



Migrant and Refugee Health Matters!

**Violations of the Right to Health and the access to Health and Health Care
for (undocumented) migrant and refugee peoples in the Netherlands**

Report prepared for the PPT Berlin, 23-25 October 2020

Submitted by Transnational Migrant Platform-Europe (TMP-E)

Amsterdam, October 2020

1. INTRODUCTION

This Report on the violation of the Human Right to Health and Migrant and Refugee Right in the Netherlands is prepared for submission to the Berlin Hearing of the Permanent Peoples Tribunal (PPT). This PPT Hearing is convened as part of the 45th Session of the PPT on the **Violations with Impunity of the Human Rights of Migrant and Refugee Peoples**. The Hearing in Berlin (October 23-25, 2020) is dedicated to assessing the violations of the Human Right to Health in Member States of the European Union and to establish the level of actual access to Health care and preventative health measures.

This Report addresses the situation of migrants and refugees in the Netherlands in terms of their Human Right to Health and their level of access to Health care, particularly for those “undocumented migrants” and “out-of- procedure” refugees.

The Report is based on the following sources:

- A consultation on September 25th, 2020 with 14 migrant self-organisations, migrant and refugee rights organisations drawn from 4 major cities in the Netherlands – Amsterdam, The Hague, Rotterdam and Utrecht (see list organisations section 6.1).
- The testimonies from key staff who have worked over a long period with migrant and refugee communities in their challenges to access health care.
- And from academic research and shadow reports on the implementation of human rights treaties in the Netherlands.

This Report “**Migrant and Refugee Health Matters!**” is submitted by the Transnational Migrant Platform-Europe (TMP-E) to the Hearing of the Permanent Peoples Tribunal.

2. FRAMING THE RIGHT TO HEALTH - MIGRANT & REFUGEE PEOPLES

The articulation on the Right to Health has developed in parallel to the overall trajectory of human rights in the past 50 years - principally as the result of organised struggles on the ground – health rights in the context of community – demanding an environment free of toxification caused by mineral and oil extractivism; implementation of clean water and sanitation; safe and nutritious food free of pesticides – whether from the harvest of land or water/sea and rivers; widespread vaccination against curable diseases; women’s reproductive rights; access to necessary and affordable drugs and medication for people living with HIV-Aids; workers struggles and health – in mining, agriculture, construction, oil rigs; and the rights of health, care and domestic workers in relation to their own health and that of their patients. Migrant and Refugee peoples have in many cases played a role in these struggles to strengthen the Human Right to Health. These advances on the ground have generated enriched and expanded understanding of the role of the Right to Health in the 20th-21st century which have become enshrined in many UN Conventions and other statements of principle and government policy throughout the world.

2.1. Key references on the Human Right to Health as principle

The Right to Health is one of our fundamental human rights. It is laid down in the Convention on Economic, Social and Cultural Rights (ICESR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on the Rights of Children (CRC) and in the European Social Charter and European Convention on Human Rights.

In the ICESR it is stated that the state parties “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹ That means that all services, goods and facilities must be available, accessible, acceptable and of good quality.²

The World Health Organisation (WHO) emphasizes in Factsheet no 31 on the Right to Health³:

- Everybody has the right to health, including access to health care.
- Prevention, treatment, protection, access to essential medicines, mother and child care including maternity care and reproductive rights, equal and timely access to basic health services, physically and financially accessible to all, on the basis of non-discrimination (so also regardless immigration status).

However, while these articulations of principles in relation to the Right to Health and equal access to health care are very important in setting the strategic goals and standards on health and well-being, this Report will show that achieving them as realities in peoples lives is a matter of continuing struggle, especially for migrants and refugees, and most particularly for those who are “undocumented migrants” and “out-of- procedure” refugees. The Report will focus primarily on the undocumented persons in the Netherlands, whether migrants or refugees, since they are regularly confined to the “sites without rights” in Dutch society and excluded from “the sites with rights”.

3. RIGHT TO HEALTH POLICY CONTEXTS IN THE NETHERLANDS

3.1. Health care in the Netherlands

Generally, in the Netherlands every citizen has access to health care. However to achieve this, it is mandatory to take out a basic health insurance, otherwise the person will be fined. This basic package is the “medically necessary care” that everyone is entitled to. The government determines the content of the basic package, and it is very basic – for example dental care for adults is not covered or physio and other therapies. Most Dutch citizens therefore find it necessary to take out an additional health insurance – the content of which is determined by the Health insurance companies who also decide what will be covered in re-imburement and to what level of costs.

