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Tracing the Human Right from Law to Policy to Reproductive Healthcare: Exploring the Strengths and Shortcomings of Undocumented Migrant Women’s Access to Reproductive Healthcare in Switzerland

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Tracing the Human Right from Law to Policy to Reproductive Healthcare: Exploring the Strengths and Shortcomings of Undocumented Migrant Women’s Access to Reproductive Healthcare in Switzerland

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Fall 2015

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Abstract

**Background:** Through the UN Human Rights Declaration and articles of other UN treaty bodies, access to healthcare is a fundamental human right that has been granted to all, including undocumented migrants (UDMs). In Switzerland, reports estimate that there are between 80,000 to 100,000 UDMs. Among European countries, Switzerland is one of the few countries where UDMs have the right to access healthcare services beyond emergency healthcare, as they are included in the Swiss Federal Law on Compulsory Healthcare (LAMal). For UDM women, they face two layers of vulnerability (their irregular living status and the reproductive health needs that come with their gender).

**Objective:** This research paper will explore UDM women’s legal right to access reproductive healthcare in Switzerland. The objective is to put the unique framework of Switzerland’s healthcare policy for UDMs under examination, following human rights law to its intersection with reproductive healthcare, ultimately ending with the specific provision of reproductive healthcare for UDM women who are victims of FGM, analyzing the successes, gaps, and challenges that occur during the translation from theory to practice through looking at adequacy, accessibility, affordability, adaptability, and quality.

**Method:** To conduct research capturing the evolution of legal and healthcare policies, the data used was a combination of primary and secondary sources, combining research reports from organizations that analyzed undocumented migration in Switzerland with focuses on human rights, healthcare and/or reproductive healthcare for UDMs with an interactive approach of formal and informal interviews to expand on the intersections of law and reproductive health for UDM women in Switzerland.

**Results/Findings:** This research finds that both shortcomings and strengths exist in the enactment of UDM women’s human right to access reproductive healthcare in Switzerland. Experts discussed key challenges for migrants to enact their human right to healthcare afforded
to them in the health policy due to the high costs of health insurance premiums and challenges
due to their irregular stay to receiving subsidies in different cantons. The fact that UDMs could
access reproductive healthcare in Switzerland is a success, however challenges exist due to the
accessibility of healthcare providers in different cantons, the accessibility and affordability of the
costs of care, the adequacy of reproductive healthcare to meet the needs of UDM women due to
challenges in adapting to cultural and linguistic specifications, and the quality of care for UDM
women who are victims of FGM.

**Conclusion:** Tracing the human right to access healthcare for UDMs points for the need for a
more integrated system of healthcare for UDMs throughout Switzerland. In theory with the
incorporation of cultural sensitivity education for healthcare providers, the accessibility of
interpreters, policies facilitating the access to subsidies in the cantons, and organizations helping
UDM women navigate the healthcare system, UDM women’s experience seeking reproductive
healthcare in Switzerland could be more aligned with their human right to access healthcare and
the Swiss healthcare policy supporting this right. Going forward, further research on this topic
should expand to more cantons in Switzerland and see how to establish a framework to assess
UDM women’s reproductive health in the long term.
Preface

My interest in public health, particularly women’s health, is not just from a medical perspective but is also from a legal framework. I believe that all women around the world should have access to reproductive healthcare, as access to reproductive healthcare is a human right. My previous research interests have explored challenges for women in the United States and in Switzerland to access abortion and reproductive healthcare due to restrictive policies and high costs, leading to inaccessibility and unaffordable care for those without means. Given the recent migration crisis in Europe, I wanted to focus my attention on a population of migrants who have been in Switzerland for some time and continue to arrive – undocumented migrant (UDM) women. If my previous research revealed inequities for citizens to access reproductive healthcare, I wanted to see the abilities and struggles UDM women face in accessing reproductive healthcare. I plan to devote my career to making laws accessible to women so that they can exercise their right to access reproductive healthcare. For this reason, I chose to focus on Switzerland, as for a European country it uniquely has a human rights based policy to providing care for UDMs. Yet, my question remained whether or not the policy translated to equitable reproductive healthcare for UDM women, tracing how legal frameworks get applied in law and then hopefully disseminated to UDM women so that they can know and exercise their legal rights. This topic allowed me to combine my interests in law and public health, while expanding my research knowledgebase on reproductive healthcare access to a new group – UDM women.
Acknowledgements

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Introduction

Access to healthcare is a fundamental human right that has been established for undocumented migrants (sans-papiers) in the UN Human Rights Declaration and articles of other UN treaty bodies. Countries have different populations of undocumented migrants (UDMs) and experience different obstacles in providing them with needed resources to meet basic human rights obligations. In Switzerland, while it is currently unknown the exact number, it is estimated by the Federal Office for Migration in 2005 that “between 80,000 to 100,000 UDMs live in Switzerland i.e. persons residing in Switzerland without valid residence documents for an unspecified period of time” (Wyssmüller & Efionayi-Mäder, 2011, p. 9). Among European countries, Switzerland is one of a few countries where UDMs have the right to access healthcare services beyond emergency healthcare. The healthcare policy in Switzerland for UDMs is uniquely framed from a human rights perspective with health equity in mind. That being said, it appears that discrepancies exist between the legal human right and its accessible implementation on the ground, largely depending upon the canton. Particularly for the population of undocumented female migrants who have two layers of vulnerability (their living status and gender), inequalities in exercising their legal human right to healthcare translates into challenges in accessing reproductive healthcare.

Thus, this research paper will explore UDM women’s legal right to access reproductive healthcare in Switzerland. The objective is to put the unique framework of Switzerland’s healthcare policy for UDMs under examination, following human rights law to its intersection with reproductive healthcare, analyzing the successes, gaps, and challenges that occur during the translation from theory to practice through looking at adequacy, accessibility, affordability, adaptability, and quality. Combining legal and public health frameworks, the paper will examine the legal right of UDM women to access healthcare as established by UN treaties and laws within Switzerland, the policies in place to provide healthcare for UDM women in Switzerland,
how reproductive healthcare is offered to migrant women, and how healthcare providers work with legal assistance organizations to empower UDM women to express their human right to healthcare. Specifically within the topic of reproductive healthcare for undocumented women, a case study will be explored: migrant women’s access to healthcare due to female genital mutilation (FGM).

**Literature Review**

What legal rights apply to UDMs? A UNHCHR report, *Migration, human rights, and governance*, was conducted, which notes that international human rights law applies “not only to the nationals of a state, but to everyone within the state’s jurisdiction, including migrants, be their status regular, irregular, documented, or undocumented” (UNHCHR, 2015, p. 40). The report detailed that “many international instruments exist that outline the role, purpose, and application of international law as the normative foundation for national law and policy to effectively govern migration” (UNHCHR, 2015, p.40). Further, “International law recognizes the right of everyone to leave any country, including their own, and to return to their own country” (UNHCHR, 2015, p. 21). In a policy statement by the International Federation of Medical Students’ Associations (IFMSA), *Access to Healthcare for Undocumented Persons*, the associations argued for the ability of undocumented persons to access the same standard of healthcare as any other person because the universal declaration of human rights states that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including medical care and necessary social services” (IFMSA, 2014).

In the article *Ethical Inquiry: Do Undocumented Immigrants Have a Right to Healthcare?*, the 1990 UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families was discussed, which “recognized that even migrants who enter a country illegally are entitled to basic level of assistance, including medical care” (Rees, 2012). This declaration continued the conversation of healthcare rights for all
individuals on an international stage. In this article, the work of Norman Daniels was highlighted for his remarks on healthcare needs and distributive justice, arguing that “denying healthcare to anyone is a grievous act that prevents individuals from being whole” (Rees, 2012). The article came to the consensus that regardless of one’s political views, “the issue of undocumented immigration is separate from healthcare policy and it should be conceptualized as two separate issues: one of immigration policy and one of national health policy, void of immigration status” (Rees, 2012). The problem is that in countries, healthcare is not seen as a separate topic from immigration, as discussed in the article, *Access to Healthcare for Undocumented Migrants From a Human Rights Perspective: A Comparative Study of Denmark, Sweden, and the Netherlands*,

Entitlements to healthcare on a national level is often at odds with undocumented migrants’ rights as stated in international human rights law, which acknowledges the right to health for all persons, regardless of their migratory status. Providing healthcare may represent challenges for health care professionals, as entitlements are often at odds with codes of medical ethics (Biswas et al., 2012, p. 54).

Thus, the issues concerning access to healthcare for UDMs represent an intersecting field between medicine, public health, medical ethics, politics, and national and international law (Biswas et al., 2012, p. 58).

