Annex 2. Studies included in the report

Study	Study design and/or period	Country[a]	Population	Study aims and objectives	Methods	Main results
Issue 1						
Broeders 2010 (24)	R	DE, NL	Migrants who do not have a legal right of residence (any more), who are apprehended at the border or by the domestic police or are asylum seekers whose asylum request was turned down	To review the regulation of administrative detention of apprehended irregular migrants, who are to be expelled, in light of stagnating expulsion policies to clarify whether it is a rational administrative measure supporting migration policy	Application of 2 theoretical lenses: expulsion and detention	In the Netherlands, undocumented residence is not a criminal offence and, therefore, not punishable by criminal law In Germany, it is a criminal offence, although it is seldom punished under criminal law; detention of undocumented migrants is usually an administrative detention, and the goal is not to punish migrants with a prison sentence or a fine but to prepare them for expulsion
Kassar & Dourgnon 2014 (66)	2013–2014	North-Africa, Europe	Sea migrants	Analysis of determinants and patterns of new routes for undocumented migration through the Mediterranean Sea and the characteristics of the migrants	Analytical framework of local, international and regulatory context	Undocumented trans-Mediterranean migration is growing exponentially; Tunisia, Morocco and, from 2011, Libya are the main north African transit countries to Europe; north African countries should share public policies with European countries Boat migrants mostly consist of men aged 20–40 years and poorly educated; population is becoming more heterogeneous, with more women and more educated individuals
Kassar et al. 2014 (67)	R, 1975–2013	North Africa, Europe		To explore the patterns of migration from north African countries	Review of data from several websites, United Nations and IOM	Migration mostly is for labour to Europe, North America and, to a lesser extent, the Arab Gulf area; all has increased enormously since the mid-2000s because of political instability in most north Africa countries but most to Europe and North America; a recent increase in

						the proportion of women migrating is remarkable
Keygnaert et al. 2012 (71)	Community-based participatory research, 2007	BE, NL	223 refugees, asylum seekers or undocumented migrants aged 15–49 years, living in East Flanders in Belgium or the Randstad region in the Netherlands and enrolled through networks of the Community Advisory Board and Red Cross asylum reception centres	To explore the nature of sexual gender-based violence and to identify determinants for its prevention	In-depth interviews	Majority of respondents were either victims or close to victims; most violence was committed by ex-partners or asylum professionals; results suggested this group was extremely vulnerable to violence and, specifically, to sexual violence Specific health-promotion and violence-prevention interventions are urgently needed, ensuring the participation of the target population: *Individual level*: behavioural change, sensitization to sexual gender-based violence and its risk and protective factors, and enhancement of objective and subjective social status *Interpersonal level*: social networks to improve social capital and enhance social learning, create social support and community resilience *Organizational level*: provision of health care to all regardless of residence status *Societal level*: structural changes in asylum policies to ensure all fulfil their human rights
Keygnaert et al. 2014 (70)	Community-based participatory research, 2008	MA, Europe	154 sub-Saharan migrants 15–49 years old living in irregular situation (refugee, asylum seeker or undocumented)	To investigate the nature of violence experienced in Morocco, assess the determinants and develop recommendations for prevention	In depth interviews	Multiple victimizations reported by 139 (90%): 110 were personally victims, 41 were forced to witness relatives or co-migrants victimized, and 18 knew peers victimized; 45% of violence was sexual, predominantly gang rape; perpetrators were mostly Moroccan or Algerian officials and sub-Saharan gang leaders unofficially managing migration "hubs" Respondents linked risk factors mainly to their undocumented and unprotected status; severe long-lasting ill-health consequences were reported even though there was no access to the official health care

						system Comprehensive cross-border and multilevel legal and policy changes enforcing human rights are needed, together with severe punishment of perpetrators
Kraler & Reichel 2011 (73)	R, case study	EU27	Undocumented migrants	Critical appraisal of available data sources, indicators and methods to provide a heuristic model of undocumented migrants from a demographic point of view and to contribute to better understanding of related indicators	Narrative review of available evidence and case study built on statistics of apprehensions at the EU external borders in eastern Europe	Three undocumented flows: geographic, demographic and status related Methods for estimating undocumented migration flows: (1) from comparison of stocks of undocumented migrants at different points in time, (2) from undocumented border crossings based on a multiplier estimate, (3) from overstaying based on entry and exit records, (4) from information drawn from sample surveys of migrants, and (5) from comparisons of different data sources for geographical migration flows Statistics of border apprehensions represent the most frequently used indicator for undocumented migration flows; although these serve as useful indicators of trends, clear conclusions of numbers cannot be drawn in the absence of plausible information on the rate of detected versus non-detected
Laczko 2002 (74)	R, 1990–2000	AT, BE, DE, DK, ES, FI, FR, GB, GR, IE, IT, LU, NL, PT, SE		Assessment of migration in Europe and public reactions based on recent trends and measures being considered by European governments to promote selective labour migration	Narrative review	Western European countries are not prepared to promote a substantial increase in permanent immigration; what is more likely is that there will be more selective and temporary labour migration into western Europe, specifically to meet skill shortages in certain occupations and industries Thousands of migrant workers are already employed without legal documentation in western Europe, mostly in low-skilled low-paid work; by regularizing the workers' status, several mainly southern European countries have brought these workers into their social security and health insurance systems in recent years Creation of more regular channels for labour migration

						into Europe could help to reduce undocumented migration pressures, and smuggling and trafficking of migrants; a managed approach to migration requires the cooperation of both source and destination countries
Lazaridis & Poyago-theotoky 1999 (76)		GR	Undocumented migrants from Albania	To examine migration and socioeconomic integration and/or exclusion of Albanians in Greece through analysis of the Greek Government's conditions for regularization of undocumented migrants	Analytical framework	All southern European countries have regularized undocumented migrants with the exception of Greece, which only recently began to do so; regularization is an important issue in Greece and the government has recently passed a framework law that, if successfully enforced, will increase the cost of labour to Greek firms; if implemented properly, the measures adopted could diminish excesses of overt discrimination against Albanians and other undocumented migrants but the only secure means of full incorporation into the society and polity is naturalization Spain, Italy and Greece are heavily dependent on *ius sanguinis* (nationality by descent), whereas Portugal's tradition resembles the British *ius soli* (citizenship by birthplace); naturalization requirements have been gradually made even stricter and the incorporation of migrants into these societies has become even more difficult The study shows that the optimal policy for a government is not to legalize an undocumented migrant under certain conditions, whereas under different conditions the optimal policy is to regularize; these conditions relate to factors such as the relative magnitude of the government’s payoffs, which are, in turn, dependent on factors such as public opinion, lobbying activities and the presence of migrants’ associations

Maroukis et al. 2011 (83)		GR, IT, ES	Undocumented migrants	To explore the interaction between undocumented migration and the shadow economy in southern Europe and in central and eastern Europe, investigating the correlation between migration policy, economic context and entrapment of migrants in irregularity, plus ways to break this vicious cycle from migrants' experience		Policy that does not facilitate the channels of labour migration, either temporary/seasonal or permanent, perpetuates the grounds for the unequal treatment of the ethnically and culturally diverse population
Vogel et al. 2011 (7)	R, 2002, 2005, 2008	EU27	Undocumented foreign nationals (without any legal residence status or violating the terms of their status so that their stay may be terminated)	Review of past attempts at European level to estimate undocumented migrants	Country estimates for 12 countries covered by CLANDESTINO and literature review for the other countries; extrapolation for missing data from comparable countries (geographic location, general migration context, history and policies) and adjustment (through multiplier factors) of estimates	The presented estimate indicates a minimum of 1.9 million and a maximum of 3.8 million undocumented foreign residents in the EU27 (2008); unlike rules-of-thumb, the aggregated EU estimates indicate a decline in the number of undocumented foreign residents between 2002 and 2008, which has been influenced by the EU enlargement and legalization programmes; the collection of more systematic estimates should be encouraged
Wahlberg et al. 2014 (113)	CSS, 1997–2010	SE	7925 deaths not registered in the Swedish Cause of Death Register	To study causes of death among undocumented migrants compared with Swedish residents to establish if there are different patterns for the undocumented migrants	Analysis of death certificates on the basis of ICD-10 according to age at death, country of origin, place of death, postmortem findings	Among undocumented migrants, external causes (49.8%) were the most frequent cause of death, followed by circulatory system diseases, and then neoplasms; within the group of external causes, transportation accidents were the single largest cause of death (28.3%) followed by intentional self-harm (suicide) (21.7%) and assault (13.7%); undocumented migrants had a statistically significant increased risk of dying from external causes and circulatory system

						diseases compared with residents, and a lower risk of dying from neoplasms; mean age at death was much lower for undocumented migrants
Issue 2						
Rechel et al. 2011 (9)	R, 2011	Europe	Migrants (including refugees, asylum seekers and undocumented)	To analyse health needs, health care access and national policy for migrant health within Europe	Literature review	Compared with locally born citizens, there are higher rates of stillbirth and infant mortality among migrants, with refugees, asylum seekers and undocumented migrants being particularly vulnerable; a high prevalence of unintended pregnancies and violence during pregnancy among undocumented migrants is also reported The few studies addressing undocumented migrants indicate that they are exposed to poor housing and nutrition, psychological pressure and a higher prevalence of tuberculosis and other infectious diseases, which is likely to have an impact on perinatal and infant health Undocumented migrants may encounter particular difficulties in accessing antenatal care and pregnancies should normally be considered high risk and be carefully monitored even though some studies have found pregnancy risks comparable to those of women from the host country
Affronti et al. 2011 (11)	CSS, 2003–2009	IT	1758 migrants mostly from Africa, followed by Asia and Europe	To analyse health needs by reviewing treatment provided at the day hospital at the Department of Migration Medicine, Palermo	Analysis of medical records	Gastroenterological diseases ranked first (dyspeptic syndromes most frequently diagnosed) followed, in descending order of frequency, by infectious and parasitic diseases (mainly sexually transmitted diseases), diseases of the genitourinary system, metabolic disorders (half being diabetes mellitus in patients from South-east Asia) and circulatory system disorder (hypertension) as the most frequent pathology Data confirmed a marked persistence of the phenomenon known as the ‘‘healthy immigrant effect’’,

						as well as the prominent role played by ‘‘social determinants’’ in conditioning the health of migrants, particularly in the case of some infectious diseases
Almeida et al. 2013 (13)	R, 1990–2012	BR, PT	Migrants (including undocumented) in Europe, Australia, Canada, the United States of America	Analysis of maternal health care in migrant populations to understand the specific problems in achieving equality of care	Systematic review of population-based studies indexed in MEDLINE and Scopus	In Italy, undocumented migrants tend to be at a higher risk of teenage delivery, complications of pregnancy, miscarriages and induced abortions; other studies showed higher rates of anaemia, excessive bleeding and fetal distress among undocumented women; in Italian women, documented and undocumented migrants, the percentages of teenage deliveries were 0.7%, 2.9%, and 8.4%, respectively; age-related increase in miscarriage risk was steeper among documented migrants; the induced abortions to deliveries ratio peaked among Italians aged <25 and documented migrants aged >35 years
Aragona et al. 2013 (16)	CSS, 2013	IT	Migrant population including undocumented enrolled at the primary care outpatient service of the Caritas Health Service	Examination of psychiatric disorders to identify potentially traumatic events, post-traumatic stress disorder, anxiety, depression, somatization and post-migration living difficulties	Questionnaire	Significant rates of potentially traumatic events and post-migration living difficulties found, with consequent psychopathology
Basile et al. 2011 (18)	CSS, 2009	BE, CH, DE, ES, FR, GB, IT, NL, PT	Subjects of any age born in countries endemic for Chagas disease who were documented residents, undocumented migrants or children adopted into the European	To estimate the expected and observed aggregate data from the literature and official sources of prevalence of *Trypanosoma cruzi* infections, annual incidence of congenital transmission and estimated rate of under-diagnosis to provide a view of Chagas disease	Examination of aggregate data from the literature and official sources of data regarding *T. cruzi* infections in the 9 European countries with >400 cases/year of Chagas disease	In 2009, 4290 *T. cruzi* infections were diagnosed in the study countries, and 89% being detected in Spain; total observed prevalence rate was 0.13% among migrants, with the lowest observed prevalence in Germany (0.002%) and the Netherlands (0.003%) and the highest in Switzerland (0.223%) For undocumented migrants, the estimated numbers infected by *T. cruzi* were very high, substantially higher than for documented, with the highest estimated prevalence in Spain (3.9–7.8%) and Switzerland (2.5–

			countries	among migrants in Europe		7.8%) Among adopted children, the overall expected prevalence in the participating countries ranged from 1.2% to 2.4% of total adoptions of children from endemic settings; France had the highest number of positive cases Of the almost 53 000 children were born in 2009 from mothers originating from endemic countries, estimated congenital transmission was 0–3 per 1000 births; there were 0–6 cases of congenital transmission per year
Baussano et al. 2013 (19)	CSS, 1991–2010	IT	27 358 socially marginalized migrants systematically screened in an area of low tuberculosis incidence (Turin)	To investigate the rates of and risk factors for *Mycobacterium tuberculosis* infection and transmission in order to assess if socially marginalized groups may create a reservoir	Tuberculin test, chest radiology, sputum	Screening identified 804 cases: 557 (69%) definite cases and 247 (31%) other than definite; 744 (93%) were diagnosed at first visit
Bodenmann et al. 2009 (23)	Descriptive exploratory study, 2007	CH	161 undocumented migrants (>15 years of age) with no major psychiatric disabilities visiting for the first time 2 urban health care centres for vulnerable populations in Lausanne	To investigate the acceptance of screening, prevalence of positive findings and adherence to treatment for latent tuberculosis	Questionnaire and blood sample (interferon-γ assay)	Of the 161 participants, 131 (81.4%) agreed to screening and 125 had complete examinations; 24 of the 125 patients (19.2%) had positive interferon-γ assay results, 2 of whom had active tuberculosis; only 5 patients with latent tuberculosis completed full preventive treatments, 5 others initiating treatment but did not complete
Castañeda 2009 (27)	CSS, 2004–2006, 2008	DE	183 patients attending a Berlin clinic providing the	Assessment of patients' characteristics, mother–child care, chronic care	Participant observation, interview, collection and analysis of data from grey	The common reasons for visiting the clinic were prenatal care (27.9% of all visits), chronic illness (13.1%), paediatrics (8.7%), dental issues (7.6%), acute

