Mother & Child

Mother & Child Project

Brief analysis of implementation and key findings

ΓΙΑΤΡΟΙ ΤΟΥ ΚΟΣΜΟΥ

MSD

MSD for mothers

Committed to Saving Lives

"Mother & Child" project is a two year program implemented in Greece by the Doctors of the World, supported by MSD for Mothers.
The program offers maternal health services to pregnant women and their babies, before, during and after childbirth".

On alert...

Doctors of the World are and always be on the alert, as they have all these years, to monitor closely, step by step, the developents.

It is certain that, with the implementation of the right policy on health, we can achieve maximum sustainability in the healthcare system, and safeguard public health.

Preface

Doctors of the World – Greece is a humanitarian organization following its own path based on the particularities of Greece, and maintaining its economic and administrative independence. Operating continuously for the past 27 years it has earned a place in people's mind as a reliable and efficient organization promoting the sentiment of solidarity of the Greek society. With dozens of humanitarian aid missions in Greece and developing countries, Greek doctors, health workers, and administration staff offer their voluntary services.

At the missions' field, MdM, maintaining their independence, both operationally and financially, organize, staff, and finance missions aiming to provide humanitarian aid to populations in need. MdM Greece, in difficult times of budgetary cutting for NGO's in Greece, have managed to expand their activities with limited funding, by promoting voluntary work via beguine planning, following accurate and transparent implementation standards.

Doctors of the World...wherever people are...

MdM Greece – Key Activities

Médecins du Monde Greece was established in 1990 and they constitute a unique Greek Organization. At the same time, however, they remain part of the International Network of MdM which consists of 15 chapters. The guiding principle underlying MdM's activities is that every human being has a right to humanitarian assistance, irrespective of their ethnic origin, religion, ideology or political persuasion. MdM are, therefore, guided by the principles of neutrality and impartiality. Being neutral, however, does not preclude MdM from speaking out. MdM fight injustice in all its forms. Constant defenders of human rights MdM object decisively to social exclusion and the marginalization of vulnerable groups.

MdM rely on the commitment of volunteers and the financial support of its donors. The resources that emanate mainly from donations of individuals ensure the independence and the effectiveness of our action. Unfortunately, the recent severe financial conditions in Greece have led the Organization to the conclusion that activities within the country have to be intensified to meet the massive needs that have been created.

MdM–GR operate activities with the support of more than 600 active volunteers and over 300 paid staff members. At present, MdM run 30 different projects, as a response to the increasing needs created by the socio-economic and migratory crisis in Greece.

Most important MdM activities include:

- Operation of 8 Open Polyclinics: 2 in Athens (1997, 2016), 1 in Piraeus (2016), 1 in Thessaloniki (2001), 1 in Chania (2007), 1 in Perama (2009), 1 in Patras (2012), and 1 in Kavala (2007).
- Operation of 4 accommodation centres for: 1 homeless population, 1 for unaccompanied minors, 1 for vulnerable families and 1 for asylum seekers.
- Operation of 10 medical mobile units offering medical services to people living in isolated and remote places all over Greece, as well as refugee camps.
- Provision of medical services and psychosocial support to refugees and third country national stranded in Greece, in 15 open camps.
- Social medical offices in remote islands that lucked medical facilities.

Awards

In 2016 MdM were awarded with the Superbands award as the most effective humanitarian organization in Greece. In 2014 the organization was awarded by the Academy of Athens for their contribution in promoting humanitarian care and social welfare in Greece. The Onassis Foundation instituted the Onassis International Award "Estia" in order to honor the remarkable social and groundbreaking initiative. The "Open Polyclinic" of Médecins du Monde won the award in 2009.

Completing 27 years of continuous action, in 2017, MdM have been recognized to the conscience of the citizens as a reliable and effective organization which promotes the feelings of solidarity of the Greek society.

Greece – The situation on the Ground

Greece has been facing multiple crises over the past three years, in particular the financial one which has led to hardship for millions of Greek citizens, putting enormous pressure on the country's health and social systems, which have been further strained by the historically unprecedented recent migrant crisis, with millions of refugees arriving in Greece over the past months. As a result, MdM has been observing a dramatic rise in demand for essential and primary health care services.
We are honored to count on MSD to help us

strengthening our capacity to provide life-saving care to the most vulnerable.

As a result of the global financial crisis and recession, Greece has been facing a dramatic increase in the percentage of 'relative poverty' as well as a constant shrinking of social benefits provided by the government.

The National Healthcare System is going through one of its most worrying and critical stages since its inception, and at the same time more and more people are unable to cover their basic living needs.

Since the beginning of the crisis, the situation in Greece remains particularly worrying. **The total number of registered unemployed in Greece rose up to 956,041 people in February 2017. Of those, 43.58% are males and 56.42% are female.** The figure shows an increase of 1.13% compared to the previous month, January 2017[1]. Additionally, crisis hits women and especially young mothers very hard. A big number of pregnant women lack proper access to maternal care and an increasing number of new mothers are forced to return to work or join the labour market for the first time so to contribute to their household's income and find a job.

The percentage of Greek people at risk of poverty in Greece is 23.2% at the end of 2016. Crisis and austerity policies have left a large amount of the population without healthcare coverage. Economic inequalities have risen with more people facing survival problems.
Within five years, the Greeks lost 1/3 of their buying power, 1/4 of their income[2]. In poverty or social exclusion are living more than one in three people in Greece and on average one in four in the EU, according to data of 2015, which released today by Eurostat.

Specifically, in Greece in 2015 was faced with the risk of poverty or social exclusion in 35.7% of the population (3.8 mil.), compared with 28.1% in 2008. In the EU, the figure was reduced in 2015 at 2008 levels, 23.7% (118.8 mil.). According to Eurostat, a man is in poverty or social exclusion when facing one or more of the following problematic situations: Whether considered poor (smaller than 60% of the national median income), either living in poverty (lack basic goods or fail to meet minimum financial obligations), or live in families on unemployment[3] .

The percentage of people reporting unmet medical care needs has increased since the beginning of the crisis, rising to 6 million people in 2016[4] . While 60% of the population faces problems of access to health services because they do not have to pay the participation[5].
The financial crisis has created new vulnerable groups, leading, at the same time, to extreme poverty in single-parent families, migrants/refugees, children and young people, elderly persons, the long-term unemployed, and people living in appalling housing conditions.
The number of people requesting provision of free primary health care has increased dramatically in recent years. **During the last year alone, MdM's Athens Open Polyclinic offers medical services and pharmaceutical coverage to 40,678 beneficiaries and to over 2,808 beneficiaries' psychosocial support.** Uninsured, destitute, homeless, unemployed, women who cannot afford their insurance and therefore do not have free access to the National Healthcare System, are only some of the many vulnerable groups of patients that accessed the Polyclinics.

