Undocumentedness, human rights and nurses’ obligations: An appeal

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Introduction

There is a huge protection gap between undocumented migrants’ need of health care and access to health care all over the world. Various authorities such as police, immigration authorities and health professionals are facing dilemmas which occur in the middle of the ongoing, unsolved conflict of interest between human rights, health care, social welfare and the security and sovereignty of the modern state.

In the area concerning the marginalization of undocumented migrants, there is most likely a complex interplay between every person’s vulnerability, national law and financing systems, and health professionals’ awareness of human rights. Language barriers and cultural constraints impact on undocumented migrants’ ability to apply for assistance as well as the health professionals’ ability to access their need for health care. In addition, this very state of undocumentedness implies a fear of police and immigration authorities, which represents a considerably stressful condition in their lives.

We are asking: What is important to ethics of care to make us playing a part to decrease this protection gap?
Some major challenges of today associated with the refugee question

According to The United Nations Refugee Convention of 1951 and the protocol of 1967, the definition of the term refugee is “any 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, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it”. 

As a result, the definition of the term “refugee” is based on each individual refugee (the italics are ours) proving his/her claim of asylum which is a challenge in today’s Western world and may be viewed as a heavy burden on the refugee’s shoulders and as an unsolved problem in our time. To be one of many living in a war zone or in need of protection due to disasters is not enough. The logistical capacity of the United Nations High Commissioner for Refugees and host countries is challenged by those with the status of asylum seeker who have to prove their asylum claims according to the United Nations Refugee Convention, all of which makes their flight and resettlement even more hazardous. 

As noted by Agamben:

Every time refugees represent not individual cases but – as happens more and more often today - a mass phenomenon, both these organizations (United Nations, High Commissioner for Refugees) and individual states prove themselves, despite their solemn invocations of the “sacred and inalienable” rights of man, to be incapable of resolving the problem and even of confronting it adequately.  

A second challenge is every refugee’s access to and support of the asylum process. Included in this maze of problems are the differences between European countries in terms of access to necessary support in the asylum process and differences in the prospects of attaining or being granted asylum on humanitarian grounds. Though the aim of the Dublin Regulation was to reduce asylum seekers’ burden in the asylum process, it seems to have reduced refugees’
access to prove their asylum claims. Because of the use of detention to enforce the transfer of asylum seekers from the state where they applied to the state deemed responsible known as the Dublin transfers, refugees may face separation from their families as well as limited opportunities to appeal against these transfers. Moreover, the countries on the external border regions of the European Union are often least able to offer asylum seekers support and protection

A third challenge is in relation to the question of citizenship with respect to participation socially and politically, with respect to access to health care and to that of whether health professionals have to report undocumented migrants to the police and/or immigration control authorities in Western countries.

In Khosravi’s study of undocumented migrants in Sweden, the importance of citizenship becomes even clearer. His main findings are undocumented migrants’ fear and uncertainty, their risk of exposure to exploitation and violence and their loss of freedom and control, as well as their law abidingness in order to remain unnoticed. With a departure point in the philosophy of Hannah Arendt and Giorgio Agamben, Koshavi discusses undocumented migrants in terms of non-citizens and anti-citizens. The position of being a non-citizen is reflecting the bare life, the body deprived of any formal rights. As stated by Koshravi, undocumented migrants are illegal in their bare bodies. The position of being an anti-citizen reflects the breach with norms and law(s) important to construing differentness. Both positions place undocumented migrants into a place of non-existence, losing the right to have rights while at the same time citizens are placed in a position of no longer acknowledging a political or moral responsibility for them. Hannah Arendt says with a particular emphasis on the refugee question: “So long as these people are not resettled, they will constitute a grave political danger, precisely because they have been driven into a political vacuum”.

Undocumented migrants

Undocumented migrants are not a homogeneous group and include those who have no documents when they access a host country, those who never register themselves in the host country, those who are denied asylum and have gone underground and other overstayers as
well as people who have been trafficked. Undocumented migrants are understood in this appeal according to the Platform for International Cooperation on Undocumented Migrants, hereafter known as PICUM, as “migrants without a residence permit authorizing them to regularly stay in the country of destination”.¹

We cannot be sure of how many undocumented migrants there are today, either internationally or nationally. The global estimate is approximately 30 million undocumented migrants, of whom five to eight million are expected to live in Europe and eleven million in the US (ibid). Statistics Norway estimates about 18196 of them were living in Norway as of 1 January 2006.²

Undocumented migrants’ difficult life situation due to the dilemma mentioned above is reflecting in the different interpretations of them. Undocumented migrants are named illegal, irregulars, underground and as hard to reach, as pariah, anti-citizens and non-citizens. The representation is not only an intellectual question, but an epistemological one with both ethical and political implications ³ (p. 284).