			single largest source of medical assistance for unauthorized people in Germany	and emergency care to explore how undocumented status influences illness experiences, medical treatment and convalescence, and impacts health (mental and emotional stress), illness and convalescence	literature, systematic collection of media coverage and legislative debates	illness (6.6%) and injuries (6.6%); men were more likely to seek care for injuries, dental issues and acute illnesses (e.g. gastrointestinal infections or tonsillitis); pregnancy was the single most frequent reason for women; when those seeking prenatal care were excluded, chronic illnesses became the primary reason for women (25%) Undocumented status resulted in mental and emotional stress, creating a syndrome characterized by stress, anxiety and depression
Chernin et al. 2012 (28)	Cohort study, 2000–2010	IL	15 undocumented-uninsured and 77 age-matched insured patients treated with dialysis at the Tel-Aviv Medical Centre	To compare referral to nephrology consultant for the 2 groups	Analysis of medical records, periodical reports of social workers in the dialysis unit, blood cultures	All 15 undocumented-uninsured patients presented initially with symptoms attributed to uraemia and with stage 5 chronic kidney disease compared with only 6 of the age-matched cohort; haemoglobin and albumin were lower in the undocumented–uninsured group compared with the age-matched insured patients at initiation of haemodialysis therapy and significant differences persisted throughout the treatment period
Depallens et al. 2010 (39)	PS, 2003–2006	CH	103 children without a residence permit taken into care by the Children's Hospital of Lausanne between August 2003 and March 2006	To assess social, economic and medical data to evaluate children's specific needs	Questionnaire	The general health status of children without a residence permit was good; most could benefit from regular check-ups; prevention, focused on a healthier life style, was particularly important among this population
García-García et al. 2011 (48)	Multicentre cohort PS, 2006–2007	ES	Migrant and native-born population from 53 health centres in different regions	To examine tuberculosis characteristics of the 2 groups in order to develop specific strategies for management of tuberculosis within the	Analysis of medical records	The following variables showed a positive and significant relationship with migrant tuberculosis: younger age, living in a group situation, employment status, primary or emergency care admission, drug resistance, treatment default, lower frequency of alcohol and cigarette consumption, more directly observed treatment, and poor understanding of

				migrant population, including improvement of social and work conditions		tuberculosis disease and its treatment The following variables showed a negative and significant relationship with tuberculosis: lower frequency of disabled and retired, lower frequency of pulmonary disease presentation A higher percentage of primary multidrug-resistant tuberculosis was found in migrants than in the native-born population (2.2% vs. 0.1%)
Heldal et al. 2008 (52)	CSS, 2004–2007	Various	Participants in a working group and correspondents of a national tuberculosis programme	To gather information on undocumented migrants and their access to tuberculosis services in order to identify interventions to strengthen diagnosis and treatment and to formulate recommendations on how to ensure adequate tuberculosis prevention and control	Questionnaire	Undocumented migrants represent 5–30% of migrants and 5–10% of tuberculosis cases; most countries reported full access to diagnosis and treatment, but in practice there were limitations and a range of measures were reported to ensure access; most countries also reported that they could and did deport patients who were in the process of being treated for tuberculosis
Huffman et al. 2012 (56)	CSS and QS, 2008	KZ, UZ	Labour migrants: 8 groups in Kazakhstan and 4 groups of Uzbek migrants who had returned home	To understand the mechanisms that impede migrants' access to care in general, and tuberculosis treatment in particular, through examination of structural contexts, employment, and legal and health care contexts that in concert may render migrants vulnerable to exploitative work conditions and cause barriers to health	Focus group and in-depth interviews	Vulnerability, exploitation, undocumented status, poverty and social marginalization determine a specific pattern of risk among migrants; in particular, male construction workers are a vulnerable group and only about one-third of the migrants in the focus groups had ever heard of tuberculosis

				care		
Jackson et al. 2012 (60)	CSS, 2011	CH	Latin American migrants with Chagas disease diagnosed in Geneva since 2008	To study the metabolic and mental health, behavioural and socioeconomic characteristics of migrants with Chagas disease in a non-endemic country	Interviews and blood tests	Prevalences were obesity 25.5%, hypertension 17.5%, hypercholesterolaemia 16.1%, impaired fasting glucose 23.4%, diabetes 2.9%, metabolic syndrome 16.8%, anxiety 58.4%, depression 28.5%, current smoking 15.4% and sedentary lifestyle 62.8%
Jackson et al. 2010 (59)	CSS, 2007–2008	CH	313 undocumented migrants without health insurance living in Geneva and attending the community mobile care unit from November 2007 to February 2008	To measure the prevalence of chlamydial infection, assess associated factors, estimate the need to develop specific screening programmes	Questionnaire and urine sample for chlamydial detection	At screening, 1.3% of men and 10.9% of women reported urinary tract symptoms; 22.7% of women recently noticing vaginal discharge; 18 of 313 (5.8%) were positive for chlamydial infection; prevalence was higher in women than men but this difference was not significant (6.5% and 4.0%, respectively); significant differences were found for age (four-fold higher risk of infection in those <25 years) and number of sexual partner (4–5 times higher risk in those with >2 partners during the previous year compared with those with 1 or 0 sexual partners)
Jaeger et al. 2012 (61)	R, 2000–2012	CH	Migrant children	To provide an overview of the health of migrant children and differences in health problems compared with native-born children in order to adapt health services	Systematic review of quantitative primary research studies published in English, French, German or Italian and indexed in Embase, MEDLINE and Global Health; review of grey literature	Infectious diseases such as tuberculosis, intestinal parasites, *Helicobacter pylori* infection, hepatitis A were more prevalent Migrant children compared with their Swiss peers had higher rates of hospitalization (+40%) and intensive care admissions, more dental caries, twice the odds of being obese Migrant adolescents seemed more frequently affected by psychological problems and twice as often requested abortions

Jolivet et al. 2012 (65)	CSS, 2009	FR	Migrants who lived or intended to live in Cayenne or Saint-Laurent du Maroni for at least 6 months	To examine the migrant population of French Guinea in relation to that of the native-born population with regard to relations between health status and socioeconomic status, psychosocial factors, country of birth and the duration of residence	Interview	Undocumented migrants reported a worse health status and self-perceived health than did the native-born population and had a higher prevalence of chronic disease and functional limitation; differences were partially explained by socioeconomic status and psychosocial factors, but country of birth and the duration of residence also had an impact
Madianos et al. 2008 (81)	CSS, 2006	GR	157 foreign migrants visiting an NGO in the Athens area	To study how acculturation, length of stay, existence of family in Greece, legal status of residence and employment influence depressive symptomatology	Interview	The more "illegal" the residence status of the migrant, the more depressive symptoms suffered and reported; the more acculturated the migrant, the lower the number of depressive symptoms
Majori et al. 2008 (82)	CSS, 2004–2005	IT	182 undocumented sub-Saharan African migrants living in Verona	To investigate seroprevalence of viral hepatitis in sub-Saharan African migrants and its possible impact on migrant communities and the indigenous population	Questionnaire, blood sample for hepatitis markers	Hepatitis A and B positivity is higher in the migrant population than in the indigenous population; while the hepatitis A seropositivity merely represents past infection and was the same as for the Italian population, the serology for hepatitis B indicated both past and current infective status, was higher than the native-born population and may represent a risk for hepatitis B transmission
Mor et al. 2012 (88)	CSS, 1999–2010	IL	Adults with tuberculosis notified to the Ministry of Health	To define populations with high tuberculosis burden by nationality and country of origin	Analysis of official notifications	During 1999–2010, 4652 adult tuberculosis cases were notified; the annual incidence rate per 100 000 population decreased from 7.5 in 1999 to 4.3 in 2010 (average annual decrease of 2.7%); average female:male ratio was 1:1.4 and the majority of infected patients were foreign born (87.6%) Pulmonary tuberculosis was most common (80.5%); the most common non-pulmonary sites were lymph nodes

						(37.5%), pleura (17.5%) and urinary system (11.9%); average reported HIV infection rate among all patients was 5.1%
Pace-Asciak et al. 2013 (90)	Retrospective population study, 2002–2005	MT	All (4570) undocumented migrants landed in Malta by boat between 1 January 2002 and 31 December 2005 (81% young adults aged 15–34 years, 86% male, 88% from Africa)	To describe the demography and tuberculosis epidemiology of undocumented migrants compared with the native-born Maltese population in order to tailor control strategies to this specific population	Analysis of national surveillance data	Overall, 85% of undocumented migrants were screened on entry using chest radiology; 3.5% had features suggestive of tuberculosis, of whom 12.5% had active disease; using both active and passive surveillance, 33 cases of active tuberculosis were diagnosed in these migrants, 31 (94%) during their first 12 months of residence; entry screening detected 20 (61%) cases Of the total number of cases in Malta, the proportion in undocumented migrants increased markedly from 33% in 2002 to 60% in 2005; the reported incidence per 100 000 was 390 among migrants and 2.1 in Malta born
Pezzoli et al. 2009 (91)	CSS, 2004–2007	IT	3976 undocumented migrants	To study the incidence of HIV infection in undocumented migrants to assess risk factors associated with HIV-1 and HIV-2 infection and the circumstances of infection	Interviews and blood tests	HIV-1 infection was detected in 29 (0.97%) of 3003 participants; no participants were infected with HIV-2; factors independently associated with increased risk for HIV infection were migration from sub-Saharan Africa, commercial sex, and unsafe sex (many undocumented migrants practiced unsafe sex)
Rechel et al. 2013 (122)	R, 2010–2011	WHO European Region, including the Commonwealth of Independent States	Undocumented migrants	To describe the key aspects of migration and health in Europe with regard to international migration, migrant health, barriers to accessing health services, ways of improving health service provision to migrants, and migrant health policies adopted across Europe	Literature reviews from MEDLINE, PubMed and Google Scholar (to update the study on migration and health in the EU undertaken by the European Observatory, the IOM and the European Public Health Association Section on Migrant and Ethnic Minority Health)	Undocumented migrants tend to be more exposed to risk factors for mental health (including exposure to violence in their countries of origin and stress during migration and after arrival in the host countries); some studies also suggest that migration might be a risk factor for schizophrenia Undocumented migrants and refugees have shown to be at particularly high risk of negative perinatal health outcomes

Robert et al. 2014 (97)	CSS, 2008 and 2011	ES	318 migrant workers from Colombia, Ecuador, Morocco and Romania residing in Spain	To study the employment and working conditions of migrant workers, and their relationship to health to evaluate the influence of changes in employment conditions on the incidence of poor mental health of migrant workers	Interview	There was an increased risk of poor mental health in workers who lost their jobs, whose number of working hours increased, whose monthly income decreased or who remained within the low income bracket; this was also the case for people whose permission for working and residing in Spain was temporary or permanent compared with those with Spanish nationality or those without documents A decreased risk was observed among those who reported being registered in the Social Security system
Rondet et al. 2013 (99)	CSS, 2010	FR	250 French-speaking patients attending general medical consultations at the Baudelaire Outpatient Clinic at the Saint-Antoine Hospital in Paris One (1 day a week)	To estimate the prevalence of depressive episodes in a vulnerable population seeking primary care, to define the sociodemographic characteristics of the depressed patients and to assess their demand for health care	Questionnaire	The prevalence of major depressive episodes was 56.7% overall, 53.5% in men and 62% in women *Men*: 70.0% had health insurance for the poor; 64.5% of those who were receiving public medical assistance (Aide médicale d'état) were depressed compared with 40.0% of men with standard health insurance *Women*: all uninsured women were depressed; 87.5% of those receiving public medical assistance and 75.0% of those with universal health insurance (Couverture médicale universelle) were depressed compared with 50.0% of women with standard health insurance Risk factors for depression were female gender, not being in a managerial/professional position, a low educational level, being single, not having complete health insurance and foreign nationality
Sabbatani et al. 2007 (100)	CSS, 1999–2004	IT	All hospitalizations of extra-EU children aged <14 years at S. Orsola-Malpighi Hospital, Bologna	To examine childbirth, abortions and diseases responsible for hospital admission in order to evaluate the health problems of young migrants and their	Analysis of medical records	From 1999 to 2002 there was a trend towards an increased number of births; in 2002, there was a fall in the overall births Odds ratio for trend of childbirth versus voluntary abortions decreased during 1999–2004; abortions were an infrequent cause of admission in 1999 (25), 2000

				children		(15) and 2001 (14) but there was a 10-fold increase in 2002 (148); 65.5% of abortions were requested by women from eastern Europe Foreign (extra-EU) children <1 year of age were hospitalized for infectious/parasitic diseases (28.8%); genetic/congenital disorders (22%); dysmetabolic, functional or organic illnesses (20.9%) and nutritional deficiencies (5%); no significant difference was found for country of origin even if children from eastern Europe were slightly predominant among undocumented children Foreign (extra-EU) children >1 year of age were hospitalized for a broader spectrum of diseases included dysmetabolic, functional or organic disorders (24.7%), genetic/congenital diseases (15.7%), and infectious/parasitic illnesses (13.5% of episodes); an increased number of admissions was observed from 2002 to 2004 (P <0.001), mainly attributable to eastern European children (44.1%); 14.4% of admissions were for paediatric malignancies, and 9.1% of hospitalizations were directly linked to the delivery of haematological cytotoxic chemotherapy or radiotherapy In children >1 year of age, internal medicine and dysmetabolic disease occurred more frequently in children coming from eastern Europe (41.5%), followed by children from undocumented families (24%) and children from northern Africa (14.1%); genetic/congenital illnesses mainly involved children from eastern Europe (36%), northern Africa (23.2%) and undocumented as a whole (34.9%)
Schoevers et al. 2009 (103)	CSS, 2009	NL	100 undocumented migrant women aged >18 years living in different	To gain insight into the health situation and specific health problems of undocumented migrant women through	Interview and questionnaire	65% of the undocumented migrant women rated their health as "poor" and 35% as "good"; 91% spontaneously mentioned having current health problems