Many reports have been conducted focusing on the health, access, and population of UDMs in Switzerland. The reports highlighted the role politics have played in policies surrounding UDMs. According to the report by Nowhereland, a project aimed at creating a knowledge base for providing, exchanging, and developing good practice of healthcare services for UDM, and The Federal Office of Public Health, *Policies on Healthcare for Undocumented Migrants in Switzerland Country Report*, the issue of illegal migration became a “new focus of Swiss public and political discourse on immigration during the 1990s when asylum figures were exceptionally high” (Bilger & Hollomey, 2011, p. 8). In the beginning of the 1990s, a major political debate on “illegal migration” sparked off from a popular initiative launched by the
Swiss People’s party demanding “increased efforts against illegal immigration” (Bilger & Hollomey, 2011, p. 8). According to the report, “the initiative was rejected by the Swiss population” (Bilger & Hollomey, 2011, p. 8). In 1991, Switzerland introduced the “so called three circle policy,” which divided foreigners into three groups: nationals of the EU and EFTA countries which would enjoy first immigration priority, followed by citizens from the USA, Canada, Australia, and New Zealand, and then including all other nationalities who were allowed immigration only in exceptional cases (Bilger & Hollomey, 2011, p. 8).

According to the report, at the end of the 1990s, “first initiatives were launched to urge the Swiss government to revise immigration policies, to stop cultural and gender discrimination, and devise measures that helped improve the precarious situation of many foreigners,” as the three-circle model was “widely criticized as being radically discriminative” (Bilger & Hollomey, 2011, p. 9). Due to this model, in the 1990s, “an increasing number of former seasonal workers became undocumented,” thus cantons had to “face the fact that a number of former temporary workers could no longer renew their seasonal work permits, but, at the same time, could also not return to their home country and thus remained undocumented” (Bilger & Hollomey, 2011, p. 9).

Mobilization started in the French speaking cantons to renew the permits of former seasonal workers, which soon

Developed into a nation wide pro-regularization movement, which was supported by a wide range of actors and cantonal administrations and initiated a parliamentary debate on improving the rights of UDMs in Switzerland (Bilger & Hollomey, 2011, p. 9).

The report Policies on Healthcare for Undocumented Migrants in Switzerland Country Report also highlighted the progress made in 2002, when members of the National Council and representatives of human rights, solidarity, and trade union organizations as well as the sans-papiers movement founded the “platform for a round table on sans-papiers” to discuss the agenda on this specific group or persons beyond the regulation on “acute individual hardship” (Bilger & Hollomey, 2011, p. 10). In addition, “access of UDMs to healthcare was given priority on the
political agenda of the Federal Office of Public Health, which explicitly refers to the situation of UDMs in its second national Strategy Migration and Health 2008-2013” (Bilger & Hollomey, 2011, p. 10).

The report *Policies on Healthcare for Undocumented Migrants in Switzerland Country Report* further noted that the Swiss National Advisory Commission on Biomedical Ethics supported the Swiss law, remarking “health professionals have a moral duty to provide medical assistance to persons in distress, irrespective of their residence status and irrespective of any political regulations” (Bilger & Hollomey, 2011, p. 15). The report highlighted some debates surrounding health insurance coverage for UDMs, as a 2010 motion by a representative of the Swiss People’s Party opened a debate on the right of UDMs to health insurance by “pointing to the fact that health insurance coverage conflicts with the duty of the state to control immigration;” the Federal Council rejected the motion by “clarifying that access to high quality care for the entire population represents a major social progress that should not be restricted” (Bilger & Hollomey, 2011, p. 16). While the law might support access, the report found that “evidence shows not all UDMs may be able to take out health insurance or practice” (Bilger & Hollomey, 2011, p. 16). For those that do not receive coverage, the report described that they have to bear the full costs of the treatment, with the exception of emergency care. In reality, the cantons and municipalities “are free to regulate the condition of the right to basic healthcare, as long as they keep the minimum threshold as defined in Article 12 of the Swiss Federal Constitution” (Bilger & Hollomey, 2011, p. 17).

In Switzerland, research focusing specifically on reproductive healthcare for UDM women was less prevalent. A report, *The Reproductive Health of the Migrant Population in Switzerland and in other selected host nations*, conducted by the National Programme Migration and Health from the Federal Office of Public Health, found that “pregnancy terminations are more frequent in the migrant population, especially for women without papers” (Merten & Gari, 2013, p. 2). In addition, the report also noted that “the migrant population in Switzerland is
unable to realize its health potential in the area of reproductive health” (Merten & Gari, 2013, p. 2). In Healthcare and illegality: a survey of undocumented pregnant immigrants in Geneva, among pregnant immigrants in Genève, similar results were found in that among 134 pregnant and undocumented women who attended a free antenatal facility (the majority were educated, young, Latin-American women living in poor housing conditions and wages below the legal minimum), “83% of pregnancies were unintended with 70% due to lack of contraception” (Wolff et al., 2005, p. 2149). Further, a study, Sexual and Reproductive Health Behaviors of Undocumented Migrants in Genève: A Cross Sectional Study, discovered that out of 313 mainly young, Latin American, single, well-education, and currently working women surveyed, they had multiple partners and reported frequently engaging in sexual intercourse with rare use of contraceptive methods or protection against STIs (Sebo et al., 2011, p. 510). As a result, “nearly half of the women had had at least one inducted abortion, 40% had had an unplanned pregnancy, and one in four participants reported a current or past STI or other genital infection.” The study called for “specific sexual and reproductive educational programs targeting this hard to reach population of UDM women” (Sebo et al., 2011, p. 515).

Minimal research existed on the topic of FGM for undocumented women. A report by the Federal Office of Public Health, Prevention, care, protection, and intervention in female genital mutilation/circumcision in Switzerland, “reported that the number of girls and women living in Switzerland who have been or are at risk of being circumcised is currently estimated at around 10,000 and is mainly the result of persistent migration” (De Pietro et al., 2014). In Switzerland, all forms of genital mutilation have been prohibited since July 1 2012 under Article 124 of the Swiss Criminal Code. In parallel, “the Roth-Bernasconi motion (2005) requires the implementation of prevention, care, protection, and intervention measures in the field of FGM” (De Pietro et al., 2014). The report recommended implementations referring to “the work on awareness-raising and prevention, to the care of individual who have to deal with FGM, and to measures in the fields of protection and intervention” (Di Pietro et al., 2014). A study published
in 2002, *Female genital mutilation in Switzerland: a survey among gynecologists*, found that among Swiss gynecologists, “20% reported having been confronted with patients presenting with FGM” (Jäger, Schulze, & Hohlfeld, 2002, p. 259). In addition, gynecologists were “occasionally asked about the possibility of performing FGMs in Switzerland, however no activity concerning FGM is reported by health authorities in the Cantons” (Jäger, Schulze, & Hohlfeld, 2002, p. 262). FGM is not taught in the curriculum of Swiss medical schools. Another finding was that prevalence was higher in the French speaking part of Switzerland, which could be explained by the fact that French is spoken in many sub-Saharan countries (Jäger, Schulze, & Hohlfeld, 2002, p. 262). The study noted that even though cases of FGM are few in Switzerland,

Physicians can play a key role in prevention since they have closer contact with the affected group than any other professional group and when facing FGM, physicians are not only confronted with a legal and medical issue but also with an ethically and culturally sensitive issue (Jäger, Schulze, & Hohlfeld, 2002, p. 263). Thus, the study called for improvement of care by proper education and health care providers.

A 2005 study, *Female genital mutilation in the context of migration: experience of African women with the Swiss health care system*, found that

The fact that health care providers rarely see such patients and the absence of professional guidelines gives rise to misunderstandings, such as counseling of the women is often inadequate and there is a striking lack of communication about FGM between health care providers and users as well as within the women’s communities (Thierfelder, Tanner, & Kessler Bodiang, 2005, p. 86).

The findings of the study were that at present,

The specific gynecological and obstetric healthcare needs of migrant women who have undergone FGM are not adequately addressed in the Swiss health system; the situation could easily be improved as the women surveyed suggested receiving more information about what to expect during delivery and more emphatic care, especially in terms of
doctors taking time for discussions during consultation (Thierfelder, Tanner, & Kessler Bodiang, 2005, p. 86).

