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Universidad del País Vasco

Euskal Herriko Unibertsitatea

Osasun sistemak immigranteen osasun eskubidea errespetatzen du? Emakume immigranteen Euskadiko osasun zerbitzuetarako sarbidearen azterketa

Does the health system respect immigrants' right to health? Analysing immigrant women's healthcare access in the Basque Country

Doktorego-tesia/PhD thesis

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En Europa, construimos muros y vallas, no para ser más libres, sino para quedarnos dentro de ellas. Millones de europeos estamos conectados a la ilusión de la seguridad, que es la que alimenta y da sentido a esos muros y vallas. Además, el muro nos despoja de la responsabilidad de nuestros actos, pues no nos deja ver lo que les hacemos a los que están al otro lado. Pero al otro lado, aunque no lo creáis, late un gran instinto de supervivencia que busca estrategias y llaves para saltar esos muros.

Helena Maleno

Mujer de frontera y activista española por los Derechos Humanos, conocida *"Por ser la voz de los sin voz y denunciar, a veces con riesgo de su vida, gravísimas violaciones a los derechos de la población migrante subsahariana, especialmente mujeres y niños"*

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TAULA ETA IRUDIEN AURKIBIEA/LIST OF TABLES AND FIGURES

AKRONIMOAK ETA LABURDURAK/ACRONYMS AND ABBREVIATIONS

CASSIN Centre for Social and Health Attention for Immigrants

CI Confidence interval

EAE Euskal Autonomia Erkidegoa

EB Europar Batasuna

EU European Union

GKE Gobernuz kanpoko erakundeak

LMA Lehen Mailako Arreta

NGO Non-governmental organization

NHS National Health System

PH Primary healthcare

RDL 16/2012 Royal Decree-Law 16/2012

REDER Network of Denunciation and Resistance to the Royal Decree Law 16/2012

RR Rate ratio

SRH Sexual and reproductive health

SUO Sexu eta ugalketa osasuna

SSA Sub-Saharan Africa

UN United Nations

LABURPENA

Aurrekariak

Osasun zerbitzuetarako sarbidea, osasuna mantentzeko faktore erabakitzailea da eta osasun sistemek, helburu honi laguntzeko, kontuan izan beharreko alderdi garrantzitsua ere. Sarbidea ez dago bakarrik osasun zerbitzuen erabilerarekin erlazionaturik, hiru maila hartzen baititu kontuan: osasun zerbitzuak jasotzeko eskubidea, hauetarako sarbidea eta hauen egokitasuna.

Errenta baxu eta ertaineko herrialdetatik datozen immigranteek, osasun zerbitzuetarako sarbiderako oztopo anitz dituzte, haien gizarte eta bizi baldintza okerragoak direla eta. Gainera, emakume immigranteek osasun langileekin kontaktu sarriagoa daukate, ugalketa kontsulta eta arazo mental gehiago pairatzen baitituzte. Horregatik, gure testuinguruan immigranteek osasun sistemarako sarbidean topatzen dituzten arazoak identifikatu nahian, tesi honek emakume immigranteen Euskadiko osasun zerbitzuetarako sarbidea aztertzeko helburua dauka.

Metodologia

Tesi hau, ikerketa kuantitatibo batean eta bi ikerketa kualitatibotan oinarritzen da. Lehenengo ikerketarako datu bilketa, kontsulta kopuruaren kontaketaren bitartez egin zen; bigarren eta hirugarren ikerketarako, elkarrizketen bidez egin zen. Lehenengo ikerketan, 114/2012 Dekretuaren onarpenak dohaineko klinika baten kontsulta kopuruan izan zezaken eragina ebaluatzeko, bertako erregistroko datuei erregresio analisi binomial negatiboa aplikatu zitzaion. Bigarren eta hirugarren ikerketetan, edukiaren analisi kualitatiboaren metodologia aplikatu zen. Hauen helburua, emakume immigranteen sarbiderako oztopoak ezagutzeko nahian, dohaineko kliniketan lan egiten duten osasun langileen pertzepzioa ezagutzea eta Afrika Sub-Saharararreko emakume immigranteen Euskadiko osasun sistemarekiko pertzepzioak eta esperientziak ezagutzea zen, hurrenez hurren.

Emaitzak

Lehenengo ikerketan, ez zen erlazio argirik aurkitu legearen aldaketa eta dohaineko klinikaren kontsulta kopuruaren artean.

Bigarrenaren emaitzarik esanguratsuenek, immigranteen sarbiderako oztopoak eta bideratzaileak, lau talde hauetan sailkatutako faktoreetan oinarritzen direla diote: 1) immigranteen ezaugarri pertsonalak, haien jatorriarekin estu erlazionaturik daudenak; 2) osasun zentroetako langileen immigranteenganako jarrera; 3) osasun sistemaren ezaugarriak eta funtzionamendua eta 4) eskakizun legalak.

Hirugarren ikerketaren bitartez, aurreko faktoreez gain, arrazismo estrukturalaren eraginak ere immigranteen osasun zerbitzuetarako sarbiderako oztopoa suposatzen duela aurkitu zen.

Bitartean, legeei buruzko informazioa, akonpainamendua eta sostengua jasotzeak sarbiderako faktore bideratzaileak kontsideratu ziren. Hauek, profesional indibidualengandik, gizarte erakundeengandik edo sare sozial pertsonalarengandik jasotzen dituztelarik.

Ondorioak

Oztopoek, sarbiderako maila guztietan eragiten dutela aurkitu zen. Hau da, osasun zerbitzuak jasotzeko eskubidean, hauetarako sarbidean eta hauen egokitasunean. Maila bakoitzean, immigranteentzako sarbidea oztopatzen duten faktore estrukturalak eta bideratzaileak diren faktore indibidualak aurkitu ziren. Arrazismoa gizartean oso erroturik egoteak, kultura eta hizkuntza anitzeko pertsonei arreta emateko osasun sistemen eta profesionalen prestutasunean negatiboki eragiten du.

Immigranteek eskuragarri dituzten gizarte baliabideen artean, dohaineko klinikak nabarmendu ziren, bai immigranteen osasuna hobetzen dutelako, zein osasun eskubidearen gainean egindako intzidentzia politikoagatik. Populazio zaurgarrienen osasun zerbitzuak jasotzeko eskubidea indartzeko eta diskriminazioa ekiditeko, eskubideetan oinarritutako arretaren balioa indartu beharko litzateke, osasun sistema barneratzaileagoa izan dadin.

Hitz gakoak

Immigrazioa; Migrantea; Osasun zerbitzuetarako sarbidea; Osasun desberdinkeria; Osasun politika; Dohaineko klinika; Sexu eta ugalketa osasuna; Osasun eskubidea; Arrazismoa; Ikerketa kualitatiboa

ABSTRACT

Background

Access to healthcare is a key health determinant and is central in the performance of healthcare systems. Access is not only related to the utilization of the healthcare services, but it also includes its entitlement and appropriateness, which represent the fit between services and patients' needs. Immigrants from low and middle-income countries, due to their poorer social and living conditions in the host countries, experience several barriers at all levels of access. Moreover, immigrant women are more likely to interact with professionals at the health centres as they present more often mental and reproductive health problems than their male counterparts. Thus, in order to identify which are the barriers that influence the access of immigrants in our context, this thesis analyses the access to public healthcare services for immigrant women in the Basque Country (Spain).

Methods

This thesis is based on one quantitative study and two qualitative studies. Data collection was conducted through analysing routine data on consultations on the first study, and in-depth interviews in the second and third ones. In the first study, data was analysed using negative binomial regression with the aim of assessing the impact of the implementation of a health policy on the number of consultations at a free clinic. In the second and third studies, qualitative content analysis was applied. The aim was to analyse the perception of healthcare professionals working in free clinics on the barriers and facilitators for access by immigrant women, and to analyse Sub-Saharan African immigrant women's perceptions and experiences on access to appropriate healthcare within the public healthcare system, respectively.

Results

In the first study, no clear relationship could be found between the application of the new more restrictive health policy and an increase in the attendance at a free clinic.

The main findings of the second study showed the factors that compromise an appropriate access to the public healthcare system: 1) immigrants' personal characteristics, which are very dependent on their origin; 2) attitude towards immigrants of healthcare and administrative staff; 3) characteristics and functioning of the healthcare system, and 4) legal requirements.

The third study brought up that, besides the factors specified in the previous study, structural racism is found in the basis of the barriers that hinder access of immigrants to healthcare services. Moreover, the barriers presented before are also reinforced by the racism and the poor social consideration of immigrants.

Meanwhile, provision of legal information, accompaniment and support by individual professionals, social organizations and their personal network represented the main facilitators to access.

Conclusions

Barriers to access were found in its different levels, namely entitlement, access and appropriateness. Each level contains structural barriers that hinder access of immigrant women to the health system, and some facilitators that represent individual efforts to counteract these barriers. The predominant structural racism enrooted in the society and its institutions influenced the willingness of health systems and staff to be organized for considering the needs of a culturally, linguistically and socially diverse population. Among the available social resources, free clinics were considered important actors in improving the health of immigrants, but mainly due to their role as advocators for the right to health for everyone. Besides ensuring the entitlement of vulnerable social populations, there is a need of reinforcing non-discrimination values, and rights based attention among staff at the health centres to get more inclusive and culturally appropriate health systems.

Keywords

Immigration; Migrant; Health care disparity; Health inequity; Sexual and reproductive health; Health access; Health services research; Health service accessibility; Free clinic; Health policy; Right to health; Racism; Qualitative research

PROLOGUE/HITZAURREA

Locating myself

I was raised in a working class neighbourhood in the outskirts of Bilbao and since I was a child, I was aware of discrimination based on gender, ethnicity and social class, even if I could not understand the reasons behind. Due to this awareness, as a teenager, I did a lot of social volunteer work on social organizations. At the university, I studied nursing, which led me to my first paid work at an elderly care and later on to the hospital setting in the public healthcare system.

My desire to get to know other cultures took me for the first time to Latin America, one year after graduation, where I felt that I was far from understanding the cultural tips and customs to be able to effectively work and live in a foreign country. That is why, being back to Spain, I decided to study social and cultural anthropology. Anthropology opened my mind in several ways, but above all, it showed me that the social and cultural patterns could be understood and studied in a scientific way. While I studied and worked as a nurse, I led the International Amnesty group of the University of Deusto, where we used to make campaigns of awareness condemning the violation of the Human Rights.

I enrolled in an International Master in Cooperation and I started volunteering in the non-governmental organization (NGO) Médicos del Mundo Euskadi, where I first realized the need that healthcare should be accessible for everyone, without any discrimination. The master took me to an internship in Malawi to work in agriculture and gender policies. After the year of internship, I did my masters on Gender and feminist studies and I started becoming interested in doing research.

After being volunteering on awareness campaigns against the practice of female genital mutilation with that NGO, I enrolled as a nurse in the free clinic they run, just after the implementation of the retrogressive health laws of 2012, which limited access to the healthcare system for undocumented immigrants. There, I could experience how the disinformation of the law change affected immigrants, and the vulnerability they experienced when trying to access public healthcare services.

In 2013, I enrolled as a lecturer at the Nursing Department of the University of the Basque Country (UPV/EHU) and had the opportunity to begin my PhD, where I could deeply explore the experiences and situations of immigrants in accessing public healthcare services. The connection of the access of immigrant population and the right to health, made me choose the rights approach to the topic. The importance of considering the specific experiences of women was the rationale behind including a gender perspective.

Structure of the thesis

The first part of the thesis describes the situation of immigrants in terms of access to healthcare services in different settings: Europe, Spain and the Basque Country. After this contextualization, the conceptual frameworks in which the thesis is based are presented. The right to health and two access frameworks are first described, alongside the connections between them and how these conceptual frameworks have been useful for exploring immigrants' access to healthcare services.

The second part of the thesis focuses on the original studies carried out in the Basque Country. On each chapter, the aim, method used, main findings, discussion and methodological considerations are described.

The discussion section follows, where the findings are located within Watters' access framework, for analysing the healthcare access of immigrants in the host countries. The thesis ends with conclusions and implications for further research.

INTRODUCTION/SARRERA

This thesis explores access to healthcare services for immigrants who live in the Basque Country, looking at the barriers they face to get appropriate healthcare. It focuses on access to healthcare of undocumented immigrants and those coming from low-income countries, since they are the ones who are in the most vulnerable situations. Likewise, it is centred on women, as they are more likely to utilize healthcare services, and consequently to interact with staff at the health centres.

In order to contextualize the topic, the introduction is divided in two sections: 1) the general situation of access to healthcare for immigrants in Europe and Spain, 2) the legal framework that has ruled the access to the healthcare system of immigrants in Spain and in the Basque Country.

Health and access to healthcare for immigrants in Europe and Spain

In recent years, the number of immigrants in the European Union (EU) has consistently increased. In 2008, there were 19.5 million nationals of non EU-27 countries residing within the EU (1) and by January 2017, the number of people living in the EU-28 who had been born outside of the EU was 36.9 million (2).