			areas of the Netherlands, recruited through voluntary support organizations, GPs, a domestic workers' organization, shelter homes, churches and midwives	self-rating approaches		When provided with a list of 26 common health problems, subjects reported on average 11.1 complaints; gynaecological and psychological complaints were very prevalent but seldom mentioned spontaneously; obstetric problems were common
Scotto et al. 2009 (104)	CSS, 2003	IT	2392 migrants (including undocumented) attending 35 infectious diseases clinics	To evaluate the epidemiology and the diagnostic, clinical and therapeutic aspects of migrants affected by tuberculosis	Questionnaire	53% of the patients were legal residents and were assisted by the national health service; 48.3% came from African regions; the mean length of residency in Italy at the time of hospitalization was 4 years 300 (12.5%) had active tuberculosis, 10.3% of whom had concomitant HIV infection; the main clinical forms were pulmonary (66%), lymph nodal (15.3%) and bone (5.3%); 16% had drug resistance and multidrug resistance was seen in 5.3% Complete adherence to treatment was achieved in 213; there was a significant correlation between compliance with treatment and documented citizenship status
Sebo et al. 2011 (105)	CSS, 2007–2008	CH	241 consecutive undocumented migrants attending a mobile unit in Geneva and agreeing to participate in a related study estimating the prevalence of *Chlamydia trachomatis*	To explore and better describe sexual and reproductive health behaviours of undocumented migrants	Questionnaire	73.9% of people completing the questionnaire were women (mean age 32.6 years); 91% of undocumented women (compared with 70% of undocumented men) came from South and Central America, mainly from Bolivia and Brazil; 52 (21%) reported 1 or more current or past sexually transmitted diseases or other genital infections; 116 (65%) of women reported urogenital complaints in the last week, mainly lower abdominal pain (35%), unusual vaginal discharge (23%), pollakiuria (19%) and dysuria (18%); men reported pollakiuria (16%), dysuria (12%) and lower abdominal pain (7%); only 1 man reported discharge from the penis

			infection			
Stornaiuolo et al. 2013 (106)	Repeated CSS, 1999–2009	IT	2681 migrants in a mainly rural area (Castelvolturno; many undocumented) recruited using a mobile unit and/or through enrolment at the outpatient unit dedicated to migrants in the local medical centre	To evaluate the prevalence of hepatitis B and C and HIV infection in a socially and economically disadvantaged area and to compare active recruitment with a passive system	Questionnaire and serological screening	206 subjects (7.6%) were positive for hepatitis B surface antigen (92% negative for e antigen), 84 (3.6%) for antibodies to hepatitis C virus, 129 (5%) for HIV; 17 were coinfected with hepatitis B and HIV, 9 with hepatitis C and HIV and 1 with hepatitis B and C; 4.8% were positive for *Treponema pallidum* (haemagglutination test); 84 (3.1%) were drug users, and 436 (16.3%) were alcohol abusers The recruitment method significantly influenced the type of patients identified in the study: prevalence of hepatitis B surface antigen and anti-hepatitis C virus remained consistent throughout the study period (the first with and the second without active recruitment) while the prevalence of HIV significantly decreased after active recruitment was stopped At multivariate analysis, hepatitis B was associated with male gender, hepatitis C with drug addiction, and HIV with female gender, drug addiction and active recruitment
Villanueva et al. 2010 (112)	PS, 2003–2006	CH	103 children without a resident permit taken into care by the Children's Hospital of Lausanne	To assess medical data in order to evaluate the specific needs of children without a resident permit	Questionnaire	87% of the children were native of Latin America, 36% being <2 years of age; the children lived in precarious conditions with a family income lower than the poverty level (89% of the families with less than 3100 CHF/month); 45% of the children had health insurance The main reasons for consultation were infectious diseases, a check-up requested by the school or a check-up concerning newborn children; most were in good health and the others were affected by illnesses similar to those found in other children of the same age; at least 13% of the children were obese and 27% were overweight, which was higher than for Swiss children schoolboys attending the sixth year of primary school

Wahlberg et al. 2014 (113)	CSS, 1997–2010	SE	7925 deaths not registered in the Swedish Cause of Death Register (860 classified as likely undocumented migrants)	To study causes of death among undocumented migrants compared with Swedish residents to establish any different patterns	Analysis of death certificates on the basis of ICD-10 according to age at death, country of origin, place of death, postmortem findings	860 were classified as likely to have been undocumented migrants; external causes (49.8%) were the most frequent cause of death, followed by circulatory system diseases and then neoplasms Among external causes, transport accidents were largest (28.3%) followed by intentional self-harm (suicide) (21.7%) and assault (13.7%) Compared with residents, undocumented migrants had a statistically significant increased risk of dying from external causes (odds ratio (OR), 3.57; 95% confidence interval (CI), 2.83–4.52) and circulatory system diseases (OR, 2.20; 95% CI, 1.73–2.82), and a lower risk of dying from neoplasms (OR, 0.07; 95% CI, 0.04–0.14); mean age at death was much lower for undocumented migrants
Wolff et al. 2005 (119)	CSS, 2002–2003	CH	134 pregnant undocumented women presenting to a free and anonymous health care facility in Geneva	To study the sociodemographic characteristics and the specific health problems of pregnant, uninsured undocumented migrants	Questionnaire, midwife interview, blood test, Pap test	Undocumented migrants lack access to important preventive measures; the main health issues were unintended pregnancies (83%), insufficient rubella immunization (86%) and lack of cervical cancer screening (only 44% had a Pap test within the last 3 years and 31% had never had one in their life)
Wolff et al. 2008 (118)	Cohort PS, 2005–2006	CH	175 undocumented pregnant women requesting termination of pregnancy and presenting at the Woman's University Hospital between March 2005 and October 2006 and 208 women with legal	To compare the prevalence of *Chlamydia trachomatis* infection in women with and without legal residency permit	Interview and *C. trachomatis* assay	Undocumented women came primarily from Latin America (78%); frequently, they lacked contraception (23% compared with 15% of controls); 13% of undocumented migrants were found to have chlamydial infection (compared with 4.4% of controls)

			residency permit and mandatory health insurance undergoing termination in the same hospital between November 2005 and May 2006			
Wolff et al. 2010 (120)	CSS, 1992–2002	CH	Different groups of undocumented migrants	To estimate whether being undocumented is a determinant of tuberculosis, independently of origin	Interview and chest radiology	Compared with documented residents, undocumented migrants had a higher, even though not significant, risk for tuberculosis-related fibrotic signs; a higher proportion of tuberculosis-related fibrotic signs was found among Latin Americans, independently of their residency status
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Keith et al. 2014 (68)	R, 2014	ES, 2012–2014; SE, 2013–2014	Undocumented migrants	To describe legal reform (emergency care, primary and secondary services), implementation challenges, developments and experiences to provide insights on the impact on health systems of providing and restricting health care entitlements to undocumented migrants	Review of European literature regarding legal reforms and developments for undocumented migrants	Policy changes in Spain and Sweden provide insights on the impacts on health systems of restricting and broadening the level of health services provided to undocumented migrants Legal restrictions have resulted in the diverse provision of services by health professionals and local and regional authorities, leading to inconsistency and uncertainty as well as challenges in data collection, monitoring and resource allocation Evidence shows that providing non-discriminatory access to health services is beneficial for public health, reduces expenditure and administrative burdens, promotes the welfare of health professionals and social cohesion, and improves fulfilment of human rights obligations and safeguarding duties towards vulnerable and at risk populations

Teunissen et al. 2014 (108)	CSS, 2013	NL	15 undocumented, first-generation, non-Western-descent migrants residing in 4 cities and recruited through trusted representatives from NGOs, migrant organizations, churches, GPs and the researcher's own informal network	To explore health-seeking behaviour and experiences of undocumented migrants at GPs in relation to mental health problems to elucidate their perspectives, specific needs and expectations on contact with GPs and primary care, and barriers and facilitators to accessing care	Interview	Undocumented migrants often see their precarious living conditions as an important determinant of their mental health; they do not easily seek help for mental health problems and various barriers hamper access to health care, such as taboos on mental health problems, lack of knowledge of and trust in GPs' competencies regarding mental health, and general barriers in accessing health care as undocumented migrants (lack of knowledge of the right to access health care, fear of prosecution, financial constraints and practical difficulties) Barriers experienced in seeking professional care should be tackled at an institutional level as well as at the level of GPs
van Ginneken 2014 (111)	R, 2014	EU27 (not Croatia), CH, NO	Undocumented migrants in Europe	To assess eligibility for health care and policy options to facilitate access to care in terms of access barriers and policy background	Review of European literature until 2014 regarding undocumented migrants in Europe	While a few countries in theory provide full access to their health system, undocumented migrants mostly only have access to emergency care across Europe; there are substantial differences between official policies and the practical experiences of undocumented migrants, health workers and public officials Policies should create legal clarity of entitlements among undocumented migrants, doctors and officials; ensure confidentiality for all parties involved and take away the fear of being reported, losing a job or facing prosecution; mitigate financial and administrative barriers for undocumented migrants and providers; and address cultural and language barriers
Keygnaert et al. 2013 (69)	R, 1961–2013	BE	Migrants	To examine if there are discrepancies between a proclaimed rights-based approach to health and actual obstacles to migrants' attainment of good sexual reproductive	Literature review	Legal and policy frameworks in individual countries heavily determine the accessibility of sexual reproductive health services for migrants regardless of ratification of the International Bill of Human Rights by the EU27; access to health care often is also framed by other binding documents that may restrict care In several EU Member States, legal provisions on health

				health		at (sub)national level overlook migrants or restrict care access to emergency care and “core benefits”; emergency care was not accessible to undocumented migrants in 9 of the EU27 in 2010; often emergency care is defined in different ways, and rights with regard to sexual reproductive health are often uncertain While, historically, the Mediterranean and Benelux regions used to grant access to a wider range of services to all, current policies to counter the economic crisis have altered this practice and countries providing free access to sexual reproductive health care rarely advertise it well and migrants ignore such entitlements
Welbel et al. 2013 (114)	CSS, 2013	AT, BE, CZ, DE, ES, FR, GB, HU, IE, IT, NL, PL, PT, SE	Six marginalized groups: long-term unemployed, homeless, street sex workers, asylum seekers/refugees, undocumented migrants (those not in possession of a legal residency permit), people from travelling communities	To examine the accessibility of addiction treatment within services providing mental health care and support for people from socially marginalized groups in deprived urban areas across EU countries; assessment of services, type of provider organization and funding, staff and client characteristics, programmes, coordination with other services, evaluation	Questionnaire, interview	Results varied substantially among EU capitals: 30% of all the assessed services provided addiction treatment, in 20% addiction was a criterion for exclusion Among services providing addiction treatment, 77% accepted self-referrals, 63% were open on weekends or in the evening, 60% did not charge any out-of-pocket fees, 35% provided access to interpreters, and 28% ran outreach activities
Biswas et al. 2012 (22)	R, 2011	DK, NL, SE	Different groups of undocumented migrants	To address access to health care from a human rights perspective for undocumented migrants, considering practices, right to free emergency care, nonemergency care,	Desk research on national laws, policies, peer-reviewed studies, and grey literature	In Denmark, access is to emergency care; additional care is provided if it is not reasonable to refer them to their home country; depending on the case, the undocumented patient may be required to pay for this care In Sweden, access is only to emergency care, with the

				dental care, general health care		exception of former asylum-seeking children, who have rights equal to those of Swedish citizens In the Netherlands, undocumented migrants have greater entitlements and access to primary, secondary and tertiary care, although shortcomings remain
Castañeda 2012 (26)	R, 2010	DE	Unauthorized migrants	To examine discourses and practices embedded within larger national debates on migrant integration and the specific manifestations in the health sector	Systematic review of MEDLINE, qualitative review of German medical and nursing curricula, original ethnographic data	Individuals lacking residency or work permits are not included in the German comprehensive social health insurance system and health care is largely restricted to emergency care The current situation for unauthorized migrants has been extensively criticized by human rights organizations and the German Council of Physicians; a parallel system of care for this population is not sustainable because it relies on the volunteer efforts of medical personnel and does not allow for adequate prevention, diagnosis and treatment One solution that has gained favour in recent years is the concept of an anonymous health insurance card, which would be obtained by visiting a physician-run triage centre and billed anonymously to the Social Services Office under the provisions in the Asylum Seekers Benefits Act
Dauvrin et al. 2012 (34)	CSS, 2008–2010	AT, BE, DE, DK, ES, FI, FR, GB, GR, HU, IT, LT, NL, PL, PT, SE	240 health professionals with knowledge and practical experience of providing health care to undocumented migrants: mental health services (48), A&E (48), primary care (144)	To explore provision of care in 3 health care services across 16 European countries in order to identify specific clinical challenges and issues of access and entitlement	Semi-structured interviews as part of the EUGATE project	Three patterns of health care entitlement were found: no rights (Finland, Sweden), minimum rights (Austria, Belgium, Denmark, Germany, Greece, Hungary, Lithuania, Poland, the United Kingdom), full rights (France, Italy, the Netherlands, Portugal, Spain) Health professionals reported facing similar issues when caring for undocumented migrants regardless of the pattern of health care: all in A&E reported full access for undocumented migrants; primary care respondents reported that no access was provided, because of either lack of legal entitlement or financial barriers; 25% in mental health services reported that it was unlikely for

						undocumented migrants to come to their services Professionals in primary care and mental health services experienced more difficulties in performing further diagnostic and/or therapeutic interventions because of restricted access; drug prescription was difficult because of costs; difficulties in continuity of care occurred when supplementary treatment was arranged within the same service or when undocumented migrants had to be referred to another service even in countries where undocumented migrants were guaranteed full rights Some professionals, especially in primary care, reported transferring patients between services or having to delay treatment while waiting for legal issues surrounding the patient's undocumented status to be resolved
Gray & van Ginneken 2012 (50)	R, 1990–2012	AT, BE, BG, CH, CY, CZ, DE, DK, EE, ES, FI, FR, GB, GR, HU, IE, IT, LT, LU, LV, MT, NL, PL, PT, RO, SE, SI, SK	Undocumented migrants	To examine how access to care is handled in European health systems by focusing on health care arrangements and policies regulating care of uninsured migrants	Literature review summarizing different primary studies and analysis based on authors' experience, existing theories and models	Even with supportive policies, undocumented migrants often face language, legal, cultural and bureaucratic barriers to obtaining care Strategies to improve access to care have different areas of focus: (1) segments of the population (e.g. children or pregnant women), (2) types of service, (e.g. preventive services, infectious diseases), (3) specific funding policies (e.g. allowing undocumented migrants to purchase insurance)