Thus far, undocumented migrants have not been paid much attention to neither by nurses nor by other health professionals. A brief overview of undocumented migrants’ known health problems is therefore important. However, an overview can neither be taken in full here nor should an overview be considered as a complete picture of undocumented migrants’ need of health care.

A brief look at undocumented migrants’ need of health care

Reproductive health and infectious diseases are health domains given international attention, as have living and working conditions. Undocumented migrants who suffer health problems within these areas experience limited access to diagnosis, treatment and nursing care, representing a serious problem for each of them as well as challenges to public health in the broadest sense of the word.
Reproductive health includes sexuality, pregnancy, delivery, abortion, contraception and sexually transmitted diseases (STD). In studies of pregnant undocumented women, more unintended pregnancy, delayed prenatal care and a higher prevalence of genital Chlamydia trachomatis infections (CTI) compared to control women has been found, with a lack of contraception being the primary reason for unintended pregnancy. The lack of access to prenatal care for these women is a professional and moral challenge that gives rise to concern, not least of which because of women and children’s vulnerability.

Pregnant undocumented women also have poorer living and working conditions despite their level of education and more exposure to violence during pregnancy than the controls. Half the mothers had at least one child previous to leaving their home country, which increases an altogether difficult life situation.

Hunger and food insecurity are defined as “uncertain access at all times to culturally appropriate foods” by Hadley and Galea, who found that hunger was indicated by approximately 28% of undocumented migrants in their study of hunger and the associations between hunger and mental and physical health in this population group in the US. Poorer mental and physical health was also found, which may indicate a need for access to emergency help, not least because of the unpredictable work possibilities and limited access to public assistance. A limited ability to pay may lead to immigrants having to choose between medication or food according to Saether and Chawphrae, who found that the cost of medical treatment was a major obstacle to antiretroviral therapy in their study of HIV-positive immigrants in Thailand. The cost of medical treatment and health care is also a major obstacle in regard to health care access in many European countries and the main reason why Sweden and Austria are the two European countries where access to health care is found to be least accessible to undocumented migrants according to PICUM. A higher risk of developing tuberculosis among those already infected due to inadequate or poor nutrition also requires a greater attention to nutrition in its own right.
According to the World Health Organization, one-third of the world's population is infected by tuberculosis, which makes tuberculosis a major threat to public health. That is likely the main reason why tuberculosis screening is provided to asylum seekers in nearly every European Union member state in a study on access to health care for asylum seekers. 

In their report, Heldal and his colleagues present and discuss the results from a comprehensive study on the prevalence of tuberculosis among undocumented migrants (including 24 of 40 European countries asked to participate in addition to Australia, Canada, Japan and the US). In most countries with available information about the prevalence of tuberculosis, 5-10% of tuberculosis cases were found or estimated among undocumented migrants. It is important to note that the prevalence of tuberculosis and HIV/Aids varies from country to country and from group to group. This is why the prevalence of tuberculosis and HIV/Aids in the country of origin, and how recently each immigrant has settled in the host country, are the most important reasons in relation to the level of tuberculosis in various immigrant groups. Additionally, poor or inadequate nutrition and stressful living conditions increase the risk of worsening tuberculosis among those already infected.

Medicine and socio-political inequalities are interrelated says Holmes, who links the hierarchy of health status of organized working and housing conditions from best to worst according to ethnicity and citizenship status in the US and Mexico. Poor living, working and housing conditions also give rise to concern since these factors increase the risk of work-related injury and infection by tuberculosis. Restricted access to treatment and care also makes this even more serious with respect to their ability to work in the future (ibid).

There is a significant knowledge gap regarding undocumented migrants’ mental health. In our opinion this area of health should be paid more attention not least due to what is known of refugees’ mental health. Refugees may be exposed to trauma while in their country of origin, during the flight and in the resettlement phase. In addition, tight immigration controls bring more and more people into the hands of smugglers, making refugees vulnerable to
traumatic experiences during the flight and at the border, e.g. death, and children being separated from their parents.

