



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



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ABSTRACT

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

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

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1. Introduction

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

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

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

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

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

within EU societies [30]. Yet, those topics remain largely ignored.

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

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

migrants' health as “going beyond the traditional management of diseases and intrinsically linked with the broader social determinants of health and unequal distribution of such determinants as such as services” [36]. Understanding health as a holistic state has thus lately irrigated literature on both SRH and migrants' health.

Yet, this holistic perspective in the context of migrants' SRH was little developed at an EU level. Given the specific SRH needs and vulnerability of extra-EU migrants, the objectives of our study were fourfold. We wanted to (1) explore whether the current European policy frame on extra-EU migrants' SRH is consistent with a rights-based approach, respecting the right to health for all; (2) assess if and how this frame creates obstacles for migrants in the EU to attain a good SRH; (3) examine the current migrant health field suggestions on how to overcome these obstacles. Based on this analysis, we finally aimed (4) to formulate SRH policy, practices and research recommendations in order to promote SRH in the EU holistically and in a migrant-inclusive manner.

2. Methods

2.1. Conceptual framework

The conceptual framework in which we conducted our study combines a rights-based approach with the socio-ecological model on health. The rights-based approach considers health as a human right and assesses policies, programmes and legislation accordingly [19,37], expecting them to promote health and guarantee access to health care for all independently of any status. This approach is rooted in the overarching principle of universality [38].

Obtaining good health is a complex and dynamic social issue involving multiple determinants. The socio-ecological model identifies determinants at the individual, interpersonal, organizational and societal levels, allowing a better understanding of health complexity and facilitating multi-levelled strategic policy-making [39]. As both favour a holistic vision of health, it is compatible with a rights-based approach.

We restricted the review to the 27 EU MS as of April 2013. Because intra-EU migration is submitted to different frameworks, we focused on extra-EU migrants solely, further referred to in this paper as “migrants”. As we wanted to explore the impact of legal status on the right to health, we included refugees, asylum seekers, and irregular migrants. Finally, we gave special attention to migrant sex workers (MSWs) and LGBT migrants. The rationale behind those choices is our hypothesis that diverse migrant groups might face specific vulnerabilities and depend upon different legal and policy documents.

2.2. Review method

To address our four objectives, we were confronted with both grey (including legal) and academic literature. Given the diversity of this data pool, we opted to conduct our review with the Critical Interpretive Synthesis (CIS) method [40], specifically created and frequently used

to study inequalities within health care systems [41–43]. Designed to handle a large and heterogeneous set of references, CIS allows for the development of concepts and theories along the review process [44–46], for a synthesis of “a diverse and complex body of evidence” [42] and for a focus on “a more flexible, iterative, dynamic, critical and reflexive approach to synthesis” [41]. This conceptual framework served to conduct our review and analyze our findings, combining CIS with a rights-based approach and a socio-ecological model.

We searched for academic references on Web of Science using ‘SRH’ or ‘SRHR’ as Mesh terms associated with ‘Europe/EU’ and ‘migrant’. To those main ones, we added: ‘regular’, ‘legal’ ‘refugees’, ‘asylum seekers’, ‘undocumented’, ‘irregular’ and ‘illegal’, ‘LGBT’ and ‘sex work/sex workers’. As European institutions and competences were reorganized following the adoption of the Lisbon Treaty in December 2007, the period chosen for academic sources was 2008–2013. Yet, the references of this literature provided us with additional relevant academic references published between 2000 and 2008. We included two non-EU studies with general recommendations on migrant-friendly health services applicable to any setting. Grey literature was sought for manually, with a European/EU perspective and a focus on policy-making as selection criteria. International (WHO and UN), Council of Europe and EU (European Parliament, Commission and Council) institutions' websites were used to find relevant legal provisions. Field recommendations on migrant health practices were searched for by assessing websites and newsletters of major NGOs and networks working in the field of health and/or migration. Given the language skills of the authors and the diversity of EU official languages, this search was however limited to those providing information in English, French, Dutch or German. We eventually included 187 advocacy and legal references (grey literature) and 80 academic articles.