We need to clarify that these people may have access to the NHS, but have not the required economic means to pay for the mandatory percentage of own funds contribution in order to receive medical care.

The crisis has generated austerity measures that have had a deep impact on all social safety nets, including healthcare provision where the share of out-of-pocket expenditure for patients has been significantly raised. As a consequence, people delay or even abandon seeking healthcare.
According to a report published by the OECD in

2011 onwards, the most common reason mentioned in Greece for self-reported unmet needs is the cost.

Groups who were already facing numerous vulnerability factors before the crisis, have seen a reduction in or a termination of social safety nets and networks which provide them with basic help. Families unravel under the weight of a crisis that is as much human as it is financial.

According to the latest official figures from the General Confederation of Greek Workers, the number of uninsured citizens in Greece is currently close to 3,000,000 out of a total population of 10,815,197, while according to data from the National Health Services Agency, the estimated number of uninsured was 4,000,000, in 2015 and has risen to 6,000,000 in 2016[6].

Children are most at risk of poverty in Greece. Children's experiences of poverty are multidimensional and differ from those of adults and their dependency on adults for support and protection means that loss of family care poses them at significant risk. The poor children are likely to occur more health problems, compared to the non-poor and may experience greater delays in cognitive and socio-emotional development, particularly when poverty is long. Moreover, they are more likely to be malnourished and hassled by lack of heat and moisture in the home. Single parent families, large rural families and the families of economic migrants and unskilled workers are the most affected. It should be added that the majority of poor children live in working poor households, while at the same time the number of poor children living in jobless households is increasing. Families without children face lower extreme poverty rates than families with children, but families with three children seem to be in a better position than those with one or two.

Greece has continued downgrades in the ranking for life expectancy among the EU Member States, where the 2nd place in 1991, came in 11th in 2014.
While chronic diseases faced in Greece 24.8% of people stating poor compared with 16.2% declaring themselves "not poor".

According to the Economic Report of VPRC and Social Indicators for 2009, which excludes foreign households, 40% of Greeks did not have the financial capacity to deal with emergencies and necessary expenses, such as health.Today more and more people are experiencing the adverse effects of social exclusion. Social exclusion is a multidimensional and dynamic phenomenon resulting from the limited access to social and public goods and equal access to services and health structures is one of the main priority axes in the implementation of social policy worldwide.

Families who live in rent face much higher extreme poverty rates than those staying in their own home without a mortgage (30.5% in 2016 versus 10.8% in 2015)[7]. Childhood by its nature, and by its very vulnerability, demands of a civilized society that children should be the first to be protected rather than the last to be considered. This principle of 'first call' for children holds good for governments and nations as well as for the families who bear the primary responsibility for protection. And because children have only one opportunity to grow and to develop normally, the commitment to protection must be upheld in good times and in bad. It must be absolute, not contingent[8].

MdM are offering social, medical care and pharmaceutical coverage via the Social Pharmacy, to vulnerable populations apart from the poor health of adults has observed a big number of children lacking appropriate access to treatment and vaccination.

The Mother & Child Project

The need for free access to health care for women and children is supported by MSD via MSD for Mothers program. This program reinforces the existing activities of MdM Greece and is implemented for 2 years.

Initial Program Activities included the following:

- Provision of gynecological services to 8,400 women.
- Providing pediatric services to newborns and infants.
- Distribution of 1,400 baby kits.
- Implementation of 70 visits of the mobile medical unit.
- Development of educational content for health professionals and training of 480 people through the e-earning platform of MdM Greece at: http://mdmelearning.gr
- Distribution of information material in 5 languages.
- Development of a Survey based on TCN access to Primary Healthcare.

After one year of project implementation, certain issues were identified and new needs analysis was conducted, leading to the following new project activities, in order to enhance the whole program:

- Provision of gynecological services to women in Kara -Tepe open refugee camp in Lesvos.
- Coverage of prenatal gynecological examinations for women refugees.
- Establishment of an emergency shelter for women just after giving birth.
- Development of two extra educational content materials for women beneficiaries: a) Breastfeeding and b) Infant care, in five languages: Greek, English, French, Arabic and Farsi.
- Development of an Antenatal Guidelines Booklet in Greek and English for HCP's.
- Development of project videos regarding the progress, key outputs, as well as beneficiary testimonials.

Reception Centre for Vulnerable Asylum Seekers MdM Shelter in Athens

After the massive inflow of Third Country Nationals in the first trimester of 2016 and the closing of Idomeni Borders, the majority of TCNs expressed their will to apply for international protection in Greece. They were transferred in different sites all over Greece and in some of the cases in regional areas that it was difficult to reach proper health facilities. Cases that arrived in MdM Shelter were in serious neglected health condition. They didn't have any kind of information about the asylum processes and some of them they were seniors that have been abandoned by their families in Idomeni and Piraeus port. All of them received direct health care services and legal information. Cases that suffering from mental health symptoms were referred to Mental Health Daily Centers or they began having sessions with the psychologist of MdM.

Pregnant women and single mothers describe incidents of sexual violence in Turkish coast by smugglers. That type of cases are having serious grounds of trauma and potential mental health symptoms or disorders and need of special treatment and psychological support. Women that were being pregnant by smugglers, after the first intake, receive support and counseling in order to manage their anxiety and stress symptoms, and cases that decided to stop the pregnancy, they interconnected with family planning clinic of "Alexandra" Hospital of Athens. However a big obstacle for that type of cases is the lack of administrative documents and social insurance number.

According to the Greek Legislation and the Law 4368/2016 TCNs can attend to the NHS offices of civil services in order to register and to receive the Health Card for Foreigners (KYPA). In terms of implementation the KYPA system never took place until today. All the TCN's and patients without insurance status have to register in an online system under the name "IDIKA" in order to receive a documentation as uninsured patients, this fact creates serious barriers to access PHC or NHS for vulnerable cases that are stranded in different sites of regional Greece and they can't reach municipal social services. The fact of the presence of medical NGO units in some of the sites is helpful but no one can ensure the universality in the provision of healthcare in different camps or the access to secondary health care[9].

Another important obstacle is related with the capacity of the regional health facilities to address the needs of TCN's, there is no option of communication through interpretation and the majority of medical personnel and public servants haven't intercultural competency. These two facts also raises quiet often serious risks of violence of the right of the patient due to the lack of communication in the framework of approval of any kind of medical action even in cases of emergency condition. MdM has noticed that in the majority of the TCNs cases that found access in NHS in terms of emergency, the patients had never receive information or asked about the medical actions and never informed properly about the medical & medication directions and the option of follow up after their hospitalization.

Health Problems & Social Vulnerability

The most common problems are linked with chronic diseases such as skin diseases, respiratory illnesses, cardiovascular problems, disabilities since the period of infancy, neurological, mental health disorders, orthopedic problems, cancer, chronic allergies, blood diseases, endocrine disorders & diabetes, gastrointestinal, history of addiction in drugs & alcohol, surgical traumas and pregnancy.