In this overall context, the access to health care for migrants and refugees is generally disproportionately impacted by factors such as precarious socio-economic position, unhealthy or dangerous labour conditions and low quality housing. They are also impacted by the cuts and long waiting lists imposed under government austerity programmes as well as by the corporate interests of the global pharmaceutical corporations placing profits before people’s health – which has a knock-on effect on everybody. However, specific cuts (i.e. interpretation services or translation of information to languages other than Dutch crucial in the facilitation of access) have particular impacts on migrant and refugee communities.

3.2. Access - between Principle and Reality

In principle and on paper, undocumented migrants and out-of-procedure refugees have some rights for access to health care in the Netherlands – however there are many obstacles to achieving this:

- The “Linkage Act” (Koppelingswet 1998) which denies those without regular immigration status in the Netherlands access to social services, makes it impossible for undocumented to insure themselves for health care - neither for the basic or supplementary package.

¹ <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>, article 12

² General Recommendation ICESR, no 14, para 1.12 (<https://www.refworld.org/pdfid/4538838d0.pdf>).

³ <https://www.ohchr.org/documents/publications/factsheet31.pdf>

- Access to “medical necessary care” – this means that a doctor has to certify that s/he considers the undocumented in a state of “medically necessary” treatment so that the treatment is covered in the basic package of the Dutch health insurance.
- Health practitioners (doctors or hospitals) can reimburse such costs by the CAK (Dutch health administration office) up to 80%. However, they first have to present the bill to the undocumented who is required to indicate if s/he cannot pay the bill. When inability to pay is indicated, the doctor or hospital can send the bill to the CAK. Often reimbursement can take up to 1 – 1,5 years. Many health practitioners are therefore repeatedly in first instances inclined not to provide the necessary health care to the undocumented.
- Access to prescribed medicines for undocumented persons carries a mandatory ‘own’ fee of € 5,00. This also can be an obstacle when a person is on regular medicine or is homeless and destitute.
- In principle, the doctor or health professional is not obliged to report the undocumented persons to the police. However, out of fear of being reported or traced as undocumented, many delay their necessary medical care or skip it until it is too late.

So, although there is some access to health care in the Netherlands for undocumented, the reality of achieving access is very complex. While it may look “good” on paper, the reality of achieving access to quality health care and the practices around delivery for undocumented is too often unnecessarily complicated and restricted – resulting in the serious violation of the Right to Health and access to Health care. Formal Reports and direct feedback from undocumented confirm that access to the right to health and health care is a systemic problem for undocumented migrants and refugees. Deterrents are embedded in structural obstacles including institutional racism, and in the opaque bureaucracy which is perceived and experienced as threatening their precarious immigration status in the Netherlands

3.3. On COVID-19 and its specific impacts

Overall, during the consultation on September 25th, as well as from reports in media, and from other sources and from migrant and refugee rights solidarity organisations – the evidence is that COVID-19 has intensified the impacts and exposed the structural gaps in accessing the right to health and access to health care, but is not the underlying cause. However, while the major challenges and structural gaps and violations pre-existed the COVID-19 pandemic, it disproportionately impacts those undocumented workers in concentrated work conditions - as in industrialised agriculture, meat factories, construction, catering industry, hotels – or where big job losses have been experienced in domestic and care work. As in other countries throughout Europe, the COVID-19 conditions have shown that much of this so-called informal but essential work is done by undocumented migrants and refugees.

While fear of identification prevents undocumented migrants from approaching medical practitioners, infectious diseases are not barred by immigration status. Therefore, overall, more effective access to healthcare would also provide public health benefits for all residents of the Netherlands. It is significant, that even in these COVID-19 times full access to health rights is not available to all citizens, and disproportionately exclude the undocumented.

Another important consequence of C-19 conditions for undocumented is the limitations on social networking – and the closure of spaces – community centres or community activities – frequently spaces where undocumented could break isolation, and enjoy social support and human solidarity.