2.3. Analysis

Subsequently, we analyzed this data pool through the lens of our research questions:

1. Is the current European policy frame on SRH of extra-EU migrants consistent with a rights-based approach respecting the right to health for all?
2. Does this policy frame create obstacles for migrants in the EU to attain good SRH and if so, how?
3. What does the current migrant health field suggest on how to overcome these obstacles and what unconsidered SRH issues are to be found?
4. Which policy, practice and research recommendations can we formulate on the basis of our analysis in order to promote SRH in the EU holistically and in a migrant-inclusive manner?

We used NVivo 9.0 to analyze the grey literature, initially coding the findings around 47 grounded thematic nodes and three main transversal categories, being legal status, people and gender. Subsequently, we applied our conceptual framework, structuring nodes and categories

along the four socio-ecological levels. We used the resulting blueprint to filter academic references for results and merged outcomes. This process was iterated by the two main researchers.

3. Results

We will firstly discuss the applicable EU legal and policy SRH frameworks and their consistence with a rights-based approach. National particularities are only mentioned when they highlight a lack of coherence throughout the EU. Subsequently, we address some major obstacles in migrants' attainment of good SRH in the EU and compare them with current field suggestions on improvement of migrant health practices.

3.1. An inconsistent rights-based approach in legal and policy frameworks

The scarcity of specific European and international legal and policy provisions illustrates the relative newness of SRH and rights (SRHR) in EU health policy discussions. However, specific obstacles for migrants' SRH and measures to overcome them from a rights-based approach were already identified at the 1994 ICPD Conference and in the General comment no. 14 in 2000. Despite a formal recognition of SRH issues and an acknowledgement of a needed rights-based approach to SRH, the EU has taken few actions accordingly. Among other documents, its latest Women's and Men's Health reports barely address migrants' health needs or SRH [27,47]. This reticence hinders the inclusion of migrants into SRH policy-making and sustains legal uncertainties, fuelling discrimination and the difficulty for migrants to seek redress [21]. Moreover, the review of the few legal provisions on migrants' SRH reveals that most retain a 'reproductive' logic and have not yet broadened their scope to all the dimensions of SH. This means that existing provisions focus on women, particularly pregnant [48–50], increasing thus legal uncertainties for other non-pregnant migrants, leaving their specific needs unaddressed and their right to the highest attainable standard of SH potentially breached.

Research has shown that addressing migration as a threat to European health systems and finances also hinders the realization of migrants' SRHR by impacting both public opinion [51] as well as migrants themselves, who "*fear of being thought of as using too many resources*" [52]. Studies on the intersection between ethnicity and gender indicate that migrant women may suffer from particular discrimination within general [21] and SRH care [53]. In the case of MSWs, irregular migrant status combined with legal frameworks surrounding sex work has shown to lead to a heightened fear among MSWs, preventing them from accessing SRH services [54]. Despite the General Comment no. 14, the IOM stressing the fundamental role of access to quality care in the attainment of the highest standard of health and migrants' social inclusion [55] and a few EU statements in this direction [56,57], the overall policy focus at both European and MS levels undoubtedly remains on controlling migration flows. The collision of health and immigration policies thus acts as a "*blackmailing*" [58],

detering migrants and particularly irregular ones from entering SRH care and consequently attaining good SRH.

While the rights-based approach of health seems to gain some momentum in international and regional frameworks, EU MS face a hiatus between these requirements and their own migration policies. This clearly conflicts with a rights-based approach, as the prioritization of migration controls creates obstacles preventing migrants from realizing their right to health, particularly by restricting access to care. Allowing (ir)regular migrants to access health care is now often considered a State charity or generosity [31] while General Comment no.14 specifies that accessibility is core in the right to health [32] and thus a "*legal obligation and not a matter of charity or political choice*" [59].