Traumatic experiences in the new country are associated with uncertainty and fear of deportation, \(^4,12,21,22\) length of stay in asylum centres \(^23,24\) and with detention, \(^17,18,20,25,26,27\) the latter as a part of deterring the influx of asylum seekers. \(^22,25\)

To sum up, undocumented migrants suffer from poorer health and living conditions within all areas we have knowledge of in comparison to other groups of immigrants as well. This is in keep with Doctors of the World’s report on undocumented migrants’ experienced health. \(^36\) This is also most likely the primary reason why nearly every article that discusses undocumented migrants’ health also discusses the relevant judicial and ethical circumstances in connection to what cannot be considered as anything but a protectionist gap between undocumented migrants’ need and access to health care. To us, it seems that undocumented migrants are facing marginalization in every sense of the word. This is important not least because mental difficulties, severe mental disorders and learned helplessness increase a person’s vulnerability with respect both to one’s own health, with respect to applying for assistance and with respect to a subsequent exposure to trauma. \(^28,29,30\)

**Barriers to access to health care for undocumented migrants**

In PICUM’s report on access to health care for undocumented migrants in 11 European Union member states in Europe, both formal and informal hindrances are identified. \(^1\) They present what they call a difficult categorization for the countries included in the study based on whether access to health care is offered to undocumented migrants and to what extent without the threat of deportation. According to PICUM (ibid), Italy and Spain provide the widest health coverage, while as previously mentioned, health care in Austria and Sweden is considered to be the least accessible to undocumented migrants. This is due to the fact that in most cases undocumented migrants are obliged to pay the full cost of treatment which is very expensive and therefore out of reach for them. That is also the case in Norway unless the treatment is defined as urgent health care or emergency help.
Limited access to health care and welfare may also be a way of adjusting immigration as a response to “health tourism”. PICUM says there is a growing tendency to restrict access to health care and to reinforce the link between this, which eventually leads to access and immigration control policies. In some countries, different laws make the access to health care for undocumented migrants a risk because health professionals are claimed to report undocumentedness to police and/or immigration authorities. This can be illustrated with the situation in Germany and Denmark.

In Germany, these claims are due to The Residence Act. According to Castaneda, two sections in The Residence Act prohibit and criminalize health care for undocumented migrants. One section claims undocumented migrants must be reported to authorities if they seek public services, which may initiate deportation. Another section criminalizes any assistance of undocumented migrants including health care with a fine or imprisonment up to five years, especially if the health care cannot be defined as emergency help. As far as Castaneda knows, no health professionals have been imprisoned under the law, although there have been many deportations of undocumented migrants. With these laws, undocumented migrants as well as health professionals face a situation of uncertainty, ambiguity and fear.

In Denmark there is the Danish Immigration Service, who is responsible for health care to those without legal stay, but only if their address is known. Furthermore, the Danish Immigration Service is obliged to inform the police of the address. The right to health care is also restricted because the right is limited to emergency help.

However, nearly all countries in the world, including all European countries, have ratified the United Nations’ International Covenant on Economic, Social and Cultural Rights. Norway did include the UN’s Covenant on Economic, Social, and Cultural Rights in § 2 of the 1999 Human Rights Act, which took precedence over other Norwegian legislation. Also the new Immigration Act in Norway (effective as of 1 January 2010) states that humanitarian
assistance as medical aid shall not be criminalized. Nevertheless, undocumented migrants’ access to health care remains unclear in many countries which implies arbitrary help. 

In summation, there are discrepancies between human rights, payment terms and national laws regarding access to health care for undocumented migrants. As long as the common law system does not assure undocumented migrants adequate health and social care, health professionals have a common challenge in both capacity building and awareness rising with concern to health care access for undocumented migrants who hold a unique position regarding exclusion and thus marginalization. What is needed will be different in each country and is dependent on each country’s economic conditions, overall standard of health care, access to health care for undocumented migrants without risking deportation, country of origin for undocumented migrants and their reasons for immigration.

**Human rights and the ethics of care: Professional and moral recommendations**

Thus some responses are called for to eliminate formal and informal barriers to undocumented migrants’ access to health care, and general recommendations are stated by PICUM. Recommendations with respect to diagnosis, treatment and care for immigrants who are suffering from tuberculosis are stated by the International Union Against Tuberculosis and Lung Disease, which is partially expressed by Heldal and his colleagues. Detailed recommendations as they pertain to the health consequences of women and adolescents trafficked in Europe are given by Zimmerman and her colleagues in their summary report on this matter. We would recommend readers to study these recommendations closer, though a few key points will be underscored here. We would also like to emphasize that these matters cannot be left to each health professional alone and therefore are important to health - and other authorities as well.

In the first place, there is a need for low-threshold facilities free of charge based on every person’s need for health care and every country’s standard of health care, not on unclear definitions or interpretations on what is to be understood as emergency help, urgent health care or sufficient or necessary health care.
Second, there is a need for health professionals to take a common professional responsibility against any law that represents a breach of human rights or any motion put forward on this matter. This is also important to health professionals themselves and will include eliminating barriers that may bring health professionals into a situation of uncertainty or civil disobedience in their efforts for the treatment and care of undocumented migrants.