4. HEALTH REALITIES - UNDOCUMENTED MIGRANT AND REFUGEE PEOPLES

This Report, underlines that all human beings – including migrant and refugee peoples – have a right to health: physical, psychological and mental well-being and access to quality health care. This includes migrants and refugees, many of whom are employed in high-risk-to-health employment – agriculture, meat factories, catering industries, domestic and care work, often during COVID-19 referred to as “essential workers doing essential work”. However, the Report pays particular attention to the issues highlighted in the Consultation of September 25th and also to the experiences reported by the organisations that provided testimony in the preparation of this report and focuses on “undocumented migrants” and “out-of-procedure refugees”. In addition, it pays particular attention to the situation of women, to the situation of undocumented children and youth and to those in immigration detention

The trajectory of migration policy in the Netherland has effectively closed pathways of regular (labour) migration from the Global South. There is however a “cherry” picking” exception – men and women with high-level skills are identified as being “needed” to address gaps in the Dutch economy. They can apply (or the corporation recruiting them can apply) for a “Kennismigranten visa” - a visa for so-called high-skilled/paid migrants.

Furthermore, the “au-Pair” visa with limited time frame is also another legal pathway exception. This “au-pair” status and visa is identified for cultural exchange. However, it is widely acknowledged and documented that the “au-pair” visa is used to employ migrant domestic workers at relatively low wages and without the right to achieve any resident or longer term rights.

4.1. The reality of the right to health for migrants and refugees

These factors of immigration and asylum status have a determining significance when it comes to the Human Right to Health and access to Health care. It is a baseline that determines both access and delivery of health care.

- Migration status becomes an obstacle to register with a GP (huisarts-doctor) or to approach a hospital. Even in emergencies, undocumented migrants will be hesitant for fear of being reported to the authorities and then being deported.
- Another consideration is the cost. The policy requirements for reimbursement of costs obliges the doctor or hospital to first ask the undocumented person if s/he can pay – a process that is frequently reported as humiliating – “as if I am a thief”. Besides, not all costs are reimbursable - so the prescribed care will not cover all the health needs of the undocumented patient if these are not specified or designated by the doctor in her/his categorisation as “medically necessary treatment”. The undocumented migrant or refugee therefore has to make the choice for a debt that eventually s/he may not be able to pay since her/his savings from a low income is often committed to the upkeep of family in her/his home country.
- Besides the emergency occasions, undocumented migrants and refugees do not have access to regular health checks for breast or cervical cancer; hypertension and blood pressure; work related injuries (backpain etc).
- Exclusion from the established determinants of the Right to Health: safe housing, regular income, safe labour conditions, future perspective – has a profound impact on all dimensions of the health of (undocumented) migrants and refugees – their physical, psychological and mental well-being.

From peer policy brief ISS (July 2020):

“A range of studies, including our own, have highlighted that irregular immigration status itself is the greatest health risk for undocumented people leading to, e.g., mental and (psycho) somatic

problems, such as high blood pressure, gastric diseases, headaches and back problems. Regularization addresses these risks, but also acknowledges irregular migrants' potential economic and social contributions".

4.2. Access to health care services

The General Practitioner (GP) is the front door to other health care services in the Netherlands. They are deciding what the “necessary medical care” which undocumented persons can have access to. To register with a GP practice is not that easy.

An “undocumented migrant or refugee status” in immigration context through which the access is “filtered”:

- Lack of knowledge by the GP that undocumented has the right to register and that costs can be reimbursed. But also the bureaucratic system that takes a lot of time and delay on reimbursement of costs and the extra work burden for GPs, since many undocumented have often complicated health issues, as well physical as psychological due to their unsafe and unsure circumstances. Therefore, GPs are often reluctant to have (too many) undocumented persons as patients.
- These conditions are further intensified in the COVID –19 context – it has actually become even more difficult than before the C-19 pandemic to find a GP in the big cities where undocumented can be registered.
- Lack of knowledge by the undocumented themselves - thinking they don't have the right to health care. Being locked outside the official and state system of health care, undocumented migrant and refugee can only rely on two main sources of support – their own self-help organisations or from solidarity and human rights - including health rights or humanitarian – organisations. The result is that undocumented are hugely depended for their access to health care of social network and support/community organisations that can provide the knowledge on their rights and/or act as intermediaries.

Another concern is the “growing older” generation among the undocumented – who very often have additional health needs related to the nature of the work they have undertaken. This is often combined with the lack of any financial security or pension leading to extreme poverty despite having worked their entire lives.

Impacts on psychological and mental health

Besides, the impacts on physical health and well-being, migrants and refugees who are undocumented experience an immense toll on their psychological and mental health. This leads to constant anxiety, tension and fear of being discovered, being reported, being deported and the loss of a livelihood which is a mainstay support for their children or families in the Netherlands and/or in their home country.