3.2. Legal and policy obstacles to migrants' SRH

Legal and policy frameworks heavily determine the accessibility of SRH services for migrants and their review shows that they are consistently barring the realization of migrants' SRHR. Above all, within the examination of a rights-based approach, the question of access to health-care in general is central since it is a "*crucial component of a person's fundamental right to health*" [21]. Despite of all 27 EU MS having ratified the "International Bill of Human Rights", and thus acknowledging migrants' right to health, migrants' access to health care is simultaneously framed by other binding documents [60,61]. The EU Charter of Fundamental Rights for example sets out in Article 35 that "*everyone has the right of access of preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices*" [61]. This leaves room to different and potentially more restrictive national or subnational provisions which might be inspired by other pressing issues and policies, as is migration.

The 'criminalization of migration' affects migrants' realization of their right to health as their access to health care can easily be restricted [62]. In several MS, legal provisions on health at (sub)national level overlook migrants or circumscribe their access to emergency care and "*core benefits*" solely [63]. Additionally, a consistent definition of what emergency care exactly entails is often lacking, provoking uncertainty around SRH among countries and over time. The UK removed for example HIV treatment from its emergency care list in 2009, hence abandoning free of charge treatment for all patients [64]. Pace stressed that MS restricting access to health care to emergency care only fail as such to meet the principle of non-discrimination set out in Article 2 of the ICESCR [62]. Restrictions often increase for irregular migrants. Research of Rechel et al. demonstrated that even emergency care was not accessible to irregular migrants in nine of the EU MS in 2010 [65]. Yet, already in 2005 the European Court of Human Rights stated that social benefits as health services are a property right, irrespective of work or other contributions, and that denying health care to irregular migrants may equally breach the right to be free from inhumane and degrading treatment (resp. Article 1 and Article 8 of the first Protocol to European Convention on Human Rights) [62]. Similarly, the European Parliament (EP) recently advocated for a better integration of all migrants within health systems [66].

Beyond emergency situations, the access to care is dependent on regional and subnational differences. While historically the Mediterranean and Benelux regions used to grant access to a wider range of services to all, current policies to counter the economic crisis alter this practice [64,65,67]. Finally, countries providing free access to SRH care rarely properly advertise it and migrants ignore such entitlements [64].

Although public health policy remains a MS national competence, since the Lisbon Treaty entered into force in 2009, positions and powers are shifting. The European Charter of Fundamental Rights became binding on MS (except opt-outs) and respect for human rights was emphasized as a founding value for the EU [62]. Subsequently, promoting “wellbeing” – as linked to health in the WHO Constitution – became a new EU objective and the EU may now introduce binding public health legislation regarding health safety concerns [62]. The EU level in health policy is thus slowly strengthening. Yet, the current combination of (sub)national, European and international frameworks consequently turns the right to (SR)health into a patchy situation with an array of obstacles barring the exercise of this right [12,37,65,68].

3.3. Additional obstacles barring migrants' access to SRH services

The current complexity and uncertainty prevents migrants from accessing SRH health care and attaining good SRH. Navigating health systems and available NGO services is arduous because of linguistic difficulties, rendering basic interaction a challenge [52,69]. Interpreters and cultural mediators are rarely used to facilitate dialogue and mutual understanding of body, health and illness [70], while the building of a “safe space” [53] is considered essential to effective migrant-friendly SRH care and consequently of the right to health [32]. Though a 2013 report of the EU FRA highlights the crucial role of understanding to exert one's rights to information, explanation and informed consent [21]; potential discrimination within healthcare hinders such communication. Literature shows how perceptions of race, ethnicity and gender participate in excluding migrants, particularly female, from care [53]. This is heightened, in the case of MSWs, by social and moral views on sex work [13].

Covering the (often full) costs of care constitutes an additional barrier affecting especially but not exclusively undocumented migrants [65,67], who experience for example strong (sub)national variations in perinatal care costs, being charged recently between €0 (in Spanish Catalonia and Andalusia) and €2685 (Sweden) for a delivery [65,67]. Additional indirect strains include housing and transport costs when migrants are obliged to move regularly or live in under-served areas [52].