In Spain, by January 2018, 10.11% of the population was represented by registered immigrants (3). As it happens in other contexts, no official figures exist about how many undocumented immigrants[2] could be residing in Europe or in each country, which represents a challenge for healthcare providers and policy makers (4). In the Spanish context, the only official figure available for undocumented immigrants was given in 2013, when the Spanish government declared in a report for the EU that the individual healthcare cards of at least 873,000 undocumented immigrants were cancelled (5). The personal healthcare card is the document that entitles individuals to healthcare access throughout the National Health System (6).

When it comes to the health status of immigrant populations, the "healthy immigrant effect" states that immigrants have in general better health outcomes than native population, despite having a lower socioeconomic level and poorer access to healthcare services (7–10). However, their advantage on health outcomes disappears the longer the residence time is (9–12), and it is strongly dependent on the health outcomes considered

[2] An undocumented immigrant is a non-national who enters or stays in a country without the appropriate documentation. This includes, among others: a person (a) who has no legal documentation to enter a country but manages to enter clandestinely, (b) who enters or stays using fraudulent documentation, (c) who, after entering using legal documentation, has stayed beyond the time authorized or otherwise violated the terms of entry and remained without authorization (117). See glossary section.

(10). Nevertheless, the "healthy immigrant effect" does not apply equally to different origin populations (7,8,10,13), as all the immigrants do not arrive to host countries in the same conditions. The conditions of the migration process itself may turn them vulnerable to poor physical and mental health: during transit for the risky conditions or for facing physical and sexual violence, or once in the host countries, because of poorer living conditions (13–15).

Among immigrants, women are more likely to present mental and reproductive health issues than their male counterparts (16,17). In addition, women are more frequently exposed to gender based violence during their migration process on its multiple forms (18). Apart from being a human rights violation and negatively influence several health outcomes, gender based violence can also reduce women's autonomy and therefore their possibility to access healthcare services (19).

In the European context, due to insecure living conditions, undocumented immigrants were found to report more stress, depression and anxiety symptoms (20) and to be three times more likely to report health problems than documented ones (21). The literature has also shown that asylum seekers in Europe have more and more severe health problems than the general population, including more difficulties on accessing healthcare (22,23). In general, undocumented immigrants present poorer self-reported health and are main users of free clinics for underserved populations (20,24–26). Thus, undocumentedness acts as a great barrier not only for maintaining good health and mental health outcomes, but also for access to the healthcare system (26).

Access to healthcare acts as an important health determinant (27) and is central in the performance of healthcare systems (28). Studies regarding access of immigrants to healthcare services in Spain conclude that they utilize them in a lesser extent than natives (8,11,29). However, the results are varied, mainly depending on immigrants' origin and the type of healthcare service (8). A recent review showed that, in general, the immigrant population uses the emergency services more than natives do and make less use of specialised care and mental health services. However, the results varied regarding the use of primary care services, depending on the country of origin, gender and the autonomous community in which it was measured (11). This divergence in the results has been explained by the different methodological approaches applied in the studies, the lack of separation of the results by country of origin and the different classification of what it is considered to be an 'immigrant population' as the study sample (30).

Access to healthcare is, thus, dependent on many individual and systemic factors, as different populations on different locations may have a very different healthcare access experience, even under the same level of entitlement. In general, undocumented immigrants have a more restricted access to healthcare services and higher risk of having a poorer physical and mental health (26), while immigrants original from other EU countries

or high income countries tend to present health indicators and access entitlement similar to native populations (7,8).

Nevertheless, the migrant status is not the only condition to consider to understand migrants' vulnerability on healthcare access. Other social, cultural, economic and gender factors need to be recognized in order to explore the intersectionality of conditions that place certain subgroups of immigrants in a more vulnerable position (31–33).

There are very diverse legislative frameworks to rule the access to healthcare of undocumented immigrants. For healthcare access, EU countries establish different legal conditions for nationals and for foreign origin populations, like immigrants or asylum seekers (21,34). The recognition of the access entitlements varies from being restricted to emergency care to include access at all healthcare levels, i.e. childbirth is not considered an emergency situation in all European countries, and thus free access to institutional delivery is not warranted for all women in certain EU countries (35). In a comparative study of EU-27 countries in 2011, only in five on them (including Spain) were undocumented immigrants entitled to healthcare in the same conditions as natives and regular immigrants, in twelve of them they were only entitled to receive emergency care and in ten, even emergency care was restricted (36).

Restrictive legislation is often represented as the greatest barrier for accessing healthcare services for certain groups of immigrants (7,34,37). But, even in countries where healthcare access to immigrants is legally recognized on equal terms as for natives, other barriers at various levels influence their access. Such barriers include among others, health system bureaucracy, professionals' behaviour and characteristics of the immigrants themselves (37,38). In addition, different perceptions about health and illness, religious motives, language and communication barriers, lack of knowledge on rights and functioning of the healthcare system, staff behaviour, fear of rejection, lack of financial resources, low time of residence and racist attitudes, have also been pointed out in the literature as factors hindering the access of immigrant populations (37). Because of social vulnerability and poorer living conditions of undocumented immigrants, other barriers as lack of awareness about entitlement to health care, fear of being reported to the police and poor language skills affect them more (39).

Spanish and Basque legal framework for immigrants' access to healthcare

The European Social Charter of 1996, on its articles 11 and 13 respectively, ensures the protection of the health and the right to social and medical assistance for anyone without adequate resources (40). However, the design and implementation of the social welfare systems rests with the respective member state (41).

The Spanish Constitution of 1978 in the Article 43 establishes the right to the protection of the health for Spaniards and all citizens living in Spain (42). In addition, *General Health Law 14/1986, 25th April* and later *Law 16/2003, 28th May, on the Cohesion and Quality of the National Health System* and the *Organic Law 4/2000, 11th January, about rights and freedoms of foreigners in Spain and their social integration* regulated more extensively the access for foreigners to the National Health System. Since 1986 until 2012, healthcare in all the regional health systems of Spain was provided free of charge to any person, regardless of nationality, under the condition of being registered in a Spanish municipality for at least 90 consecutive days. Emergency care, antenatal, delivery and postnatal care, and healthcare for minors was guaranteed to anyone with no exception (Table 1).

However, in 2012 access to healthcare services for undocumented immigrants was dramatically reduced as part of a wider package of austerity measures applied to the health system (43), which negatively influenced the health outcomes of local and immigrant population (17,38). In April 2012, the Ministry of Health of the Spanish Government enacted the *Royal Decree-Law 16/2012, of 20 April, on urgent measures to ensure the sustainability of the National Health System and improve its quality and safety* (RDL 16/2012). For its approval, nor impact study neither economic report was presented (44,45), even if the measures stated on the RDL 16/2012 were taken on behalf of public money saving and improvement of the health system.

Since then, access became limited to legal residents in Spain that have an insured status, mainly obtained as a contributor to the Social Security System (46). The decree left undocumented immigrants without access to healthcare services, with the exception of emergency care, antenatal, delivery and postnatal care, and healthcare for minors (43) and from 2013, infectious diseases that might be a public health problem if left untreated (47).

The European Committee of Social Rights and different Special Rapporteurs from United Nations (UN) expressed their concern about the impact of the health policy on migrants' health (48). In addition, the majority of the autonomous communities created exceptional norms and took legal actions against the central government because of the restrictive measures stated in the RDL 16/2012. Consequently, the Constitutional Court ruled in favour of some autonomous communities, letting them to apply the law in different less restrictive forms (45,49).

In the Basque Country, *Decree 114/2012 of 26th June on the benefits of the National Health System within the Autonomous Community of Euskadi* was launched to regulate access to the Basque Public Health System for those people excluded from healthcare services due to the national RDL 16/2012 (50). Even if the Basque Decree was more permissive than the RDL 16/2012 in terms of undocumented immigrants' access to the public healthcare system, it was more restrictive in terms of access for both documented and undocumented immigrants than the previous legislation, as at least one year (instead

of three months) of consecutive municipality registration in the Basque Country became the main requirement to access. In addition, other requirements as not having higher income than the basic income for social inclusion and not having the right to public protection system by other ways were included for being granted access (50). The justification for these "extra" requirements was the allegation of avoiding what is called "*medical tourism*", which is mainly practiced by other EU origin immigrants and consists of "*travelling across international borders to receive some form of medical treatment*" (51). In any case, whatever the time of registration or administrative situation, the health coverage was guaranteed in the Basque Public Health System for all cases related to serious chronic and mental diseases and infectious diseases that could be a public health problem (52).

In December 2017, when the Constitutional Court definitively rejected the application of the Decree 114/2012, the Basque Government, instead of applying the RDL 16/2012 conditions, in an attempt to approach again to a universal healthcare coverage, applied the conditions valid before the 2012 reform. Nevertheless, an unexpected government change occurred in Spain during June 2018. The new government expressed the commitment to recover the universal coverage for everyone in the whole National Health System. In July 2018, the new *Royal Decree-Law 7/2018, July 27th, about the universal access to the National Health System* was launched (53), reversing the measures stated in RDL 16/2012, restoring the conditions in force before the 2012 law reform.

As the data collection for this thesis was conducted from September 2015 to October 2017, it does not include the influence of the last law reform on the access of immigrants to healthcare services. However, this most recent change in the law is included in the general discussion section. In Table 1, the main regulations and conditions for immigrant people regarding the access to National Health System and the Basque Public Health System can be found.

Table 1. Main regulations and conditions for foreign origin people in the access to National Health System and the Basque Public Health System*

1986- *General Health Law 14/1986, 25th April*
3 months of council registration in the Spanish Territory
Healthcare attention in any case to: minors, emergencies, antenatal, delivery and postnatal care

1997*- *Law 8/1997, 26th June, for health ordinance in Euskadi*
3 months of continuous council registration in the autonomous community of the Basque Country
Healthcare attention in any case to: minors, emergencies, antenatal, delivery and postnatal care

2000- *Organic Law 4/2000, 11th January, about rights and freedoms of foreigners in Spain and their social integration*
3 months of council registration in the Spanish Territory
Healthcare attention in any case to: minors, emergencies, antenatal, delivery and postnatal care

2012- *Royal Decree-Law 16/2012, of 20 April, on urgent measures to ensure the sustainability of the National Health System and improve its quality and safety*
Having an insured status
Payment of special agreement
Healthcare attention in any case to: minors, emergencies, antenatal, delivery and postnatal care

2012- *Judicial Decree 239/2012, 12th December 2012*
Access conditions based on Decree 114/2012 are considered valid

2012*- *Decree 114/2012 of 26th June on the benefits of the National Health System within the Autonomous Community of Euskadi*
12 months of continuous council registration in the autonomous community of the Basque Country
Not having higher income than the basic income for inclusion
Not having the right to public protection system by other ways

2013- *Health intervention in situations of risk for the public health*
Attention to infectious diseases that may be a public health problem

2013*- *Order of 4th July 2013, on the recognition of healthcare assistance in the autonomous region of Euskadi to the persons who do not have the insured or beneficiary of the National Health System condition*
Attention to infectious diseases that may be a public health problem, mental and chronic illnesses

2017- *Sentence 134/2017, 16th November 2017*
Decree 114/2012 is considered invalid and its applications is cancelled

2018- *Royal Decree-Law 7/2018, July 27th, about the universal access to the National Health System*
3 months of council registration in the Spanish Territory
Healthcare attention in any case to: minors, emergencies, antenatal, delivery and postnatal care

OBJECTIVES/HELBURUAK

In the Spanish context, plenty of studies on the access of immigrants to the public health system have been done, considering the legal aspects and barriers on the access to the healthcare services. Qualitative studies have considered the perceptions and opinions of groups of immigrants or professionals working at the public health centres. Therefore, due to the existence of free clinics in the Basque Country, we aimed to approach the topic considering the perspectives of the professionals at the free clinics and the analysis of the available data at these social-based health centres. Likewise, immigrant women present gender factors that need to be recognized in order to explore the intersectionality with other conditions that place them in a more vulnerable position in relation to healthcare access. Thus, the objective of this thesis is to analyse the access of immigrant women to public healthcare services in the Basque Country.

Specific objectives

1. To assess the impact of the implementation of the Basque Decree 114/2012 on the number of consultations attended at a primary healthcare free clinic, using institution-based retrospective data

2. To determine the perception of healthcare professionals working in free clinics on the barriers and facilitators in the access by immigrant women to general public healthcare services and sexual and reproductive health in the Basque Country

3. To analyse Sub-Saharan African immigrant women's perceptions and experiences on access to appropriate healthcare in the public healthcare system in the Basque Country

CONCEPTUAL FRAMEWORKS ON THE ACCESS TO HEALTHCARE/OSASUN ZERBITZUETARAKO SARBIDERAKO MARKO KONTZEPTUALAK

This thesis has been inspired by three conceptual frameworks. Two of these frameworks come from the literature on access to healthcare – Levesque's person-centred access to care (28) and Watters' multi-level framework of access (54) – while the third one refers to the right to health (55,56).