A 2014 study, *Missed opportunities for diagnosis of female genital mutilation*, investigated missed opportunities for diagnosing FGM at the Department of Gynecology and Obstetrics at the Hôpitaux Universitaires de Genève (HUG) between 2010 and 2012. The study found that “in 48 cases (37.2%), FGM was not mentioned in the medical file, in 34 (26.4%) women the diagnosis was correct, and in 28 cases (21.7%), FGM was identified but erroneously classified” (Abdulcadir et al., 2014, p. 257). Thus, the researchers noted that “opportunities to identify FGM are frequently missed and measures should be taken to improve FGM diagnosis and care” (Abdulcadir et al., 2014, p. 256).

**Research Questions**

PICUM (Platform for International Cooperation on Undocumented Migration) released a report, *Undocumented Migrant Women’s Lack of Access to Justice in Europe*, calling for countries to realize that

Migration is not a gender-neutral phenomenon and that the integration of a gender perspective is, therefore, essential to the analysis of the position of female migrants and the development of policies to counter discrimination, exploitation, and abuse (PICUM, 2013).

This research paper follows the framework outlined in PICUM’s report, viewing undocumented migration in Switzerland from a gendered perspective. The question explored throughout the paper is: does the legal right of UDM women to access reproductive healthcare in Switzerland translate to equitable, affordably, adaptable, accessible, and adequate healthcare? The sub-question is: how is reproductive healthcare provided for particularly stigmatized undocumented populations in Switzerland who have the same legal right to access healthcare: victims of FGM? While research has been conducted by the Federal Office of Public Health, Médecins du Monde,
and PICUM on the legal right of UDMs in Switzerland to access reproductive healthcare, few reports have solely taken a gender perspective to UDMs’ access to healthcare and no reports focusing on reproductive healthcare access by migrant women have also incorporated a human rights framework. This research uniquely takes both a top-down and bottom-up approach, examining human rights legal policies and frameworks, provision of reproductive healthcare to UDM women, and then the experiences of UDM women working with legal organizations and healthcare providers to exercise their right to access reproductive healthcare in Switzerland.

Minimal research has been conducted on UDM women who are victims of FGM, thus shining light on a particularly vulnerable population and challenges in their accessing of healthcare in Switzerland.

Research Methodology

As the debates around UDMs peaked in the 1990s in Switzerland, it is clear that UDMs have been arriving in Switzerland for some time and continue to arrive, thus the situation and nature of undocumented migration in Switzerland is fluid. To conduct research capturing the evolution of legal and healthcare policies surrounding UDM women’s access to healthcare in Switzerland, the data used was a combination of primary and secondary sources, combining research reports that offered an analysis on undocumented migration in Switzerland with an interactive approach of formal and informal interviews to expand on the intersections of law and reproductive health for UDM women in Switzerland. Reports analyzed were those conducted by organizations with a focus on either human rights and undocumented migration, undocumented migration and healthcare, or on undocumented migration and reproductive healthcare: Médecins du Monde, Swiss Federal Office of Public Health and the National Program on Migration and Health, PICUM (Platform for International Cooperation on Undocumented Migrants), Nowhereland, the Swiss Forum for Migration and Population Studies, UN High Commission for Human Rights, and the International Centre for Migration Policy Development.
With the nature of my research focusing on the intersection of macro-level policies (law and healthcare) with the micro-level providing of reproductive healthcare, data was obtained through experts and reports at both levels. At the macro-level, experts on the legal right of migrants to access healthcare were interviewed from the Université de Neuchâtel and the Université de Genève Faculté de Droit. In addition, the research report complied by the Faculty of Law at the Université de Genève, Les droits des femmes sans statut légal à Genève, was used to provide an overview of the laws surrounding the rights of UDM women in Genève, which generally also pertained to Switzerland as well. I attended a conference on Undocumented Migrant’s Legal Access to Healthcare in Switzerland sponsored by the Medical Anthropology Society of Switzerland where experts from around Switzerland discussed the legal and health policies surrounding UDMs’ access to healthcare from both a human rights and access perspective. Specifically focusing on healthcare policies, experts were formally interviewed from the Université de Genève and Consultation ambulatoire mobile de soins communautaires, CAMSCO (HUG), and Meditrina (a medical center for sans-papiers in Zurich run by the Swiss Red Cross).

In moving to observing the provision of reproductive healthcare and the facilitation of UDM women’s right to access reproductive healthcare in Switzerland, formal and informal interviews were conducted with healthcare professionals (CAMSCO and HUG Santé Sexuelle et Planning Famillial) and organizations in both health (Meditrina, EPER, Fondation Profa, Sante Sexuelle Suisse) and legal assistance (EPER and Caritas). Focusing on the provision of reproductive healthcare for UDMs who suffer from FGM, formal and informal interviews were conducted with the Hôpitaux Universitaires de Genève (Gynecology and Santé Sexuelle et Planning Famillial) and Terre des Femmes. Through the assistance of the Centre hospitaliser universitaire vaudois, I attended a support group for UDM women and was able to observe UDM women speak about their experiences accessing healthcare. The research on reproductive healthcare for UDM women in Switzerland was scarce, particularly for FGM, so the majority of
the data was obtained through formal and informal interviews and was supplemented by journal articles and research reports.

My approach to data collection centered mainly on formal and informal interviews, as few publications existed combining the different frameworks of my research: law (human rights) and reproductive healthcare for UDM women. In addition, the literature that existed was mainly from around 2011, as updated statistical information has not been compiled, so the main way to obtain current information on UDMs’ access to reproductive healthcare in Switzerland was through interviewing experts at the macro and micro levels. Due to time constraints, the majority of interviews that were conducted outside of Lausanne and Genève were informally conducted via email or telephone. A questionnaire was devised for each of the three types of experts interviewed: legal assistance organizations, healthcare facilities, and policy experts. The same questions were used for each expert interviewed from one of the three types with minimal changes due to the specific area of focus of the expert.

Ethical considerations were taken into account during the process of every interview. Interviews were conducted with interviewees selected based upon their knowledge of human rights law for UDMs, health policy and healthcare in Switzerland for UDMs, reproductive health for UDMs, legal assistance for UDMs, and reproductive health treatment for FGM. Interviewees must have been willing to speak frankly on the subjects detailed above but maintain anonymity if worried about their views being associated with their name. Interviewees were contacted via email and/or telephone and were informed about the nature of my research. In-person interviews were organized with each interviewee at the location of the interviewee’s choosing to ensure the comfort of the interviewee.

Before each interview commenced, the interviewee was again informed about the subject of my research and research intentions, was presented with a consent form, and was informed that the interview could be stopped at any time if he/she did not feel comfortable answering questions. During the interview, I observed the participant’s body language and manner of
speaking to assess their level of comfort and asked questions accordingly. Based upon the interviewee’s preference, the interview was either conducted in French or English and the interview was either recorded or notes were taken by hand. Each interview was coded using the same framework of information pertaining to: human rights law, health policy in Switzerland for UDMs, healthcare for UDMs, reproductive health, legal assistance, and FGM. Each interview was divided into the relevant coding frameworks in order to approach each interview in a standardized way and reduce bias on the part of the researcher when analyzing each interview. Twenty-five interviewees were contacted with a non-response rate of 52% to have a total of twelve informal or formal interviews conducted. I was upfront with each interviewee about the other organizations that I was speaking with for my research so as to be transparent about the other interviewees and sources of information in my paper. Additionally, I offered each interviewee access to my final report if desired.

In addition, ethical policies were consulted when I observed a support group for UDM women in Lausanne with Ms. Julie Maillard, a social worker from Centre hospitalier universitaire vaudois. An IRB review proposal was submitted and approved before my research began. Ms. Maillard knew the social worker who was running this particular support group, so prior to my arrival at the meeting, my presence at the support group was known and approved for observational purposes. During the support group, Ms. Maillard introduced the topic of my research to the support group and then I presented to the group my research question, why I was observing the meeting, and my intentions for attending the meeting. I believe that in further pursuits of this research subject, interviews should be conducted with UDM women, but due to the logistical timing constraints of my paper I was unable to follow up with the UDM women from the support group to speak with them one on one. In order to interview UDM women, a great deal of ethical considerations would need to have been taken into account, ensuring that the rights of the participant were recognized and supported.
Analytical Framework

The main concepts explored throughout this paper are human rights, what it means to be an UDM in Switzerland, healthcare laws in Switzerland for UDMs, reproductive healthcare, and access to healthcare for FGM. While access to reproductive healthcare for UDM women is being discussed, it is important to note that my research delved deeper into access in the cantons of Vaud, Zurich and Genève. Before moving to exploring the intersections of these topics, it is necessary to establish the definitions I used in my research and provide some brief background of key concepts.