The “pillarization and silo approach” in the psychological and mental health care system means a complex maze of differentiated layers of suitable health services. This causes big delays in the processing of patients in accessing the appropriate care that they so desperately need, which in itself contributes to psychological pressure and anxiety. Every time there are new applications – this piles up on waiting lists which can be as long as nine (!) months. In the mean time, the urgent care needed by the undocumented - because of trauma, experiences living as undocumented on the street, an insecure and unsafe life, lack of future perspectives – is delayed and symptoms deteriorating.

These conditions also put a lot of pressure on support/community organisations who are committed to open the door for access to needed.

4.3. Undocumented Women

Migrant women organisations and women's rights organisations are applying CEDAW concerns about access to healthcare for undocumented women.

As Sara a migrant woman comments:

"Migrant (undocumented) women and healthcare professionals still lack knowledge on the right to health of women and the existing regulations. As a consequence undocumented migrant women often achieve access to the healthcare system when it is too late – symptoms got worse, their cancer is too advanced. The continuity of needed care is seldom or not guaranteed, and sometimes they are denied any care at all. In practice undocumented migrant women are often dependant on NGO's that act as intermediaries between undocumented migrants and the healthcare system".

Women Migrant Workers

The vast majority of undocumented women – migrants as well as refugees – find employment mainly as workers in the private household – either as live-in or live-out workers – including those who are working in the homes of diplomats or as au-pair – or in hotels and catering industries. Most of them came legally to the Netherlands – with a temporary work permit, through family reunification or with a tourist visa. They were forced to become "over-stayers" and therefore undocumented when their visa for various reasons expired. Likewise, women who are refused asylum, also became undocumented.

While there are employers who uphold treatment of workers according to their human rights as workers and as women, however this depends on the "goodwill" of the employer. Because of the undocumented status of the worker, the relationship is a very unequal power relationship, constantly under threat of reporting to the police or immigration authorities. This relation frequently also leads to other forms of exploitation and violation of rights.

Associations of migrant domestic workers such as IMWU, RESPECT Network or TRUSTED as well as researches and shadow reports to CEDAW their exploitation have been extensively documented – in terms of wages (underpay and overwork); on-call work when live-in, multiple tasking (child minding, or elderly care work, cooking, house-cleaning, laundry, gardening, shopping), unsafe and unhealthy labour conditions, without personal protective equipment (PPE) and experiences of gender based harassment and violence on the work floor. The work done is precarious work – very often without any agreed contract or the working relationship can be unilaterally ended by the employer – either because of change of circumstances – transferring to another city or country, illness, loss of employment or other unexplained reasons on the side of the employer.

Women as Single mothers

Single mothers among the undocumented women have particularly challenging pressures – to work a job that provides a wage that can support their life in the Netherlands and combined with support to family in the home country which most migrants carry as key double responsibility

According to Eddy (15 years undocumented in NL),

"if undocumented women who are single mothers – and are even temporarily without work – their savings will be consumed in a short time and they will not be able to fulfil their family obligations and may have to go into unsustainable debt or rely on exploitative support".

Violence against Women and domestic violence

For those who find themselves in a violent partnership – the impacts can be devastating while they endure long term violence. In such circumstances, they will experience Isolation, loss of social

networks, unsafe environment, a crippling “dependency” on a violent partner – afraid to leave for fear of homelessness or deportation.

Migrant women who are abused by their partner may apply for an independent residence permit. However, in the NGOs’ experience supporting women in this context, the heavy burden of proof and uncertainty about the outcome of an application for continued residence often cause women to try to endure the violence as long as possible, even with the risk that the violence will escalate. This situation has become exacerbated by the increase in the duration of the “dependency” period (obligatory stay with partner), the introduction of the integration exam as a condition for an autonomous residence permit, and the increase in the burden of proof of the experienced violence.

Since 2012 a declaration from both the police and/or the prosecutor as well as from the shelter/support service are both required - before 2012 only one of these “proofs” was needed. This makes it more difficult for all women in violent partnerships to qualify for an autonomous, independent residence permit, but it is now especially difficult for those enduring “non-visible” (psychological) abuse despite the fact that psychological violence is included in the definition of domestic violence.