These frameworks originate from diverse perspectives, so they allow for exploring the aspects of access in different depth and from different angles. Watters' multi-level framework depicts a holistic model that integrates all necessary aspects for a comprehensive examination of access for immigrants to healthcare services (54). Levesque's person-centred access framework is useful to address and contextualize the experiences of access from the perspective of the care-users (28). Finally, the right to health approach is useful to understand the roles and responsibilities of different social actors on the fulfilment of this right (55,56).

The following sections present the characteristic and limitations of each framework. Afterwards, an explanation of how each framework complement the others and the way they have contributed to different purposes in this thesis is provided.

Multi-level framework of access to healthcare for vulnerable populations

The integrated and multi-level model proposed by Watters considers three necessary aspects, elements or "levels" in access: 1) entitlements, 2) access, and 3) appropriateness. These three elements integrate a model for critically analysing the healthcare access of immigrants in their host countries (54).

Entitlement is defined by Watters as the level of written, formal instruments that have a direct bearing on the available healthcare services for immigrants. These can be conventions, charters and national or regional laws and policies. As the only exploration of the written content of such documents may tell little about the real experience of users, Watters also stresses the need to examine not only the document content, but the way these rights are interpreted and applied within existing health facilities.

Access, according to Watters, refers to the gateways to reach healthcare and the accessibility of those gateways for immigrants. It is related to the extent to which immigrants are actually able to receive the healthcare services that they are entitled to and the factors that inhibit or facilitate the realization of their entitlement. Assessing access thus, requires an active scrutiny both of immigrants' experiences with healthcare services and of those involved in providing them.

Finally, appropriateness indicates the healthcare services' ability to integrate an effective assessment of health care needs of users and the provision of an appropriate treatment. It relates to the content of the received healthcare services and the extent they are responsive to the particular needs of immigrants, so the direct interrelationship between healthcare service providers and immigrants needs to be considered.

Watters' model's contribution to this thesis lies on providing a research roadmap, establishing the different levels of access that must be explored. This model- in contrast to Levesque's that scrutinize in detail the elements and abilities within each dimension- fails to go deeper in the definition of the specific characteristics contained by each level of access. For that purpose, Levesque's framework, described below, might be more fruitful.

Patient-centred access to healthcare framework

From a person-centred perspective, access to healthcare is defined by Levesque as "*the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled*" (28). Access, from this perspective, lies in the interface between the characteristics of the persons, their social environment, and the characteristics of health systems, including the organisation and the healthcare providers. This framework enables to analyse experiences of social groups in their attempt to reach healthcare services. It considers different dimensions of access and how each of them connect with associated abilities of access; namely the dimensions of approachability, acceptability, availability, affordability and appropriateness, related to the abilities to perceive, seek, reach, pay and engage (28).

Table 2 depicts Levesque's framework, defining the dimensions of access and its elements and making correspondence with individuals' abilities that facilitate or hinder fulfilling each dimension. While the dimensions of access represent the supply-side, the abilities represent the demand-side determinants for an effective access. Corresponding to each dimension, the ability that allow persons to interact with social and physical environments, the characteristics of the health systems and service providers to generate access are explained.

Levesque's model is centred in the individual access and it is useful to appraise the individual abilities for accessing care, beyond the dimensions, that are focused on health systems' factors. However, this framework does not give enough consideration to entitlements as an important aspect of access, as Watters' model does. When it comes to entitlements, the rights approach to health offers a deep explanation of this concept.

Table 2. Levesque's person-centred access to healthcare model depicting dimensions and abilities

Person-centred perspective of access: *"the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled"* (28)**.**		
Dimensions	**Definition and elements**	**Related abilities**
Approachability	Identification of services and the way to reach them Ways of providing information	Ability to perceive need for care, determined by their health literacy, knowledge and believes on health
Acceptability	Cultural and social factors that make persons to accept aspects of the service Professional values and norms	Ability to seek, conceptualized by personal autonomy and capacity to seek care and having knowledge about healthcare options and rights
Availability	Physical existence of the healthcare resources, with sufficient capacity to produce services and being reachable in a timely manner Geographic location, appointment mechanisms	Ability to reach health care refers to personal mobility, time flexibility and knowledge
Affordability	Economic capacity for people to spend resources and time on accessing healthcare Costs of services	Ability to pay and generate economic resources
Appropriateness	The fit between services and patients' needs, on technical and interpersonal quality of the given services Technical and interpersonal quality and adequacy	Ability to engage in healthcare relates to the participation and involvement on decision-making and treatment. Also considering the capacity to communicate, the health literacy and the interaction on the provided service

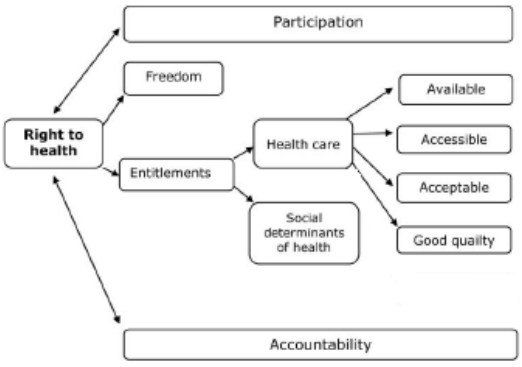
The right of everyone to the enjoyment of the highest attainable standard of physical and mental health

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (57). In consequence, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', for convenience often shortened to 'right to health' (as referred to in this thesis), has captured great attention and has been included in several international documents and declarations accepted and ratified by Spain and other EU countries[3] (55).

The right to health is not limited to the right to receiving timely and appropriate healthcare. It also includes factors or conditions that protect and promote health beyond health facilities, goods and services (referred in advance as healthcare services in this section) and that can help lead a healthy life, which are called "underlying determinants of health"[4] (55,56). In this thesis, however, the focus will be on the first aspect, the right to appropriate and timely relevant healthcare, which requires an effective an inclusive health system for its fulfilment (58).

Two aspects of the right to health concept are also important in this thesis: freedoms and entitlements. Freedoms include the right to control one self's health and body (56). Entitlements, among others, include the right to a system of health protection which provides equal opportunities to everyone to have their right to health fulfilled and equal and timely access to basic health services (55,56). To fulfil these entitlements, health services must be available, accessible, acceptable and of good quality (Figure 1).

Figure 1. Right to health (59)



[3] Alma-Ata Declaration, Ottawa Charter, International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR) in the article 12.1 and Convention on the Elimination of all forms of Discrimination against Women (CEDAW) articles 11, 12 and 14. In the 1948 Declaration of Human Rights, health was mentioned as part of a broader right to an adequate standard of living (55).

[4] Underlying determinants of health include, among others: access to safe water and adequate sanitation; adequate supply of safe food, nutrition and housing; healthy occupational and environmental conditions; access to health-related education and information, including on sexual and reproductive health and gender equality (55,56)

Responsibilities and obligations on the right to health

From a right to health approach, individuals are conceptualized as right-holders while states are duty-bearers, meaning that they are responsible for ensuring the social conditions for warranting that individuals can fulfil their right to the highest attainable standards of health. However, not only states are accountable for this duty; other actors in society such as NGOs, health professionals, United Nations agencies and the private sector also have responsibilities.

In regards to the states' obligations towards the right to health, they are of three types. First, the *obligation to respect*, which implies refraining from interfering with the right to health for everyone, which in terms of access to the health system means refraining: 1) from denying or limiting access to healthcare services, 2) from imposing discriminatory practices related to vulnerable population's health status and needs, 3) from limiting access to means of maintaining health, and 4) from withholding or censoring health information (55,56).

Second, the *obligation to protect* obliges the states to prevent third parties from interfering with the right to health through: 1) adopting legislation that protects individuals from the violation of their right to health and health related information, and 2) taking measures to protect all vulnerable or marginalized groups of society. States must also ensure that private actors conform with human rights and healthcare service quality standards when providing healthcare services (55,56).

Finally, the *obligation to fulfil* implies allocating the maximum of available resources to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health (55,56).

Participation of the population in health related decisions is a very important aspect to achieve the fulfilment of the right to health (56). Civil society and citizens need to claim for a fair health system that ensures that services are available, accessible, acceptable and of good quality. Citizens must be personally committed as well, so as to make possible the necessary redistribution of health goods and services, i.e. by eluding corruption in form of evasion of tax paying (60). Healthcare service providers need to dedicate all the good professional deeds with the aim of improving healthcare services and enabling the fulfilment of the right to health for all. Likewise, they must elude promoting their personal interest on their professional exercise, if it supposes a detrimental to health goods and services (58,60).

Principles guiding the right to health

Non-discrimination is a key principle to ensure the enjoyment of the right to health. It is defined as lack of any distinction, exclusion or restriction made on the basis of various grounds[5], which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms (55).

Certain population groups are considered more vulnerable for the enjoyment of their right to health: women, children and adolescents, persons with disabilities, people living with HIV and AIDS and migrants. For migrants, the entitlement to the right to health is often limited. Moreover, they suffer from discrimination based on language and other social and cultural factor that make them more vulnerable (55).

According to the right to health, vulnerable members of society must be protected, and to provide them healthcare is a core obligation of the states. Even during hard financial times, states have the obligation to provide healthcare to those who do not have sufficient means (56). Moreover, provided healthcare services need to be culturally appropriate and healthcare staff need to be trained to recognize and respond to the specific needs of vulnerable or marginalized groups (55).

Accountability is a key aspect of the fulfilment of the right to health. There are some actors that can make states accountable: NGOs can perform monitoring and advocacy, judicial mechanisms can provide remedies to individuals whose right to health has been violated, and United Nations agencies are requested to cooperate with states on the implementation of the right to health. Among other United Nations monitoring tools, the United Nations Special Rapporteur on the right to the highest attainable standard of health attends individual complains and conduct missions to report on status when areas of concern are detected. In no circumstances, a country's difficult financial situation can justify the application of retrogressive measures on the right to health (55,56).

The right to health is very centred on the concept of entitlements and is very specific on what concerns to the establishment of obligations, principles and responsibilities of the different social actors to get the fulfilment of the right to health for everyone. Likewise, it also considers the characteristics that a health system should fulfil in order to provide adequate healthcare services, even if they are not developed in-depth. Therefore, for understanding what each of the characteristics imply, there is need to resort to a more specific framework to complement it, like the ones previously described.

[5] Discrimination is traditionally performed as based on the following grounds: race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status which has the effect of nullifying or impairing the equal enjoyment or exercise of the right to health (56)

Utilization of the frameworks in the thesis

The three frameworks described above are useful to illuminate the experiences of access of vulnerable immigrant populations to healthcare services in their host countries. Each framework by itself is a complete model that pursues the purpose they were created for. However, in this thesis, we have looked to their interrelations in order to understand in a more complete way what all considered aspects of the access entail. Taking the levels of the multi-level framework as the basis, as they represent the aspects that should be explored in order to make a complete research on immigrants' access, we have merged their content in the following way:

At entitlement level, Watters considers the content of all kind of national and international documents and policies setting the entitlements of native and immigrants populations. The right to health goes beyond that statement and details the roles and responsibilities of different social actors in order to get its fulfilment and the principles that should guide the healthcare service provision. That is it, the right to receiving timely and appropriate healthcare and the underlying determinants of health. Moreover, it states that the right to health applies to everyone following the principle of non-discrimination, and the minimum services that should be provided to any person, regardless its social condition or migrant status. Through the combination of the two frameworks, in this thesis we are able to answer to the question: "To which services and under which conditions should be different populations entitled to healthcare?"

At access level, Watters recommends studying the barriers and facilitators of the actual realization of the entitlement. Levesque's framework explores the accessibility of individuals specifying the characteristics of the healthcare system and services that allow their access and the individual abilities that facilitates reaching them. This person-centred perspective brings the framework closer to the experiences of access of the care-users. The right to health, focused on the health system perspective, states the characteristics that the health systems should fulfil in order to put into practice the healthcare services everyone should be entitled to. Through the joint exploration of this level, the question "Which are the needed characteristics that a health system should fulfil in order to be able to provide accessible and good quality healthcare services? Which are the factors that facilitate persons to reach them? " can be answered.

Finally, Watters places appropriateness as a subsequent aspect of access and suggests exploring how the content of the received healthcare services are responsive to immigrants' particular needs. Nevertheless, Levesque considers this aspect as part of access itself, but describes it in a very similar way than Watters. Therefore, this aspect needs to be explored thorough the reported experiences of the care-users. The right to health framework also considers, under acceptable characteristic of the health systems, which aspects of appropriateness need to be necessary elements of the provided services for the right to health to be fulfilled. Being the aspect on which the three frameworks has

coincided the most, the question that can be responded is "Do healthcare services respond to immigrant patients' needs? Do they consider them culturally appropriate?"

Table 3 presents the utilized frameworks and the interrelation spaces between them. Considering the different approaches of the presented frameworks, in this thesis, they have been used both in a separate and in a joint way, taking advantage of the strengths of each of them:

The multi-level framework was useful to plan the necessary aspects that needed to be explored in the thesis. Therefore, each of the objectives correspond to each of the levels of the access identified by Watters: the first study's objective, assessing the impact of the law change on the utilization of alternative healthcare services, corresponded to the entitlement field. The second study's aim, exploring the perception of healthcare professionals on immigrant women's access, focused on the access level. Finally, the objective of the third study, analysing the experiences of Sub-Saharan African women with healthcare services, corresponded to the appropriateness level.