We have to emphasize on the fact that the majority of the vulnerable cases of Asylum Seekers are living under completely inadequate conditions for their health in different sites in regional Greece and the Islands of Northern Aegean or being homeless in urban areas.

All beneficiaries received, immediately after their placement, supporting services, medical care and proper information about their rights and NHS. Also noting that social service have made steps to facilitating the interaction of beneficiaries in the public sector, be it for health and welfare services or for asylum service. Several of the guests coming to the center were suffering from neglected health problems and were in very bad emotional state. Through constant medical care, psychological support and ensured housing conditions they achieve to addressing their personal problems.

Overall up to the end of December 2016, 229 TCNs and asylum seekers were housed and received support services (167 of them were new placements in 2016) while at the same time 18 family reunifications (total number of 49 individuals) were realized (with the support of the consortium professionals).

Regarding the vulnerability in terms of social assistance, MdM provided services to 32 cases of single parent families (101 individuals), to 10 unaccompanied minors, to 7 cases of seniors-single persons without relatives over the age of 65, to 35 cases of SGBV survivors, to 8 LGBTQI cases and to 11 victims of torture. In terms of healthcare from the total number of 229 beneficiaries, 43 individuals are facing mental health disorders, 12 cardiovascular, 7 respiratory diseases, 7 beneficiaries have history of drug and alcohol addiction, 1 woman with breast cancer, 6 with diabetes diseases, 10 with orthopedic problems, 9 with neurological (epilepsy), 2 beneficiaries with blindness, 1 with serious hearing

problems, 12 ophthalmological problems, 1 ischemic stroke, 8 with hematological problems, 5 with gastrointestinal disorders, 4 with chronic allergies and 3 with surgical trauma.

MdM Greece Survey Background & Rational

The issues of improving access of Third Country Nationals (TCN) to Primary Healthcare (PHC) has been on both national and European agenda for decades. It has been integrated as a central component to many contemporary health agreements and EC directives, as well as National Greek Laws for the National Healthcare System (NHS), and is being translated into substantial health service reforms. These reforms apply both to the supply-side and demand-side of access to PHC. Not with standing these efforts, little evidence remains of equity of access to PHC at a TCN population level. Furthermore, interventions designed to improve access of TCN to PHC are often highly fragmented and under-resourced. Inequitable access to healthcare translates into unmet healthcare needs, worse and inequitable health outcomes and increased healthcare costs.

Excluding persons from regular access to healthcare discourages early detection and treatment of preventable conditions. It leaves populations dependent on community health centers and other voluntary initiatives and increases the likelihood that healthcare services are only contacted in case of an emergency. Some research shows that most of the short-term cost-savings from excluding individuals from health-care and notably from primary care-meaning regular visits to a doctor-might be lost by shifting the costs to healthcare providers in secondary or community settings.

Equity of access to PHC is a major social determinant of health and is considered as a strategy for addressing health inequity. The Greek PHC sector as a whole has a responsibility to promote health equity as part of its social mandate and National Legal Framework. This means developing interventions which support access via fair arrangements based on equal access to healthcare for all in equal need.

Determinants of access to healthcare are amenable to change, both at a system level (e.g. transforming the way that health systems and organizations function, supporting the development of new professional roles and expanded scope of practice, etc.) and at an individual or population level (e.g. empowering TCN patients to participate in decision-making processes regarding their care, advocating for community-led services, etc.). However, we are still striving to find effective ways of reaching equity of access to PHC to support those most in need, and to identify which aspects of services and abilities of people to strengthen in order to achieve transformative change. A strong primary healthcare system is paramount to optimizing population health, yet PHC services are not always readily accessible. Striking differences in health still exist within and between populations, and inequities in access to PHC persist and tend to affect the most vulnerable people in our communities, those with the most complex healthcare needs. From a human rights perspective, access to healthcare should be within reach of all, regardless of race, gender, culture, religion, political belief or socioeconomic condition. Inextricably linked with access to healthcare is the notion of equity, which gives emphasis to its underpinning values of fairness and social justice.

The literature on TCN access to healthcare is abundant, diverse and complex, offering varying definitions and conceptualizations. In general, access can be defined as the opportunity or ease with which beneficiaries or communities are able to use appropriate services in proportion to their need. In the past, it has been characterized with an emphasis on either attributes of health systems, organizations, services and providers (supply-side determinants of access) or abilities of individuals and populations to access services (demand-side determinants of access). More recently,

a framework has been proposed that integrates both supply and demand side determinants in an attempt to capture the complexity of the phenomenon in the context of healthcare systems in perpetual transformation. In line with an equity perspective, conceptual frameworks of access should direct attention to demographic, social, economic, geographic and cultural factors which may structure the experience and opportunities of different social groups to reach and obtain appropriate healthcare.

Between January and June more than 17,000 patients visited some of the mobile and fixed clinics included in anothersurvey run by MdM in Greece. Approximately 55% of these patients were men and 45% were women. Children under 18 represented 25% of the total number of patients. Few unaccompanied children were seen. In Chios and Lesbos, we saw 202 pregnant women. Nationalities varied significantly from one site to another but tended to be homogeneous at each site. In Elliniko (Athens suburbs), 98% of the patients interviewed were Afghans and 2% were Iraqis. During June (Ramadan time), the medical consultations were mainly offered to exhausted and dehydrated people, in need of immediate intravenous fluid administration.

We suppose that Sub-Saharan Africans were directly transferred to the Moria camp which became a closed hotspot in Lesbos. As the first asylum appointments in Athens are set for December 2016, no migrant/refugee can leave the island. Thus, the Karatepe Camp has started being adapted to meet the needs of the people staying there. Tents are being replaced by wooden shelters, shaded areas are being migration-and-health-key-issues installed, as are water coolers (in June, knowing that heating might soon be needed...). In addition, some work has begun on the supply of electricity. In Chios, 62% of patients were Syrians, 21% Afghans, 6% Iraqis and 2% were from the Maghreb.
The most common symptoms were related to stress anxiety disorders, panic attacks and psychiatric problems. In spring 2016, the numbers of referrals made by both the medical team and social services to the hospital in Chios for psychiatric and child psychiatric assessments increased. The referrals are regularly monitored by psychologists and psychiatrists from the hospital, with whom our team has been collaborating closely[10].

Moreover, we came across self-inflicted injuries, in the context of suicide attempts, mainly by males between 17 and 28 years old. The lack of prospects in terms of their destination since all borders have been closed and impoverishment after months without beingable to work lead to despair.
In Lesbos, the patients seen by our teams were 85% Syrian and 11% Afghan. From March 2016, we noticed a diversification in the nationalities of the people arriving in Greece. However, the proportion of migrants from Sub-Saharan Africa did not increase in the survey sites (Karatepe, and other sites served as needed by the mobile unit).