The Framework for Undocumented Migrants

Who is an UDM? The Universal Declaration of Human Rights, 1948 states that "The use of the term ‘illegal’ should be avoided and instead used ‘undocumented’ in respect of migrants and migration because of its negative connotations with criminality and in acknowledgement that everyone should have the right to recognition everywhere as a person before the law" (UNHCHR, 2015, p. 37). A report, Issues in International Health Policy: Healthcare for Undocumented Migrants: European Approaches, framed UDMs as people who have “entered a country without documentation as well as those whose visas have expired” (Gray & Ginneken, 2012, p. 1). In Switzerland, the definition of an UDM is broken down further as discussed in Access to Healthcare for Undocumented Migrants in Switzerland: People as:

Persons who unlawfully entered Swiss territory, persons who legally enter Swiss territory but remain in the country after the validity of their visa/residence permit has expired (overstayers), persons who cannot renew their residence permit but remain in the country, and unsuccessful asylum seekers who disappear during their asylum procedure, receive a negative decision or whose application was dismissed without entering into substance and who should thus leave the country within a set time limit.
but remain in the country or cannot be removed for other technical reasons (Efionayi-Mäder & Wyssmüller, 2011, p. 2).


The most recent estimate is provided by a study conducted on behalf of the Federal Office for Migration in 2005, which refers to 80,000 to 100,000 UDMs i.e. persons residing in Switzerland without valid residence documents for an unspecified period of time (Bilger & Hollomey, 2011, p. 7).


Typical undocumented workers are young to middle-aged South American females; rejected or dismissed asylum seekers are usually young males from the Balkans, Africa, or Asia; overstayers are typically other third-country nationals who have lost his or her right to stay in Switzerland (Efionayi-Mäder & Wyssmüller, 2011, p. 2).

Further, the report found that “the majority of UDM living in Switzerland are aged twenty to forty and live in urban areas” with “many women from Latin America working in (several) households, while others working in hotels and restaurants, or in the sex industry” (Efionayi-Mäder & Wyssmüller, 2011, p. 2). While many UDM women may be from Latin America, it is necessary to remember that the “population of UDMs in Switzerland is quite diverse with varying health needs” (Y. Jackson, personal communication, 12 November 2015).

*The Framework for the Rights of Undocumented Migrants*

What basic human rights are entitled to UDMs? The Universal Declaration of Human Rights by the United Nations General Assembly in 1948 stated,

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. Everyone is entitled to all the rights and freedoms set forth in this Declaration, without
distinction of any kind, such as race, color, sex, language, religion, political, or other opinion, national or social origin, birth, or other status (UNHCHR, 2015, p. 37).

In addition, a UNHCHR report, *Migration, human rights, and governance*, highlighted that international law on human rights “establishes unequivocally that migrants and members of their families are first and foremost human beings, the holders of universal human rights whose dignity and security require specific protection” (UNHCHR, 2015, p. 43).

The UN Committee on Economic, Social, and Cultural Rights issued Article 12, which establishes the “right to the highest attainable standard of physical and mental health” (Biswas et al., 2012, p. 55). The committee specified the meaning and implications of this provision in General Comment 14, which “while not strictly legally binding, gives an authoritative and comprehensive overview of the meaning and implications of the right to health” (Biswas et al., 2012, p. 54). In addition, UN treaties such as Article 12 of Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and Article 24 of Convention on the Rights of the Child (CRC) grant all women and children a right to health, without regard to legal status (Biswas et al., 2012, p. 54).

What policy allows UDMs to seek healthcare in Switzerland? The Swiss Federal Law on Compulsory Healthcare (LAMal) went into effect on 1 January 1996, introducing a “managed competition scheme across the country with universal coverage in basic health insurance for any person residing in Switzerland for more than three months” (Macherey, Simonnot, & Vanbiervliet, 2015, p. 107). This law applies equally to UDMs regardless of their living status. Under Article 41(1) a and b of the Federal Constitution of the Swiss Federation,

The Confederation and the Cantons shall, as a complement to personal responsibility and private initiative, endeavor to ensure that: every person has access to social security; every person has access to the healthcare that they require (Macherey, Simonnot, & Vanbiervliet, 2015, p. 107).
The Framework for Reproductive Healthcare and FGM

On the topic of healthcare, the WHO defines health as a “state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (WHO, 2015). According to WHO, reproductive health thus

Addresses the reproductive processes, functions, and systems at all stages of life, implying that people are able to have a responsible, satisfying, and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so (WHO, 2015).

Under reproductive healthcare, one topic will be explored: FGM. Female genital multination (FGM) is defined as “a procedure involving partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non therapeutic reasons” (Thierfelder, Tanner, & Kessler Bodiang, 2005, p. 86).

These concepts are crucial to seeing how reproductive healthcare and health policies for UDM women in Switzerland match the Swiss law and legal human rights obligations. Each concept fits into the broader framework of assessing the healthcare system in Switzerland through examining adequacy (sufficiently meeting the needs of UDM women), accessibility (physical healthcare system and insurance), adaptability (to the needs of migrants), affordability (insurance and healthcare), and quality (of the health system and care). The reflection of the fit between macro-level policies and micro-level reproductive healthcare through these five terms will allow for tentative conclusions about the ability of UDM women in Switzerland to exercise their legal right to reproductive healthcare.

Analysis

Examining the Legal Right to Healthcare in Switzerland

In comparison to other European countries, Switzerland’s policy for providing healthcare to UDMs is unique because the legal framework includes UDMs in the provision of healthcare.
However, the fact that the legal framework exists does not mean access to healthcare for all. From my research findings, I will argue that within Switzerland there appears to be a gap between the theoretical and legal right to healthcare for UDM women in Switzerland and the applied access to reproductive healthcare with issues arising due to access and cost, challenges navigating the system, cantonal variations, and issues adapting to the needs of migrants. That being said, through speaking with healthcare providers and those who work directly with UDM women, the fact that these women are undocumented does not mean that they do not try to obtain healthcare and exercise their rights. Migrants shouldn’t be looked at as irregular migrants but migrants in an irregular position or situation. Within Switzerland, being a migrant in an irregular position uniquely means that you have the legal right to access healthcare, however challenges exist in expressing that right and the system should be improved to better integrate UDMs into the Swiss healthcare system.

The healthcare policy in Switzerland for UDMs is quite different given other European countries. Thus, it is important to start by detailing Switzerland’s commitment to human rights and how that plays out in the healthcare policies for UDMs. Switzerland has made a commitment to the implementation of human rights through the ratifying of the UN conventions concerning human rights: ICESCR (social rights), ICCPR (civil rights), convention against racism, convention against torture, convention on women’s rights, convention on children’s rights, and the rights of persons with disabilities (The Swiss Human Rights Portal, 2015). As discussed earlier, Article 12 of the UN Committee on Economic, Social, and Cultural Rights establishes the “right to the highest attainable standard of physical and mental health” and articles of the convention on women’s rights and the convention on children’s rights grant all women and children a right to health without regard to legal status (Biswas et al., 2012, p. 56). In addition, the World Health Organization’s Constitution, which Switzerland is obliged to follow as a WHO member state, established the “right to health,” by enshrining “the enjoyment of the highest attainable standard of health as a fundamental right of every human being” (WHO, 2013). Thus,
Switzerland’s ratifying of UN Conventions establishes in theory that the country should enact laws in alliance with a human rights framework, applying as well to UDMs migrants as “no papers does not mean no rights” (Undocumented Migrant’s Access to Healthcare in Switzerland, conference attended, 10 October 2015).

It is important to analyze Switzerland’s healthcare system for UDMs in terms of how healthcare is provided and the legal access. First, the legal access will be discussed. According to the report, *Access to Healthcare for Undocumented Migrants in Switzerland Policies*, in Switzerland, UDMs have the “right to access basic healthcare when in need, which is guaranteed by the Swiss Federal Constitution and regulated by the Public Health Insurance Law” (Hollomey, 2011, p. 3). Under Article 12 of the Federal Constitution of the Swiss Confederation, “persons in situations of distress have the right to be helped and assisted and to receive the essential resources to lead a dignified human existence” and under article 41b, “the federal state and the cantons are obliged to ensure that everyone has access to the healthcare that they require” (Hollomey, 2011, p. 3). Further, Article 117a1, relating to basic medical care, states that, “within the limits of their respective powers, the Confederation and the cantons shall ensure that everyone has access to sufficient and high quality basic medical care” and Article 118 “enshrines the protection of health, for which the Confederation shall, within the limits of its powers, take measures” (Macherey, Simonnot, & Vanbiervliet, 2015, p. 107).

