of all those who contributed in any way to the so-called union without receiving the free and express consent of each of the spouses, including parents and ministers of any religion;
 - h. to inform all migrants of these provisions and of the civil and criminal consequences of failure to abide by them;

- i. to adopt criteria and guidelines dealing with women seeking asylum, in order to enhance a gender-sensitive approach and ensure that women's specific needs are met, particularly at ports of entry;
- j. to provide access to adequate health services, and ensure that female medical and social staff (including interpreters) are available for refugee women;
- k. to give more attention to reproductive health care, including counselling in regard to sexually transmitted diseases and access to family planning information and devices, in accordance with the manual published by the United Nations Population Fund in collaboration with the World Health Organisation and UNHCR;
- l. to provide professional counselling and therapy as well as general support for refugee women who have suffered traumatic experiences;
- m. to encourage the establishment of non-governmental refugee organisations to help refugees overcome mental problems which may have resulted from traumatic experiences;
- n. to identify shortcomings in the provision of educational opportunities for refugee women, and provide them with facilities which would give them access to education (child care, seminars for working refugee women, etc);
- o. to support programmes designed to facilitate women's return and reintegration, in particular training and income-generating programmes linked to the situation in the country of origin;
- p. to co-operate more closely with UNHCR and local non-governmental organisations and promote the networking of their activities.

51. Recommendation 1645 (2004) of the Parliamentary Assembly on access to assistance and protection for asylum-seekers at European seaports and coastal areas (excerpt)²⁶⁶

Adoption: 29 January 2004

1. The Parliamentary Assembly is deeply concerned about the increasing number of people who put their life and safety at risk by attempting to enter the territory of Council of Europe member states on board unsafe and overcrowded boats or hiding on board ships, secreted in containers, trailer carriers or other facilities, travelling in conditions of extreme hardship which sometimes result in their death.
2. The Assembly recalls its Recommendation 1467 (2000) on clandestine immigration and the fight against traffickers, in which it voiced its shock at the death of fifty-eight Chinese clandestine passengers who were found in a container in the port of Dover, and affirms its dismay at the death of eight Turkish nationals of Kurdish origin, including three children, found in a container in the port of Wexford (Ireland) in 2001. To these dramatic deaths innumerable other persons should be added who have lost their lives drowning in the Strait of Gibraltar, the Adriatic, the Aegean and off the shores of Sicily, while fleeing from hardship, extreme poverty, discrimination and persecution.
3. The Assembly reaffirms its recommendations designed to improve the protection and treatment afforded to asylum-seekers, in particular its Recommendation 1163 (1991) on the arrival of asylum-seekers at European airports; Recommendation 1236 (1994) on the right of asylum; Recommendation 1309 (1996) on the training of officials receiving asylum-seekers at border points; Recommendation 1327 (1997) on the protection and reinforcement of the human rights of refugees and asylum-seekers in Europe; Recommendation 1374 (1998) on the situation of refugee women in Europe; and Recommendation 1440 (2000) on the restrictions on asylum in the member states of the Council of Europe and the European Union.
4. Despite statistics gathered by the International Maritime Organisation (IMO), it is not possible to know how many people manage to gain clandestine entry into Council of Europe member states by travelling

²⁶⁶Text available at: <http://www.coe.int/>. See Doc.10011, report of the Committee on Migration, Refugees and Population, Rapporteur: Mr Danieli.

on board ships or unsafe craft, as shipping companies do not systematically report stowaway and rescue incidents. However, the increasing number of those who are apprehended while trying to do so, as well as the number of unfortunate victims, show that this is not a negligible phenomenon.

5. Aware that this manner of entry can be used by genuine asylum-seekers as well as other migrants, the Assembly reiterates that those in need of international protection should neither be punished nor deprived of the right to lodge an asylum application in compliance with the 1951 Geneva Convention on the Status of Refugees on account of their clandestine manner of entry or attempted entry.
6. The Assembly is concerned that effective access to the asylum procedure for those who arrive at European seaports or coastal areas may be hindered by legal and practical hurdles, including lack of independent legal advice, limited availability of professional interpreters and inadequate information on how to lodge an asylum application. In addition, in the case of clandestine passengers, there is a concern that their effective access to the asylum procedure may be impeded by an unclear and non-harmonised legal framework applying to them as well as by the concurrent responsibilities of several actors.
7. The Assembly regrets that often, especially in cases of large-scale arrivals in coastal areas, the only interviews taking place before the adoption of an expulsion order have the exclusive purpose of determining the identity and the nationality of the person concerned, with the result that a number of potential refugees may be returned in breach of the principle of *non-refoulement* risking their lives and safety. On the contrary, effective access to the asylum procedure should imply that every person seeking entry into a Council of Europe member state should have the possibility of expressing the reasons why he or she is trying to do so in full, in an individual interview with the relevant authorities of the country.
8. Similarly, the Assembly fears that the effective exercise of the right of appeal against the refusal to receive an asylum application, or against expulsion, may be nullified by expeditious or accelerated procedures that do not allow sufficient time to lodge an appeal, by inadequate information, lack of independent and free legal advice and representation and by the limited availability of professional interpreters.

9. The Assembly also notes with regret that, despite the large numbers of asylum-seekers and migrants arriving on European shores every year, permanent reception facilities in the areas concerned are still the exception, and that their material and humanitarian conditions are often below acceptable standards.

(...)

iii. call on member states to:

(...)

g. ensure that vulnerable persons, such as unaccompanied minors and separated children, the elderly, the sick and pregnant women who arrive at seaports or coastal areas, even if they do not apply for asylum, be given appropriate assistance and accommodation pending their being sent back or being granted legal status; in addition, unaccompanied minors and separated children should be provided with effective legal guardianship as soon as their presence comes to the attention of the authorities of a member state;

h. establish appropriate and permanent reception structures in coastal areas and near seaports, to provide accommodation for the new arrivals, whether they apply for asylum or not;

(...)

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