Data indicate that more than 80% of the women in domestic violence with a dependent residence permit are granted continued residence based on domestic violence. For undocumented women, this is only 25% - this percentage only concerns women who did apply for an independent status. In the experience of NGOs, there are many more women who experience and endure domestic violence, but they are afraid to come forward for fear of losing their right to stay.

Undocumented women experiencing violence are also denied access to women shelters. Temporary shelter may be sometimes available, but these shelters are not specialised in handling and treating violence against women or for care of psychological or mental health. Furthermore, these specialised services are often only available when the migrant or refugee women have agreed to leave the country.

Women in Asylum seekers centres

There are many reports and indications of inadequate protection and services in asylum seekers’ centres for women who have endured or endure gender based violence. Excluded from regular and specialised shelters and support services, they have access only to the most basic non-specialised shelters and services for asylum seekers. Those shelters are frequently under resourced with minimal provisions and with little privacy. Members of staff and volunteers often lack necessary specialised skills and knowledge on the applicable laws and regulations.

Likewise they have not been provided training in relation to coping mechanisms regarding traumatic experiences, cultural sensitivity or client-centred prevention, care and support. In many cases, staff and volunteers are ill-equipped to talk about sexual violence or they assume that it is a taboo for the women themselves or even that “migrant and refugee women consider domestic violence an accepted part of their culture”.

Among the undocumented in asylum seekers centres, who identify as LGBTI + also report experiencing and enduring violence and discrimination and in addition have a difficult challenge to be recognised as LGBTI+ within the asylum procedures.

4.4. Undocumented Children and Youth and Access to Health Care

There is a widespread perception that undocumented migrant and refugee children are particularly vulnerable to trauma – including the trauma of being “unaccompanied” on their migrant or refugee

journey. It is also recognised that detention and confinement in prison or detention centres or in locked-in camps is particularly devastating for children. However, this practice has become “normalised”. In the many instances of arrival in or deportation from Europe, including the Netherlands.

Less recognised or acknowledged is the impact on the psychological and mental health of teenagers and young adults who because of being undocumented (even if they are born in the Netherlands) if their parents are undocumented, they too are undocumented.

Undocumented youth, whether born in the Netherlands or if they arrived as children or teenagers, have the right to education until they reach the age of 18th. After the age of 18th only the education that was already started, may be finished, including a vocational training. However, to finish a vocational training it is often mandatory to follow successfully an internship, but undocumented are not allowed to follow an internship in the Netherlands.

With this exclusion, their options for the future are set on a pre-determined path of being only able to find employment in the “undocumented sectors” where their parents are employed in informal and exploitative work. It also leads to a rupture with friends from second level education and a break with peers – an important element in personal development; isolation in not being able to share the normal social experiences of teenagers and frequently leads to depression and a sense of a closed future.

As Alma, one such teenager expresses:

“I have done well in my second level education. I don’t understand why I should be excluded and denied the right to pursue my studies and training. And I am afraid to lose my friends as our pathways go separate ways now – they go to university or professional training and I am left outside... but I will continue to live with my dream”.

Since identity is a crucial factor in personal and social development - this “crucially different identity” as “undocumented” is a stigma which most teenagers will keep as a secret. It also has a very significant impact on their sense of identify, self-confidence and psychological and mental well-being. It is also linked with the “security” and continued stay of themselves and their parents in the country and leads to anxiety and a strong sense of a deprived future horizon.

4.5. Migrants and refugees in immigration detention

Migration is not a crime. Nevertheless, the detention of undocumented migrants and out-of-procedure refugees had become commonplace in the Netherlands – as it has in other EU countries. Immigration detention has a deep negative effect on individuals and families. It has a profound impact on the physical and mental health on the detained and on their relatives and friends outside. The most experienced mental health problems are depression, anxiety and post-traumatic stress disorder (PTSD) and the longer the detention continues, the longer lasting the implications will be. The regular use of isolation and solitary confinement is a serious risk factor for long lasting mental health damage, so is the use of segregation units.

Kofi experiences the detention policy in the Netherlands:

I don’t understand and it makes me crazy. It happened already 2 times: arrested, put in prison, released after 18 months because they couldn’t deport me, after a few years arrested again and after 18 months again released. This is NOT HUMANE!

Furthermore, next to the direct impact on mental and physical well being, detention is often associated with the additional stigma and narrative of being “criminal” – both by those who experience unjust detention and in the public perception.