In addition, Public Health Insurance Law articles 84-86 state that “Insurance companies are not allowed to pass on data on the residence status of their clients” and Swiss Criminal Code, article 321, details that “Persons bound by professional secrecy (health staff) may not report any personal data of a client to third parties” (Hollomey, 2011, p. 3). According to Ms. Denise Effionayi-Mäder (personal communication, 3 November 2015), Université de Neuchatêt, “UDMs are not usually mentioned in the law because they are not supposed to exist in society, however they are covered under many laws in Switzerland, which is a great strength in Switzerland.” All healthcare laws mentioned above apply equally to UDMs and documented
Swiss citizens. In addition, Dr. Sandro Cattacin, Université de Genève, discussed the change in perspective in Switzerland corresponding with the new laws, as “access to health insurance is possible even if you don’t have papers, signaling an acceptance of the urban world” (S. Cattacin, personal communication, 24 September 2015).

While the strength of the existence of the healthcare law should be applauded, the practice of the law needs to be questioned. A report by Médecins du Monde, *Legal Report on Access to Healthcare in 12 Countries*, notes that only authorized residents benefit from social assistance, so others can only exercise their right to “emergency assistance under the terms of Article 12 of the Swiss Constitution” (Macherey, Simonnot, & Vanbiervliet, 2015, p. 111). In addition, although Article 65(1) of the Public Health Insurance Law LAMal states that Destitute UDMs can benefit from the same premium reductions as destitute nationals; this is not possible in all cantons. Indeed, most cantons ask for proof of income tax in order to grant access to premium reductions (Macherey, Simonnot, & Vanbiervliet, 2015, p. 111).

As UDMs do not work legally, they do not pay taxes, so they cannot have access to premium reductions. Problems exist in terms of the definition of Article 12, as a report, *Policies on Healthcare for Undocumented Migrants in Switzerland Country Report*, by the Federal Office of Public Health notes that Article 12 does not define the particular services of benefits to be allocated in order to ensure the right assistance when in need, but the cantons and municipalities are responsible to respond to Article 12 in their respective bodies of law, which may well exceed the absolute minimum threshold set in Article 12 but is subject to interpretation and debate (Bilger & Hollomey, 2011, p. 15).

The report by Médecins du Monde, *Legal Report on Access to Healthcare in 12 Countries*, came to the conclusion that in practice, UDMs “try to obtain health coverage, even if it is expensive, spending most of their wages on private insurance contributions” (Macherey, Simonnot, &
Vanbiervliet, 2015, p. 111). That being said, in practice, UDMs face many difficulties in “respecting the obligation to take out health insurance because of lack of financial means, lack of knowledge of the system, and fear of being reported” (Macherey, Simonnot, & Vanbiervliet, 2015, p. 111). Insurers are required by law to maintain confidentiality with third parties, but in the event of non-payment of premiums, “the insurer initiates a debt-collecting procedure,” which poses an additional risk of being discovered (Macherey, Simonnot, & Vanbiervliet, 2015, p. 112).

Thus, assessing the strengths and weaknesses of the legal framework in Switzerland for providing healthcare for UDMs, it is clear that there appear to be gaps in translating the law to health policy. According to Ms. Efionayi-Mäder (personal communication, 3 November 2015),

In the worst-case scenario where UDMs cannot receive a premium subsidy from the canton to (almost) cover the premium, that means that the system is not fair, i.e. does not guarantee equal access in practice, since it depends on the local context and the information network of the UDM.

Without the subsidies, the costs for “basic health insurance are significant (between 230 CHF to 420 CHF per month as of a 2009 survey) and present a substantial obstacle for UDMs to obtain health insurance” (Hollomey, 2011, p. 3). Raising the question about fairness brings into question the adequacy of the translation from law to healthcare policy to meet the needs of UDMs and the affordability of such a policy. As noted by the report by the Federal Office of Public Health, Access to Healthcare for Undocumented Migrants in Switzerland: Policies, “although the legal framework regulating UDMs’ access to healthcare is quite inclusive in Switzerland, in practice, there exists various problems that prevent effective implementation of the regulations” (Hollomey, 2011, p. 4). The question of implementation of the regulations for UDMs in Switzerland involves different sources of healthcare.
Moving from Healthcare Policy to Practice

Healthcare policies regarding UDMs’ access to healthcare are distributed through three types of practices. According to the report by the Federal Office of Public Health, *Access to Healthcare for Undocumented Migrants in Switzerland: Practices*, the most common type of practice providing healthcare is

Low-threshold medical or social drop-in centers run by non-profit organizations of the private sector, which facilitate access to healthcare for UDM, and sometimes also for other marginalized patients (Efionayi-Mäder & Wyssmüller, 2011, p.3).

The next two types are where services are integrated into public university hospitals (Lausanne and Genève), which provide a wide range of medical/healthcare services that are also accessible to UDM, and publicly co-financed services offering specialized care in specific area of healthcare for specific groups at risk (Efionayi-Mäder & Wyssmüller, 2011). In the opinion of Ms Efionayi-Mäder, a strength of the Swiss healthcare system for UDMs is the combination of the legal framework of the system with “specific complementary facilities for UDMs that have developed overtime in many places” (D. Efionayi-Mäder, personal communication, 3 November 2011). Further, Dr. Yves Jackson from CAMSCO, the integrated service providing UDMs with healthcare in Genève, discussed the beneficial role that “private practitioners, NGOs, and churches play” in expanding healthcare and access among the UDM population (Y. Jackson, personal communication, 12 November 2015). At the same time as the differentiated sources of care is a strength for providing care for UDMs, problems also arise.

“UDMs are hard to reach or are they easy to miss?” (Y. Jackson, personal communication, 12 November 2015). That was a question presented by Dr. Jackson regarding providing care for UDMs in Switzerland. The reality is that throughout Switzerland, according to the report by the Federal Office of Public Health, differences between cantons exist and “are not only due to the particular profile of the UDM population, but also due to the prevailing political opportunity structure” (Efionayi-Mäder & Wyssmüller, 2011, p. 5). According to the report, as
well, over the past decade, specialized counseling and care facilities for UDM “were set up in most bigger cities and in 10 of the 26 cantons, taken largely by the private sector targeting vulnerable populations (UDM)” (Efionayi-Mäder & Wyssmüller, 2011, p. 3). Thus, many services were created aimed at facilitating access to healthcare for UDM and “were able to gain at least limited public support to them” (Efionayi-Mäder & Wyssmüller, 2011, p. 3). Ms. Linda Stoll, a provider of healthcare at the NGO Meditrina, points out that

Only Genève and Lausanne have particular clinics that are integrated in the public health system (funded by the government) accepting UDM’s, while all other parts of Switzerland have particular clinics that are funded and run by NGOs, who face problems in the funding of services (L. Stoll, personal communication, 5 November 2015).

This point was reinforced by Ms. Efionayi-Mäder, who commended the role of low-threshold centers run by NGOs or the private sector, like Meditrina, for “facilitating access” (D. Efionayi-Mäder, personal communication, 3 November 2015). A challenge, in the eyes of Dr. Jackson is that “public funders are not very motivated to subsidize the costs for people who are here but not existing legally, creating tension in resource allocation to people not a part of the system” (Y. Jackson, personal communication, 12 November 2015). Thus, while the three pronged system works to facilitate access to healthcare for UDMs, challenges still exist in terms of the sustainability of the differentiated system and its lack of integration in the mainstream healthcare system to provide care for UDMs, creating challenges in accessibility of care, adequacy of services to meet their health needs, and quality of care for UDMs in different cantons.

**Tracing the Human Rights Based Policy to Reproductive Healthcare**

For UDM women, where do they fall in the process of the translation from law to healthcare policy in Switzerland in their accessing of reproductive healthcare? Recently, the Université de Genève Faculté de Droit published a brochure, Les droits des femmes sans statut
légal à Genève, with the goal of “expanding UDM women’s access to rights” (Université de Genève Faculté de Droit, 2015, p. 2). Ms. Djemila Carron (personal communication, 4 November 2015), Université de Genève Faculté de Droit, remarked that in Switzerland, “undocumented women have rights but need to make these rights work in practice.” With 26 different cantons and varying policies throughout Switzerland, it can be difficult for UDM women to navigate the legal system and how their legal rights should be translating into rights to healthcare, as the introduction to the brochure noted, “the main difficulty that meets women without legal status constitutes asserting her rights, being given the risk to see their status given to the migration authorities” (Université de Genève Faculté de Droit, 2015, p. 2). The brochure answered frequent questions received by organizations that work with UDM women, “helping to consolidate information and facilitating access,” according to Ms. Carron (D. Carron, personal communication, 4 November 2015).