Grit et al. 2012 (51)	R and CSS, 2007–2008	GB (England), NL	Representatives from medical associations and NGOs speaking in front of undocumented migrants	To focus on health care policy development and implementation for undocumented migrants under 2 different national systems (public national health service in England, private health insurance system in the Netherlands) in the light of factors determining policy-making, including contextual factors (cost-containment and migration issues), key actors and institutional factors (mode of governance and health care system)	Analysis of policy papers and law texts; interviews	*England*: primary care is ineligible for free care for undocumented migrants except when GPs register them on the practice's patient list (in case of registration, national health service funding); nonemergency secondary care can be accessed only when undocumented migrants confirm the ability to pay; emergency secondary care must always be provided and charges do apply; A&E is free all the time; treatment for communicable diseases is free apart from HIV treatment; mental health care is ineligible for free care, except when care is compulsory *The Netherlands*: undocumented migrants are entitled to free primary care if unable to pay (reimbursement provider is linkage fund) and are also entitled to free "medically necessary" nonemergency secondary care, free emergency secondary care, free A&E care, free communicable disease care if unable to pay (dubious debtors); they are ineligible for free mental health care except when care is compulsory (compulsory: government funding)
Huffman et al. 2012 (56)	CSS and QS, 2008	KZ, UZ	Labour migrants: 8 groups in Kazakhstan and 4 groups of Uzbek migrants who had returned home	To understand the mechanisms that impede migrants' access to care in general, and tuberculosis treatment in particular through examination of structural contexts and employment, legal and health care contexts that in concert may render migrants vulnerable to exploitative work conditions and cause barriers to health care	Focus group and in-depth interview	Migrants most often resorted to self-treatment, using home remedies or purchasing basic drugs from a pharmacy; there is a reluctance to seek care and treatment seeking is often delayed until absolutely critical When seeking care, lack of legal registration was the most significant barrier to accessing health services; migrants without registration were usually asked to pay "fees" in exchange for health care services, which might represent a significant problem In Kazakhstan, many Uzbek migrants were uncomfortable explaining their health problems in Kazakh or Russian; they felt discriminated against on the basis of their ethnicity and felt the majority of health care workers held negative or condescending

						views toward migrants and their access to the Kazakh health care system Many health professionals complained of being overworked and underpaid, and did not welcome the additional burden that migrants represented; they expressed frustration and confusion as to what to do with migrants without legal registration, and mentioned the extra bureaucratic problems of these migrants Clinicians dealing with tuberculosis held much more positive attitudes toward migrants and there was unanimous agreement that migrants with tuberculosis would not be turned away for lack of documents; some undocumented migrants did receive access to free tuberculosis treatment but these were only the "tip of the iceberg" as they were only the migrants who sought care and who managed to successfully navigate their way through the health care system
Larchanché 2012 (75)	R and QS, 2007–2008	FR	Undocumented migrants	To identify obstacles to realizing health care rights by undocumented migrants and to analyse how intangible factors hinder access to health care	Review of legislative debates, recently published reports, participant observation	While undocumented migrants are entitled to health care rights in France, the consequences of their social stigmatization, precarious living conditions, and the climate of fear and suspicion generated by increasingly restrictive immigration policies in practice hinder many from being, or feeling, entitled to that right; intangible factors such as fear and suspicion have powerful "subjectivation" effects that influence how both undocumented migrants and their interlocutors (i.e. health care providers) think about "deservingness"
Mladovsky et al. 2012 (85)	R, 1990–2012	Europe	Migrants	To describe good practices in delivering health services for migrants including government policy, health services and health workers	Review of existing literature and current practices	Undocumented migrants have been granted virtually complete health care coverage in 5 EU countries (France, Italy, the Netherlands, Portugal and Spain); the United Kingdom grants undocumented migrants entitlement only to emergency care and gives GPs discretion as to whether to register them as patients A second set of policies has been enacted by most European countries with high levels of immigration in

						order to operationalize the entitlement of migrants under international conventions and national laws and to ensure the responsiveness of health services to migrants' needs; these policies are often of limited scope Many tools are available to health workers to overcome barriers to delivering high-quality services to migrants, including methods to overcome language barriers and social and cultural barriers
Priebe et al. 2012 (95)	QS, 2007–2010	AT, BE, CZ, DE, ES, FR, GB, HU, IE, IT, NL, PL, PT, SE	162 practitioners, from 28 deprived areas in 14 European countries, with expertise in providing mental health care for 6 marginalized groups: long-term unemployed, street sex workers, homeless, refugees/asylum seekers, undocumented migrants (not in possession of a legal residency permit, which includes failed asylum seekers), members of the travelling communities	To explore the experiences and views of experts regarding mental health care to elucidate patient pathways, information provision, services providing an initial response to needs, further treatment options, barriers to access	Semi-structured interviews with case vignettes	Mainstream mental health services commonly expect people with mental disorders to be active in seeking treatment; experts saw this as unrealistic for people in socially marginalized groups of which some (e.g. undocumented migrants or those without appropriate insurance cover) may not be entitled to use services and, therefore, have no easy access Undocumented migrants are often afraid to ask for help in organizations, using only those recommended by other migrants; they always need to be reassured that they will be not asked for documents

Straßmayr et al. 2012 (107)	CSS, 2007–2010	AT, BE, CZ, DE, ES, FR, GB, HU, IE, IT, NL, PL, PT, SE	25 experts from the capital cities of 14 European countries with a professional background in mental health, general health or social care, selected through contacts with relevant services providing care for undocumented migrants	To assess service provision in 2 highly deprived areas of each participating capital, to identify components of good practice in mental health care and to identify barriers to care	Interview	Even in countries where access to health care is legally possible for undocumented migrants, various other barriers remain; some are common to all migrants while others are specific for undocumented migrants Attempts at improving mental health care for undocumented migrants should consider barriers beyond legal entitlement, including communicating information about entitlement to mental health care to professionals and patients, providing culturally sensitive care and ensuring sufficient resources
Willen 2012 (116)	CSS and QS, 2000–2010 (29 non-consecutive months)	IL	170 unauthorized migrants at an NGO-run open clinic (mostly Nigerian and Ghanaian) in Tel Aviv; staff, volunteers and board members at 3 Israeli migrant advocacy organizations	To investigated the issue of health-related deservingness by examining how undocumented status is configured by the state and civil society in relation to economically motivated transnational migrants, and how this rapidly changing status shapes and constrains migrants' experiences of health and ill-health and their broader experiences of subjectivity, morality and ethics	Interview and participant-observation	Unauthorized migrants did not appear to be "freeloaders" and rigorous investigation was needed on how unauthorized migrants conceptualize their own relative deservingness of health-related concern and investment

Biswas et al. 2011 (21)	CSS and QS, 2009–2010	DK	10 undocumented male migrants from Bangladesh, India and Nepal (overstayers, failed asylum seekers); 8 A&E nurses (4 head nurses, 4 nurses) from 4 hospitals in the Capital Region	To analyse sociodemographic characteristics, health-seeking behaviours and formal and informal barriers to health care for undocumented migrants; to investigate nurses' views on undocumented migrants and health care experiences with them	Semi-structured interview and observation	Undocumented migrants reported difficulties accessing health care, with barriers of limited medical rights, arbitrariness in attitude of health care professionals, fear of being reported to the police, poor language skills, lack of network with Danish citizens, and lack of knowledge about the health care system and informal networks of health care professionals Barriers induced alternative health-seeking strategies, such as self-medication, contacting doctors in home countries and borrowing health insurance cards from Danish citizens Nurses expressed willingness to treat all patients regardless of their migratory status but also reported challenges in the encounters with undocumented migrants, including language barriers, issues of false identification, insecurities about the correct standard procedures and not always being able to provide appropriate care
Cuadra 2011 (32)	R and CSS, 2009	Europe	Experts from NGOs and authorities in the EU27	To characterize policies regarding the right of access to health care for undocumented migrants in the EU27 and to identify the extent to which these entitlements are congruent with human rights standards by examining relevant indicators for the welfare system, health care system, policies regarding undocumented migrants	Questionnaire and assessment of available reports and official web sites	The right to access care that is more extensive than emergency care is seen in 5 countries; access is only to emergency care in 12 countries and not even emergency care can be accessed in 10 countries Variations are independent of the system of financing or the numbers of undocumented migrants; rather, they seem to relate to the intersection between practices of control of migration, the main types of undocumented migrants present and the basic norms of the welfare state
Dias et al. 2011 (42)	CSS, 2008–2009	PT	Migrants >18 years of age living in the Lisbon	To investigate health care seeking patterns and factors associated with	Questionnaire	Most participants had used health services; half used primary care and one third used A&E Promoting service utilization, focusing on primary and

			region	utilization of health services, including demographic and socioeconomic variables (sex, age, educational level, employment status, self-perceived income, immigration status, country of origin, length of stay in Portugal), self-perceived health status, consecutive sick days in the last 6 months, utilization of the national health service and the first health service used in Portugal		preventive care is critical for vulnerable migrant groups and innovative community-based strategies should be supported
Dorn et al. 2011 (44)	CSS, 2008	NL	Consecutive sample of undocumented migrants held at one of the 2 detention facilities in Zaandam	To gather basic epidemiological data on health and health care utilization of both care-seeking and non-care-seeking undocumented migrants in order to assess knowledge of how to access medical care, care seeking, and seeking but being denied care by a health care provider	Structured interviews, analysis of medical records	Undocumented migrants may differed from care-seeking migrants with respect to the time being in the country, but not with respect to age and chronic health problems; according to medical files, 15% of both care seekers and non-care seekers suffered from chronic health problems, 11% reported past suicidal thoughts and 20% were using medication Non-care seekers more often originated from Asian countries A health care provider was consulted by 46%; hospitals were most often consulted, followed by GPs and clinics for underserved populations such as the homeless and uninsured; about 25% of the care-seeking undocumented migrants reported being refused treatment by a care provider Injuries and dental problems were the leading reasons for seeking care

Duguet & Bévière 2011 (45)	R, 2011	FR	Undocumented migrants	To describe the humanitarian approach of French legislation for social protection, the Couverture médicale universelle and the Aide médicale d'état	Narrative review of French legislation regulating access to health care for migrants from 1995 to 2011	Public medical assistance (Aide médicale d'etat), established in 1995, is directed at "people without a stable residence and to illegal aliens" and does not make any selection by country of origin or by nationality; in France, emergency medical care is available without any restrictions to all foreigners who need it, whatever their legal status; a special health protection system is open to undocumented migrants living in the country without any residence permit Following the establishment of universal health insurance (Couverture médicale universelle), which does not cover people without regular residency status, Aide médicale d'état has become a framework for state-funded social medical assistance; it is provided by social services of the place of residence and candidates must prove eligibility (beneficiary has to prove that they stayed in France for at least 3 months); for those qualified, all medical expenses paid during the month before the delivery of the certificate can be reimbursed
Goossens & Depoorter 2011 (49)	CSS, 2011	BE	86 GPs in one municipality of the Brussels Capital Region; 11 migrants without a residence permit	To examine the extent to which GPs are consulted by undocumented migrants, their use of the reimbursement system and the difficulties encountered in order to elucidate barriers to seeking and using health care	Questionnaire and semi-structured interview	The average number of contacts per GP per month by undocumented migrants was 1.1 for all GPs and 2.0 for those GPs that specifically see undocumented migrants; contacts are predominantly one-time encounters; the mean probability that a GP will not use the reimbursement programme is 66% The most common reasons for consultation are, in decreasing order: acute respiratory illness, digestive tract complaints, gynaecological care, psychological problems, sexually transmitted diseases and rheumatic ailments Insufficient knowledge of the system is the main barrier seen by GPs (almost half of the GPs with contacts), followed by its complex and time-consuming administrative process (one third of the GPs with contacts); an infrequent barrier is the welfare agency

						contesting a GP's certification of ''urgent care'' GPs use the following alternatives to the reimbursement system: free consultations, free pharmaceutical samples, referring patients to other health care suppliers who are free of charge, referring patients to care suppliers with a larger capacity (e.g. hospitals), using health insurance papers of others Language barriers are solved by consulting with physicians originating from their own country of origin
HUMA Network 2011 (58)	R, 2009–2011	BE, CY, CZ, DE, ES, FR, GB, GR, IT, MT, NL, PL, PT, RO, SE, SI	Undocumented migrants and asylum seekers	To summarize legal entitlements for access to health care in each system and compare countries where there are legal mechanisms to protect seriously ill undocumented migrants from deportation, policies regarding the duty to denounce, and the criminalization of providing assistance	Analysis of immigration, asylum and health care legislation from 2003 to 2011 in 16 European countries	An EU directive establishes minimum reception standards for asylum seekers, including minimum guaranteed health care protection, but there is no EU provision for undocumented migrants' right to health care or other basic social needs; standards set by the main international treaties are far from being respected and EU Member States instead of working on the "progressive realization" of this right are increasingly using it as a tool to discourage the entry of new migrants
Jensen et al. 2011 (64)	CSS, 2008–2009	DK	GPs, physicians working in A&E, and managers of psychiatric residential units selected from 3 urban hospital catchment areas with high proportions of migrants in the vicinity of Copenhagen	To study the experience of health care professionals in providing treatment for undocumented migrants in order to explore differences in treatment and whether the right to health care is a reality	Semi-structured interviews	Physicians in A&E considered that treatment of undocumented migrants did not differ from that of any other person; GPs thought that undocumented migrants would encounter formal barriers when trying to obtain treatment