In case of children in detention: in principle that is not allowed in the Netherlands. For the purpose of deportation, children and their family are detained in so called “closed family facilities”. Families have their own living units, where they can cook for themselves and there are activities for the children. However - there is a closed fence around the facility. The families are often moved to other facilities, there is no privacy and there are hardly any care to deal with the traumatic experiences. Deportations occurs early in the morning, what is particularly for the children extremely stressful and traumatic: they are lying awake in anticipation will this be the day that they will be deported. And every day they are missing friends that were deported in the morning.

5. OVERALL KEY FINDINGS AND RECOMMENDATIONS

A number of key finding emerge in this review of the implementation of the Right to Health and access to Health care in the Netherlands in relation to Migrant and Refugee peoples.

5.1. Overall Key Findings

There is a major disjuncture between the commitments in principle and on paper and the daily access to enabling conditions for the right to Health and access to Health care which result in systematic violations of this human right – particularly (but not exclusively) in the case of “undocumented migrants and out-of-procedure refugees”.

As in Europe as a whole and arising from policies of austerity and pressure for privatisation the accessibility and quality of care is also in the Netherlands under increasing pressure.

Migration and Asylum status – A Pivotal determinant

Migrant and refugee peoples, especially those “undocumented migrants” or “out-of-procedure refugees” find themselves “in sites without rights” – denied of basic rights – in terms of work, wages, housing, education as well as the right to access to health for themselves or for their family members and children. This “constructed” status imposed by immigration policy in the Netherlands and in conjunction with the immigration and asylum policy in the EU as a whole, in relation to migrant and refugee peoples results in the systematic violations of their human rights and generate major impacts on health and well-being including / such as:

- Damage to psychological and mental health is long-term and detrimental:
 - It brings sustained daily anxiety, worry and insecurity.
 - It denies the fundamental freedom of having a horizon and aspiration for the future.
- Subjected to conditions of exclusion or obstacles preventing reasonable access to health care:
 - Prohibition on health insurance; dependency on the “medically necessary” declaration of a GP; a maze of bureaucracy on payment and re-imburement for treatments and medicines, that also result in serious damage to physical health;
 - Exclusion from regular health checks and access to health care even if they are seriously ill.
 - Confined to conditions of precarious, informal work brings health endangering threats and impacts with exposure to dangerous chemicals, pesticides and heavy work whether in the context of domestic or care work, agriculture and meat industry, construction, warehouse work.

- Undocumented Women – migrant and refugee – experience disproportionate gender specific impacts:
 - Locked in violent partnership – with little options for a secure exit.
 - More likely to be exposed to gender based violence in crowded conditions in Asylum seekers centres.
 - Excluded from support services in relation to reproductive rights and contraception as well as oversight in pregnancy.
 - Deprived of regular-check-ups for breast and cervical cancer.

- Undocumented Children and Youth experience systematic violations of their rights
Despite the broad acknowledgement that undocumented migrant and refugee children are particularly vulnerable to trauma – including the trauma of being “unaccompanied” on their migrant or refugee journey, continue to be subjected to other violations of the rights which impact on their health and well-being:
 - They experience the insecurity and anxiety of being “different” in being “undocumented” and also endure racist labels while younger children before the age of 18 can go to school, they can avail of the health check-up provided by the school.
 - The condition of being undocumented has serious impacts on psychological and mental health of teenagers – particularly when they realise they are prohibited to continue their third level education – impacting their social networking and interaction with peers but also closing down their future horizons locking them into the corridors of personal anxiety, imposed invisibility, exploitative work without rights, and the inequality of opportunity and poverty of their parents.

- The practice of Detention continues to increase
 - It is also recognised that detention and confinement in prison or detention centres or in locked-in camps is particularly devastating for all human beings. However, this practice has become “normalised” in the many instances of arrival in or deportation from Europe, including the Netherlands.

- Daily realities under C-19
 - COVID 19 conditions have intensified the pressures on undocumented migrants and out-of-procedure refugees and have it more visible.
 - In terms of work:
 - Loss of job (because of lock-down) and therefore loss of income, capacity to pay for food, rent, medicine and eventually homelessness and dependency on foodbanks or other forms of humanitarian support.
 - Continued employment in “essential work” – but in high risk conditions in care work, (also reported in agriculture, meat industry, construction) – but without adequate protective clothing and other necessary requirements for health and safety.