Regarding sexual and reproductive rights, the brochure informed UDM women: that they can address concerns to the Santé Sexuelle et Planning Familial at HUG, of the services it can respond to, and where and how much it costs to obtain a pregnancy test or emergency contraception. Tools such as this brochure help make the transition between law to healthcare policy and reproductive healthcare for UDM women accessible, facilitating the accessibility of healthcare. However, the tool is currently only available in French and the process of still disseminating information regarding rights to UDM women continues to be a great struggle. The question then remains: what is offered when UDM women try to access reproductive healthcare and exercise their right?

For UDM women, reproductive healthcare adds an additional stress to the already vulnerable situation they are in, highlighting the need for healthcare facilities to meet their reproductive health needs. According to Dr. Jackson of CASMCO (personal communication, 12 November 2015), “UDM women come to Switzerland with diverse sexual health behavior practices and different epidemiology on disease and infections.” Past research on reproductive
healthcare for UDM women in Switzerland found inequities in accessing contraception, leading to higher rates of induced abortions, and inequities in knowledge about sexual and reproductive health, resulting in lacking prevention and increased rates of STIs, calling for increased sexual and reproductive health education (Merten & Gari, 2013). During my research, I interviewed healthcare providers at both NGOs and specific complementary health clinics for UDMs about the providing of reproductive healthcare to see the health needs and successes and challenges of providing care: HUG, CAMSCO and Santé Sexuelle et Planning Familial, (Canton Genève), Fondation Profa (Canton Vaud), Meditrina (Canton Zurich), and Santé Sexuelle Suisse (across Switzerland). In the following paragraphs, each organization will be described and then overall obstacles will be assessed.

In the canton of Zurich, Meditrina is a small NGO funded by the local Red Cross in Zurich that offers direct medical care and social counseling; it is the last point in the Eastern direction of Switzerland for UDMs to access care from a facility dedicated specifically to providing care for UDMs. At Meditrina, care for general medicine is offered, so particular services regarding reproductive healthcare for UDM women, according to Ms. Linda Stoll of Meditrina (personal communication, 5 November 2015), “are provided by Gynäkologische Sprechstunde in Zurich or to other gynecologists working with us.” Further, Ms. Stoll notes that “generally, undocumented women have the same needs (prevention, family planning, STIs) like other women. In particular cases of unwanted pregnancies, we organize safe abortion with reduced fees” (L. Stoll, personal communication, 5 November 2015).

Fondation Profa is an NGO focused on providing reproductive healthcare in the canton of Vaud. A specific element of their work is called migration intimité, which is focused on “prevention and promotion of reproductive healthcare among migrants with a community approach” (C. Nkanga Bokembya, personal communication, 10 November 2015). Mr. Claude-Isofa Nkanga Bokembya from Fondation Profa noted that the UDM population his organization serves is mainly Africans and Latin Americans, with “African UDMs having a high rate of HIV
and STIs and undocumented Latin American migrants having increased rates of abortions” (C. Nkanga Bokembya, personal communication, 10 November 2015). The Fondation works with UDMs and speaks to them in different spaces, such as Center EVAM (site in canton Vaud for providing information to migrants) and Point d’Eaux in Lausanne, which provides hygiene, health, and guidance to poor or disadvantaged individuals regardless of their legal status (C. Nkanga Bokembya, personal communication, 10 November 2015). According to Mr. Nkanga Bokembya, the foundation takes “a global approach with a focus on sexual and reproductive health working with other services to spread information among the UDM population” (C. Nkanga Bokembya, personal communication, 10 November 2015).

At Santé Sexuelle Suisse, a public interest foundation with the goal of promoting sexual and reproductive health in Switzerland, their focus is on expanding sexual health education. According to Ms. Christine Sieber (personal communication, 20 October 2015), Santé Sexuelle Suisse, the foundation recently launched, Sexual Health info, a website that provides comprehensive and up-to-date information on a wide range of sexual health issues in more than 10 languages, with topics including: contraception and the different contraceptive methods, pregnancy, abortion, and sexually transmitted infections.

Ms. Sieber emphasized that “starting next year, the project will be communicated towards the migrant population in Switzerland, including organizations specifically focused on providing care to UDMs” (C. Sieber, personal communication, 20 October 2015). Thus, through this foundation, an initiative will be taken throughout Switzerland in the coming years to expand awareness of sexual health. The spreading of knowledge is something that Dr. Jackson at CAMSCO in Genève emphasized as “educating and including UDM women in sexual and reproductive healthcare in Switzerland is more protective to public health than excluding them” (Y. Jackson, personal communication, 12 November 2015).
In canton Genève, CAMSCO, a specific healthcare clinic affiliated with HUG offering care for migrants, works with the unit of Santé Sexuelle et Planning Familial at HUG, which focuses on psychosocial support, to provide reproductive healthcare for UDM women. At CAMSCO, 60% of the patients seen are women, bringing women’s healthcare needs to the forefront of their work (Y. Jackson, personal communication, 12 November 2015). At Santé Sexuelle et Planning Familial, in the last year, 14.5% of its patients were undocumented women (L. Bettoli Musy, personal communication, 9 October 2015). CAMSCO focuses on early detection of pregnancy, identifying and treating STIs, and the emotional needs and well-being of reproductive bearing age women. Santé Sexuelle et Planning Familial provides free consultations about contraception, information to women about abortion and those seeking support during the process, advice for gynecological problems, and information about sexuality. The majority of women who visit the unit are Latin American or African. According to Dr. Jackson from CAMSCO,

The vast majority of UDM women come in for general reproductive health problems, but because of the fact that UDMs are a high risk group, they have different types of suffering and require the need for detection and screening for additional reproductive health risks (Y. Jackson, personal communication, 12 November 2015).

Ms. Lorenza Bettoli Musy from Santé Sexuelle et Planning Familial at HUG felt similarly, noting that

The biggest health needs for UDM women are in the area of contraception, as a large problem in Genève and in Switzerland is that UDM women are three times more likely to have an abortion than the rest of the population due to a lack of information and accessibility (L. Bettoli Musy, personal communication, 9 October 2015).
Excluding Shortcomings in Providing Reproductive Healthcare

These different healthcare providers highlighted the strength that reproductive healthcare is being provided for UDM women in Switzerland, yet Ms. Bettoli Musy’s comment brings up the need to question the ability for women to use these services that exist in the system and at what challenges from the framework of access, adequacy, adaptability, affordability, and quality.

Before examining obstacles when UDM women seek healthcare, interviewees mentioned the fact that for many UDM women, seeking care for reproductive healthcare “is not a priority.” According to Mr. Nkanga Bokembya, “services exist but UDMs don’t go because they don’t see the problem as immediate” (C. Nkanga Bokembya, personal communication, 10 November 2015). Similarly, Ms. Bettoli Musy noted,

Migrant people before coming here have problems in terms of where to live, the job, and the money, so among these problems of how to live, find a job, eat, and send money home, health is not a priority – it should be a priority but it is not (L. Bettoli Musy, personal communication, 9 October 2015).

In addition, UDM women might also experience challenges accessing the healthcare system for reproductive healthcare because of the availability of care in different cantons. Meditrina is the last specialized care facility for UDMs in the Eastern direction of Switzerland, showing inequities in the quality of care available in different cantons and at times a sheer lack of accessibility. If UDM women make it to the healthcare system for reproductive health, they might struggle to fully enter into the system due to problems of cultural adaptability. Dr. Jackson discussed the role of culture in sexual health in that “it is very different how to talk to types of UDM women about sexual health because you have to be planned in how to approach the topic and adapt to cultural competencies” (Y. Jackson, personal communication, 12 November 2015). Further, Mr. Nkanga Bokembya mentioned problems with services not adapting to the needs of migrants as for instance, “a woman wants an abortion and she is from Brazil and the healthcare professional has never performed an abortion on a woman from Brazil, so her needs might not be
met due to cultural discrepancies in care” (C. Nkanga Bokembya, personal communication, 10 November 2015). Santé Sexuelle Suisse recently released a guide, *Le Conseil En Santé Sexuelle et Reproductive Pour Les Migrants et Les Migrants: Guide à l’usage des professionnels*, for professionals on providing sexual and reproductive health for migrants, noting the importance of “intercultural mediation and concerns about the confliction between their traditional family values from their home culture and that of Swiss society” (Sieber, 2014, p. 2). Thus, this guide is a sign of a step to make reproductive healthcare culturally accessible for UDM women and bridge some gaps in their seeking of reproductive healthcare, yet it will be seen how effectively this guide is implemented.