Cuadra 2010 (31)	R, 2008–2010	FR	Undocumented migrants	To understand the health risks of undocumented migrants and the challenges posed to public health through their growing presence in order to improve their health care	Literature review from 1950s to 2010 about policy approaches regarding access to health care for undocumented migrants, focusing on the main characteristics of the health system, aspects of policies regarding undocumented migrants and the general context of migration	In 2010, entitlements for people without regular residency status were removed from the Universal Health Coverage Act (Couverture médicale universelle) and a parallel administrative system (state medical assistance; Aide médicale de l'etat) was created specifically for undocumented migrants, allowing them and their dependants to access publicly subsidized health care under certain conditions relating to their length of stay and income (e.g. consult GPs free of charge) Access to care for undocumented migrants is also affected by the presence of humanitarian medical associations
PICUM 2010 (92)	R, 1989–2010	EU27 and CH	Undocumented migrants in Europe	To provide an overview of policies/regulations within 20 EU Member States as a frame of reference for emerging practice strategies on how to cope with the challenge of including the undocumented migrants within health care systems; examples from country contexts where there is no access, partial access and full access	Review of literature	Undocumented migrants are a vulnerable group exposed to high health risks; access to health care is subject to national regulations that differ within the EU27, ranging from none to full access (corresponding with policy contexts that range from ignorance to acknowledgement); one practice element decisive in all contexts is the level of structural compensation provided by NGOs
Schoevers et al. 2010 (102)	CSS, 2009	NL	100 undocumented women aged >18 years, living in different parts of the Netherlands, recruited through voluntary support organizations, GPs,	To obtain information about the actual use of health care facilities by undocumented women and to identify obstacles in accessing health care facilities	Questionnaire and semi-structured interview	Undocumented female migrants have unmet health care needs and low health care utilization; they refrain from seeking health care because of personal obstacles (e.g. shame, fear and/or lack of information), poor language proficiency, and lack of awareness of their rights, the health care system and the duty of professional confidentiality of doctors Institutional obstacles to access care should be

			a domestic workers organization, shelter homes, churches and midwives			removed since they strengthen reluctance to seek help
WHO Regional Office for Europe 2010 (115)	R, 2010	Europe	Vulnerable populations including the homeless, elderly, minors, migrants and undocumented migrants	To increase the health of selected groups disproportionately exposed to poverty and social exclusion	Literature review from 1945 to 2010 about efforts made by health systems to confront poverty and health, and interventions designed to improve the accessibility, availability, acceptability and quality of health services for populations living in poverty and social exclusion	The WHO Regional Committee for Europe passed resolutions EUR/RC51/R6 in 2001 and EUR/RC52/R7 in 2002 calling for increased action on the links between poverty and health; these resolutions emphasized the need for a rights-based approach to tackling the impacts of poverty on health
Castañeda 2009 (27)	CSS, 2004–2006 and 2008	DE	183 patients attending a Berlin clinic providing the single largest source of medical assistance for unauthorized people in Germany	Assessment of patients' characteristics, overall quality and quantity of mother–child care, chronic care and emergency care to explore how undocumented status influences illness experiences, medical treatment, and convalescence, and impacts health, illness and convalescence	Participant observation, interview, collection and analysis of data from grey literature, systematic collection of media coverage and legislative debates	Undocumented status resulted in 4 areas of inequality: (1) limits to the overall quality and quantity of care for mothers and infants; (2) delayed presentation and difficulties accessing a regular supply of medication for patients with chronic illnesses; (3) difficulties in accessing immediate medical attention for unpredictable injuries and other acute health concerns; (4) lack of mental health care options for generalized stress and anxiety affecting health An incoherent policy environment in Germany contributes to inadequate services and treatment delays; solutions must address these legal ambiguities, which represent a primary barrier to equity in a nation with otherwise universal health coverage

HUMA Network 2009 (57)	R, 2007–2009	BE, DE, ES, FR, GB, IT, MT, NL, PT, SE	Undocumented migrants and asylum seekers	To provide an updated overview of regulation of access to health care for different groups and types of care/treatment in order to assess existing discrimination in regards to legal entitlement and administrative conditions and provide an overview of daily practice and the main obstacles encountered in seeking health care	Analysis of legislation from 1961 to 2009 in force in 10 European countries in the fields of immigration, asylum and health care	The access to health care by undocumented migrants is not guaranteed in the EU and standards set by the main international treaties are far from being respected Instead of working on the "progressive realization" of these rights, countries are increasingly using them as a tool to discourage the entry of new migrants; this results in part of the population being excluded from the mainstream health system, with risks for general public health There is the need to increase the visibility and regulation of the problem at EU level and to urge Member States to improve access to health care so as to avoid any discrimination on the basis of administrative status
Chauvin et al. 2009 (84)	CSS, 2008	BE, CH, DE, ES, FR, GB, GR, IT, NL, PT, SE	1218 undocumented adult migrants from 31 towns in 11 European countries	To define legal and practical barriers for undocumented migrants in accessing health care in 11 European countries based on social situation, health status, violence experienced, barriers to care, experience of being denied access to care; plus rights in terms of access to health care and treatment in practice	Interview	In countries that lack regulations on financing treatment costs for undocumented migrants, individuals encounter severe obstacles to accessing health services even in emergencies European governments are required to strengthen or introduce mechanisms that ensure health coverage and health care access for all vulnerable people, including undocumented migrants
Wolff et al. 2008 (117)	Cohort PS, 2005–2006	CH	161 undocumented and 233 control pregnant women in Geneva	To compare preventive measures and pregnancy care for undocumented women and the general population in order to identify specific elements of vulnerability in undocumented migrant	Questionnaire and blood tests	Not having a legal residency permit is associated with particular vulnerability for pregnant women; compared with the control group, undocumented women had more unintended pregnancies, used preventive measures less frequently, delayed prenatal care more frequently and were exposed to more violence during pregnancy

				pregnant women		
PICUM 2007 (8)	R and CSS, 2005–2007	AT, BE, DE, ES, FR, GB, HU, IT, NL, PT, SE	Undocumented migrants in 11 European countries, either new patients or patients who had previously gone to the Médecins Sans Frontières network for medical assistance	To provide an overview of law and practice regarding access to health care, including information on the general health care systems, specific legal entitlements to full or partial access to publicly subsidized health care and variations in financing systems used for undocumented migrants' health care needs; to provide practical recommendations to address problems arising from inadequate access to health care for undocumented migrants in the EU	Interview and narrative review (from 1948 to 2009) of inadequate access to health care for undocumented migrants residing in Europe	Undocumented migrants are a vulnerable group exposed to high health risks; a climate of repression and the existing link between immigration control policies and access to basic social services creates a fear of discovery, deterring the exercise of entitlements and care seeking While numerous international instruments in human rights law have been ratified by EU Member States confirming the right to health care as a basic human right (regardless of administrative status), laws and practices in many European countries deviate from these obligations Undocumented migrants are not yet formally considered as being one of the most marginalized and socially excluded groups in Europe; very few documents of European institutions acknowledge this fact and the problem remains almost totally invisible in plans to combat social exclusion in EU Member States
Torres-Cantero et al. 2007 (109)	CSS, 2005	ES	380 equatorian migrants, >15 years of age, who had lived in Spain for more than 3 months and resided in the one district in Madrid	To assess whether sick documented and undocumented migrants use health services with similar frequency irrespective of their legal status	Interview	There were no differences in the utilization of health services when ill between the groups, but a significantly lower utilization of health services was associated with less education Policy changes that remove barriers to health services and improve health care access for undocumented migrants may be effective to increase health care utilization by undocumented migrants
Yates et al. 2007 (121)	R, 2007	GB (England)	Undocumented migrants and failed asylum seekers	To analyse to what extent regulations represent a serious breach of the right to health as	Analysis of the current laws from 1989 to 2007	Exemptions from charging include treatments started while an asylum claim was being processed, emergency care and treatment for certain infections including tuberculosis and most sexually transmitted diseases;

				envisaged in international law and to describe the problems for doctors of having to decide who is or is not entitled to free care and how costs will be recovered		HIV care is not exempted and although free HIV testing is available, antiretroviral therapy is not
Romero-Ortuño 2004 (98)	R, 2004	BE, DE, ES, GB, IT, NL	Undocumented migrants	A theoretical approach to justify undocumented migrants' entitlement to use publicly funded health care services through description of 2 different legal systems: Belgium, Germany and the Netherlands with social health insurance systems and Italy, Spain and the United Kingdom with tax-financed national health services	Library-based research from 1948 to 2004	All 6 countries gave full access to A&E *Belgium*: full access for pregnancy and maternity care, tuberculosis and HIV care, access with some exceptions to primary health care; no access to mental health care *Germany*: full access for tuberculosis care; no access to HIV/AIDS care *The Netherlands*: full access for pregnancy and maternity, tuberculosis and HIV/AIDS care, primary health care; no access to mental health care *England*: full access for tuberculosis care; access with some exceptions to pregnancy and maternity care, primary health care, inpatient care; no access to HIV/AIDS care *Spain*: full access for pregnancy and maternity care; access with some exceptions for inpatient care *Italy*: full access for pregnancy and maternity care, tuberculosis and HIV/AIDS care, inpatient care and some other care
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Almeida et al. 2014 (14)	QS, 2011–2012	PT	31 recent undocumented migrant mothers from eastern European countries, Brazil, Portuguese-speaking African countries and 6 native-born Portuguese recent mothers (for comparison), all of low socioeconomic status, receiving support from NGOs and/or from governmental institutions	To examine perceptions about quality and appropriateness of care during pregnancy and postpartum in order to assess perceived needs and cultural challenges that potentially influence mother–child care, management of medical difficulties, quality and consequences of care by health professionals, treatment adherence and effectiveness of health advice	Interview	Despite generalized satisfaction, most migrants report having had severe reproductive disorders in previous pregnancies, whether they occurred in their country of origin or in Portugal African women consistently reported more complications during pregnancy, most when already in Portugal: more infection, hypertensive disorders and gestational diabetes as well as more miscarriage, perinatal and neonatal death in previous pregnancies Brazilian women tend to report high satisfaction with care received during pregnancy; difficulties most identified referred to unfamiliarity from physicians and administrative professionals about a pregnant women's free access to health care, if undocumented Women from eastern European countries claim to be very satisfied with pregnancy consultations especially when they occurred in their hospital of reference; those having their second child in the host country reported some progress over the years concerning medical attention, humanization of contact with health professionals, and their own comprehension of the functioning of the health system Regarding medical care for infants after discharge from hospital, several migrants report difficulties in attaining sufficiently clear medical consultations; this was not found among African or Portuguese women unless a family doctor was not allocated; Brazilian and eastern European women reported widespread dissatisfaction with baby follow-up when it was carried out in primary health care (by GPs), since in their own countries paediatric services are provided at this level

Buja et al. 2014 (25)	Retrospective cohort study, 2010	IT	35 541 patients aged 18–65 years accessing A&E in a local health unit in the Veneto Region, including temporarily present foreigners (including migrants with no legal residence permit, who are considered ‘‘irregular’’ by national immigration law)	To analyse accesses to A&E by citizenship in order to define characteristics of patient management, diagnosis and outcomes	Analysis of medical records	The use of A&E for non-urgent conditions is a problem affecting all nationalities, including native born; the length of stay in A&E and the consistency between level of urgency and priority of the visits at entry and exit triage were similar for all citizenship groups; the potentially inappropriate use of A&E for non-urgent conditions was common among all the patient groups considered and barriers to primary care may enhance this behaviour among migrants; this situation could also explain the higher odds ratio for migrants’ hospitalization (with a significantly higher proportion of digestive diseases) and discharge to ambulatory services after A&E visits
Costa et al. 2014 (30)	CSS, 2014	AT, BE, CZ, DE, ES, FR, GB, HU, IE, IT, NL, PL, PT, SE	Service managers or members of staff in 617 services located in 2 highly deprived areas of 14 European capital cities and providing mental health care to 6 marginalized groups: long-term unemployed, homeless, street sex workers, asylum seekers/refugees, undocumented migrants and people from travelling	To assess mental health, social care and general health services that potentially serve marginalized groups with mental health problems in order to develop a measurement of service effectiveness and assess if this measure could reflect service characteristics or socioeconomic indicators for a country	Development and application of an assessment index	The Quality Index of Service Organization (QISO) index score range was 0–15, with values given as means with standard deviation (SD); variation was from 8.63 (SD, 2.23) in Ireland to 12.40 (SD, 2.07) in Hungary The number of programmes provided was the only service characteristic significantly correlated with the QISO score; national gross domestic product was inversely associated with the score Nearly 15% of the variance of the QISO score was attributed to country-level variables, with gross domestic product explaining 12% of this variance

			communities			
Teunissen et al. 2014 (108)	CSS, 2013	NL	15 undocumented, first-generation, non-Western-descent migrants residing in 4 cities and recruited through trusted representatives from NGOs, migrant organizations, churches, GPs and the researcher's own informal network	To explore health-seeking behaviour and experiences of undocumented migrants at GPs in relation to mental health problems to elucidate their perspectives, specific needs and expectations of contact with GPs and primary care, and barriers and facilitators to accessing care	Interview	Undocumented migrants consider mental health problems to be directly related to their status and refer first to friends and religion for support, the GP being their last resort Barriers for seeking help include taboos on mental health problems, lack of knowledge of and trust in GPs' competencies regarding mental health and general barriers in accessing health care as undocumented migrants (lack of knowledge of the right to access health care, fear of prosecution, financial constraints and practical difficulties) Once access has been gained, satisfaction with care is high, mainly because of the attitude of the GPs and the effectiveness of treatment; reasons for dissatisfaction with GP care are lack of time, lack of personal attention and absence of physical examination
van den Muijsenbergh et al. 2014 (110)	R, 2014	AT, GB (Scotland), GR, IE, NL	Migrants	To substantiate the importance of research about barriers and levers to the implementation of support for cross-cultural communication in primary care settings and highlight problems in routine practice across different European settings	Literature review focusing on communication as a barrier from 1970s to 2014	Language and cultural barriers hamper communication in consultations between doctors and migrants, with a range of negative effects including poorer compliance and a greater propensity to access A&E; there is a need for skilled interpreters and for professionals who are culturally competent to address this problem A range of professional guidelines and training initiatives exist that support communication in cross-cultural consultations in primary care but these are commonly not implemented in daily practice