- Migrant and Refugee peoples - protagonists for their rights
 - In the face of conditions of grave violations of their rights and the intense struggle for survival – undocumented migrants and refugees – continue to assert and claim their human rights to health as integral to their fundamental human right to a life of dignity.
 - As communities who organise themselves, they reach out to those most vulnerable among them and many insisted in the consultation preparing this report that they

see themselves as an actual or potential resource in strengthening through their integration as community members and information activities to be social actors that can/should be acknowledged and resourced and trained to contribute to ensuring the right to health for all.

- Solidarity is alive and dynamic on the ground
 - It is everywhere acknowledged that racism, xenophobia and all forms of discrimination have increased not only in the daily society encounters and institutional settings - but also in the representative politics in Parliaments throughout Europe, including in the Netherlands.
 - Despite this and the increasing criminalisation of solidarity, there are multiple manifestations of solidarity against the experiences of exclusion and violations of rights – as attested in the daily support experienced by “undocumented migrants and out-of-procedure refugees” that supports a joint demand for equal human rights including the right to health and well-being.

5.2. Recommendations

In the light of the above findings, we address the PPT to urge the European Commission and the EU member states including the Dutch government to:

1. Uphold the human right to health and health care for everybody based on the principle of non-discrimination, in the areas of prevention, protection and treatment, as well physical and psychological and with disregard of immigration status or ethnic origin.
2. Implement regularisation of undocumented migrants and refugees- as this report as well as several studies establish that the various versions of constructed “undocumented” migration and refugee status is itself a key/pivotal factor of risks to health and well-being leading to serious and sustained violations of the right to health (physical, psychological and mental) and access to health care.
3. In the Netherlands context, the government is called to abolish the "Linking Act "(Koppelings Wet 1998). This law is the main reason why people who have no residence permit are not allowed to apply for insurance, work permit and prohibited access to other public services such as shelter. All these are connected to the health issue. To achieve an effective access to health care for migrants and refugees with no residence status, this law must be abolished.
4. Establish and implement mandatory zero tolerance of racism (including necessary steps to end institutional racism and all forms of discrimination and xenophobia) in society including in public services access to health care, labour conditions, housing and education.
5. Address the threat to democracy within the European society with the rise of white, rightist and supremacist forces – and the stereotyping of migrant and refugee peoples
6. Stop the criminalisation of migrant and refugee communities and of the solidarity that confronts the European policies leading to massive loss of life (at sea and on land) the closure of legal path ways for migration and asylum.
7. Break with the policies of seeing migrant and refugee peoples as Europe’s problem – place a human rights based approach at the centre of policy frameworks across all the countries of Europe and end the policy of double standards, systematic violations in the access to the human right to health and all other human rights.

8. End detention for all – including closure of Camps and so-called hotspots, and asylum centres and construct an enabling environment both for migrant and refugee peoples – with particular attention to undocumented women, children and youth, LGBTI+ including necessary transition skills - and provide the necessary and skills training (gender violence, trauma) of the health and other personnel and NGO and human rights workers who have responsibilities in joint claiming and delivery of access to health and other human rights.
9. Urgently end the exclusions and risks for undocumented people and ensure that the human right to health and access to health care is not only a human right on paper, but is genuinely implemented with accessibility to GP's, hospitals, dentists, physiotherapist, physical and mental care professionals, specialist, maternity and baby care and pharmacies.
10. Address the challenge expressed by undocumented people that “it is not a crime to migrate or seek refuge – it is a human right” – move from a hostile health threatening environment to a human rights based environment – where all migrant and refugee people are enabled to achieve equal human rights and their human potential.

6. ORGANISATIONS AND REFERENCES & SOURCES

6.1. List organisations participating in September 25th Consultation

- CAAT projects www.caatprojects.eu / www.facebook.com/caatprojects.nl
See also their statement (2020) prepared for the PPT Berlin
- Commission for Filipino Migrant Workers (CFMW)
<https://www.facebook.com/CommissionforFilipinoMigrantWorkers/>
- FILMIS, Filipino Migrants In Solidarity www.fil-mis.org /
<https://www.facebook.com/Filmis-Migrants-146600019039259>
- Indonesian Migrant Workers Union (IMWU) www.facebook.com/imwu.nl
- Koop Natin – Migrant Workers Co-Op organisation
- Migrant Domestic Workers FNV www.facebook.com/profile.php?id=100001610715174
- OKIA (Support Comité Undocumented Workers)
- RESPECT Network NL <http://www.respectnetworkeu.org/>,
<https://www.facebook.com/RESPECTNetworkEurope>
- Stichting Malak Amsterdam (Organisation for social participation, self-reliance and emancipation) www.stichtingmalak.com/
- Support Group Undocumented Women www.svzv.nl/en/ /
<https://www.facebook.com/SVZV1995>
- Transnational Migrant Platform Europe www.transnationalmigrantplatform.net /
www.facebook.com/TransnationalMigrantPlatform
- TRUSTED - Migrant Domestic Workers in Amsterdam
- Wereldhuis Amsterdam www.wereldhuis.org
- Wereldhuis Den Haag - Stek voor Stad en Kerk www.denhaagwereldhuis.nl