Inclusion Criteria & Conceptual Framework

We deliberately decided not to use a predetermined definitions and other evidence based studies, as our main focus was on trying to collect information from people who might have experienced a wide range of potentially innovative interventions, from a beneficiary perspective.

The Levesque et al. (2013) access framework was used as the conceptual foundation for the study. The framework builds on previous conceptualizations of access, and is in continuous development with proposals which take into account social and health dimensions of access within an equity perspective. Building on a comprehensive view of access articulated around factors pertaining to the healthcare system, individuals and context, the authors integrate both supply and demand side dimensions into their access framework, allowing operationalization of access along the pathway of utilization of care from

perception of need through to the outcomes of service use.

The framework is comprised of five dimensions of accessibility of care (approachability, acceptability, availability and accommodation, affordability, appropriateness) and five corresponding abilities of patients and populations to access care (ability to perceive, ability to seek, ability to reach, ability to pay, ability to engage). These dimensions of access are considered as interdependent constructs. The framework is arranged in pairs: each supply-side dimension of accessibility of care is mirrored by a matching demand-side ability of patients or populations to access services. The combination of a corresponding supply and demand side dimension is referred to here as "paired dimensions".

Analyzing the Qualitative Data

As said before, this survey is based on the collection and analysis of both quantitative and qualitative data. The quantitative data outputs has been presented in the previous section, while the qualitative data collection procedure is described below. In order to approach the survey from a qualitative perspective, we implemented interviews with key MdM Greece staff, and also discussion with beneficiaries.

The survey questions for MdM personnel were based on the following:

- The way they perceive TCN difficulties, problems and barriers while trying to access PHC, on a daily basis.
- Personal experience while assisting a TCN beneficiary in order to ensure their access to PHC.
- Subjective opinions and ideas on how the Greek NHS could enhance in a realistic way proper access of TCN to healthcare services.
- Setting out the key barriers to entry and categorization main obstacles.
- Proposition of suggestions for TCN inclusion in order to access PHC, based on their extensive knowledge of the way the Greek healthcare system is functioning.

The survey questions for MdM Greece TCN beneficiaries were based on the following:

- The way they perceive the difficulties they are having while trying to access PHC.
- The outline of key factors preventing them from understanding their actual rights to healthcare.
- Statements from personal experience from access to PHC.
- Statements from personal experience in accessing PHC via other supply vendors, such as other NGO's and mainly MdM Greece.

Two key testimonials from TCN beneficiaries are presented below.

Testimony 1

Mrs. R.M. is a refugee from Syria. She traveled from Turkey to Greece through sea with a boat in January of 2016. She traveled with her 2 underage boys and was eight months pregnant. She gave birth in Greece during the period of accommodation in the refugee camp in region of Attica. MdM had provided medical care and have secured access to prenatal and maternity care during the period that R.M. accommodated in another refugee camp in Central Greece. 2 months after the birth of her baby, R.M. found herself homeless along with 3 children in Victoria Sq. for more than 1 week. As she describes her compatriots expelled her from a refugee camp in Attica after their requirement to give them money in order to continue to reside there. Having left the camp, she spent three weeks in an apartment in Athens by a family of compatriots that was being selected for the relocation program. She shared room in the apartment with two other families, a total of 13 people lived in an small apartment of 2 separate spaces and 1 WC. After the fulfillment of relocation process for the compatriot family she had to leave from the apartment, R.M. stayed in a bench with her children. The baby suffered from skin allergies and

severe allergic asthma while R.M. had neglected gynecological problems and panic attacks episodes. The 2 children for more than 18 months were out of educational activities and from school. The family found again through outreach activities of MdM volunteers and referred to MdM central services. Through MdM actions, the family of R.M. received medical care and psychosocial support while placed directly in the Reception Centre for Vulnerable Asylum Seekers of MdM. In February 2017 the R.M. completed the process of family reunification and traveled to Germany, where her husband has granted with the refugee status.

Testimony 2

Mr. A.A.S. from Afghanistan was working in Kunduz's municipal services. In September 2015 Taliban men captured the area for three days and attacked the residents with extreme violence. Then 2 of his six children were killed by the Taliban. Mr. A.A.S. With his wife and four surviving children escaping and going to Iran, then traveled to Turkey and there the family was separated. The mother with the three children passed to Greece and the father with the youngest son stayed in Turkey because of the 14-year-old son's difficulty in moving.
R.A. Suffers from juvenile diabetes, which due to a lack of access to health services due to war at the beginning of the last decade, caused him severe loss of vision, hearing and kidney damage. When, after about two months, they managed to reach Greece, they were homeless for about 10 days in Athens and could not find food, medicines and a place to stay. They were identified in the Field of Areas Park by a mobile MK stadium. A meeting with a physician and social worker was planned at the MDG Open Polyclinic and placed in the guesthouse of vulnerable asylum seekers of the MD.
Thereafter, MRI actions were followed for the treatment of R.A. And for accelerating the request for family reunification with the rest of the family in Austria. The father had an episode of myocardial infarction while R.A. Hospitalized. The MCs took care of the father's hospitalization and visited R.A. at the hospital. A few days later the father went into good shape. The request for medical expedition was accepted and the family managed to travel for 3 weeks to Austria after a request to expedite the family reunion.
After conducting a series of interviews with MdM Greece medical staff, social workers, as well as collecting testimonials from beneficiaries, the key aspects of barriers into accessing PHC are summarised below.

Family Planning and Preventive Care

About one million people needed humanitarian assistance in Greece 2015. The health of these refugees is often thought of as a short-term problem that can be solved by providing only food and water, and the goal is often to sustain refugee populations until they are able to move to a more permanent living situation. It is easy to forget that for many, refugee camps are a long-term living situation. Therefore, a more holistic approach to the healthcare needs of refugee populations is needed. Reproductive health is an issue that is very poorly addressed in refugee settings. In many camps, women struggle with unplanned or unwanted pregnancy, and the poor spacing of these pregnancies put women's health at even further risk. As a result of these dangers, fifteen percent (15%) of pregnant women in refugee settings will experience a life threatening condition[11].
Though different refugee camps present unique challenges to reproductive health, unplanned pregnancies generally occur due to an absence of available contraceptives or a lack of information about reproductive health[12].

Family planning is viewed as a human right, and access to contraceptives and information should be guaranteed in refugee settings[13].
Family planning has been proven to improve the health of women by reducing unsafe abortions and rapid subsequent childbearing, both of which put the mother at risk of maternal death or disability. These results and their significance

are no different in refugee settings. The Women's Refugee Commission released the Statement on Family Planning for Women and Girls as a Life-Saving Intervention in Humanitarian Settings in May 2010, which makes the basic assertion that people's reproductive health needs do not disappear upon their entering a refugee camp. In fact, those needs may become greater, as women and their families attempt to postpone pregnancy to avoid exposing an infant to the stresses of displacement.
The Women's Refugee Commission asserts, "At the onset of the emergency, it is important to make contraceptive methods...available to meet demand[14] ."