In addition to linguistic and financial obstacles, migrants face a high administrative burden. A survey on 1218 irregular migrants in 11 EU MS showed that 74% of them deem health systems as too complex [64]. Even when legally entitled to care, migrants are often required to provide proofs of residence, insurance or resources,

requirements that remain in most cases obscure to themselves and health professionals [19].

Those uncertainties are attested by medical and administrative staff reporting difficulties in determining what level of service they can provide to which migrant groups. This lack of information adds to the absence of reimbursement guarantees and leads practitioners to adopt discretionary measures. Whether (mostly) more excluding or more beneficial to individuals, this breaches equal treatment [12,71]. Uncertainties force local authorities to implement small scale mechanisms and NGOs to become care providers [64,67]. Research has questioned the sustainability of such strategies, denouncing differentiated treatment as a contradiction to a rights-based approach. Despite formal acknowledgments of NGO expertise and a “shift” of responsibility [67,71] from MS to NGOs, the latter still receive little public funding [72–74]. As the Greek, Spanish and Portuguese examples recently prove, public funding for health and social care is often among the first to be cut when (forced) austerity measures are issued in times of economic crisis, inducing high health risks for the most vulnerable [75]. As an effect of austerity in Greece, NGOs that initially provided free health care to undocumented migrants are now called upon by the general population while they are not able to provide on such level [76]. Finally, some NGOs are reluctant to include LGBT migrants or MSWs, isolating them even further [77]. Outsourcing SRH care could be a sign of EU States' reluctance to address migrants' SRH in a positive and holistic frame.

3.4. Migrant health field recommendations on SRH

Literature provides field recommendations addressing these gaps. They aim at strengthening a rights-based approach to SRH in the EU and inclusive SRH policies. Two aspects that have been particularly explored by previous research are culturally sensitive SRH care and strategic policy planning. We articulate here non exhaustively the main field recommendations socio-ecologically clustered. They address both European and national policy-makers and serve as tools for a more comprehensive rights-based approach.

Cultural and Gender Sensitive Health Care

Individual and Interpersonal levels

Involving migrants and communities	Considering migrants as “active agents of choice” towards SRH [13] Encouraging communication on family planning, sexual behaviours and gender equality [19,53] Collecting “input for services planning and development” [55] through participatory methods [78]
Overcoming language barriers	Generalizing the use of professional interpreters [79,80] Guaranteeing interpreting services with legal provisions [80,81]
Raising Awareness for migrants	Providing information on the right to health to migrants [63] Circulating information packages including SRH information, legal entitlements, financial assistance, local services [82]

Developing health literacy of migrants	Considering cultural understandings and taboos around body, sexuality and health [78] Including socio-cultural dimensions in sexual education [83]
<i>Organizational level</i>	
Raising awareness for health staff	Encouraging staff to propose counselling over systematic medication [52] Raising awareness of discrimination among health staff [84]
Enhancing cultural competence of staff	Integrating gender, legal, cultural, socio-economic and communication aspects in health professionals' formation [13,82] Providing specific cultural training on dealing with traumatic experiences, including sexual violence [70,78,85]
Act upon financial barriers	Assessing the impact national healthcare systems [12,21]
Improve accessibility of healthcare services	Considering diverse populations' (migrants-inclusive) needs for services (opening hours, appointments, etc.) [21] Recognizing multi-dimensional aspects of accessibility [32]
<i>Societal level</i>	
Strategic Policy Planning	
Collecting Data	Enhancing the use of uniform indicators on migration and include improved questions on migration in existing data collection processes [3] Conducting large statistic studies to obtain strong comparable EU data [21,86] Collecting quantitative and qualitative data and clinical evidence on migrants' health and SRH determinants [2,87]
Developing European coordination	Implementing horizontal technical cooperation on specific SRH topics [88]
Mainstreaming Health & Migration	Integrating health and migration from a rights-based approach in all policies for a "holistic approach" [55] Understanding migration as a phenomenon spilling beyond immigration control policy [71]
Building Policy	Targeting health inequalities through systematic interventions, from observation to implementation and evaluation [89] Improving acceptability and quality of health facilities, goods and services for all [32]
Developing Funding	Making EU financial resources for asylum and migration policies more coherent [73] Enhancing funding for migrant-friendly hospitals and practices [90]
Assessing Impact and Monitoring	Combining different methods of evaluation: audits, questionnaires, anonymous reporting, benchmarking... [82] Ensuring evaluation is continuous [13]