Wahlberg et al. 2014 (113)	CSS, 1997–2010	SE	7925 deaths not registered in the Swedish Cause of Death Register (860 classified as likely undocumented migrants)	To study causes of death among undocumented migrants compared with Swedish residents to establish if there are different patterns for the undocumented migrants	Analysis of death certificates on the basis of ICD-10 according to age at death, country of origin, place of death, postmortem findings	Undocumented migrants had a statistically significant increased risk of dying from external causes, suggesting inequity in health Legal ambiguities regarding health care provision must be addressed if equity in health is to be achieved in a country otherwise known for its universal health coverage
Pace-Asciak et al. 2013 (90)	Retrospective population study, 2002–2005	MT	All (4570) undocumented migrants who landed in Malta by boat between 1 January 2002 and 31 December 2005 (81% young adults aged 15–34 years, 86% male, 88% from Africa)	To describe the demography and tuberculosis epidemiology of undocumented migrants compared with the native Maltese population in order to tailor control strategies to this specific population	Analysis of national surveillance data	Of the total number of cases in Malta, the proportion in undocumented migrants increased markedly from 33% in 2002 to 60% in 2005; the reported incidence per 100 000 was 390 among migrants and 2.1 among Malta-born; despite free access to tuberculosis care for immigrants, lack of information and language/cultural barriers create a relative inaccessibility
Rechel et al. 2013 (122)	R, 2010–2011	WHO European Region, including the Commonwealth of Independent States	Undocumented migrants	To describe the key aspects of migration and health in Europe with regard to international migration, migrant health, barriers to accessing health services, ways of improving health service provision to migrants, and migrant health policies adopted across Europe	Literature reviews from MEDLINE, PubMed and Google Scholar (to update the study on migration and health in the EU undertaken by the European Observatory, the IOM, and the European Public Health Association Section on Migrant and Ethnic Minority Health	In 2010, emergency care was effectively inaccessible to undocumented migrants in 9 of the EU27; access to health services beyond emergency care (e.g. primary and secondary care) was offered only in 5 EU Member States (France, Italy, the Netherlands, Portugal and Spain); many countries in Europe charge undocumented migrants the full costs of their medical treatment The main obstacles to health care were administrative problems; language barriers; unfamiliarity with rights, entitlements and the overall health system; gaps in health literacy; social exclusion; and direct and indirect discrimination
Biswas et al. 2012 (22)	R, 2011	DK, NL, SE	Different groups of undocumented migrants	To address access to health care from a human rights perspective for undocumented migrants,	Desk research on national laws, policies, peer-reviewed studies and grey literature	In Denmark, access is to emergency care; additional care is provided if it is not reasonable to refer them to their home country; depending on the case, the undocumented patient may be required to pay for this

				considering practices, rights to free emergency care, nonemergency care, dental care, general health care		care In Sweden, access is only to emergency care, with the exception of former asylum-seeking children, who have rights equal to those of Swedish citizens In the Netherlands, undocumented migrants have greater entitlements and access to primary, secondary and tertiary care, although shortcomings remain
Dauvrin et al. 2012 (34)	CSS, 2008–2010	AT, BE, DE, DK, ES, FI, FR, GB, GR, HU, IT, LT, NL, PL, PT, SE	240 health professionals who had knowledge and practical experience of providing health care to undocumented migrants: mental health services (48), A&E (48), primary care (144)	To explore provision of care to undocumented migrants in 3 different health care services across 16 European countries in order to identify specific clinical challenges and issues of access and entitlement	Semi-structured interviews as part of the EUGATE project	Three patterns of health care entitlement were found: no rights (Finland, Sweden), minimum rights (Austria, Belgium, Denmark, Germany, Greece, Hungary, Lithuania, Poland, the United Kingdom), full rights (France, Italy, the Netherlands, Portugal, Spain) Communication barriers were perceived as more problematic in primary care and mental health services than in A&E Primary care services saw issues associated with patients becoming stressed through not being able to express themselves to professionals Health professionals recommended or used face-to-face interpreters or telephone interpreting services but still reported underuse of these services or lack of full access to them Some reported problems related to culture, such as the refusal of care because the health professional was of the opposite gender or cultural beliefs that hindered recovery
Grit et al. 2012 (51)	R and CSS, 2007–2008	GB (England), NL	Representatives from medical associations and NGOs speaking in front of undocumented	To focus on health care policy development and implementation for undocumented migrants under 2 different national systems (public national	Analysis of policy papers and law texts; interviews	Access to primary care seems fairly similar in England and the Netherlands and undocumented migrants have formal access to health care except for some aspects of secondary care; emergency life-saving care is, in general, easily accessible in both countries while access to non-urgent secondary health care appears to be

			migrants	health service in England, private health insurance system in the Netherlands) in the light of several factors determining policy-making, including contextual factors (cost-containment and migration issues), key actors and institutional factors (mode of governance and health care system)		easier in the Netherlands
Kluge et al. 2012 (72)	CSS, 2008–2010	AT, BE, DE, DK, ES, FI, FR, GB, GR, HU, IT, LT, NL, PL, PT, SE	240 health professionals who had knowledge and practical experience of providing health care to undocumented migrants: mental health services (48), A&E (48), primary care (144)	To present available data on service organization and staff, utilization by migrants, monitoring and evaluation systems, patient characteristics, programmes and policies over the 3 services	Questionnaire as part of the EUGATE project	*Migrants serviced*: 8 countries had at least 1 service collecting data on refugees, 7 reported as least one service with data on asylum seekers, 6 for victims of human trafficking and 11 for undocumented migrants *Service use*: despite the relative sizes of these services, the highest proportion of migrant patients was found in mental health services (23%), followed by primary care (16%) and A&E (13%) *Interpreting services*: 53% of services never provided any direct interpreting service, 59% never provided a telephone interpreting service, 24% reported always using direct interpreting service for patients with language difficulties, 17% of services always used a telephone interpreting service
Larchanché 2012 (75)	R and QS, 2007–2008	FR	Undocumented migrants	To identify obstacles to realizing health care rights by undocumented migrants and to analyse how intangible factors (social stigmatization, precarious living	Review of legislative debates, recently published reports, participant observation	While undocumented migrants are entitled to health care rights in France, the consequences of their social stigmatization, precarious living conditions and a climate of fear and suspicion generated by increasingly restrictive immigration policies in practice hinder many from being, or feeling, entitled to that right Intangible factors such as fear and suspicion have

				conditions, fear and suspicion related to increasingly restrictive immigration policies) hinder access to health care		powerful "subjectivation" effects that influence how both undocumented migrants and their interlocutors (i.e. health care providers) think about "deservingness"
Priebe et al. 2012 (95)	QS, 2007–2010	AT, BE, CZ, DE, ES, FR, GB, HU, IE, IT, NL, PL, PT, SE	162 practitioners, from 28 deprived areas in 14 European countries, with expertise in providing mental health care for 6 marginalized groups: long-term unemployed, street sex workers, homeless, refugees/asylum seekers, undocumented migrants (not in possession of a legal residency permit, which includes failed asylum seekers), members of the travelling communities	To explore the experiences and views of experts regarding mental health care to investigate patient pathways, including ways of obtaining relevant information, services that are likely to respond initially to their needs, further treatment options, barriers to access and ways to overcome them	Semi-structured interviews with case vignettes	Mainstream mental health services commonly expect people with mental disorders to be active in seeking treatment; experts saw this as unrealistic for people in socially marginalized groups of which some (e.g. undocumented migrants or those without appropriate insurance cover) may not be entitled to use services and, therefore, have no easy access Undocumented migrants are often afraid to ask for help in organizations, using only those recommended by other migrants; they always need to be reassured that they will be not asked for documents
Priebe et al. 2012 (94)	CSS, 2012	AT, BE, CZ, DE, ES, FR, GB, HU, IE, IT, NL,	Service managers or members of staff in 2 highly deprived areas in different European capital cities	To assess the number, characteristics of and programmes offered by generic and group-specific services that provide some type of	Questionnaire	516 out of 575 identified services in 8 capital cities were assessed (90%); 297 services were generic (18–79 per city) and 219 group specific (13–50) All cities had group-specific services for the homeless, street sex workers and asylum seekers/refugees;

		PL, PT, SE	providing care for 6 marginalized groups: long-term unemployed, street sex workers, homeless, refugees/asylum seekers, undocumented migrants (not in possession of a legal residency permit, which includes failed asylum seekers), members of the travelling communities	mental health care		services for undocumented migrants, travelling communities and the long-term unemployed were found only in some cities Among group-specific services, the 10 for undocumented migrants had the following characteristics: 100% accepted self-referrals, 20% operated outside normal office hours, 30% had no exclusion criteria and 20% (2) had a waiting list
Sandhu et al. 2012 (101)	CSS, 2008–2010	AT, BE, DE, DK, ES, FI, FR, GB, GR, HU, IT, LT, NL, PL, PT, SE	Professionals directly delivering mental health care (psychiatrists, mental health nurses, psychologists, therapists and social workers) to migrants	To examine provision and management of mental health through professionals' experiences of delivering care to migrants	Semistructured interviews	Specific challenges in treating migrants' mental health included concerns with diagnosis (language barriers, belief systems, cultural expectations, previous traumatic experiences), difficulty in developing trust, increased risk of marginalization
Biswas et al. 2011 (21)	CSS and QS, 2009–2010	DK	10 undocumented male migrants from Bangladesh, India and Nepal (overstayers, failed asylum seekers); 8 A&E nurses (4 head nurses, 4 nurses) from 4	To analyse sociodemographic characteristics, health-seeking behaviours and formal and informal barriers to health care for undocumented migrants; to investigate nurses' views on undocumented	Semi-structured interviews and observations	Undocumented migrants reported difficulties accessing health care, with barriers of limited medical rights, arbitrariness in attitude of health care professionals, fear of being reported to the police, poor language skills, lack of network with Danish citizens, lack of knowledge about the health care system and informal networks of health care professionals Nurses in A&E expressed willingness to treat all patients

			hospitals in the Capital Region	migrants and health care experiences with them		regardless of their migratory status but also reported insecurities about the correct standard procedures
Cuadra 2011 (32)	R and CSS, 2009	Europe	Experts from NGOs and authorities in the EU27	To characterize policies regarding the right of access to health care for undocumented migrants in the EU27 and to identify the extent to which these entitlements are congruent with human rights standards by examining relevant indicators for the welfare system, health care system, policies regarding undocumented migrants, health care for undocumented migrants and context of migration	Questionnaire and assessment of available reports and official web sites	Right to access care that is more extensive than emergency care is seen in 5 countries; access is only to emergency care in 12 countries and not even emergency care can be accessed in 10 countries Variations are independent of the system of financing or the numbers of undocumented migrants; rather, they seem to relate to the intersection between practices of control of migration, the main types of undocumented migrants present and the basic norms of the welfare state
De Jonge et al. 2011 (37)	Retrospective cohort study, 2005–2006	NL	141 undocumented uninsured and 141 documented insured ethnic minority women from areas outside Western Europe	To quantify maternal and perinatal health care in terms of number of visits, complications and compliance with guidelines by midwives between women in the 2 groups plus pregnancy outcomes	Analysis of medical records	Compared with documented insured women, undocumented women attended their first prenatal visit 5 weeks later and received care elsewhere or disappeared from care more frequently (59.6% versus 34.3%) Midwives were equally likely to follow referral guidelines in both groups Based on the expected number of visits usual in the prenatal care schedule in the Netherlands, undocumented women had an excess of visits (110%) more often (32.4% versus 16.9%), were more likely to have a preterm birth and give birth at home and were less likely to receive maternity home care assistance

Devillé et al. 2011 (41)	QS, 2008–2009	AT, BE, DE, DK, ES, FI, FR, GB (England), GR, HU, IT, LT, NL, PL, PT, SE	134 experts in 16 EU Member States representing 4 different fields: academia, NGOs, policy-making and health care practice	To assess the views and values of professionals working in different health care contexts as to what constitutes good practice in health care for migrants, exploring 9 issues: (1) easy and equal access to health care, (2) empowerment, (3) culturally sensitive services, (4) quality of care, (5) patient–health care provider communication, (6) respect towards migrants, (7) networks, (8) targeted outreach activities, and (9) availability of specific data about migrant health care and prevention	Delphi process	All mentioned the need for an easily accessible general health care system for all citizens; although they had initially been asked to propose good practice principles for migrants with regular legal incomes and speaking the local language, experts from several countries also specifically prioritized equal access for refugees and undocumented migrants
Goossens & Depoorter 2011 (49)	CSS, 2011	BE	86 GPs in one municipality of the Brussels Capital Region; 11 migrants without a residence permit	To examine the extent to which GPs are consulted by undocumented migrants, their use of the reimbursement system and the difficulties encountered in order to elucidate barriers to seeking and using health care	Questionnaire and semi-structured interviews	The main barrier for GPs is insufficient knowledge of the system, followed by its complex and time-consuming paperwork Primary care is an active channel in health care for undocumented migrants, with community health centres taking the lead Barriers experienced by undocumented migrants include fear of deportation, lack of funds, insufficient health care-related knowledge and communication barriers The reimbursement system should prevent financial barriers to access, but because it is complex and so not

						often used properly, it does not substantially lower financial barriers
Huffman et al. 2012 (56)	CSS and QS, 2008	KZ, UZ	Labour migrants: 8 groups in Kazakhstan and 4 groups of Uzbek migrants who had returned home	To understand the mechanisms that impede migrants' access to care in general, and tuberculosis treatment in particular, through examination of structural contexts and employment, legal and health care contexts that in concert may render migrants vulnerable to exploitative work conditions and cause barriers to health care	Focus group and in-depth interview	Three structural contexts, employment, law and health care, cause a series of barriers to health care; the most significant barriers were lack of legal registration, payment of a "fee" in exchange for health care services by migrants without registration, and language barriers There was increased exposure to tuberculosis and heightened risk of reactivation through lower immunity, treatment-seeking delays and increased disease severity; seasonal migration patterns also contributed to treatment interruption, thus risking drug resistance