Family planning and reproductive health needs change over time as refugee camps stabilize and become long-term homes for displaced persons. At this stage in a refugee crisis, family planning must become more comprehensive. It is important to offer community education on reproductive health, especially as children mature into adolescents within the camps.
After conditions stabilize, families continue to grow within refugee camps, just as they do outside them. Studies have shown that over the course of 20 years within a refugee camp, fertility rates remained relatively stable, with only minor fluctuations in fertility due to repatriation[15] .
The goal, therefore, is not to prevent pregnancy within refugee camps altogether, but rather to allow women to plan pregnancies for when conditions are relatively stable and to space the pregnancies in order to avoid health problems[16].
Such timing and spacing of pregnancies is crucial to the health of both mother and child, especially in vulnerable settings. The health of children is often dependent on their mothers, and motherless children are nearly 10 times more likely to die prematurely than those whose mothers survive childbirth.

Access to Healthcare for Non-Greek Nationals

Undocumented migrants

In Greece, there is a legislation prohibiting care beyond emergency care for adult undocumented migrants. However, the new law 4368/2016 introduced exceptions to this rule, allowing the most vulnerable categories of people to access healthcare. The new Migration Code, implemented by Law 4251/2014 and repealing Law 3386/2005, continues to prohibit healthcare for undocumented migrants.

In particular, Article 26§1 Law 4251/2014 states that "public services, legal entities of public law, local authorities, public utilities and social security organizations shall not provide their services to third-country nationals who do not have a passport or any other travel document recognized by international conventions, an entry visa or a residence permit and, generally, who cannot prove that they have entered and reside legally in Greece.

Third-country nationals who are objectively deprived of their passport shall be given the right to transact with the agencies referred to above, simply by showing their residence permit".
In addition, Article 26.2a states that "the arrangements of the previous paragraph shall not apply to hospitals, treatment centers and clinics in the case of third-country minors and nationals who are urgently admitted for hospitalization and childbirth, and the social security structures which operate under local authorities".

It should be noted that Law 2910/2001 expressly excludes minors of the prohibition to provide healthcare. Since April 2016, undocumented migrants can be entitled to free healthcare if they belong to one of the vulnerable groups defined by Article 33, section 2 of the 4368/2016 law and Article 3 of the joint ministerial decision implementing it.

For instance, are entitled to free healthcare, undocumented:

- Pregnant women
- Children (under 18 years old)
- Chronically ill individuals
- Seriously ill individuals
- Victims of severe crimes
- Disabled individuals

Asylum Seekers and Refugees

According to article 33 Section 2 of the 4368/2016 law, asylum seekers and refugees are considered as vulnerable groups and thus have access to the public healthcare system for free, same as destitute Greek nationals. To access free healthcare, asylum seekers must hold and display a special Foreigner Healthcare Card (K.Y.P.A.). Before the 2016 law, the Common ministerial decision KYA Υ4α/48566/05 provided for free healthcare for asylum seekers and refugees.

Moreover, Article 14 of the Presidential Decree 220/2007 on the transposition into the Greek legislation of Council Directive 2003/9/EC from January 27, 2003 laying down minimum standards for the reception of asylum seekers, already stated that "applicants [for refugee status] shall receive free of charge the necessary health, pharmaceutical and hospital care, on condition that they are uninsured and financially indigent. Such care shall include:

- Clinical and medical examinations in public hospitals, health centers or regional medical centers. Medication provided on prescription from a medical doctor serving in one of the above institutions and acknowledged by their director. Hospital-based care in public hospitals, class C of hospitalization.
- In all cases, emergency aid shall be provided to applicants free of charge (...)".

In principle, asylum seekers and refugees have free access to hospitals and medical care. However, Greece is witnessing an unprecedented increase in the inflow of refugees and migrants to its territory and, even though the Greek state and population showed great solidarity with the migrants, the ability of the Greek health system to provide adequate health care to refugees upon entry is severely stretched. Thus, asylum seekers and refugees still encounter difficulties in gaining access to healthcare.

Survey Discussion Outputs

Healthcare policies must respect the requirements which derive from international and European human rights law. This includes the specific provisions incorporated in EU law for TCN which have been extensively analyzed in several reports. They should furthermore be guided by public health considerations, not only by cost considerations. The economic models presented in this paper suggest that providing access to regular preventive healthcare for TCN would not only contribute to the fulfillment of the right to enjoy the highest attainable standard of PHC, but would also be economically sound. Although the savings margin may not always be extremely high, the model is static, which leaves out many external and wider social benefits and costs that point to higher likely cost-savings. Whereas this analysis focuses only on healthcare cost-savings, the evidence suggests that avoiding conditions associated with lack of PHC generates wider benefits. Even though these wider benefits are not included in the present economic analysis, a very strong case can be made to take them into consideration when evaluating the benefits of TCN access to PHC. The results of testing the economic models are a conservative but powerful indication that governments would save money by providing access to primary healthcare to TCN. More research would be needed on the financial implications of providing PHC and on the applicability of the results to other uninsured groups of the population.

The problem of reproductive health in refugee settings is challenging to solve. It is not simply a matter of identifying the funding sources for contraceptives and family planning resources.

Pronatalist ideologies within refugee camps are a barrier to care, but it is crucial both to understand the internal logic behind this ideology and to approach this in culturally sensitive ways[17]. These ideologies may put women's health at greater risk, but they have an important place in the culture of many displaced groups.
It is important, therefore, to approach health interventions in refugee settings with sensitivity and understanding. Interventions should not serve to reduce the agency of displaced populations, but should rather empower them in healthy and beneficial ways. Family planning interventions have the power to achieve this. In line with the Alma-Ata declaration on universal health coverage (1978)[18] , Health 2020 (the European policy for health and well-being)[19], World Health Assembly resolution WHA on migrants' health[20] and the 1951 Refugee Convention[21] all state that refugees and asylum seekers should have non-discriminatory, equitable access to health care services, including vaccines, irrespective of their legal status. Access to vaccines is indeed a specific objective in the WHO European Region, as outlined in the European Vaccine Action Plan 2015–2020[22], which was endorsed by all 53 Member States.

The plan proposes that all countries in the Region ensure that immunization policies are non-discriminatory and that the services are fully inclusive and user-friendly. In addition, the Convention on the Rights of the Child[23] and the United Nations Children's Fund (UNICEF) Core Commitments for Children in Humanitarian Action[24] call for equitable access of all children, adolescents and women to essential health services, with sustained coverage of preventive and curative interventions. These include timely immunization against vaccine-preventable diseases, particularly measles and polio.