Person-centred access framework has been used for guiding the qualitative studies with healthcare professionals and immigrant women, since the dimensions of approachability, acceptability, availability, affordability and appropriateness, are very close to the reported experiences of the care-users and care-providers.

Finally, considering that accountability is a guiding principle of the right to health, it has been used to critically explore how the statements of the right to health were applied and made accountable when the adoption of retrogressive measures for immigrants' access to healthcare were taken in Spain in 2012. Moreover, through the perceptions and experiences described in the studies two and three, how the law change affected access of immigrant women is discussed.

Based on the questions arisen from the joint perspective of the framework, the result from the quantitative and qualitative studies has been organized in the discussion. This allowed to link the results from all the three studies under a common frame of the three levels of entitlement, access and appropriateness.

Table 3. Summary of the frameworks used in this thesis

	Multi-level access to healthcare	Person-centred access to healthcare	Right to health
Levels of access	***Entitlement level*** Written, formal instruments that have a direct bearing on the available healthcare services for immigrants. Conventions, charters and national or regional laws and policies		***Entitlement*** to receiving healthcare as timely and appropriate medical care and underlying determinants of health Obligations of social actors on the right to health Guiding principles of the right to health
	Access level The gateways to reach healthcare and the extent to which migrants are able to receive the healthcare services that they are entitled to Related to the factors that inhibit or facilitate the realization of their entitlement	***Dimensions of accessibility and related abilities:*** ***Approachability.*** The extent the health services and the way to reach them can be identified. Ability to perceive need for care ***Acceptability.*** Cultural and social factors that make persons to accept different aspects of the service. Ability to seek care ***Availability.*** Physical existence of the healthcare resources with sufficient capacity to produce services and being reachable in a timely manner. Ability to reach healthcare ***Affordability.*** Economic capacity for people to spend resources and time on accessing healthcare. Ability to pay and generate economic resources ***Appropriateness.*** Fit between services and patients' needs, given the technical and interpersonal quality of the services. Ability to engage in healthcare	***Characteristics of health systems to fulfil the right to health:*** ***Available.*** Sufficient in quantity ***Accessible*** physically, financially and based on non-discrimination ***Of good quality.*** ***S***cientifically and medically appropriate ***Acceptable.*** Respect of ethics and being gender sensitive and culturally appropriate
	Appropriateness level Healthcare services' ability to integrate an effective assessment of health needs of immigrants Related to the content of the received healthcare services and the extent they are responsive to the particular needs of immigrants		

KOKAPENA/SETTING

Ezaugarri sozio-demografikoak

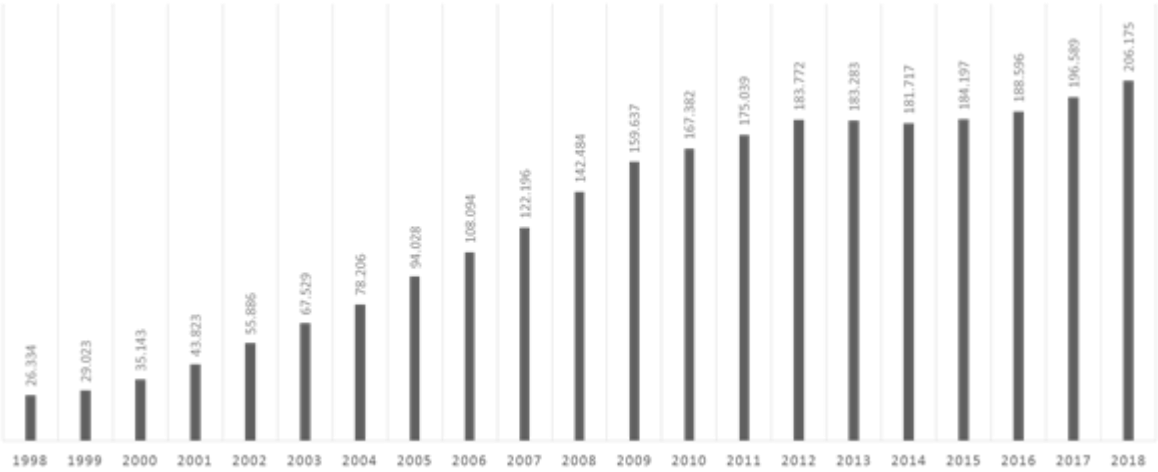
Euskal Autonomia Erkidegoa (EAE), Euskadi bezala ere ezagutua, Espainiako 17 autonomia erkidegoetako bat da. Espainiako iparraldeko kostaldean kokaturik dago eta 7.242 km2-ko azalera dauka. Euskadi, 3 probintziatan dago zatiturik: Gipuzkoa, Bizkaia eta Araba (2. Irudia).

2. Irudia. Europako eta Euskadiko mapa

Iturria: Ezezaguna

2018ko urtarrilean, autonomia erkidegoak 2,198,657 pertsonako populazioa zeukan, zeinetatik 206,175 jatorri atzerritarrekoak ziren. Hau da, populazio osoaren %9.4a. Hauen artean, %47.39 gizonezkoak eta %52.61 emakumezkoak ziren (61). Azkenengo 20 urteetan, erroldan erregistratutako jatorri atzerritarreko populazioak gora egin du urtez-urte, 2013 eta 2014 urteetan salbu, zeinetan beherakada txikia eman zuen (3. Irudia).

3. Irudia. Euskadin erregistratutako atzerritarren kopurua urteko



Iturria: Ikuspegi, 2018 (61)

Euskadin erregistraturik dauden immigranteen jatorrien artean, hamar jatorri prebalenteetatik zazpi Latino Amerikarrak dira. Hala ere, jatorri prebaleentenak Maroko, Colombia eta Romania dira (61). 2018an erroldan erregistratutako atzerritar gehien zeukan probintzia Bizkaia zen, 100,611 immigranteekin (61). Bilbo, Bizkaiko hiriburua da eta immigrante gehien zuen hiria, hauek 26,074 zirelarik; hau da, bere populazioren %11.5a. Hauetatik, %50 inguru emakumezkoak ziren (62).

Beste testuinguruetan gertatzen den bezala, Euskadin erregistratu gabeko zenbat immigrante egon daitezkeen ezin da estimatu, osasun sistemako kudeaketarako erronka suposatzen duelarik. 2017an, dokumentu judizial batek Euskadin egon daitezkeen erregistratu gabeko immigranteen kopurua 14,632 eta 22,886 artean estimatu zuen (63).

Osasun sistema nazionala eta Euskadiko osasun sistema

Espainiako osasun sistema nazionala deszentralizatua da eta gobernu zentraleko eta 17 erkidego autonomikoen osasun sistemek osatutako osasun zerbitzuen multzoa bezala definitzen da (64).

Erkidego bakoitzak berezko osasun sistema dauka eta honen kudeaketaren arduraduna da, Estatuko lege berdin eta lege autonomiko desberdinen bidez arautua. Osasun sistema nazionaleko lurralde arteko kontseiluak, autonomia erkidegoen osasun administrazioak koordinatzeko eta hauen arteko kooperazioa kudeatzeko ardura dauka (76).

4. Taula. Osasun sistema nazionalaren konpetentzien ardura

Osasun sistema nazionaleko lurralde arteko kontseilua	**Gobernu zentrala**	Osasun printzipioak eta koordinazioa Kanpo-osasuna Medikamentuen kudeaketa Osasun Kudeaketarako Institutu Nazionalaren kudeaketa
	Autonomia erkidegoak	Osasun plangintza Osasun publikoa Osasun zerbitzuen kudeaketa
Udal kontseiluak		Osasungarritasuna Osasun zerbitzuen kudeaketarako laguntza

Iturria: Sistema Nacional de Salud, 2012. Government of Spain (64)

Euskadiko osasun sistema honakoek eratzen dute: alde batetik Osasun Departamentua, planifikazioa, kudeaketa, finantziazioa eta erregulazioa jarduten duena eta bestetik, Osakidetza, osasunerako euskal erakunde publikoa dena, eta osasun zerbitzuak eskaintzen dituena (65).

Euskadiko osasun sisteman hiru mailako arreta eskaintzen dira: lehen mailako arreta (LMA), arreta espezializatua eta osasun mentalekoa. Osasun sisteman sartzeko biderik ohikoenak, ospitaletan eta irekiera zabaleko osasun zentroetan kokaturiko emergentzia unitatetatik eta lehen mailako arreta zentroetatik izaten dira. Autonomia erkidego osoan 16 ospitale, 313 lehen mailako arreta osasun zentro eta 47 osasun mentalerako zentro daude, beste espezialitateak eskaintzen dituzten zentroez gain (65).

Bezeroen arretarako profesionalak, edo administratiboak ere deituak, bezeroei informazioa emateko eta osasun sistemarako sarbidea arautzen duten legeak aplikatzeko arduradunak dira, besteak beste (66). Osasun zentroetako sarreretan kokatzen dira eta orokorrean, zentrora heltzen diren pertsonek topatuko dituzten lehenengo profesionalak dira.

Osasun langileen artean, erizainak eta medikuak dira betiere osasun zentroetan topatu daitezkeenak. Erizainek osasunaren promozioa, prebentzioa, mantentzea eta berreskurapenerako zainketak ematen dituzte (67). Medikuek, horrez gainetik, gaixotasunen diagnostikoak eta tratamenduak eskaintzen dituzte (68). Sexu eta ugalketa osasun arreta emaginek lehen mailako arreta osasun zentroetan eskaintzen dute. Osasun zentro espezializatuetan, emaginez gain, obstetrek eta ginekologoek eskaintzen dute.

Dohaineko klinikak Euskadin

Euskadin, osasun sistemaz gain, immigranteei eta osasun sistematik kanpo geratzen direnei osasun arreta eskaintzen dieten dohaineko klinikak badaude. Dohaineko klinikak "*lehen eta bigarren mailako osasun arreta eskaintzen duten komunitatean oinarrituriko eta irabazi gabeko erakundeak dira. Zerbitzu hauek dirurik edo asegururik gabeko pertsonei dohainik edo kostu baxuan eskaintzen dira*" (25). Bilbon kokatzen dira autonomia erkidegoan dauden dohaineko lau dohaineko klinika bakarrak: Batean, osasun sistematik kanpo dauden pertsonei osasun eta gizarte arreta eskaintzen diote (1. Kutxa). Beste hirurek, edozein emakumeri sexu eta ugalketa osasun arreta eskaintzen diote (2. Kutxa).

1. Kutxa. Lehen mailako arreta dohaineko klinika

CASSIN, immigranteentzako osasun eta gizarte arreta zentroa, dohaineko klinika da, non lehen mailako osasun arreta eta gizarte-lan kontsultak eskaintzen diren. Médicos del Mundo Euskadi Gobernuz kanpoko Erakundeak (GKE) finantzatzen du. Bilboko zentrotik oso gertu dago, San Frantzisko auzoan, populazio immigrate ugari daukana eta maila sozioekonomiko baxukoa dena.

1997. urtean hasi zen pertsona guztien osasun eskubidea lortzeko helburuarekin. Gaur egun, CASSIN-en arreta jasotzeko baldintzak, osasun sisteman sartzeko eskatzen diren baldintzak ez betetzea eta 18 urtetik gorakoa izatea dira. Osasun kontsultak astean 2 egunetan eskaintzen dira, 2 ordu eta erdi egun bakoitzeko.

13 mediku, 14 erizain eta hainbat administratiboren artean kudeatzen dituzte kontsultak, guztiak boluntarioak direlarik. Osasun kontsulta orokorrak, zaurien sendaketa, haurdunaldi testak, GIB testak, errezetak, odol analisiak, sexu eta ugalketa osasun dohaineko kliniketara deribazioak eta abar egiten dira. CASSIN-en emandako errezetak edozein farmazietan ordeztu daitezke. Gainera, beste erakunde sozial batek dohaineko medikazioa ematen die hau erosteko dirurik ez daukatenei.

Osasun kontsultarekin batera, kontratauriko gizarte langile batek, beste gizarte langile boluntario batzuekin batera, gizarte arreta kontsultak eskaintzen ditu. Hauetan, legeriari buruzko informazioa eta osasun sistema publikoan sartzeko informazioa eskaintzen dute. Gainera, osasun sinteman emandako immigranteen eskubideen urraketak bildu eta Ararteko herriaren defendatzailearen aurrean aurkezten dituzte, immigranteen osasunerako eskubidearen aldeko intzidentzia politikoa eginez.

2. Kutxa. Sexu eta ugalketa osasun dohaineko klinikak

Klinika hauek 70. eta 80. hamarkadetan sortu ziren, osasun sistemak ematen ez zituen zerbitzuaz eskainiz, emakumeen osasun egoera hobetzeko helburuarekin. Nahiz eta emakume talde eta auzokide erakundeen kontuz hasi, gaur egun, Bilboko Udalak eta Eusko Jaurlaritzak finantzatzen ditu.