6.2. References & sources

Doctors of the World (Dokters van de Wereld) (2018), *The Door to Care. The right to health and care for undocumented migrants*. (De Deur naar Zorg. Het recht op gezondheid en zorg voor ongedocumenteerde migranten.) Report.

https://doktersvandewereld.org/wp-content/uploads/2018/07/Dokter-van-de-Wereld-Hoofdrapport_Zorgrecht-2018.pdf

Doctors of the World (Dokters van de Wereld, the Netherlands) (April 2020). *Questionnaire UN Committee on Migrant Workers General Comment No. 5 on Migrants' Human Right to Liberty and their Protection from Arbitrary Detention*.

<https://www.ohchr.org/Documents/HRBodies/CMW/GC5/DoctorsWorld.docx>

Dutch CEDAW Network (2016). *Unfinished Business - Women's Rights in The Netherlands*. Shadow report by Dutch NGOs and CSOs. 6th report cyclus CEDAW. <https://www.vn-vrouwenverdrag.nl/wp-content/uploads/Schaduwrapportage-2.0-DEF.pdf>

Dutch CEDAW Network (2018). *Joining Forces to Break the Circle of Violence against Women*. Shadow report by Dutch NGOs and CSOs for GREVIO (Istanbul Convention). <https://www.vn-vrouwenverdrag.nl/schaduwrapportage-verdrag-van-istanbul/>

Hintjens, H.M, Siegmann, K.A, & Richard, H.J.M. (H. J.M.). (2020). *Seeking health below the radar: Undocumented People's access to healthcare in two Dutch cities*. *Social Science & Medicine*, 248.

International Institute Social Studies and Erasmus University (July 2020). *Towards realising health rights of undocumented people in the Netherlands – lessons from participatory research in the time of COVID-19*, policy brief. https://repub.eur.nl/pub/102903/ISSPolicySeminar_PolicyBrief.pdf

KIS (Platform Integration & Society) (2018). *Health care of undocumented. You can't do alone*. (Zorg voor ongedocumenteerden. Alleen krijg je het niet voor elkaar.) <https://www.kis.nl/sites/default/files/bestanden/Publicaties/alleen-krijg-je-het-niet-voor-elkaar.pdf>

National Ombudsman, Dutch Institute for Human Rights & Dutch Advisory Committee on Migration Affairs (2015), *Carefree on the street. Medical care for undocumented*. (Zorgeloos op straat), Recommendations. <https://www.nationaleombudsman.nl/system/files/bijlage/151217%20Aanbevelingen%20Zorgeloos%20op%20straat.pdf>

NJCM (Netherlands Committee of Jurists for Human Rights (2016). *Joint Parallel Report to the Sixth Periodic Report of the Netherlands on the International Covenant on Economic, Social and Cultural Rights*. https://njcm.nl/wp-content/uploads/2017/05/NJCM_JointNGO_CESCR_Parallel-Report-2016.pdf

Pharos (Dutch Centre of Expertise on Health Disparities) (2019). *Access to care for undocumented migrants. What helps to get care? (Toegang tot zorg voor ongedocumenteerde migranten. Wat helpt om zorg te krijgen?)*. Report. https://www.pharos.nl/wp-content/uploads/2019/05/Toegang_tot_zorg_voor_ongedocumenteerde_migranten-Pharos.pdf

The Guardian.com (2020) - Europe Dreamers Series. Natalia Robledo-Contreras (Netherlands), 'My mother was ordered to leave the Netherlands. I cried non-stop', <https://www.theguardian.com/world/2020/aug/03/my-mother-was-ordered-leave-netherlands-i-cried-non-stop>

Whole series "European Dreamers" (2020) <https://www.theguardian.com/world/series/europe-dreamers>