The health systems in the countries receiving migrants are well equipped and experienced to diagnose and treat common infectious and non-communicable diseases. They must be adequately prepared and organized to provide support to refugees, asylum-seekers and migrants while at the same time ensuring the health of the resident population. Vaccines should be provided in an equitable manner with a systematic, sustainable, non-stigmatizing approach. As vaccination is a health intervention that requires a continuum of follow-up until the full schedule is completed, there must be cooperation among the countries of origin, of transit and of destination.The current influx of refugees, asylum-seekers and migrants is unprecedented not only in scale but also in speed of movement. This poses particular challenges in deciding when and where to vaccinate. The situation is compounded by the fact that many vaccines must be given in consecutive doses at timed intervals. Access to the full vaccination schedule, through follow-up vaccinations, is difficult to ensure while people are on the move. Nevertheless, refugees, asylum-seekers and migrants should be vaccinated without unnecessary delay according to the immunization schedule of the country in which they intend to stay for more than a week. Measles, mumps and rubella (MMR) and polio vaccines should be priorities. Governments should consider providing documentation of the vaccinations given to each vaccine or child's caregiver to help avoid unnecessary revaccination.

MdM published a report on the European Observatory on Health Systems and Policies two years after the first European research, in 2010. That report was based on 1,218 interviews conducted in 11 European countries. It contained original testimonies on living conditions, on health status and access to health care for the poorest, the most marginalized and discriminated people in Europe, especially for immigrants without official documents (without formal legal status).

Undocumented immigrants include one of the most vulnerable groups that of pregnant women and children. One wonders if survival within Europe is considered a crime! In 2010, MdM completed and published a comparative study of the laws of ten European countries regarding

access to health care for immigrants without official documents and asylum seekers.
This study determined that the right to health for undocumented immigrants and asylum seekers is nor a reality, or a fact within the European Union. It is impossible for an undocumented immigrant in any of these countries to reach the "highest attainable standard of physical and mental health" as defined by numerous human rights organizations.

Main Observations: Incoming immigrants to Europe do not intend to take advantage of the health care system.

- They live under uncertain conditions and seriously lack access to health care.
- They have been abused before, during and after the migration.
  They live and work under harsh conditions. Therefore their health status is dramatically affected.
- Numerous barriers hinder their access to healthcare, preventative medical care and insurance. Restrictive laws, lack of information, matters of administration, and discriminatory practices are created by these obstacles.
- Consequently, their access to health care is at best insufficient. For 72% of the health problems they deal with, they received either inadequate or no medical care.
- Even the most vulnerable groups, that include pregnant women and children, do not receive special treatment or easier access to health care. Less than 1 in 2 women (48%) has access to reproductive health care.

Access to health care may be uneven between European countries, but it is certainly restrictive in all. All countries provide undocumented immigrants with access to health care. Unfortunately, immigrants are entitled access to health care, only if they pay 100% of the total cost of their medical care which is clearly impossible. The governments of Belgium, Spain, France, Italy, the Netherlands and Portugal have established laws that allow full or partial cost recovery. As far as Germany, Greece, Sweden and Switzerland are concerned, only in emergency and urgent cases can undocumented migrants' access free medical care. In the United Kingdom pathologists decide whether they will provide undocumented immigrants with primary health care services. However the system does not cover access to secondary health care services.
In fact, undocumented immigrants and their children face serious obstacles in accessing health care in every country, even in the countries with more flexible laws. The most important obstacles are:

- The medical costs mainly in France, Belgium and the UK.
- The complexity of the health care and/or insurance system mainly in Belgium and in UK.
- Administrative barriers: i.e. in Belgium, the UK, and Switzerland.
- Fear of complaint, arrest, discrimination or denial of medical care occur mainly in Sweden, the UK, the Netherlands, Italy and Greece.
- Finally, lack of information about the rights undocumented immigrants is obvious everywhere: a quarter of the people who are entitled to insurance coverage are not aware of it.

European Context on access to PHC for TCN – The case of Greece

According to a study published in 2011 by the European Union Agency for Fundamental Rights (FRA) three reports were produced overviewing the fundamental rights of TCN in the European Union (EU). At the time, FRA found that EU Member States' policies concerning their access to healthcare services vary substantially, often only allowing access to emergency healthcare.
This case is also the case of Greece, where the legislative framework to ensure the application of EC directives may exist, however, the actual and realistic situation shows exclusion of access to TCN in PHC[25].

Their report aimed to estimate the economic cost of providing regular access to healthcare for TCN, compared with the cost of providing treatment in

emergency cases only. Two specific medical conditions –hypertension and prenatal care– were selected as examples, and their associated costs were calculated using an economic model.
The model was then applied to three EU Member States: Germany, Greece and Sweden. The testing suggested that providing access to regular preventive healthcare for TCN would be cost-saving for governments. Moreover, as the model only includes costs incurred by healthcare systems, not costs incurred by the patient or society at large, it is likely that the cost savings are underestimated. For the scope of the analysis we only present the study outcomes for the case of Greece.

The report showed that providing access to healthcare to TCN would not only contribute to the fulfillment of the right of everyone to enjoy the highest attainable standard of physical and mental health, but would also be economically sound. Obligations deriving from an inclusive interpretation of international human rights law would thus be supported by economic arguments.In our case, the outputs of the above study regarding prenatal care are summarized below.

Barriers towards a PHC change

This part of the survey outlines the key barriers to entry for TCN in the Greek PHC system.

1) Lack of knowledge on how to access the Greek NHS & Insufficient flow of information on the camps. TCN in general lack the knowledge on how to access the NHS in Greece. They are not properly informed of their actual rights to healthcare as well as the structure and operation of the primary healthcare system. Moreover, they do not know about the availability of primary health services and all these stand as obstacles in them exercising their access to healthcare according to their needs. Therefore, especially undocumented TCN have access only to Emergency Departments in Hospitals, when they are in a very serious health condition and require immediate secondary treatment.

TCN accommodated in camps also have to face the aspect of lack of concrete and specific information regarding their rights in accessing PHC and NHS facilities[26] . The information is not regular nor updated, is distracted and does not always prevail the realistic situation behind it.

2) Geographical exclusion. TCN in Greece are either allocated in camps or have been integrated into the urban web via UNHCR's Relocation Scheme. In both cases they face PHC exclusion also based on geographical criteria. On border islands and remote regions in the mainland, they have very limited or no access to PHC[27]. Especially for mothers and children this is very essential, as they belong to the most vulnerable population groups. The need for a geographically even-spread PHC is of great importance and is an issue that needs to be addressed by Greek national healthcare policies.

3) Language barriers & Interpretation. Difficulties in communication is another important issues that keeps TCN excluded from accessing PHC. Their inability to communicate in Greek, stands as another obstacle in preventing them from accessing PHC, both when they need to see a medical practitioner and also when they need to use the electronic medical appointments system. They need to be accompanied by a skilled interpreter while trying to access the NHS. All medical staff and paramedical staff cannot work efficiently and provide the required services to the beneficiaries without the input ton interpreters. A TCN beneficiary cannot access the PHC system if not accompanied by an interpreter, as they need to understand their rights and moreover communicate their medical need appropriately. Any referral from MdM Open Polyclinics or camps to secondary healthcare, must be in the presence on an interpreter. At the moment, MdM Greece accompany the beneficiary in all stages by providing an interpreter, in order to achieve access to the healthcare system.