Kliniken gaur egungo aktibitatea sexu eta ugalketa osasunean zentraturik dago. Gainera, beste motatako zerbitzuak ere eskaintzen dituzte: arreta psikologikoa eta psikiatrikoa, droga adikzioetarako arreta, aholkularitza legala eta tailerrak genero berdintasunean, genero indarkerian, emakumeen jabekuntzan eta gizarte integrazioan. Kontsultak jasotzeko, klinika dagoen auzoan erroldaturik dauden emakumeek lehentasuna daukaten arren, errolda edo erregistratu gabeko emakumeei ere arreta ematen diote.

San Frantzisko auzotik gertu kokatuta dagoen dohaineko klinikan, 2000. urtetik 2014. urtera, 38.304 sexu eta ugalketa osasun kontsulta egin ziren. Hauetatik 5.151 emakume immigranteenak izan ziren. Ez dago beste kliniken datu eskuragarririk.

IKERKETA PROZESUA/RESEARCH PROCESS

Tesi hau, ikerketa kuantitatibo batean eta bi ikerketa kualitatibotan oinarritzen da. Bi metodologia hauen elkarketak, osasun langileen eta immigranteen esperientziak, eskuragarri zeuden datuen osagarri izatea bilatzen zuen.

Lehenengo, emakume immigranteak Euskadiko osasun zerbitzuetarako sarbidean dauzkaten oztopo eta bideratzaileak identifikatu nahi izan ziren. Honetarako, dohaineko kliniketan lan egiten duten osasun langileen pertzepzioa aztertu zen elkarrizketen bidez. Lortutako emaitzen artean, Afrika Sub-Saharartreko emakume immigranteak osasun sistemarako sarbidean oztoporik latzenak topatzen dituztenak direla aurkitu zen. Ikerlan hau gaiarekiko lehenengo hurbilketa izan zen.

Bigarren helburua betetzeko, datu kuantitatiboak atera ziren Médicos del Mundo Euskadik kudeatutako dohaineko klinikako kontsulta erregistroetatik. 2012. urtean emandako legearen aldaketak dohaineko klinikako kontsulta kopuruan eduki zezaken eragina aztertzeko, datuei erregresio analisi binomial negatiboa aplikatu zitzaien.

Ikerketa hau burutzen zen bitartean, hirugarren ikerketarako datuak batu ziren. Lehenengo ikerketa kualitatiboaren emaitzetan oinarriturik, emakume immigrante Sub-Saharartren osasun sistemaren izandako esperientziak aztertu nahi izan ziren. Horretarako, datuak elkarrizketen bitartez bildu ziren.

Lehenengo eta bigarren ikerketaren emaitzak prest zeudelarik, lehen mailako arreta dohaineko klinikan lan egiten duten osasun langileekin mintegi bat egin zen, emaitzak aurkeztu eta berrelikadura jasotzeko helburuarekin.

5. Taulak, kapitulu bakoitzaren helburua, ikerketa diseinua eta analisi mota biltzen ditu.

5. Taula. Kapituluen laburpena

	1. Kapitulua	**2. Kapitulua**	**3. Kapitulua**
Helburua	114/2012 Dekretuaren aplikazioak dohaineko klinika baten kontsulta zenbakian izandako eragina aztertzea	Emakume immigranteek Euskadiko osasun sistema publikorako eta sexu eta ugalketa zerbitzuetarako sarbidean topatzen dituzten oztopoak eta faktore bideratzaileak ezagutzea, dohaineko kliniketan lan egiten duten osasun langileen pertzepzioa aztertuz	Euskadiko osasun sistemarako sarbideari eta erabilerari buruzko emakume immigrante Sub-Sahararren pertzepzioak eta esperientziak aztertu
Ikerketa diseinua eta parte-hartzaileak	Osasun kontsulta kopurua 2007ko urtarriletik 2017ko uztailera (interbentzioa edo legearen inplementazioa 2013ko urtarrilean) n= 9272	11 elkarrizketa indibidual dohaineko kliniketan lan egiten duten osasun langileekin	14 elkarrizketa 8 herrialde desberdinetako emakume Sub-Sahararrekin. 9 gaztelaniaz, 1 ingelesez eta 4 frantsesez
Analisia	Erregresio analisi binomial negatiboa. Bizkaian erregistratutako immigranteen portzentaia, langabezia tasa eta aldikotasunaren arabera doituta	Edukiaren analisi kualitatiboa	Edukiaren analisi kualitatiboa

ETHICAL CONSIDERATIONS/KONTSIDERAZIO ETIKOAK

Ethical approval for each of the three studies was obtained from the Ethics Committee for Research Involving Human Subjects of the University of the Basque Country (UPV/EHU) before contacting any participant. These approvals are stated on the committee accords number 66/2015, 72/2016 and 77/2016, respectively.

For the study in chapter 1, after getting ethical clearance from the university committee, written permission and login credentials to access the registration forms and the database were requested to and given by Médicos del Mundo Euskadi direction board. All extracted data were anonymised prior to sharing it with other authors and analysing it. Data from registration forms were counted by the first author in the office of the NGO. No data that could identify any patient was used in the study.

All participants in studies of chapters 2 and 3 were given written and oral information about the project and gave written consent before being interviewed. The first author anonymised the data prior to analysis and pseudonyms have been used to identify the participants in the text. To those participants that requested it, the interview guide was sent in advance.

For the study in chapter 3, all the documents given to the participants (consent form and information letter presenting the study with contact data of the researcher) were given in Spanish, English or French, depending on the participants' preferences. All the information related to the study was also given in their preferred language.

During data collection, all participants were given written and oral information about the goals of the study and gave written consent for participating and being recorded during the interviews. Participants were asked in which language they preferred to be interviewed. In three interviews with women who were recruited in the waiting room of the free clinic, self-provided translators were used. Translators were already accompanying them as they were going to act as such in the medical consultation. Women were first alone when they were explained the goal of the study and asked about whether they wanted to use a translator or not. With the aim of reducing the potential ethical conflicts about confidentiality, translators were informed about the importance of keeping confidentiality and discretion with the information treated during the interview.

1. KAPITULUA/CHAPTER 1

Sarreran deskribatu den bezala, osasun zerbitzuak jasotzeko eskubiderik eza eta honi buruzko informazio falta, immigranteen sarbiderako oztoporik handiena da, batez ere dokumentaziorik gabekoentzat (26). Egoera honek immigranteen osasunean eduki dezakeen eragin negatiboa gutxitzeko helburuarekin, Europako herrialde askotan, dohaineko klinikak daude; bertan, osasun langileek osasun sistema publikotik kanpo dauden pertsonei arreta eskaintzen diete (20,25,26,69).

Horregatik, ikerketa honek, Euskadiko dohaineko klinika bateko kontsulta kopurua kontuan izanez, lege baten eragina aztertu nahi zuen. Denboraldi osoak, 114/2012 Dekretuaren onarpenaren aurreko eta osteko urteak hartzen ditu. Aztertutako dohaineko klinika CASSIN edo Immigranteei osasun eta gizarte arreta eskaintzeko zentroa da (Lehen mailako arreta dohaineko klinika bezala deitua tesian zehar). CASSIN-en arreta jasotzeko baldintzak, osasun sistema publikoan arreta jasotzeko eskakizunak ez betetzea eta 18 urtetik gorakoa izatea dira. Pazienteen gehiengoa, dokumentaziorik gabeko immigranteak dira.

Helburua

Osasun zerbitzu publikoetarako sarbiderako eskakizun legalak zailtzeak, dohaineko kliniketako osasun kontsulta zenbakian gorakada eragingo duelako hipotesian oinarriturik, ikerketa honen helburua 114/2012 Dekretuaren aplikazioak dohaineko klinika bateko kontsulta zenbakian izandako eragina aztertzea izan zen.

Metodologia

Datu bilketa

CASSIN-en eskainitako osasun kontsultetan, pazienteen datu pertsonalak eta medikoak erregistro paperetan apuntatzen dira. Hilabetero, datu hauek erakundeko datu-basera pasatzen dira. 2007ko urtarriletik 2017ko ekainera arte egindako kontsulta kopurua zuzenean erregistro paperetatik zenbatu eta datu-basearen datuekin konparatu zen. Datuen artean desberdintasunak aurkitu zirenean, eskuz jasotako kopurua hartu zen kontuan.

Datu analisia

Datuak, Excel orri batera pasatu ziren, denboraldi osoan emandako kontsulta kopurua hiruhilekotan zatituz. Sexu bakoitzeko pazienteen jatorria eta diagnostikoak analisi deskriptiborako bildu ziren.

Kontsulta kopuruaren joera aztertzeko, denboraldi osoa 2 fasetan zatitu zen: 2007ko urtarriletik 2012ko abendura eta 2013ko urtarriletik 2017ko ekainera. 114/2012 Dekretuaren aplikazioa interbentziotzat hartu zen, interbentzio puntua 2013ko lehenengo hiruhilekoan ezarriz. Dekretua, 2012ko ekainean onartu bazen ere, teorian bere aplikazioa abenduraino atzeratu zen, Auzitegi Konstituzionalak hau aplikatzeko baimena eman zuenean.

Lehenengo denboraldia, interbentzio-aurreko fasea deitua izan zen. Honetan, immigranteen sarbidea arautzeko osasun lege orokorrak eta atzerritarren eskubideei buruzko legeek ezarritako baldintzak aplikatzen ziren (1. Taula ikusi). Interbentzio aldagaia, 0 bezala kodifikatu zen interbentzio-aurreko fasean eta dekretuaren inplementazioaren hiruhilekoan (2013ko lehenengo hiruhilekoa) eta 1 bezala hortik aurrera.

Interbentzio-osteko faseak 114/2012 Dekretuaren inplementazioa egin zen denboraldia barneratzen du. Interbentzio-osteko aldagaia, 0 bezala kodifikatu zen interbentzio-aurreko fasearen azkenengo punturaino eta 1 bezala interbentzioa hasi eta gero (2013ko lehenengo hiruhilekoan).

Datuak, Bizkaian erregistratutako immigranteen portzentaia, langabezi tasa eta aldikotasunaren arabera doitu ziren. Langabezi tasak, ekonomi krisiak dohaineko klinikara heldutako immigranteen kopuruan eduki dezaken eragina adierazteko balio du.
Aldikotasunak, oporraldian (urte bakoitzeko hirugarren hiruhilekoan) gertatutako kontsulten kopuruaren beherakada erakusten du. Aldikotasun faktorea, 1 bezala kodifikatu zen urte bakoitzeko hirugarren hiruhilekoan eta 0 bezala beste hiruhilekoetan.

Datuak, erregresio analisi binomial negatiboa erabiliz analizatu ziren. Analisia, ekuazio honen bitartez adierazi daiteke:

$$Y_t = ß_0 + ß_{1\ \text{interbentzio-aurrekoa}} + ß_{2\ \text{interbentzioa}} + ß_{3\ \text{interbentzio-ostekoa}} + Ɛ$$

Y-k aldagaia adierazten du (osasun kontsulten kopurua)
ß0-k aldagaiaren oinarri-maila adierazten du
ß1-k aldagaiaren joera adierazten du interbentzio-aurreko denboraldirako
ß2-k interbentzio-osteko mailaren aldaketa adierazten du, interbentzioa gertatu eta geroko berehalako eragina irudikatuz
ß3-k interbentzioaren ostean aldagaiaren joeraren aldaketa adierazten du

Kontsulta kopuruari, jarraia denez eta normalitate patroi bat jarraitzen ez duenez, Poisson erregresio modelo bat aplikatu zitzaion. Lehenengo modelo honen analisiak, datuak modelo horretarako egokiak ez zirela adierazi zuen. Horregatik, moldagarriagoa den erregresio binomial negatiboa erabili zen analisia gauzatzeko. Arrisku erlatiboak (RR) eta %95-ko konfiantza tarteak (CI) atera ziren *Stata 13.0 software*-a erabiliz.

Emaitzak

2007ko urtarriletik 2017ko ekaineraino 9,272 osasun kontsulta bete ziren, %77a gizonezkoenak eta %23 emakumezkoenak izan zirelarik. Ia gizonezkoen erdiak eta emakumeen %40ak lehenengo kontsulta jaso zuten. Paziente berrien eta segimenduzko kontsultak egin zituzten pazienteen datu deskriptiboak datu-basetik atera ziren. Guztira, 4,707 pertsonen datu deskriptiboak lortu zirelarik (6. Taula ikusi).

Adin tarteen banaketak, joera desberdinak aurkeztu zituen bi sexuen artean: Gizonen %29a 18 eta 24 urte artekoak ziren, %70a 25 eta 64 urte artekoak eta %1a 65 urtetik gorakoak. Emakumeetan, %15, %81 eta %4 izan ziren, hurrenez hurren (6. Taula).