4. Discussion

4.1. Questioning the consistency of a rights-based approach to SRH in the EU

Our results clearly show the absence of an overall rights-based approach in policies regulating migrants' SRH in the

EU, as legal status remains a major determinant in accessing care and in attaining good (SR)health in the EU. This does not mean that EU nationals do benefit from a comprehensive rights-based approach to SRH, but rather that the specific legal and policy documents framing migration do not ensure a rights-based vision of SRH for migrants. Our review underlines that even when frameworks refer to a rights-based approach, their application might vary with migrants' status. Most documents constituting those frameworks, however, do not differentiate and target all groups indifferently [2]. The study of international, European, national and subnational frameworks clearly reveals a discrepancy between the increasing acknowledgement of specific migrants' needs and the simultaneous enforcement of policies restricting their right to health. This hiatus could be analyzed as "managing the paradox" [91], a concept grounded in organizational theory that aims at understanding organizations conducting two apparently contradictory policies. The International Organization for Migration applied it to migrant health and concluded that EU MS adopt diverse strategies to address the paradox between guaranteeing human rights and controlling immigration flows [37]. Such strategies aim at circumventing rather than solving the paradox, resulting in a flawed rights-based approach and negative outcomes for migrants. This diversity of strategies is also an obstacle to potential EU-wide coherent policies.

The MS are the core agents in ensuring that the right to health is fully respected within their territory, as only States can endorse the International Bill of Human Rights and as the EU Charter acknowledges national conditions to this right [92,93]. As stated earlier, all 27 EU MS ratified the International Bill of Human Rights which as such obliges them to comply. Moreover, the EU does not condone national conditioning of all human rights. Does the EU then care more for one human right than for another? This double standard would not be problematic if all MS had national laws and practices that satisfy the requirements of international human rights law. Yet, our results show that several MS do not uphold those requirements when it comes to SRH of migrants. We thus argue that this conditioning, influenced by migration policies, creates a flawed rights-based approach as well as obstacles for migrants to attain good SRH in the EU, which from a public health perspective is a risk to ill-health beyond migrant groups. For the sake of all people living in the EU today and in the future, it is thus paramount that laws and policies regulating SRH&R are altered. Firstly, we agree with the FRA that the further outsourcing of responsibility to provide accessible (SR)health care from EU MS to NGOs and civil society is revised [94]. In addition, we agree with Rechel et al. that it would already be a major step forward to strengthen the legislative basis for protection of the right to (SR)health for irregular migrants and asylum seekers at the national level and to ensure implementation [65]. Yet, we mostly support the thesis that Alston and Weiler already advanced in 1999, postulating that the role of the EU and its MS in upholding human rights were to lead to an empowered EU as "the promotion and protection of human rights is not a one-time undertaking and neither government nor bureaucracies can be counted upon to remain consistently, let alone insistently,

vigilant” [93]. Meanwhile, positions have shifted a little. The Lisbon Treaty posits that the MS remain responsible for the “definition of their health policies” and the delivery of care services, while the EU policies must ensure “a high level of human health protection” [95]. The European Commission (EC) also recently reiterated its ambitions in health public policy by stating that “respecting national responsibility for health systems does not mean doing nothing at European level” [96]. SRH&R are however only hesitantly dealt with at EU level, being hardly consensual topics [97]. Answering to a question on abortion and SRHR submitted by EP Members [98], the EC stated that this primarily remained a national competence and that the EU had no vocation to take the lead [99]. We thus consider it necessary to fuel the debate and encourage further empowerment of the EU aiming at a shared responsibility of all MS and the EU to lead by example by ensuring and controlling that also the right to (SR) health is truly upheld for all in every place of its political territory.