4) Fear of discrimination. The cultural and lingual differences between TCN and Greek

medical staff in most cases lead to the establishment of stereotypes from the doctors' side, who generalize behaviors when called to treat TCN and moreover they tend to ignore the fact that TCN differ depending on their nationality and cultural background. This behavior from medical practitioners results in many TCN adopting the feelings of neglect, social discrimination and exclusion.

5) Cultural barriers. Cultural barriers are mainly linked to the way TCN approach the aspect of healthcare and treatment in general, as well as their different perspective in the way they realize the work of healthcare professionals. These cultural differences amongst TCN groups, also state their different understanding and perception of mental health, a fact that may explain the type of services they require from the NHS.

Key study Realizations for enhancing PHC

This part of the survey outlines the key issues that result into actual suggestions by MdM Greece, in order to enhance TCN access to PHC in Greece, via the implementation of activities towards a national change in the existing framework.

Training. Healthcare workers in the NHS in Greece need to attend special training classes and seminars, in order for them to be able to offer the required services not covered by Open Polyclinics. These services may include blood tests, special prenatal care, exclusive prenatal care in cases of pregnancy abnormalities. These training classes have to be organised in a national level and specific training booklets have to be developed for all NHS staff, both medical, paramedical and administrative.

Legal framework. Substantial changes have to be adopted within the existing legal framework on a national level, in order to overcome that barriers to entry for documented and undocumented TCN. Especially in the case of vulnerable population, such as mothers, pregnant women, children, the elders, people with chronic illnesses, etc. the existing legal framework has to be readjusted to the actual needs of the population in concern.

Healthcare budget. At the moment and due to the 5 years socio-economic crisis in Greece, NHS has faced several budget cuts and restrictions[28].

An overview of these budget cuts has to beperformed, in order to ensuresound and immediate access of TCN to the NHS in Greece. This of course is a matter of extreme vulnerability, as the Greek NHS as a whole faces a budgetary insufficiency.

Establishment of mother and child clinics. NGO's, and especially MdM Greece, are operating 8 Open Polyclinics in Greece, (2 in Athens, 1 in Piraeus, 1 in Perama, 1 in Thessaloniki, 1 in Chania, 1 in Patras and 1 in Kavala), where TCN mothers and children have access to PHC prenatal care, general gynaecological care and paediatric care. Moreover, MdM are implementing medical interventions in numerous camps, where they provide emergency prenatal care, ultrasounds for the pregnant women, as well as children care[29]. The issue however, is that the State itself should establish such facilities, in order to provide the necessary services.

Provision of family planning. According to the Women's Refugee Commission, there is often resistance to contraceptive use in refugee settings. Even in camps with available family planning resources, women's partners, community leaders, or peers often discourage them from using contraceptives. The loss of friends and family members fuels a desire to have more children. Furthermore, more children could mean a larger shelter in many camps, a strong enough incentive for many to have rapid subsequent pregnancies[30]. This pronatalist ideology further exacerbates the problems associated with limited family planning. In other settings, women are not aware of the

benefits of family planning since no information is available about its importance. A lack of knowledge is also then compounded by the lack of access. Women may not know where to get contraceptives in refugee settings, but they are often not available at all. Compared to stable settings, refugee settings receive fifty percent (50%) less funding for family planning. Therefore the problem in refugee settings is twofold. There is a reluctance to use family planning services due to feelings of pronatalism, but these services are also often unavailable due to a severe funding gap. This funding gap must first be closed in order to better meet the reproductive health demand in refugee settings, and women and girls in refugee camps must be empowered to engage with planning resources when available.

Vaccination of children. Vaccination of refugees, asylum-seekers and migrants is not recommended at border crossings unless there is an outbreak of a vaccine-preventable disease in the host or transit country. In such cases, countries are urged to include refugees, asylum-seekers and migrants in any outbreak control measures taken, including vaccination. If the level of risk for serious disease transmission is considered high in an epidemiological risk assessment, countries may decide whether to vaccinate on the basis of the recommendations in the document Vaccination in acute humanitarian emergencies: a framework for decision making[31]. Provision of measles-containing vaccines is further defined in reducing measles mortality in emergencies, WHO–UNICEF joint statement[32], and provision of polio vaccines is discussed in reducing risk of poliomyelitis outbreaks in emergencies, issued by the Global Polio Eradication Initiative (GPEI)[33]. Refugee crisis should incite all countries to review any immunity gaps in their populations and ensure tailored immunization services and strong communication and social mobilization in areas and groups that have suboptimal coverage. This will help countries fulfil their shared responsibility to attain the goals of global polio eradication and regional measles and rubella elimination.

Scheduling of TCN medical appointments via EKEPY (National Centre for Health Operations) and not vis PEDY (National Primary Healthcare Network).The use of e-RDV service via IDIKA (Electronic Social Security Governance System), which refers to booking a medical appointment via the phone) is operational in Greece, but still opposes a barrier for TCN, as they cannot speak the language and therefore they cannot schedule their medical appointments via this service. Even though the service provides access for medical appointments for most Health Centres in Greece, TCN are excluded from it, as they need assistance from an interpreter in order to make use of the service. Moreover, the relevant website (http://rdv.ehealthnet.gr) not only is provided in Greek, but also in order to make use of the service TCN should have an AMKA (Social Security Registration Number), as well as TAXIS codes from the General Secretariat of Information Systems of the Ministry of Economics (GSIS). Moreover, it is important to point out, that in the refugees camps, the MdM medical teams have to deal with a number of serious medical cases, such as Ca, orthopaedic problems in need for a surgery etc. A lot of these cases have already been diagnosed in public hospitals in other regions of Greece during emergency visits. The surgery is scheduled to be done after some months. But in the meantime the population has been transferred (i.e. from an island to the mainland) and the refugee has to repeat the procedure of the diagnosis and to reschedule the surgery. This way the treatment of the refugee can be postponed for several months and this has a serious impact on his health condition.