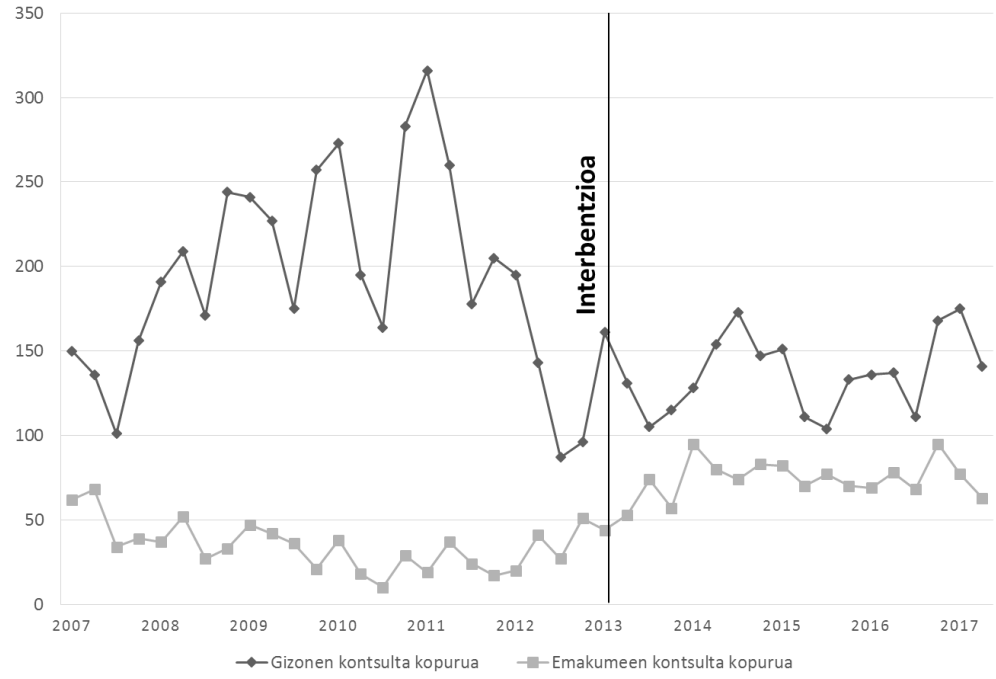
Jatorrizko eskualdeari begira, gizon eta emakumeen artean, desberdintasun garrantzitsuak aurkitu ziren: gizonen % 54a eta emakumeen %18a Afrikako Iparraldetik etorritakoak ziren. Hala ere, emakumeen %57a eta gizonen %7a Latino Amerikakoak ziren. Ordenan jarrita, gizonen jatorririk prebalenteenak Afrikako Iparraldea, Afrika Sub-Sahararra, Latino Amerika, Europako ekialdea eta Asia izan ziren. Aldiz, emakumeen artean, Latino Amerika, Afrikako Iparraldea, Afrika Sub-Sahararra, Europako ekialdea eta Asia izan ziren (6. Taula).

Emakumeei eta gizonei egindako diagnostikoetan ere desberdintasunak aurkitu ziren: Gizonetan, ordenan, arnas-sistema, digestio-sistema, sistema muskulu-eskeletikoa eta sistema tegumentarioarekin erlazionatutako diagnostikoak izan ziren prebalenteenak. Emakumeetan, ordenan, sistema genitourinarioa, arnas-sistema, digestio-sistema eta sistema muskulu-eskeletikoarekin erlazionatutakoak izan ziren (6. Taula).

6. Taula. 2007ko urtarriletik 2017ko ekaineraino CASSIN-eko pazienteen ezaugarriak eta diagnostikoak (n= 4,707)

	Gizon	Emakume
Guztira	7134	2138
	(%76.94)	(%23.06)
Lehenengo aldikoa	%40.03	%49.58
ESKUALDEAK		
Latino Amerika	%7.04	%56.55
Afrika Iparraldea	%54.34	%18.06
Europako ekialdea	%3.22	%7.32
Asia	%2.65	%0.57
Beste guztiak	%1.67	%0.49
DIAGNOSTIKOAK		
Arnas-sistema	%18.43	%10.10
Digestio-sistema	%14.31	%10.16
Sistema tegumentarioa	%13.08	%6. 57
Sistema muskulu-eskeletikoa	%14.68	%10.53
Sistema genitourinarioa	%2.90	%14.73
Beste batzuk	%36.6%	%47.90

4. Irudia. 2007ko urtarriletik 2017ko ekaineraino CASSIN-eko kontsulta kopuruak, sexuagatik bananduak



Dohaineko klinikaren osasun kontsulten kopuruaren joera

Gizonen kontsulta kopuru totala 7,134 izan zen. 2007ko lehenengo hiruhilekotik 2011ko bigarren hiruhilekora, gizonen kontsulta kopuruak igoera handia eduki zuen; gero, jaitsiera handia eduki zuelarik. Hala ere, berriro ere igoera eman zen interbentzioaren aurreko hiruhilekoan, interbentzioa eta interbentzio-osteko aldietan konstante mantenduz (4. Irudia).

2007ko urtarrilean, gizonen kontsulta kopuruaren oinarri-maila 193.23koa izan zen. Interbentzio-aurreko fasean, hiruhileko batetik bestera %2ko goranzko joera izan zuen gizonen kontsulta kopuruaren mailak, nahiz eta estatistikoki adierazgarria ez izan (RR=1.02; %95 CI=0.99, 1.04). Interbentzioa gertatutako hiruhilekoan, aurreko fasearekiko %40ko kontsulta kopuruaren mailaren igoera eman zen, hau estatistikoki adierazgarria izan zelarik. Hala ere, kontsulta kopuruaren joerak %1ko beherakada eman zuen interbentzio-osteko fasean; nahiz eta estatistikoki adierazgarria izan ez zen (RR=1.01; 95% CI=0.99, 1.03). Datuak, Bizkaian erregistratutako immigranteen portzentaia, langabezia tasa eta aldikotasunaren arabera doitutak izan ziren (7. Taula).

Emakumeen kasuan, kontsulta kopuru totala 2,138 izan zen. Kopurua jaitsiera konstantean egon zen denboraldiaren hasieratik 2011 urtera arte. Egonkortze aldi bat eman zen 2011 eta 2012 urteen artean, gero goranzko joeran finkatu zelarik denboraldiaren amaieraraino (4. Irudia).

Hasierako aldian, emakumeen kontsulta kopuruaren oinarri-maila 44.92koa izan zen. Interbentzio-aurreko fasean, hiruhileko batetik bestera kontsulta kopuruaren mailak %2a jaitsi zuen, hau estatistikoki adierazgarria izanik (RR=0.98; 95% CI=0.95, 1.01). Interbentzioa gertatu osteko hiruhilekoan, interbentzio-aurreko fasearekiko %187ko kontsulta kopuruaren mailaren igoera eman zen. Interbentzio-osteko fasean, kontsulta kopuruaren joerak estatistikoki ez adierazgarria izan zen hiruhileko bakoitzeko %1ko beherakada eman zuen (RR=0.99; 95% CI=0.96, 1.04). Emaitzak, Bizkaian erregistratutako immigranteen portzentaia, langabezia tasa eta aldikotasunaren arabera doitutak izan ziren (7. Taula).

7. Taula. Segmentatutako erregresio analisi binomial negatiboaren emaitzak 2007ko urtarriletik 2017ko ekaineraino CASSIN-eko kontsulta kopuruenak, arrisku erlatiboa bezala adieraziak (%95eko konfiantza tarteak parentesi artean) eta sexuaren arabera bereizita

	Oinarriko maila	Interbentzio aurrekoa	Interbentzio	Interbentzio ostekoa
Gizon	193.23 (147.58, 253.01)	0.99 (0.98, 1.02)	0.65 (0.46, 0.91)	1.01 (0.99, 1.02)
	205.15 (130.37, 322.87)[a]	1.02 (0.99, 1.04) [a]	0.60 (0.42, 0.84) [a]	1.01 (0.99, 1.03) [a]
Emakume	44.92 (34.35, 58.74)	0.98 (0.96, 1.00)	2.64 (1.78, 3.91)	1.00 (0.99, 1.02)
	56.99 (30.18, 107.64)[a]	0.98 (0.95, 1.01) [a]	2.87 (1.80, 4.58) [a]	0.99 (0.96, 1.04) [a]

[a] Bizkaian erregistratutako immigranteen portzentaia, langabezia tasa eta aldikotasunaren arabera doituta

Discussion

The study's findings do not support a clear relationship between the implementation of the Basque Decree 114/2012 and an increase in the attendance by immigrant population at a free clinic in the studied period, as other factors besides the policy change could also help explaining the found trends.

Different trends of attendance as well as gender and country of origin patterns between men and women were observed over the whole period. In addition, an overall slight decrease in the number of consultations for women and an increase for men was found after the application of the new Decree, though being statistically not significant in either of the trends. Because of the lack of data on the numbers of undocumented immigrants, demographic reasons explaining these trends could not be contrasted.

In general, a high number of male consultations compared to women were observed, representing 76.94% of the total. This pattern has also been reported in a study conducted in five social-based free clinics in Paris in 2008, where 65% of the total patients were men (24). However, in a free clinic in Berlin 60% of attending patients were women, but the clinic was quite specialised in prenatal care (25,26). In both Paris and Berlin free clinics, patients were mainly undocumented (24,26).

The reasons for the excess number of male consultations in our study are not clear. From 2006 to 2018, the proportion between the sexes among registered immigrants in Bilbao, Biscay and Basque Country as a whole is close to 50% (61), so the difference in attendance at CASSIN could not be explained by the highest presence of male registered

immigrants. Moreover, the majority of patients that arrive to CASSIN were not included in the city council register. However, the data on country of origin from the municipality register of Bilbao coincides with those from the free clinic patients: in 2017, 69.83% of registered immigrants from Maghreb were men while 62.35% of the immigrants originally from Latin America were women (62).

Another explanation regarding the lower number of female patients arriving at CASSIN could be related to the existence in Bilbao of three other free clinics, exclusively for sexual and reproductive health, where all women, regardless of their legal status can attend. For instance, in 2014, 517 immigrant women attended the most popular clinic among immigrants. There is not available data for the rest of the clinics. Limitation on the lack of data about how many undocumented immigrant women and men live in Bilbao affects negatively the find of a possible explanation of the low use of the free clinic for women. Data from other social resources like sheltering or feeding centres should be compiled in order to contrast if women make less use of other resources allocated for undocumented immigrants.

After the intervention, a not significant small decrease in the number of attendances at the free clinic among men was observed. This trend could reflect that not many undocumented immigrant men left the region because of lack of employment due to the economic crisis. Related to this, a slight decrease of registered immigrant men occurred from 2012 to 2015 in the Basque Country, even if it has maintained an increasing trend after it. In the case of women, an increasing trend in the number of registered immigrant women in the Basque Country has been maintained year by year (61). Women could have also remained in the region, or an influx of immigrant women coming from other Spanish regions could also have happened, even if they did not attend CASSIN.

Due to the high number of consultations attended per year, free clinics are important actors in ensuring the right to health for those who are at risk of social exclusion, such as undocumented immigrants. Furthermore, they are able to identify cases which could become a public health threat if they are left untreated.

Limitations of the study

The new policy implementation could not be the only explanation for the trend changes in the number of consultations. The interaction with other not captured external factors that also happened during the same period, such as the influence of the economic crisis or the uncertainty on the entitlement conditions during the policy change process, may also have influenced our outcome. Due to the absence of the crucial demographic data on the number of undocumented immigrants during the studied period, its potential impact on the results could not be taken into consideration.

2. KAPITULUA/CHAPTER 2

Emakume immigranteek Espainian, bertakoekin konparaturik, ugalketa eredu desberdinak aurkezten dituzte; ondorengo gehiago, lehenengo haurdunaldian adin txikiagoa eta haurdunaldiaren borondatezko etendura gehiago dauzkatelarik (70). Immigranteen sexu eta ugalketa jarrerak, besteak beste, faktore hauen menpe daudela azaldu da: jatorrizko kulturan sexuak eta ugalketak duten garrantzia, migrazio prozesua, bizi baldintzak, hezkuntza maila eta egoera legala (33,71).

2/2010 Lege Organikoa, Martxoak 3ko legean adierazten den bezala (72), sexu eta ugalketa zerbitzuetarako sarbidea, beste osasun zerbitzuen sarbiderako baldintza berdinak ditu. Horregatik, RDL 16/2012 onartu zenean, dokumentaziorik gabeko emakume immigranteentzako sexu eta ugalketa zerbitzuetarako sarbidea ere murriztu zen, besteak beste, hauen antisorgailu, haurdunaldiaren borondatezko etendura eta prebentzio zerbitzuak jasotzeko posibilitatea deuseztatuz. Are gehiago, gizarte erakunde baten txostenak, legearen onarpenaren osteko urteetan, osasun sistema publikoan hainbat emakume haurdunei arreta ukatu zitzaiela adierazten du (49).

Legea edozein izan bada ere, emakume haurdunen, erditzearen edo erditze osteko zainketak betiere osasun sistema publikoak bermatu ditu. Hala ere, eskubidea izateaz gain, emakume immigranteak zainketak jasotzeko dituzten oztopoak identifikatu nahian, ikerketa kualitatibo bat garatu zen dohaineko kliniketako osasun langileen pertzepzioa kontuan hartuz. Parte-hartzaile hauek nahita aukeratu ziren, emakume immigranteen osasun egoera gertutik ezagutzen dutelako, haiei eskainiko osasun arreta dela eta.