Norredam 2011 (89)	R, 2007	DK	Labour migrants, family reunification migrants, forced migrants	To explore any differences in access to health care for migrants and non-migrants by investigating (1) disease stage at diagnosis with cancer, (2) access to medical screening, (3) use of A&E, and (4) health care policies and entitlements for the national health systems	Review of retrospective cohort studies, CSSs and health policy analyses in PubMed 1960–2005	*Diagnosis with cancer*: migrant subgroups were less likely to be diagnosed with local stage cancer apart from women from eastern Europe who were reunited with family *Screening*: all migrant subgroups were more likely to have more advanced stage at diagnosis (or unknown stage among the subgroup with a history of cancer) at first visit compared with non-migrants *A&E visits by migrants*: often precipitated by an inability to contact a GP (13%), 62% did so because they thought it most relevant to their need and 25% because they had been referred by a primary caregiver; more migrants had irrelevant A&E visits as evaluated by caregivers *Utilization of national health system*: rates decrease dramatically with increasing income, while they increase with age; more patients in all migrant groups had considered contacting their GP or the emergency treatment service before visiting A&E compared with non-migrants, but migrants often experienced communication problems leading to unsatisfactory contact
Priebe et al. 2011 (96)	QS, 2008–2010	AT, BE, DE, DK, ES, FI, FR, GB, GR, HU, IT, LT, NL, PL, PT, SE	240 health professionals who had knowledge and practical experience of providing health care to undocumented migrants: mental health services (48), A&E (48), primary care (144)	To explore provision of care to undocumented migrants in 3 different health care services across 16 European countries in order to identify elements of good practice to overcome difficulties	Semi-structured interviews as part of the EUGATE project with case vignettes	Eight problem areas were identified 1. Language barriers (although professional interpreters help, the involvement of a third party could impact on the patient–practitioner relationship) 2. Level of entitlement to mainstream health care services 3. Stressful experiences for migrants (social marginalization, background of poverty, unemployment, language barriers, difficulties in integrating, and possibly trauma from experiences of

						war and conflict) 4. Lack of familiarity with the health care system 5. Communication (difficulties with establishing diagnosis and treatment options) 6. Cultural norms and religious practices (may impact on examination and treatment) 7. Lack of trust of some migrant patients towards staff 8. Lack of access to the medical history
Aung et al. 2010 (17)	CSS, QS, 2009	GB	Burmese migrants residing in Greater London	To investigate sociodemographic disparities in access to health care through migrant knowledge of local health services, their level of access to and utilization of GP services and the barriers to such access	Questionnaire and in-depth interviews	Registration with GP was high (80%), but there was a low rate of use of GP services during the last episode of illness (56.8%) Main barriers were age <35 years, lacking prior overseas experience, having an unstable immigration status, shorter duration of stay, lack of knowledge about health care, and resorting to self-medication
Filc 2010 (47)	R, 2010	IL	General population	To analyse the ways in which the neoliberalization of society, through partial privatization of the public health care system, and its structure of citizenship interact in excluding significant social groups from equal access to health care, such as Israeli Arabs and migrant workers	Literature review of the impact of the Israeli national health insurance on access to health care services, 1980s to 2010	Citizenship in Israel excludes migrant workers and asylum seekers from access to health care services; most undocumented workers lack access to primary and secondary care as well to elective hospitalization The public health care system is closed to migrants and poverty deprives them of access to private clinics and medical centres; treatment options are only the cheaper hospitals and medical centres in East Jerusalem or the Physicians for Human Rights' Open Clinic in Tel Aviv The exclusionary nature of the immigration regime led to more marginalizing and less effective options for migrants even though the logic of public health, health economics and human rights would support inclusion of

						these people under the National Health Insurance Act
Pikhart et al. 2010 (93)	Case–control study, 2003–2006	CZ	285 post-Soviet and Vietnamese migrants (126 documented and 159 undocumented) living and working in the Czech Republic	To assess self-rated health differences between documented and undocumented migrants to evaluate associations between exposure to individual factors and sexual reproductive health	Questionnaire	Undocumented migrants seem to be less healthy compared with documented migrants and satisfaction with work and with housing was found to have a significant role; undocumented migrants were less educated, poorer, less likely to have a partner and with a poorer knowledge of the native language
Depallens et al. 2010 (39)	PS, 2003–2006	CH	103 children without a residence permit taken into care by the Children's Hospital of Lausanne between August 2003 and March 2006	To assess social, economic and medical data to evaluate children's specific needs	Questionnaire	Precarious conditions and poverty were common among undocumented children (89% of the families were under the poverty level; <3100 CHF/month) and this may be linked to health problems and barriers to accessing health care Federal politics of integration or expulsion of immigrants without a resident permit might influence parents' decision not to acquire health insurance for children, for fear of revealing their undocumented status
Schoevers et al. 2010 (102)	CSS, 2009	NL	100 undocumented women aged >18 years, living in different parts of the Netherlands, recruited through NGOs, GPs, a domestic workers organization, shelter homes, churches and	To obtain information about the actual use of health care facilities by undocumented women and to identify obstacles they experience in accessing health care facilities	Questionnaire and semi-structured interviews	69% of women reported problems in accessing health care facilities; 47% of women reported institutional obstacles (e.g. financial barriers and refusal of services); 40% reported personal obstacles (e.g. lack of information, fear of bills, fear of being reported to the police, sense of shame, health care not a priority); 18% of women reported both institutional and personal obstacles

			midwives			
Castañeda 2009 (27)	CSS, 2004–2006 and 2008	DE	183 patients attending a Berlin clinic providing the single largest source of medical assistance for unauthorized people in Germany	To explore how lack of documentation influences illness experiences, medical treatment and convalescence including overall quality and quantity of mother–child care, chronic care and emergency care	Participant observation, interview, analysis of data from grey literature, systematic collection of media coverage and legislative debates	Barriers were found with respect to quality and quantity of care for mothers and infants, access to medication for chronic illnesses, immediate medical attention for unpredictable injuries and other acute health concerns, and mental health care options for stress and anxiety
Fakoya et al. 2008 (46)	R, 2008	NL, GB	Documented and undocumented black African migrants	To describe cultural, social and structural barriers to HIV testing plus political and legal considerations in Western Europe	Narrative review of literature from 1996 to 2008	Cultural, social and structural barriers to testing included access to testing and care, fear of death and disease, and fear of stigma and discrimination Lack of political will, restrictive immigration policies and the absence of African representation in decision-making processes were also major factors preventing black Africans from testing HIV-testing strategies need to be grounded in outreach and community mobilization, addressing fear of diagnosis, highlighting the success of treatment and tackling HIV-related stigma among black African migrant communities
Bodenmann et al. 2009 (23)	Descriptive exploratory study, 2007	CH	161 undocumented migrants (>15 years of age) with no major psychiatric disabilities visiting for the first time	To investigate the acceptance, prevalence of positive findings, and adherence to treatment of undocumented migrant patients offered screening for latent	Questionnaire and blood sample (interferon-γ assay)	Of 10 patients identified with latent tuberculosis, only 5 completed full preventive treatments, leading to fears of inadequate public health measures; the setting and patients' confidence in the system (fear of denunciation and rejection) may contribute to such a lack of adherence

			the 2 urban health care centres for vulnerable populations in Lausanne	tuberculosis		
Dias et al. 2008 (43)	CSS, 2008	PT	1513 migrants (53% men) from Africa, Asia, eastern Europe, and South America; included documented migrants and those in the process of regularization/undocumented migrants	To describe the access of migrants to health care, examining its determinants, including sociodemographic characteristics of participants and factors associated with access and utilization of the national health service	Questionnaire	Among the participants that ever used the health services, 22.4% reported being unsatisfied or very unsatisfied; barriers to appropriate and timely access were waiting times (50.2%), providers' attitudes (recognized as barriers regardless of country of origin) (17.9%), costs (3.4%), distance and transportation (2.2%) and language (1.3%)
Lindert et al. 2008 (77)	R, 1989–2008	BE, DK, ES, FI, FR, GB, IT, NL, NO, SE	Different groups of migrants, coming from various Western European countries	To describe mental health and health care utilization and give an overview on prevalence of mental disorders, suicide, alcohol and drug abuse; and to describe psychosocial care facilities and their utilization by migrants	Narrative review of the literature	Mental health differs between migrant groups; in many European countries migrants (particularly asylum seekers and undocumented migrants) fall outside the existing health and social services; access to psychosocial care facilities is influenced by the legal frame of the host country Barriers to access may originate from lack of knowledge or communication problems; those who are older, poorer and female tend to have greater language barriers
Wolff et al. 2008 (117)	Cohort PS, 2005–2006	CH	161 undocumented and 233 control pregnant women in Geneva	To compare preventive measures and pregnancy care for undocumented women and the general population in order to identify specific elements of vulnerability in	Questionnaire and blood tests	Major barriers to access were the cost of health care, language barriers, fear of being reported and lack of culturally appropriate education

				undocumented migrant pregnant women		
Devillanova 2007 (40)	CSS, 2000–2001	IT	10 571 undocumented migrants cared for at Naga, an NGO offering free primary care to undocumented migrants	To examine the role and effects of information networks on migrants' access to health care by exploring how a migrant was referred to the NGO (e.g. strong social tie)	Interview	Relying on friends and kin in order to get information on Naga significantly accelerated health care utilization, reducing the time to first visit to health care facilities by about 30%; this effect is stable across specifications and is particularly strong for less educated individuals
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Akhavan 2012 (12)	CSS, 2009–2010	SE	10 Swedish born midwives working in the district for at least 12 months	To explore their views on the factors that contribute to health care inequality among undocumented migrants, including communication, potential barriers to the use of health care services, transcultural care	Semi-structured interviews	Midwives believe that communication has a central role; an audit aimed at listening and assessing patients' needs and at addressing cultural and language differences could be a good way to provide equitable health care
Alvarez-del Arco et al. 2014 (15)	R and CSS	EU/EEA/EFTA Member States	Ministries of health and public health institutions in 31 countries	To describe current recommendations regarding HIV testing and counselling targeting migrants and ethnic minorities	Questionnaire and search of the websites of competent bodies of EU/EFTA Member States (national AIDS plans, ministries of health, public health agencies, etc.)	Although the most of the policy documents identified migrants as a vulnerable population for HIV infection, only 52% recommend HIV testing for migrant populations; national policy documents should recommend voluntary HIV testing for migrants as the first step to decrease the higher undiagnosed fraction in this population in the EU/EFTA region; although national HIV-testing policies are heterogeneous across the countries, HIV-testing approaches must link testing to care as clearly stated in the HIV-testing guidelines of the European Centre for Disease Prevention and Control

Bhopal 2012 (20)	R	GB (Scotland)		Insights from Scotland's quest for culturally sensitive health systems	Review of literature about legal framework, health policies, health strategies and major recent achievements for migrants in Scotland	The 5 key issues in Scotland's Ethnicity and Health (Fair for All) Policy were: (1) energizing the organization leadership, (2) understanding the populations under consideration, (3) taking steps to modify existing services to meet needs of ethnic minority groups, (4) guarantee equality in employment, (5) strengthening communities The 6 top priorities in Scotland's ethnicity and health research strategy were: (1) ethnic coding of routine existing health information systems; (2) data linkage work to be developed and sustained; (3) an ethnically boosted health survey to describe social/economic circumstances, risk factor patterns and prevalence of major health problems by ethnic group; (4) coordinated research on major problems; (5) audit of health and social care services to assess whether quality and access standards are met; (6) coordinating and monitoring of research by an implementation group Some of the challenges in achieving policies were implementation, insufficient monitoring, sparse budgets, competing priorities, insufficient information, mainstreaming projects into routine service, maintaining engagement between the statutory and voluntary sectors, altering service delivery, winning hearts and minds
Castañeda 2009 (27)	CSS, 2004–2006 and 2008	DE	183 patients attending a Berlin clinic providing the single largest source of medical assistance for unauthorized people in Germany	Assessment of patients' characteristics, overall quality and quantity of mother–child care, chronic care and emergency care to explore how undocumented status influences illness experiences, medical treatment and convalescence, and impacts health, illness	Participant observation, interview, collection and analysis of data from grey literature, systematic collection of media coverage and legislative debates	Undocumented status resulted in several disparities including in mother–child care, medication supply for chronic illnesses, accessing acute medical attention and mental health care options An incoherent policy environment in Germany contributes to inadequate services and treatment delays; solutions must address these legal ambiguities, which represent a primary barrier to equity in a nation with otherwise universal health coverage

				and convalescence		
Castañeda 2012 (26)	R, 2010	DE	Unauthorized migrants	To examine discourses and practices embedded within larger national debates on unauthorized migration and migrant integration and their specific manifestations in the health sector in order to explain the current situation for unauthorized migrants	Systematic review of literature indexed in MEDLINE, qualitative review of German medical and nursing curricula, original ethnographic data	The strict policy environment towards unauthorized migrants in Germany is unique in Europe and is a combination of laws restricting most documented immigration and a distinct approach towards migrants already living in the country To attain a more equitable health care system in which adequate prevention, diagnosis and treatment are available, existing policy-based barriers must be dismantled and their ideological foundations re-examined; such barriers include inequality in quality and quantity of care for mothers and infants, no rights to access medication for chronic illnesses, no rights to immediate medical attention for acute and unpredictable needs and no mental health care options for stress and anxiety
Chimienti & Solomos 2011 (29)	R	FR, GB		To understand the context and challenges of undocumented migration through analysis of the impact on conceptions of rights and citizenship and to analyse the role of networks in mobilizing undocumented migrants and their supporters	Narrative review of literature about undocumented migrant mobilization	Undocumented migration is a heterogeneous phenomenon that has increased because of shortcomings of migration management in many countries; detention, deportation and the general control of borders have continued despite a lack of evidence of the efficacy of these measures, and their purpose is in this sense more symbolic: to generate a sense of control and decrease anxieties in the wider society about globalization and migration
Cuadra 2011 (32)	CSS, 2009	Europe	Experts from NGOs and authorities in the EU27	To characterize policies regarding the right of access to health care for undocumented migrants in the EU27 and to	Questionnaire and assessment of available reports and official web sites	Right to access care that is more extensive than emergency care is seen in 5 countries; access is only to emergency care in 12 countries and not even emergency care can be accessed in 10 countries Variations are independent of the system of financing