Moreover, there is a need to remind health authorities and professionals of their obligation of confidentiality due to undocumented migrants’ risk of deportation. Health authorities should support health professionals in any possible conflict in this matter.

Fourth, as long as health care for undocumented migrants is not provided through ordinary systems of help, there is a need to protect charity based health centres. And though charity-based health centres may not be the best possible way for the affirmation of undocumented migrants as more than bare bodies in need, adequate health care may contribute to making undocumented migrants a part of at least some of our experience, and thus into a place of existence. However there is a reason to argue for, as does PICUM, that necessary health care should be provided through the ordinary system for help “since most NGOs are interested in making the common law system work rather than organizing a parallel charity-based system for undocumented migrants” as they articulate it.

Next, we must not construe any polarization because of the need for safety of the host population and the well-being of undocumented migrants or asylum seekers. These aims are equally important.

Last but not least, there is a need to develop international organizations to protect those who are the least advantaged in society. International Council of Nurses is an important organization in that matter, and the Code of Ethics for Nurses is an important tool for nurses
all over the world. For that reason, it is important to highlight human rights in nursing philosophy in general and in the ethics of care in particular. This touches the very heart of our discipline. Including the Third, understood here as the non-included and non-experienced Other, is a major challenge within as well as outside of the established health services.

**International Council of Nurses’ Code of Ethics for Nurses**

The Right to Health was affirmed at the international level in Article 25 of the Universal Declaration of Human Rights (UDHR) in 1948 which states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family...". The United Nations expanded upon the "Right to Health" in Article 12 of the International Covenant on Economic, Social and Cultural Rights in 1966. This covenant guarantees the "right of everyone to the enjoyment of the highest attainable standard of health" and calls for more specific action to provide among other things the reduction of “the creation of conditions which could assure access to all medical service and medical attention in the event of sickness”. In the discussion of the right to health as a human right, the associations between health and the underlying conditions of health, e.g. acceptable living conditions and access to health care, are also important factors. How we can contribute to fulfilling the covenant, thus contributing to assuring medical service and medical attention to all in the event of sickness, both to a sufficiently large extent within the common law system and without any discrimination, is an important question within the ethics of care.

Human rights are included in the preamble to the International Council of Nurses’ Code of Ethics for Nurses which was first adopted by the International Council of Nurses (ICN) in 1953. As they say, “inherent in nursing lays a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect”. However human rights are not universal; they represent a vision, a vision of a human and just world. The trouble with human rights says Arendt “…has always been that they could not be less than the rights of nationals and that they were invoked only as a last resort by those who had lost their normal rights as citizens”. We therefore believe in the necessity of further specification of factors that nursing care should be unrestricted by, due to limited access to health care for those who conceive a state of exclusion as have different groups over the course of history.
The preamble further states that: “Nursing care is respectful of and unrestricted by considerations of age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.”

We are asking: Is nationality to be understood as if it does not matter whether you happen to be, let us say, Norwegian or German? Or can we understand that particular point as if undocumentedness; citizenship/residence permits to authorizing them to regularly stay in the country of destination, should not matter as such?

We understand this particular point as if the first interpretation is correct and thus the situation of undocumented migrants is not considered. Thus the question is of how we can continue to develop the Code of Ethics for Nurses in the future to assure that there will be no discrepancy between human rights and the Code. We therefore would like to draw attention to the suggestions for use by the International Council of Nurses’ Code of Ethics for Nurses. It says the Code “is a guide for action based on social values and needs. It will have meaning only as a living document if applied to the realities of nursing and health care in a changing society” (ibid).

**Conclusion**

As long as we do not let human rights speak on its own without any further specification of factors that nursing care should be unrestricted by, we do not think that the Code of Ethics for Nurses is clear enough to contribute to that undocumented migrants are ensured adequate health care to day. To the best of our knowledge we do not see how we can fulfil our professional and moral obligations without including yet another specification as to what nursing care should be unrestricted by: that of undocumentedness; citizenship/residence permits to authorizing them to regularly stay in the country of destination, in the next revision and reaffirmation of the Code of Ethics for Nurses.

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References


10. World Health Organization Report 2009 on Global Tuberculosis Control Epidemiology, Strategy, Financing (accessed 09.01.10)


33. The Dublin Regulation, European Commission of Justice and Home Affairs (accessed 09.01.10)

34. European Council on Refugees and Exiles’ Comments on the European Commission Proposal to recast the Dublin Regulation (accessed 09.01.10)


39. The United Nation International Covenant on Economic, Social and Cultural Rights (accessed 23.02.09)
40. Lov om styrking av menneskerettighetenes stilling i norsk rett (The law on human rights in Norway) 21st May, 1999