Helburua

Emakume immigranteen Euskadiko osasun sistema publikorako eta sexu eta ugalketa zerbitzuetarako sarbidean dituzten oztopoak eta faktore bideratzaileak ezagutzea, dohaineko kliniketan lan egiten duten osasun langileen pertzepzioa aztertuz.

Metodologia

Parte-hartzaileak

Lagina 11 informatzailez osaturik egon zen, guztiak Euskadiko dohaineko klinikaren batean lan egiten duten osasun langileak zirelarik (medikuak, erizainak edo psikologoak). Hauetako hamar emakumeak ziren. Era berean, bederatzik osasun sistema publikoan lanean zeuden edo egon ziren datu bilketa egin zen momentuan. Parte-hartzaileen ezaugarriak, 8. taulan adierazten dira.

Lehenengo, dohaineko kliniken identifikazio, bertaratzea eta pertsona arduradunekin harremana egin zen. Hauei ikerketa aurkeztu zitzaien klinikan lan egiten zuten osasun langileei parte hartzeko aukera eman ziezaieten. Parte hartzea erabaki zuten osasun langileei, informazio gehiago jasotzeko eta elkarrizketarako data eta lekua zehazteko kontaktua eskaini zitzaien. Hala eskatu zutenei, elkarrizketa gida aurrez bidali zitzaien. Proiektuaren aurkezpen gutuna 1. eranskinean aurkitu daiteke.

8. Taula. 2. ikerketako parte-hartzaileen ezaugarriak

	Lehen mailako arretadohaineko klinika	**Sexu eta ugalketa osasun dohaineko klinika**		
		1. zentroa	**2. zentroa**	**3. zentroa**
Lanbidea	(4) medikua (1) erizaina (1) emagina	(1) erizaina (1) psikologoa	(1) medikua (1) erizaina	(1) medikua
Osasun sistema publikoan lan egin du?	(4) medikua (2) erizaina		(1) medikua	(1) medikua
Esperientzia urteak dohaineko klinikan	(3) +10 (1) 2 (1) 4 (1) 9	(2) +10	(1) 1 (1) +10	(1) 8

Datu bilketa

2015. urteko iraila eta abenduaren artean bildu ziren datuak, Bilboko hirian kokaturiko lau dohaineko kliniketan. Datuak jasotzeko, elkarrizketa sakonak egin ziren. Hauek gidatzeko, elkarrizketa gida erdi-egituratuta erabili zen (2. eranskinean). Datuak biltzeko prozesuan zehar gidan aldaketak egin ziren, agertzen ziren ideia eta kontzeptu interesgarriak hurrengo elkarrizketetan jardun ahal izateko. Datu bilketa bukatutzat eman zen elkarrizketetan behin eta berriro errepikakorra zen informazioa agertu zenean.

Parte-hartzaile bakoitzeko datu sozio-demografikoak bildu ziren. Gero, immigranteen arretan izandako esperientziari buruzko galderak egin zitzaien. Azkenik, immigranteak osasun sistemarako sarbidean eduki ditzaketen oztopo eta bideratzaileei buruz galdetu zitzaien. Elkarrizketa hasi aurretik, elkarrizketak grabatuak izateko hitzezko eta idatzizko baimena eman zuten. Elkarrizketek, 35 eta 70 minutu artean iraun zuten eta gaztelaniaz egin ziren.

Datu analisia

Datuen analisia, edukiaren analisi kualitatiboa metodologia erabiliz egin zen. Metodologia hau, eduki manifestuaren deskribapen sistematikoan eta eduki latentearen interpretazioan

oinarritzen da. Graneheimek eta Lundmanek emandako gidalerroak jarraituz gauzatu zen (73). Ikerketa honetan, eduki manifestua baino ez zen analizatu.

Elkarrizketa guztiak audioan grabatuta eta transkribatuak izan ziren. Analisia, edukiaren irakurketa arretatsuarekin hasi zen. Transkripzioak *Open Code 4.03 Qualitative data Analysis* (74) programara inportatu ziren kodifikazio prozesua egiteko. Lehenengo, esanahi unitateak, edo ikerketa galderari erantzuna ematen dioten testuaren parteak, identifikatu ziren eta hauetatik, esanahi unitate laburtuak eratu ziren. Hauen laburpenetik, kodeak atera ziren. Kodeak, era berean, aztertuak eta kategoriatan klasifikatuak izan ziren.

Emaitzak

Analisia egin eta gero, emakume immigranteek Euskadiko osasun sistema publikorako eta sexu eta ugalketa osasun zerbitzuetarako sarbidean topatzen dituzten oztopoak eta bideragarriak lau kategoriatan sailkatu ziren: 1) immigranteen ezaugarri pertsonalak, haien jatorriarekin estu erlazionaturik daudenak; 2) osasun zentroetako langileen immigranteenganako jarrera; 3) osasun sistemaren ezaugarriak eta funtzionamendua eta 4) eskakizun legalak.

Esaidazu nongoa zaren eta osasun sisteman sartzeko dituzun aukerak esango dizkizut

Lehenengo kategoria emakumeen ezaugarrietan oinarritzen da. Adibidez, Latino Amerikakoa izatea, faktore bideratzailea zela adierazi zuten, hizkuntza berdina eta antzerako kultura edukitzeagatik. Gainera, haien eskubideak eta osasun sistema hobeto ezagutzen dituztela esan zuten. Faktore hauek guztiak, osasun sistemara hurbilketa errazagoa egiten dutela adierazi zuten. Lehen mailako arreta eskaintzen duen dohaineko klinikako mediku batek, honi buruz, hauxe zioen:

Sarbidea, jatorria eta hizkuntzarekin erlazionaturik dago. Hizkuntza berdina hitz eginda, haien beharrak adierazteko eta hauek ulertuak izateko askoz ere errazago daukate… (Medikua, LMA dohaineko klinika)

Aldiz, afrikarra izatea, sarbidean negatiboki eragin dezakeela adierazi zuten gaztelaniaz hitz egiteko zailtasunagatik, kulturen arteko desberdintasun handiagatik eta eskubideen ezjakintasunagatik. Sexu eta ugalketa osasun (SUO) dohaineko klinikako erizain batek zioen bezala:

Emakume latinoek ez dute sartzeko arazorik. Afrikarrak, ordea, pilo bat! Lehenengoz, (administratiboek) ez dituztelako entzun nahi ingelesez edo nigeriarrez hitz egiten doazenean… eta horrela, ez dira osasun kontsultetara heltzen (Erizaina, SUO dohaineko klinika)

Osasun langileek, enplegatua egotea, sarbiderako bai oztopoa zein bideratzailea izan daitekeela identifikatu zuten. Alde batetik, lana edukitzeak zerbitzuak eta tratamenduak

ordaintzeko ahalmena handitzen duelako. Bestetik, betetzen dituzten lanen ezegonkortasunak, osasun zentroetara joateko ahalmena gutxitu dezakeelako, enplegatzaileek ipini ditzaketen oztopoak direla eta.

Emakume immigranteak, eta baita bertakoak ere, genero indarkeria egoeratan daudenean, osasun zentroetara hurbiltzeko autonomia gutxitua daukatela adierazi zuten. Lehenengo, erasotzaileek espresuki debekatu dezaketelako. Bigarren, haiek ere osasun langileek genero indarkeriako biktima direla jakin dezatela ekidin nahi dutelako. Sexu eta ugalketa osasuna eskaintzen duen dohaineko klinika bateko erizain batek, horrela azaldu zuen:

Genero indarkeria sufritzen duten emakumeak, etengabeko beldurrean bizi dira. Kasu batzuetan, haien bikotekideek zuzenean mehatxatzen dituzte osasun zentroetara ez joateko, hauek ere gertatzen ari dena ezkutuan gera dadila nahi dutelako. Gainera, emakumeak ere haien burua biktima bezala onartzeko arazoak dituzte. Badakite, behin pausu hori emanda egoeratik irtetzeko esfortzuak egin behar izango dituztela, eta guztiak ez daude horretarako prest (Erizaina, SUO dohaineko klinika)

Euskadin luze bizi izateak eta sare sozial pertsonal zabala edukitzeak, osasun zerbitzuetara sartzeko faktore bideragarriak zirela identifikatu zuten, eskuragai dauden zerbitzu publikoak eta gizarte erakundeak hobeto ezagutzea eragiten dutelako.

Behin osasun kontsultan, dena ondo doa. Arazoak, administratiboekin dituzte gehienbat

Bigarren kategorian, profesionalak immigranteei arreta emateko daukaten prestutasunak hauen sarbidean daukan eragina adierazten du. Osasun sistema publikoko langileek lan-karga handiak dituztela eta immigranteen arreta haien eguneroko ohikeriaren kanpokoa dela uzte zuten parte-hartzaileek. Hori dela eta, immigranteei arreta emateko prestutasuna nahiko ahula dela zioten.

Immigranteei edo bertoko bati arreta ematea ez da berdina. Sistema publikoan lan egiten dutenek lan-karga handia eta lan ohitura finkoak dituzte. Ohitura hauen aldaketak tentsioak ekar ditzake eta horregatik, immigranteekiko jarrera desberdina garatu dezakete (Medikua, LMA dohaineko klinika)

Parte-hartzaileek, administratiboak immigranteen osasun zerbitzuetarako sarbiderako oztoporik handiena direla deskribatu zuten, immigranteei arreta pobrea eskaini eta haien eskubideei buruzko informazioa faltan dutela argudiatuz. Immigranteekiko osasun langileen arreta, aldiz, egokiagoa zela deskribatu zuten.

Behin osasun kontsultan daudela, dena ondo doa. Baina administratiboenagana doazenean edozein gauza eskatzera, tontoak izango balira bezala tratatzen dituztela diote (emakume immigranteek) (Erizaina, SUO dohaineko klinika)

Osasun zentroetan immigranteen osasun egoera zaurgarriarekin sentsibilizatutako profesionalak aurkitzea, hauen sarbidea errazten duen faktore bat dela adierazi zuten

dohaineko kliniketako osasun langileek, legearen eskakizunak betetzen ez dituzten pertsonen sarbidea ahalbidetzen dutelako:

Immigranteen bazterketa bidezkoa ez dela pentsatzen duten profesionalek, batzuetan zuzenean osasun kontsultetara pasatzen dituzte (immigranteak) (Erizaina, SUO dohaineko klinika)

Osasun sistema zurruna eta pasiboa

Hirugarren kategoriak, informazio faltak eta osasun sistemaren kudeaketak sarbidean nola eragiten duten aurkezten du. Parte-hartzaileek, osasun sistemak sarbiderako informazioa osasun zentroetan baino eskaintzen ez duela deskribatu zuten. Gainera, administratiboak, informazioa eskaintzeko arduradunak direnak, immigranteen osasun eskubideei buruzko informazioa guztiz ezagutzen ez dutela zioten. Ondorioz, populazio zaurgarriek, immigranteak eta genero indarkeria egoeran dauden emakumeak barne, sarritan gizarte erakundeetara jotzen dutela informazioa lortzeko, osasun zentroetara ez joatearren.

Dokumentaziorik gabekoak osasun sistematik kanpo daude. Beste talde zaurgarriak ere badaude: prostituzioan jarduten direnak, trafikatuak direnak edo genero indarkeria sufritzen dutenak. Hauek, ez dira berez osasun zentroetara joango, nahiz eta arreta behar izan. Baina gizarte erakundeetara badatoz informazio eta arreta bila. Osasun sistema modu desberdin batean hauetara hurbildu beharko litzateke (Medikua, LMA dohaineko klinika)

Osasun zentroetako pertsonal faltak eta paziente bakoitzari arreta emateko denbora eskasak, emakumeak haien osasunari buruzko erabakiak hartzeko ahalmena gutxitzen duela adierazi zuten. Dohaineko klinikak, aho biko osasun baliabide bezala deskribatu zuten: Alde batetik, immigranteen osasuna sustatzen dutelako. Bestetik, osasun agintariei ziurtatzen dietelako, osasun publiko arazoak bihurtu daitezkeen kasuak identifikatuak izango direla. Azken honek, immigranteen osasun zerbitzuetarako sarbidearen onarpenean, osasun sistema publikoaren jarrera pasiboa indartzen duelarik. LMA-rako dohaineko klinikan lan egiten duten erizain eta mediku bik esan zuten bezala:

Dohaineko klinikak ez lirateke existitu behar, pertsona guztiak osasun sistema publikoan arreta jaso beharko luketelako. Hori posiblea den arte, beharrezko baliabideak dira, baina arriskutsuak aldi berean, osasun agintariei lasaitasuna ematen dielako pertsona hauek osasun zerbitzu bat jasotzen ari direla jakiteak (Erizaina, LMA dohaineko klinika)

Uste dut dohaineko klinikek, immigranteen osasun beharrak asetzen dituztela, baina baliabide arriskutsuak dira, osasun sistema paraleloa eratzen dutelako. Noski, immigranteen osasuna hobetzen dute baina bakarrik baliagarriak izango dira informazioa eman eta intzidentzia politikoa egiteko ere balio duten bitartean (Medikua, LMA dohaineko klinika)

Eskakizun legalak betetzen ez badituzu, kanpoan geratzen zara. Legea, legea da

Parte-hartzaile guztiek, eskakizun legalak immigranteen sarbiderako oztoporik garrantzitsuenak direla deskribatu zuten, haien eskubideen ez jakintzak indarturik. Batzuek identifikatu zuten eskakizun legalen betetzea, errolda edukitzearekin estu erlazionaturik dagoena, immigranteentzako zailak dela, batez ere dokumentaziorik gabekoentzat.