Making reproductive healthcare culturally adaptable in Switzerland is needed for care to be more accessible to UDMs, yet experts also discussed the large roles both price and language play in hindering accessibility. According to the guide from Santé Sexuelle Suisse,

A large proportion of the migrant population have difficulty passing through the threshold of services of health and have struggled to obtain contraceptives, financial means to pay for care, insurance, and access information (Sieber, 2014, p. 5).

Though UDMs can access healthcare insurance in Switzerland and even if they do not have insurance they can still access care, challenges still exist in terms of the costs of exercising care through receiving subsidies and the costs of care without health insurance, which have previously been discussed. Ms. Bettoli Musy discussed the role that language plays in impeding access, as “if UDM women don’t know the language, they can have trouble accessing the system” (L. Bettoli Musy, personal communication, 9 October 2015). Additionally, she mentioned the “possibility of migrant persons to access a translator to be sure she can communicate with the healthcare provider as it is easier for the woman to explain her problems in her same language” (L. Bettoli Musy, personal communication, 9 October 2015). The use of translators improves access to healthcare and a report, *Summary: The reproductive health of the migrant population in Switzerland and in other selected host nations*, by the National
Programme Migration and Health in Switzerland offered the recommendation that throughout Switzerland for reproductive healthcare providers for UDM women, “interpreter services should be reachable 24/7,” however in reality the accessibility of translator services appears to vary (Merten & Gari, 2013, p. 3). Barriers still exist in finding a “common language with UDM women both linguistically and culturally” (Undocumented Migrant’s Access to Healthcare in Switzerland, conference attended, 10 October 2015).

Upon examining access to reproductive healthcare for UDM women through issues of accessibility, adaptability, and affordability, it is clear that challenges still exist in adequacy – providing care to meet the reproductive health need of the UDM population. That being said, many of the organizations I spoke with talked about the strengths of forming close connections with UDM women and working with fellow organizations to facilitate the process of accessing reproductive care as an UDM woman. Dr. Jackson discussed how in terms of reproductive health, CAMSCO has taken a “primary care approach, seeing the person as a whole having physical, mental, and social contexts in mind, and trying to advance different dimensions and connect people with appropriate partners” (Y. Jackson, personal communication, 12 November 2015). Ms. Bettoli Musy discussed how Santé Sexuelle et Planning Familial

Created a project, Ambassadrice, which brings women from a lot of different communities and explains to them about sexual and reproductive health to take back to their communities, turning them into persons of reference and then following up with them to assess the situation in their communities (L. Bettoli Musy, personal communication, 9 October 2015).

The community based approach appeared to be a successful one based upon my interviews in terms of approaching the perceived taboo nature of sexual and reproductive healthcare, as Mr. Nkanga Bokembya mentioned the importance of confidentiality and trust, “going to churches and working with the community in order to gain their trust to have them come to healthcare facilities and receive reproductive healthcare” (C. Nkanga Bokembya, personal communication,
10 November 2015). For UDM women in Switzerland, it appears that navigating reproductive healthcare involves working with different organizations that help direct the UDM women to the appropriate, adequate resources to meet their needs.

**Within Reproductive Healthcare: How to Know One’s Rights and Navigate the System**

From my discussions with experts, it seems that some UDM women are aware of facilities to seek out to access reproductive healthcare, while others enter into the system through larger organizations, specifically dedicated to assisting migrants. According to Mr. Nkanga Bokembya, a challenge is that “some UDM women are aware of Fondation Profa but see it as only offering contraceptives and don’t know that they can access it for other services” (C. Nkanga Bokembya, personal communication, 10 November 2015). Thus, organizations like EPER and Caritas work with UDM women to aid them in the process of navigating the healthcare system and empowering them to exercise their legal rights to healthcare. Ms. Gaelle Martinez from EPER noted that “the healthcare situations are different for people according to the varying problems of their lives, so it is important to connect them to other organizations” (G. Martinez, personal communication, 2 November 2015). EPER works as a point of “first access,” then directing UDM women to the proper resources to meet their needs, like CAMSCO (G. Martinez, personal communication, 2 November 2015). Similarly, Caritas has a team of both lawyers and social assistants to “talk with people about their needs and direct them to the appropriate resources” (Caritas, personal communication, 27 October 2015). For instance, in the case of a

Woman UDM who has been living in Switzerland for a long time and suddenly develops cancer, many times there are ways she can change her legal status to have her health insurance fees taken care of (Caritas, personal communication, 27 October 2015). In addition, Caritas works to educate UDM women about their rights, as “many are unaware of the legal system and their legal right to access care” (Caritas, personal communication, 27
October 2015). While there might still be challenges within the healthcare system in Switzerland in terms of accessing reproductive healthcare as an UDM, organizations seem to be taking a multifaceted approach to helping direct migrants to adequate resources, as “once in the healthcare system it generally speaking works but the problem is getting into the healthcare system, knowing how to do it, and how to pay for it” (Undocumented Migrant’s Access to Healthcare in Switzerland, conference attended, 10 October 2015).

**Case Study: UDM Women’s Access to Reproductive Healthcare for FGM**

Throughout a few of my interviews with providers of reproductive healthcare, they discussed seeing cases of UDM women who are victims of FGM. Within this sub-population of UDM women who have three levels of vulnerability and added challenges (being undocumented, a woman needing reproductive healthcare, and a victim of FGM), how does their legal right to healthcare translate to access on the ground? According to the NGO, Terre des Femmes, which works with victims of FGM, “UDM women directly affected don’t call the NGO because it is a taboo topic to call a stranger to talk about,” so instead, it is usually “a social worker who is the contact link” (M. Birri, personal communication, 9 November 2015). Ms. Marisa Birri from Terre des Femmes (personal communication, 9 November 2015) highlighted

Some good examples of services treating and counseling, however those only occur in a few places and it depends on the initiative of an interested healthcare provider, so it is not a topic where the policy for care is institutionalized in Switzerland.

Further, in the big hospitals, such as: Lausanne, Genève, Bern, Neuchâtêl, gynecologists and midwives are sensitized on these issues and how to talk about them, but beyond these hospitals “care and training is minimum” (M. Birri, personal communication, 9 November 2015).

Dr. Jasmine Abdulcadir at Hôpitaux Universitaires de Genève is one of those doctors who has made FGM her focus area. Since 2010, at the HUG, there has been a clinic solely focused on assisting victims of FGM. The clinic has seen “roughly 15 patients per month usually
for clitoral reconstruction, defibulation, or to take care of complications of FGM during pregnancy” (J. Abdulcadir, personal communication, 10 November 2015). The majority of the women who visit the clinic are from “Eritrea, Sudan, Somalia, and East Africa, with those from Guinea particularly not having health insurance and normally visiting the clinic with a check from CAMSCO that they can spend there” (J. Abdulcadir, personal communication, 10 November 2015). Further, Dr. Abdulcadir reinforced the remarks of Ms. Birri in noting that “clinical recommendations in Switzerland on FGM have not been updated since they were published on 2005” (J. Abdulcadir, personal communication, 10 November 2015). She remarked that victims of FGM are “a vulnerable population that can’t complain about quality of care,” so increased research is needed to see how the healthcare system and policies in Switzerland can best meet their needs (J. Abdulcadir, personal communication, 10 November 2015). Within HUG, by next year, all healthcare professionals will receive training about FGM,

After a study, Missed opportunities for the diagnosis of female genital mutilation, conducted by Dr. Abdulcadir and colleagues found that among 129 women with FGM who visited the Department of Gynecology and Obstetrics at the Hôpitaux Universitaires de Genève between 2010 and 2012, in 48 cases, FGM was not mentioned in the medical file (Abdulcadir et al., 2014, p. 257).

Similarly, Terre des Femmes offers training for health professionals and social assistants on FGM. Thus, for UDM women who are victims of FGM, issues exist in terms of quality of care beyond the large university hospitals and even if women do access care, it might not be adequate if they do not go to a healthcare provider that specializes in FGM because of a lack of training and awareness among healthcare professionals to diagnose and treat FGM.