4.2. Legal and policy frameworks on migration as obstacles to migrant health

Migration management has become a major challenge for the EU and relevant legislation is currently being revised. The EP agreed to recast the 2003 Directive on minimum standards for reception of asylum seekers, which was accepted by the Council in 2012 and now awaits formal adoption. This was accompanied by the establishment of the European Asylum Support Office in 2011. The overall objective of the Stockholm programme setting the EU migration strategy is to realize a Common European Asylum System (CEAS) and “progressively establish an area of freedom, security and justice open to those who, forced by circumstances, legitimately seek protection in the Union” [100]. Although EU Commissioner Malmström acknowledged the necessity to protect the rights of everyone living in the EU [101], the most recent legislation and policies focus on asylum seekers and beneficiaries of international protection solely. In parallel, the EU has developed bilateral partnerships and Actions Plans through the Neighbourhood Policy (ENP). Migration is no explicit topic there, although combating ‘illegal’ migration is listed among cooperation objectives in working documents. This policy orientation has been questioned in the light of the EU responsibility in negative outcomes of border controls for migrants’ safety [102].

Migration and health/SRH remain separate in policy-making at national and EU levels [55]. The few strategic documents addressing both issues tend to tackle HIV/AIDS transmission, which might be interpreted as a construction of migration as a health security threat. This is particularly visible in the case of MSWs, where the emphasis on protection of host societies’ health is reinforced by historical perspectives on both migration and sex work [29,103], as illustrated by the continuation of mandatory HIV testing for MSWs in some EU MS (Austria, Hungary, Latvia) [13]. On July 1st, 2013, Greece has reactivated mandatory HIV testing for high-risk groups, including undocumented migrants and sex workers, a move that was globally condemned after pictures of tested women were leaked online without their

consent [104]. Coupled with current divergences among EU countries, this is an obstacle not only to the realization of migrants’ rights but also to an EU standardized and coherent policy response to migration and health issues. Previous findings indicate that discrimination towards migrants in health systems hinders their right to health in general and SRH in particular [19,53,57,58]. As noted by Dean [105], the application of a rights-based approach is currently overlooked by European welfare regimes traditionally based on citizenship rather than on universality. This may be linked to the European democracies’ conception of state sovereignty based on citizenship and subsequent perceptions of migration as a potential threat to this sovereignty [4].

The development of a true rights-based approach to health and SRH for all thus also requires rethinking the current European paradigm on migration, notably by recognizing the need for legal and policy bridges between health and migration policies. In the current economic context, mainstreaming health and migration and optimizing the use of resources has become a need [4]. However, this can only be done if migration is no longer considered a threat to public health and societies and if the discourse on migration flows stops revolving around an ever stronger securitization. Future policy-making should address such discourses and develop broader understandings of the interaction between health, welfare, citizenship and migration.

4.3. Obstacles in care provision to a rights-based approach of migrants’ SRH

The need of consistent migrant-friendly care is increasingly acknowledged in literature and legal – although mainly non-binding – provisions [66,74]. A consensus seems to be reached on different pathways to enhance culturally sensitive care [55,79,80,90,106,107]. Engaging in such reforms would help consensus building on the right to health and reinforce migrants’ integration. Simultaneously tackling frameworks and practices is consistent with research on ‘Europeanization’ process of integrating common standards in the different MS as “dynamic and contingent – taking into account informal norms, discourses, socialization, learning and the role of ideas” [108]. Further research combining those aspects would allow for a better identification of policy gaps and persistent barriers for migrants in European societies. It would also benefit European citizens through the development of patient-centred care [85,109].