				identify the extent to which these entitlements are congruent with human rights standards by examining relevant indicators for the welfare system, health care system, policies regarding undocumented migrants		or the numbers of undocumented migrants; rather, they seem to relate to the intersection between practices of control of migration, the main types of undocumented migrants present and the basic norms of the welfare state
Dauvrin & Lorant 2014 (35)	CSS, 2010–2012	BE	569 health professionals from 24 inpatient and outpatient health services	To assess whether health professionals feel responsible for adapting health services to cope with a multicultural society	Questionnaire	Identified a need for health professionals to take responsibility for adaptation of communication, values and health beliefs
Dauvrin et al. 2012 (34)	CSS, 2008–2010	AT, BE, DE, DK, ES, FI, FR, GB, GR, IT, LT, HU, NL, PL, PT, SE	240 health professionals who had knowledge and practical experience of providing health care to undocumented migrants: mental health services (48), A&E (48), primary care (144)	To explore provision of care to undocumented migrants in 3 different health care services across 16 European countries in order to identify specific clinical challenges and issues of access and entitlement (access problems, limited communication, associated legal complications)	Semi-structured interviews as part of the EUGATE project	Three patterns of health care entitlement were found: no rights (Finland, Sweden), minimum rights (Austria, Belgium, Denmark, Germany, Greece, Hungary, Lithuania, Poland, the United Kingdom), full rights (France, Italy, the Netherlands, Portugal, Spain) Health professionals recommended or used professional face-to-face interpreters or telephone interpreting services if there were language barriers; language barriers and restricted access to adequate treatment at first access and during further treatment pathways limited the therapeutic options available, lowered the quality of care and jeopardized the continuity of care
Dauvrin et al. 2012 (33)	Descriptive study, 2010–2011	BE	21 experts in the field of health and migration invited by a steering committee composed of 3 researchers and 2	To formulate recommendations to the Belgian public health authorities on how to reduce ethnic and migrant health inequalities	Consensus conference on undocumented migrants and asylum seekers; cultural competence, health promotion and prevention; and monitoring and registration of data on	The ETHEALTH group came up with 46 recommendations divided into (1) contextual and socioeconomic levels (better data on migrants and ethnic minority groups, improved coordination across the different levels of governance and making cultural competences a licensing criterion for all health care professionals); (2) differential exposure to

			civil servants from the Ministry of Public Health		ethnicity in relation to health issues	socioeconomic opportunities (fighting against discrimination and improving preventive health care); (3) administrative procedures and accessing health services (generalization of “medical cards” for undocumented migrants as these give access to health care services for a particular period, without additional administrative procedures)
Davies et al. 2011 (36)	R	Europe	Migrants from South-east Asia	To highlight the influence that migration can have on the social determinants and risk factors for noncommunicable diseases	Narrative review of literature on the epidemiological situation, health policies, health strategies	Given the increased risk of noncommunicable diseases for South-east Asians living in countries of the EU compared with the host community, strategies should take sociocultural factors into consideration when developing interventions that target lifestyle changes in high-risk populations; population risk-reduction interventions that target social determinants must recognize the effects of migration European white papers, such as the "Health programme 2008–2013: together for health" or the "Strategy for Europe on nutrition, overweight and obesity related health issues" promote the inclusion of vulnerable groups and the reduction in health inequalities
Degni et al. 2012 (38)	CSS	FI	32 doctors, nurses, midwives	To explore physicians’, nurses’ and midwives’ communication when providing reproductive and maternity health care to Somali women	Naturalistic, interpretive approach, based on open-ended questions	Health care provider’s communication style implies that the provider should take an active and even a controlling role in the interaction; culturally appropriate actions are most directly predicted by awareness that culture is relevant to medical care and that negative preconceptions can hinder service efforts
Dorn et al. 2011 (44)	CSS, 2008	NL	Consecutive sample of undocumented migrants who were held at one of the two detention facilities in Zaandam	To gather basic epidemiological data on health and health care utilization of both care-seeking and non-care-seeking undocumented migrants in order to assess knowledge of how to access medical care,	Structured interviews, analysis of medical records	There is the need for a better education of providers and undocumented patients concerning the opportunities for health care in the Netherlands; there is also a need to further clarify the reasons for denial of care to undocumented patients, as well as the barriers to health care as perceived by undocumented migrants

				care seeking, and seeking but being denied care by a health care provider		
Hellgren 2014 (53)	QS	ES, SE	44 contributors involved in the negotiation of social membership in Barcelona and Stockholm: policy-makers, immigration officials, trade union representatives, NGO activists and undocumented migrants	To describe the current situation of undocumented migrant health in Spain and Sweden	Interviews	*Sweden*: Until recently, the government rejected granting basic social rights such as health care to people with no formal right to stay in the country; since 1 July 2013, undocumented migrants have the same right to basic health care as asylum seekers, which includes urgent health care, maternity care and birth control; undocumented children were also granted the right to education *Spain*: immigration law from 2000 stated that undocumented migrants who register with their local population register will be fully entitled to health care under the same conditions as Spaniards; from 1 September 2012, a new law entered into force that formally excludes undocumented migrants from the public health care system; as in Sweden, patients will not be denied urgent health care but will be charged the full cost for this; some NGOs have given medical aid to undocumented migrants and all lobby for a legal reform that would give these migrants the same access to basic health care as Swedish citizens

Higginbottom et al. 2013 (54)	R	DE, GB	Undocumented migrant/minority women	To describe the current situation of undocumented migrants in Germany and the United Kingdom	Narrative review of literature about epidemiological situation, health policies, health strategies for women migrants	According to unofficial data, a large number of undocumented migrant/minority women are giving birth in Germany without having health insurance; the cost of care for these women is currently covered by charitable trusts and the Office for Medical Aid for Refugees Policy directives have been written to indicate that immediately necessary treatment including all maternity treatment should never be withheld for any reason; in practice, health care professionals are placed in the invidious position of having to arbitrate on who is entitled to care, which results in much confusion and concern; policy and legal frameworks are rarely gender neutral and migration status and gender intersect in complex ways, creating divergent trajectories and vulnerabilities for men and women; migrant/minority women may find themselves in a particularly vulnerable position during childbearing, partly since there are significant sensitivities around the higher fertility of migrant/minority communities and its perceived contribution to the undermining of national identities
Hollings et al. 2012 (55)	R and CSS	HU, PL, SK	2356 border officials of diverse profiles within the national border guards/police, branch offices/duty stations, regional border headquarters and detention centres, and 77 health and social work professionals	To outline the current situation with respect to undocumented migrants care in order to develop training materials and guidelines on health and border management	Desk review of the international, European and national legal instruments, standards and studies regarding the rights of migrants to health and access to health care; collection of retrospective official public and non-public data from partner countries; questionnaire	Existing data for detention centres are scant; there are gaps in health care for migrants and few existing tools for border officials and health professionals; lack of mental health assessment and social workers in detention centres were found to be important gaps With regard to the quality of care, it was found that border guards generally do not have the necessary skills nor refresher courses on first aid Shortages of interpreters and health professionals (particularly mental health professionals) are common barriers in all countries Training modules were developed for each of these groups, including common modules on migration and the right to health and intercultural communication, as

						well as targeted health modules
Jaeger et al. 2013 (62)	R and CSS	CH	Child migrants and their family	To explore policies, care approaches and potential adaptations required to meet the health and service needs of child migrants	Semi-structured interviews and review of the international literature on non-clinical hospital service needs and service responses of a paediatric migrant-friendly hospital	Key actors (child migrants, family members, health care staff, interpreters, hospitals/management, society) have different needs but face common overarching challenges (e.g. language barriers, cultural differences, service constraints) in the pursuit of appropriate service delivery to children and their families
Jensen et al. 2011 (63)	QS, 2010	DK	Health experts	To investigate experts' opinion on "best practice in the delivery of health care to migrants"	Delphi process	The top 11 factors identified were access to interpreters, quality of interpretation, ensuring medication compliance, having sufficient consultation time, coherence of offers, interdisciplinary collaboration, allocation of resources, the role of the practitioner, acknowledgement of the individual patient, education of health professionals and students, and access to telephone interpretation to supplement other services
Jensen et al. 2011 (64)	CSS, 2008–2009	DK	GPs, physicians working in A&E, and managers of psychiatric residential units selected from 3 urban hospital catchment areas with high proportions of migrants in the vicinity of Copenhagen	To study the experience of health care professionals in providing treatment for undocumented migrants in the Danish health care system in order to explore differences in treatment and whether the right to health care is a reality	Semi-structured interviews	Undocumented migrants experienced unequal access to primary care facilities and health professionals were uncertain how to respond to these patients The lack of official policies concerning the right to health care for undocumented migrants passed the responsibility on to health professionals, leaving it up to them to decide whether treatment could be obtained

Lorant & Bhopal 2012 (78)	Strategy analysis	BE, GB (Scotland)		To compare strategies for tackling ethnic inequalities in health between Belgium and Scotland by analysing recognition of the problem and its causes, policies to tackle inequalities, interventions and their underlying theories, and outcomes	Whitehead framework	*Scotland*: In 2002, the Scottish Executive Health Department issued a letter (effectively policy) requiring National Health Service organizations to tackle ethnic inequalities in health and health care with respect to 5 domains: (1) to energize organizations to deal with minority health issues positively; (2) to produce information about the population of each National Health Service board's area; (3) to acknowledge and overcome barriers to access; (4) to recruit ethnic minority staff; and (5) to consult minority ethnic communities *Belgium*: Despite the lack of a comprehensive policy on health inequality, Belgium has been keen to provide health care services to migrants who do not have compulsory health care insurance; the law allows undocumented migrants to access all care (and not only emergency care) through the local municipality's social services
MacFarlane et al. 2014 (80)	QS with participatory research, 2011–2015	AT, IE, GB (England), GR, NL	Migrant health key stakeholders (migrant service users, GPs, primary care nurses, practice managers and administrators, interpreters, cultural mediators, service planners and policy-makers)	To investigate and support the implementation of guidelines and training initiatives to support communication in cross-cultural consultations in primary care settings, examining how these can be incorporated into primary care and their sustainability	Combination of normalization process theory and participatory learning and action research	Adaptation of health care services so that they are culturally and linguistically appropriate is best approached using European collaborations to enhance knowledge about implementation of interpreter-supported consultations in diverse settings; involvement of migrants and other key stakeholders would enhance the veracity and relevance of research and policy
MacFarlane et al. 2012 (79)	QS with participatory research	AT, IE, GB (England, Scotland), GR, NL	Migrant health key stakeholders (migrant service users, GPs, primary care nurses, practice	To study implementation strategies to support patients of different origins and language background in a variety	Mapping exercise to identify relevant guidelines and training initiatives	Primary care research across 5 European settings investigated and supported the implementation of guidelines or training initiatives to support communication in cross-cultural GP consultations

			managers and administrators, interpreters, cultural mediators, service planners and policy-makers)	of primary care settings		
Mladovsky 2009 (87)	R and CSS, 2007	BE, DE, DK, EE, ES, FI, FR, GB (England), IE, IT, LT, NL, PL, SE, TR	Health policy experts from 15 European countries	To develop a framework to compare migrant health policies	Literature review of census data, health surveys, living standards surveys and health care utilization data; questionnaire	Development and implementation of migrant health policies is potentially challenging for government, considering the highly contested and political nature of any public policy relating to immigration in many European countries; policies could aim for uniform implementation throughout the country or targeted implementation confined to localities with high levels of immigration; national-level government may need to introduce penalties and incentives to promote implementation in decentralized health systems Data are needed to monitor and evaluate implementation; the risk is that policies might be confined to a specific time period, possibly linked to the period a specific political party is in government, and might be abandoned by subsequent governments, given the highly politicized nature of immigration policy
Mladovsky et al. 2012 (85)	R, 1990–2012	Europe	Migrants	To describe good practices in delivering health services for migrants including government policy, health services and health workers	Review of existing literature and current practices	The most important step that national governments can take to improve migrants' access to health services (particularly undocumented migrants) is to vest them with the same legal entitlements as other residents of the country
Mladovsky et al. 2012 (86)	R and policy analysis, 2008–2009	AT, BE, BG, CZ, DE, DK, EE, ES, FI, FR, GB (England),	Health policy experts from 19 European countries	To compare the content of health policies for migrants and analyse their strengths and limitations	Questionnaire and analysis of country reports available on the MIGHEALTHNET website	Policy initiatives typically involve training health workers, providing interpreter services and/or cultural mediators, adapting organizational culture, improving data collection and providing information to migrants on health problems and services A few countries stand out for their quest to increase

		IE, IT,LT, NL, RO, SE, SI, TR				migrants' health literacy and their participation in the development and implementation of policy
Priebe et al. 2011 (96)	QS, 2008–2010	AT, BE, DE, DK, ES, FI, FR, GB, GR, HU, IT, LT, NL, PL, PT, SE	240 health professionals who had knowledge and practical experience of providing health care to undocumented migrants: mental health services (48), A&E (48), primary care (144)	To explore experiences of health professionals providing care to undocumented migrants and create an overview of good practice	Semi-structured interviews as part of the EUGATE project with case vignettes	Good practices to overcome or control the main barriers were organizational flexibility with sufficient time and resources, good interpreting services, working with families and social services, cultural awareness of staff, educational programmes and information material for migrants, positive and stable relationships with staff, clear guidelines on the care entitlement of different migrant groups

A&E: accident and emergency services; CSS: cross-sectional study; EEA: European Economic Area; EFTA: European Free Trade Association; EU: European Union; EU27: European Union Member States at 2007; GP: general practitioner; ICD-10: International Classification of Diseases – 10th revision; IOM: International Organization for Migration; NGO: nongovernmental organization; PS: prospective study; QS: qualitative study; R: review.

[a] Country of study indicated by country codes: AT: Austria; AZ: Azerbaijan; BE: Belgium; BG: Bulgaria; BR: Brazil; BY: Belarus; CH: Switzerland; CY: Cyprus; CZ: Czech Republic; DE: Germany; DK: Denmark; EE: Estonia; ES: Spain; FI: Finland; FR: France; GB: United Kingdom; GR: Greece; HU: Hungary; IE: Ireland; IL: Israel; IT: Italy; KG: Kyrgyzstan; KZ: Kazakhstan; LT: Lithuania; LU: Luxembourg; LV: Latvia; MA: Morocco; MT: Malta; NL: Netherlands; NO: Norway; PL: Poland; PT: Portugal; RO: Romania; SE: Sweden; SI: Slovenia; SK: Slovakia; TJ: Tajikistan; TM: Turkmenistan; TR: Turkey; UZ: Uzbekistan.