**Conclusion**

Moving from the legal human rights framework regarding UDMs’ access to healthcare to the health policy in Switzerland for UDMs to the provision of reproductive healthcare for UDM
women and specifically to those who are victims of FGM has illuminated both strengths and shortcomings of the enactment of UDM women’s human right to access reproductive healthcare in Switzerland. The UN Committee on Economic, Social, and Cultural Rights established the “right to the highest attainable standard of physical and mental health” for all regardless of legal status (Biswas et al., 2012, p. 55). In Switzerland, that right has been followed in policy as compulsory healthcare in Switzerland (LAMal) applies also to UDMs who have the right to “access the healthcare that they require” (Hollomey, 2011, p. 2). However, experts discussed the key challenges for migrants to enact their human right to healthcare afforded to them in the health policy due to the high costs of health insurance premiums and challenges due to their irregular stay in Switzerland to receiving subsidies in different cantons. For this reason, Ms. Efionayi-Mäder has called for “access to subsidies to be facilitated in the cantons and for increases in cases where subsidies only cover part of the premium” (D. Efionayi-Mäder, personal communication, 3 November 2015). A change along these lines would help make the transition from human rights to healthcare policy in Switzerland a reality for UDMs.

Delving further into healthcare policies in Switzerland for UDMs, it becomes clear that cantonal differences still remain a large problem in sustainably providing healthcare for UDMs. The three-pronged system both facilitates access to healthcare for UDMs, while still leaving their healthcare for the most part (other than Lausanne and Genève) separate from the mainstream healthcare system, creating challenges in accessibility and adequacy of services to meet the needs of UDMs. Brochures such as the one produced by the Université de Genève Faculté de Droit help to make the transition between law to healthcare policy and reproductive healthcare for UDM women accessible, however success of the dissemination of this tool and similar information remains to be seen. A similar combination of praise for the variety of providers assisting UDMs to access reproductive healthcare and shortcomings in terms of accessibility, adaptability, adequacy, affordability, and quality was seen when examining UDM women’s access to reproductive healthcare in Switzerland and speaking with experts. It appears that many
UDM women do not access the healthcare system for reproductive healthcare, as among other stressors of their irregular situation, reproductive health is not seen as a priority.

For those that make their way to reproductive healthcare providers, which is not an equally accessible feat due to cantonal differences in the accessibility of healthcare providers, finding a common language linguistically and culturally proves to be a problem in terms of access and adaptability. In addition, costs of reproductive healthcare for UDM women who do not have insurance and the general costs of health insurance continued to appear in interviews due to the challenges of affordability and accessibility of the healthcare policy as mentioned above. The challenge of the cost of healthcare due to the feasibility and accessibility of insurance premiums and subsidies varies greatly by canton. Lastly, it appears that some UDM women lack knowledge of the healthcare system in order to access reproductive healthcare, so organizations like EPER and Caritas work with UDM women to direct them to appropriate resources while at the same time educating them about their right to access care. Focusing on the sub-group of UDM women, who are victims of FGM, shortcomings are magnified. These include a lack of uniform and updated health policy in place for the treatment of victims of FGM throughout Switzerland, a lack of knowledge among healthcare professionals on how to diagnose and care for FGM, and inequities in quality of care beyond large university hospitals in Switzerland.

Thus, tracing the human right to access healthcare for UDMs all the way down to the provision of care for UDM women who are victims of FGM in Switzerland from the framework of adequacy, adaptability, accessibility, affordability, and quality, points for the need for a more integrated system of healthcare for UDMs throughout Switzerland. In cities such as Genève and Lausanne, this is already the case, but my research found that large variations exist between cantons. According to Ms. Efionayi-Mäder (personal communication, 3 November 2015), “I would plead for better integration in the mainstream care system, which does not mean that complementary services should not be available for those who somehow do not find their way into the system.” Thus, particular services that focus on directly aiding UDMs would still
continue, but with a more integrated general system to providing healthcare for UDMs. Dr. Jackson touched upon the need to have an integrated system, such as CAMSCO, as a risk of working with different partners to provide reproductive healthcare for UDMs is that “you make things more complicated, so I see CAMSCO as acting as case managers that keep the lead and ask for specific advice or services from other partners” (Y. Jackson, personal communication, 12 November 2015). Based upon my research, in theory with the incorporation of cultural sensitivity education for healthcare providers, the accessibility of interpreters, policies facilitating the access to subsidies in the cantons, and organizations helping UDM women navigate the healthcare system, UDM women’s experience seeking reproductive healthcare in Switzerland could be more aligned with their human right to access healthcare and the Swiss healthcare policy supporting this right.

From my research, I believe it is important to highlight two different narratives. Firstly, it is important to both praise the healthcare system in Switzerland for being grounded in “basic human rights, ethics, and equity,” yet tracing the law through the policy to the provision of reproductive healthcare revealed gaps that need to be filled to provide healthcare for UDMs in the manner that they should receive based upon the human rights focused policy (Y. Jackson, personal communication, 12 November 2015). A reason why Ms. Carron wanted to develop the brochure on UDM women’s rights in Genève is because “in Genève there are a lot of organizations working on human rights outside of Switzerland, yet there can still be human rights violations here too” (D. Carron, personal communication, 4 November 2015). Thus amidst praise for the strengths of the healthcare policy in Switzerland in comparison to other European countries, in order to say that UDM women have the same access to reproductive healthcare as Swiss citizens in all cantons, more work needs to be done to deliver on the fulfillment of this human right in every canton.

Secondly, throughout my research and in this report, I want to make it clear where shortcomings lie. Shortcomings only exist in terms of how the healthcare policy is enacted for
UDM women to access reproductive healthcare; the shortcomings do not exist on the behalf of UDMs. At the support group for UDMs I attended, I observed UDM women talk about their struggles paying the premiums for their health insurance, yet these women were still enrolled in health insurance and trying to find ways to make them affordable. In addition, many UDM women at the meeting were aware of the different agencies that could provide them with support and where to seek healthcare. The system in Switzerland is in theory grounded in human rights, thus UDM women can access health insurance and can exercise their right to seek care and be empowered. The narrative should move beyond simply viewing UDMs as a vulnerable population, but a population that is in a vulnerable situation within the healthcare system in Switzerland, which combined leads to inequities in terms of UDM women’s ability to seek and receive reproductive healthcare in Switzerland.

This research focused on UDM women’s access to reproductive healthcare in Switzerland, however due to logistical and timing constraints, contacts were interviewed in cantons: Genève, Vaud, and Zurich. Thus, the conclusions drawn throughout this paper are based upon my interpretation of my conversations with the experts in these regions about the status of reproductive healthcare in their cantons and throughout Switzerland. To provide stronger evidence, leading to more generalizable and representative conclusions, I would continue to interview NGOs throughout Switzerland (in regions missed during my research) and spend more time observing UDM support groups throughout Switzerland to see how narratives of access to reproductive healthcare change in cantons where minimal formal healthcare is accessible for UDMs.

Going forward, I believe the next question becomes what is the quality of UDM women’s reproductive health over time, assessing their reproductive healthcare from a long term instead of a short term perspective. My paper focused on their immediate needs of UDM women to seek and access reproductive healthcare but it would be interesting to see how successes of the system or challenges in accessing the healthcare system translate into reproductive health well-being,
conceiving of health like the WHO defines it as “a complete state of physical, mental and social well-being” (WHO, 2015). According to Dr. Jackson, an important part of providing care for UDMs is also research on how best to evaluate people’s needs because “it is not possible to say we clearly know the value of what we do in terms of health because people are mobile so we have ideas about the short term but not the long term prognosis” (Y. Jackson, personal communication, 12 November 2015). Thus, further research on this topic should start trying to work with specific healthcare organizations or support groups for UDM women and see how to establish frameworks to assess UDM women’s reproductive health in the long-term or how their reproductive healthcare needs translate in later years to varying states of wellbeing.
**Abbreviations List**

CAMSCO - Consultation ambulatoire mobile de soins communautaires

CEDAW – Committee on the Elimination of All Forms of Discrimination Against Women

CRC – Convention on the Rights of the Child

EFTA – European Free Trade Association

EPER – Entraide Protestante Suisse

EU – European Union

EVAM – Etablissement vaudois d'accueil des migrants

FGM – Female Genital Mutiliation

HUG – Hôpitaux Universitaires de Genève

ICESCR – International Convention on Economic, Social, and Cultural Rights

ICCPR – International Convention on Civil and Political Rights

IFMSA – International Federation of Medical Students’ Associations

IRB – Institutional Review Board

LAMal – Loi fédérale sur l'assurance-maladie

NGO – Non-Governmental Organization

PICUM – Platform for International Cooperation on Undocumented Migration

STIs – Sexually Transmitted Infections

UDM – Undocumented Migrant

UN – United Nations

UNHCHR – United Nations High Commissioner Human Rights

WHO – World Health Organization
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