TCN health card. The idea of developing a TCN Health Card (KYPA–Foreigners Health Card) has been established in a Presidential Decree, where it is stated that all TCN can access PHC via the use of this Health Card. This card is to provide access to TCN that cannot register for the AMKA code, and that they can gain full access to the NHS just via the use of this card. However, reality is much different, as TCN in general do not have this Health Card. According to the Presidential Decree,

KYPA card will be granted to the beneficiaries from the Rights Protection Offices of Health Services or the Social Services of Public Health Structures. The duration of the KYPA card will be six (6) months from the date of issued, except for the cases of women beneficiaries that are pregnant, which then is valid for one year. Procurement of the Card will be made by the National Printing Office and distributed to the beneficiaries through Regional Health Authorities.Moreover, TCN in pre-registration status are also excluded from the AMKA (Social Security Registration Number), which in turn concludes to their exclusion from the TCN Health Card (KYPA - Foreigners Health Card). MdM Greece prepared a declaration complaint on this issues in November 2016, the State came back with an answer ensuring that TCN on pre-registration will be getting their AKMA id, however, this intention was never implemented by the State Authorities and Public Bodies Responsible.

Pharmaceutical coverage. For the prescription of medicines, TCN should have the Health Card mentioned above, a Social Security Registration Number and legal documents. For them the same rights and restrictions arise as to other uninsured vulnerable groups in Greece, such as the homeless. In order to have access to medicine they need to pay a partial amount of the total cost, same as Greek insured patients. This of course is an issue itself, as TCN do not have the required funds to pay for their medicine.

Low rate of satisfaction. Except the existence of stereotypes from healthcare practitioners, the experience of TCN patients from the healthcare systems in their countries of origin, as well as their expectations of the healthcare access in the country of arrival, are affecting significantly their level of satisfaction. Their experience of the healthcare treatment in the countries of origin reflect at a very high rate their actual expectations of the healthcare system in the country of arrival. In most cases, TCN are coming from countries where the national healthcare is very poor and disorganized. Their transition to a PHC system in the country of arrival in cases where they feel they should immediately be treated, will only lead them to further dissatisfaction and disappointment.

In regard to all of the above, and in respect to MdM Greece social agenda, we proclaim one request: Respect the right of access to health care within Europe. MdM demands equal access to preventative care and health care for everyone who lives in Europe without discrimination caused administrative reasons or financial means.
The health care system should be separated from migration policies. Specifically, MdM calls for:

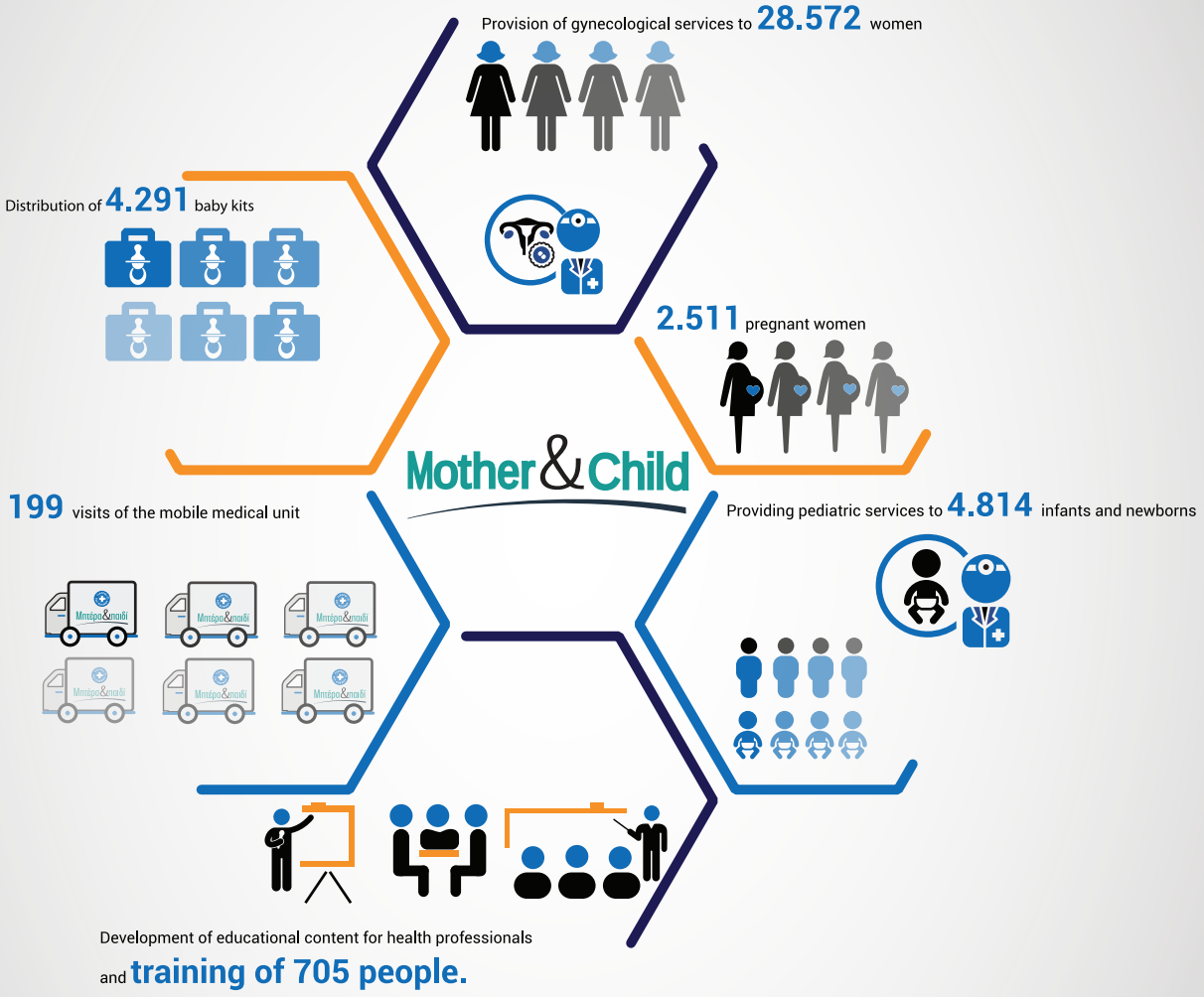
- The observance of medical confidentiality and the official prohibition of the complaint or the arrest of the immigrants, who do not possess a residence permit, during their inpatient care or their contact with public health facilities.
- Immediate action by all EU member states to ensure special protection of minors and pregnant women, so that they may have access to adequate medical care throughout an illness or during pregnancy.
- The protection of people who suffer from serious illnesses and cannot receive adequate and effective medical care in their counties of origin.

These people should not be deported but should receive a residence permit. MdM appeals to the European Parliament to commit to passing a resolution that will confirm the needs and rights of everyone, including undocumented immigrants and asylum seekers, to equal access to health care.
In 2009, MdM founded the organization HUMA (Health for Undocumented Immigrants and Asylum Seekers). Huma aims to promote the right of undocumented immigrants to access health care.

At this point our aim is to keep focusing in the provision of free access to primary healthcare for all women in need, and to further enhance the project activities and outcomes. Moreover, via the implementation of the "Mother & Child" project, we seek to envisage and establish key insights and recommendations, leading to all-inclusive social care for all women in need.

"Mother & Child" program

Results from 01.05.2016 to 31.07.2017



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