4.4. Gaps in current research and recommendations for future endeavours in the field

Grey literature on migrants’ (SR)health has been produced by a heterogeneous range of NGOs working on migration and/or SRHR. Because those organizations undertake mostly specific and small-scale research [110], their results are often limited to some dimensions of migrants’ SRH. Relevant academic sources were scarce and often narrow. Although many acknowledged the necessity to conduct multi-dimensional thinking on migrants’

(SR)health, few effectively combined political and economic analysis with field and participatory studies on migrants' access to health. Despite a growing interest, no cost-efficiency analysis of access across European countries has been consistently conducted yet [111].

Studies on migrant health have especially engaged in conflict settings and mental health issues [19]. Research addressing migrants' SRH has rarely stepped outside the scope of maternal health and HIV/AIDS. Although SH is now understood as encompassing perinatal aspects and STIs [19], research and practices in the field have undoubtedly continued focusing on those topics. As a consequence, a significant number of SH topics are left unaddressed, such as sexual education, choice of partner, deciding to be sexually active and pursuing a satisfying sexual life. Family planning, which bridges sexual and reproductive health, is another pressing issue in migrants which requires more attention. Migrants still have poor access to family planning and effective contraception, while evidence shows that access improves reproductive health outcomes as well as general health, education and economic situation [112,113]. We deem it thus paramount to prioritize family planning in migrants, starting from a positive SH promotion perspective.

Another gap arises in defining target groups as the majority of migrants in the EU are neither pregnant nor infected with an STI. Hence, future migrants' SRH interventions should stem from a holistic and positive approach and also address SH promotion in adolescents, women without children, men, elderly, LGBT and MSWs. Finally, irregular migrants remain under-researched, particularly regarding their SRH behaviours [15].

These research gaps should be addressed with a double objective. First, future research should include a broader range of migrant populations and explore currently over-looked topics. Second, EU-wide datasets should be enhanced by common indicators, durable data collection [2,3,10] and the use of disaggregated data to explore simple and multiple discriminations [21]. Data collection is deemed essential to inform policy-making and monitor the impact of future interventions [3,110,114]. Those gaps in research might be partly explained by the lack of EU funding to support SRH research and interventions in Europe [115].

5. Conclusion

The question of migrants' access to SRH services is key to understand the position of extra-EU migrants and the extent to which a positive approach of SRH is applied throughout EU MS. The assessment of the current situation clearly unveils both blurred legal and policy frameworks and patchy practices, which are major breaches to the realization of a rights-based approach to (SR)health. Given that all MS ratified the International Bill of Human Rights and the European Charter on Fundamental Rights leaving room for conditioning the right to health, they remain responsible for enforcing this right and conducting public health policy. However, our review shows that migrants' health is far from being prioritized in (sub)national policies. Since

the Universal Declaration of Human Rights was forged to ensure supranational protection of human rights and the Lisbon Treaty re-asserted their importance and EU competence, we deem it a prerequisite that the EU at least promotes the right to (SR)health for both host European societies and migrant groups more adequately and coherently and that it encourages its MS more strongly to live up to their human rights obligations. Yet, at a moment where migration policies are increasingly taken up at EU level and where the need for common policies is acknowledged, we encourage the debate to also investigate new avenues of health policy-making for a more prominent role of the EU and a stronger mutual control between the EU and MS in upholding human rights. This requires to no longer perceive migration as a threat to European societies but as a challenge and opportunity for the region's sustainability. Finally, it also requires to reconsider SRH, expand it comprehensively beyond the limited scope of reproductive health, and acknowledge it as a right for all.

Grasping the multi-dimensionality of sexual and reproductive health would thus allow for a better inclusion of diverse population groups in SRH promotion policies, an increased awareness of SRH complexity and fairer SRH care throughout the EU for all.

6. Limitations

As the language skills of the authors unfortunately do not span the rich diversity of EU national languages, we were not able to search for potentially relevant documents on national websites in other languages than English, French, Dutch or German. This is a clear limitation to our review. We however covered those national regulations when translated or covered by other grey literature provided by EU institutions and NGO documents in the above-mentioned languages. They largely confirm our findings rather than challenging them.

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