Zentroetara heltzerakoan, errolda edo dirua eskatzen diete. Ez badaukate, hortxe geratzen dira, arretarik gabe. Immigrante askok ez dute erroldarik, batez ere dokumentaziorik gabekoak, herriz-herri asko mugitzen dira eta (Medikua, LMA dohaineko klinika)

Gainera, sarbiderako, dokumentaziorik gabekoak egoera bereziki zaurgarrian daudela kontsideratu zuten, gobernuak haien legez kanpoko egoera ezagutzeak ekar dezakeen ondorioen beldurragatik:

Immigranteek ez dute haien eskubideei eta osasun sistemari buruzko informazio askorik. Gainera, dokumentaziorik gabekoak direnean, normalean ez dute hizkuntza ezagutzen eta osasun zentroetara hurbiltzea beldur dira, immigrazio erakundeekin arazoak ez edukitzeko… (Erizaina, LMA dohaineko klinika)

Azkenez, parte-hartzaileek 2012ko legearen aldaketak immigranteen eskubideei buruzko informazioaren nahastea eragin zuela adierazi zuten, bai immigranteen zein osasun zentroetako langileen artean. Bestalde, immigranteen artean, jasotako osasun zerbitzuengatik ordaindu behar izateko beldurra handitu zuela eta eskubideen urraketa kasuen kopuruak ere gora egin zuela adierazi zuten.

Legearen aldaketa eman zenetik, emakume gehiago datoz dohaineko klinikara, osasun sistema ezagutzen ez dutelako eta haien eskubideengatik galdetzeko arazoak dituztelako. Gainera, behe mailakoak izango balira bezala sentitzen dira askotan, bereziki dokumentaziorik gabekoak direnean (Erizaina, SUO dohaineko klinika)

Faktore bideratzaile bezala, informazio faltari aurre egiteko, dohaineko klinikek eskubideei buruzko informazioa eta aholkularitza legala eskaintzen egiten duten lana azpimarratu zuten.

Discussion

The results of this study indicate that there is a considerable number of barriers and some facilitators in the access of immigrant women to healthcare and SRH services in the Basque Country. The conceptualization of person-centred access proposed by Levesque allows analysing the factors that influence the access at individual level, and to classify our results on the five dimensions for an appropriate healthcare (28):

Approachability

Same as presented in the literature, our study identified that the social and cultural constructions of health and illness of the women care-seekers influence the ability to perceive the need for healthcare attention and the approachability to healthcare services (75,76). In addition, the passivity of the healthcare system that did not make any effort to do community outreach work outside the healthcare centres, reinforces the law of the inverse care, which states that the groups of population having biggest need for healthcare attention are the ones who receive it the less (29).

Acceptability

Coinciding with other studies, fearing legal consequences for being identified as undocumented immigrant (20,77) and lack of knowledge on their rights and the functioning of the health system, were recognized as important access barriers in this study (21). Having a large social network and time of residence in the host country (21,78) and having legal counselling (20) acted as facilitators.

As in our study, lack of knowledge on local language has been frequently described as one of the biggest personal barriers for access and for communication with staff at the health centres (21,70,79). Even though, existing studies usually problematize the lack of language knowledge of the care-seekers, and not of the care providers (75). The utilization of appropriate translators, same as cultural mediators, could eliminate these barriers (75). However, when "formal" translators are not provided within the system, the use of minors and relatives as "informal" translators in the consultations, especially when SRH issues are discussed, may bring ethical conflicts (4).

Availability

For our participants, not fulfilling the legal requirements for accessing was considered the biggest barrier for access of immigrant populations (29). Immigration laws ruling the residence permit and nationalization process give preference to Latin American immigrants than to other origin immigrants (80), which also facilitates their access to healthcare services.

As the emergency unit is legally recognized to be of universal access, it is the most utilized healthcare level by the immigrant population and is considered an effective way to enter healthcare services (11,81). However, limiting immigrants' healthcare attention to emergencies entails higher risk for public health, and is more costly than attending them in primary health level and reinforcing prevention measures (44).

Our study coincides with other studies in affirming that to be in prostitution and other gender based violence situations, which are more prevalent among immigrant women,

hinders their access as it limits their autonomy and ability to reach healthcare attention (19,82).

Levesque states that access to healthcare services of less technical quality and to those located in a single place, as free clinics, do not represent a real and equitable access because people have less possibilities to reach them and to choose if they are the services they need (28). However, our participants, same as in other studies, considered the free clinics as guarantors of the health and healthcare access of immigrant people (20,21,25), due to the fact that they provided not only healthcare services, but also legal attention and political advocacy. However, they were also presented as risky resources, since they can be used by the policy makers as a justification for maintaining the exclusion of immigrants from the public health care system.

Affordability

Healthcare services in Spain are provided free of change, even if the prescribed medication is only subsidized in part. However, due to the policy change in 2012, healthcare services should be billed to those accessing without fulfilling legal requirements, besides needing to pay the 100% of the cost of medicines (43,50). That is why, the fear to be billed acts as a barrier on the decision to access, especially for undocumented immigrants (77).

Having a job was considered both a facilitator and a barrier on the access. In the literature, as in our study, domestic workers are considered to be in a vulnerable situation because they suffer from constraints of their legally recognized rights (21). The greater social discrimination of African immigrants hinders their labour integration and in consequence, the regularization of their administrative status becomes more difficult than for immigrants from other origins (80).

Appropriateness

Participants considered that the attitude of healthcare professionals towards immigrants was better in comparison to administrative staff's. As it also has been stated in other studies, this statement can hide certain corporate defence (19).

The excessive workload and the small number of administrative and healthcare staff, besides their limited predisposition and prejudices on immigrants, hinder attention to cultural diversity and prevents offering care of good quality and person-centred (38,75,83). However, finding professionals who are sensitized with the healthcare exclusion situation of immigrant population is considered a key factor to facilitate their access (21).

Limitations of the study

When doing the first interviews, the general aim of the study was focused on the access of immigrant women to SRH services, so the questions were focused on access to them. However, as the participants were answering as referring to both general and SRH services, the aim was broaden for covering both levels of attention.

Another limitation of this study is that it explores the barriers and facilitators of access not directly from the experiences of immigrant women or from the perspective of the staff at the health centres. However, this study was the first one done in the thesis, so we considered that it was easier to start with healthcare professionals and then, to move to explore the experiences of women in the following study. We decided to consider the perception of healthcare professionals working at the free clinics due to their experience on providing healthcare to immigrants, so having knowledge on the immigrants' social and healthcare situation. Moreover, many of the interviewed participants actually work or had worked at the public healthcare system (see Table 8).

3. KAPITULUA/CHAPTER 3

Euskadiko testuinguruan, Afrika Sub-Sahararreko emakumeak osasun sistemarako sarbidean oztoporik gehien dituzten immigranteak direla aurkitu da (84). Horregatik, hirugarren ikerketa honetan emakume immigrante hauek dituzten oztopoak aztertu nahi izan ziren.

Eskakizun legalez gain, osasun sistemaren antolaketa, osasun zentroetako langileen jarrera eta immigranteen ezaugarriak, hauen sarbidean eragiten dute (37,84). Gainera, immigranteen sarbidea eragozten duten faktoreen artean, arrazismo estrukturala ere aurkitu daiteke (85). Arrazismoa, osasunaren faktore determinatzailea da, osasun adierazleetan negatiboki eragiten duena (86,87). Bereziki populazio zaurgarrietan eragiten du, aborigenak edo immigranteak bezala, eta batez ere, *"Euro-zuritasuna"*-ren baloreek menderatzen duten gizarteetan ematen da (88,89).

Arrazismoaren eragina osasun adierazleetan eta osasun zerbitzuetarako sarbidean, Estatu Batuetan zabalki ikertua izan da (86,87). Ikerketa hauek dioten bezala, pertsona beltzek osasun adierazle txarragoak edukitzeko arrazoien artekoa, osasun langileek diagnostikatzerakoan eta tratamendua ipintzerakoan daukaten sesgo kliniko arrazista da (90). Europan, Ingalaterran egindako ikerketa batek aurkitu zuen bezala, beltzek eta gutxiengo etnikoek osasun adierazle txarragoak eta osasun zerbitzuetarako sarbidean oztopo gehiago zeuzkaten. Bide batez, tratamendurako posibilitate gutxiago eta bertakoak baino modu desberdinean tratatuak izan zirenaren pertzepzioa zeukaten (91). Praktika arrazista hauek, ez daude osasun langileen ikuspuntu arrazistan oinarrituta bakarrik, gizartean, osasun sisteman barne, erroturik dagoen arrazismoan baino (92).

Helburua

Euskadiko osasun sistemarako sarbidean eta erabileran, emakume immigrante Sub-Sahararren pertzepzioa eta esperientziak aztertu.

Metodologia

Parte-hartzaileak

Afrika Sub-Sahararreko zortzi herrialdetatik datozen hamalau emakume elkarrizketatu ziren, Euskadiko osasun sistema publikoa erabili dutenak. Errekrutatzea hiru modutan egin nuen: Lehenengo, lehen mailako arreta dohaineko klinikaren itxaron gelara heltzen ziren emakumeei ikerketan parte hartzea eskaini zitzaien. Bigarren, immigranteekin lan egiten duten gizarte erakundeei ikerketa aurkeztu zitzaien haien erabiltzaileen artean parte hartzeko aukera eskaini zezaten. Azkenez, erakunde hauetan lanean zeuden emakume Sub-Sahararrei ere parte hartzeko aukera eman zitzaien.

Hamalau parte-hartzailetik, lau dokumentaziorik gabekoak ziren elkarrizketa egiteko momentuan. Beste hamarretatik, lau dokumentaziorik gabekoak izan ziren noizbait. Parte-hartzaileen datu soziodemografikoak eta ezaugarriak, 9. Taulan adierazten dira.

9. Taula. 3. ikerketako parte-hartzaileen ezaugarriak

Migrazio estatusa	Dokumentazioarekin (10). Hauetatik, dokumentaziorik gabekoak izan dira (4)	Dokumentaziorik gabekoak (4)
Jatorrizko herrialdea	Cameroon Guinea Bissau (2) Senegal Angola (3) Central African Republic Democratic Republic of Congo Gambia	Democratic Republic of Congo (2) Nigeria Cameroon
Egoitza-baimena mota	Senarraren bitartez etorritakoak (4) Asilo-eskatzaileak (2) Besteak (4)	Ez dute (4)
Osasun sistemaren erabilera	Beharrezkoa kontsideratzen dutenean (10)	Behin (1) 2 alditan (2) 3 alditan (1)
Beste osasun baliabideen erabilera	Dohaineko klinika, osasun txartela eduki aurretik (2) Osasun zerbitzu pribatuak (1)	Dohaineko klinika (4)
Osasun txartelaren edukitzea	10	Ez dute (4)
Adina	25 - 35 (3) 36 - 60 (6) 60 baino gehiago (1)	25 - 35 (3) 36 - 60 (1)
Elkarrizketan erabilitako hizkuntza	Gaztelania (9) Frantsesa (1)	Frantsesa (2) Ingelesa (1) Swahili (itzultzailearekin) (1)
Euskadin egondako denbora	6 hilabete baino gutxiago (1) 6 hilabete – urte bat (1) 1-5 urte (2) 5 urte baino gehiago (6)	6 hilabete baino gutxiago (2) 6 hilabete – urte bat (2) 1-5 urte 5 urte baino gehiago
Enplegua	Lanean (6)	Ez dute (4)

Datu bilketa

2016ko ekainaren eta 2017ko urriaren artean egin ziren elkarrizketak. Gida erdi egituratuta erabili zen, agertutako gaia interesgarriak hurrengo elkarrizketan ere jardun ahal izateko. Elkarrizketak, osasun sisteman eduki dituzten esperientziari buruzko galdera ireki batekin hasi ziren. Legeen ezaguerak, bertako hizkuntza ez menperatzeak, dokumentaziorik gabekoa izateak eta beste faktore batzuk sarbidean eduki dezaketen eraginari buruz galdetu zitzaien. Azkenez, gizartea, osasun sistema eta arrazismoaren arteko erlazioari buruz galdetu zitzaien.

Elkarrizketak 25-70 minutukoak izan ziren. Hauetako bederatzi gaztelaniaz egin ziren, bat ingelesez, hiru frantsesez eta bat swahili eta frantsesez. Bi alditan, parte-hartzaileen lehentasuna zela eta, frantsesetik gaztelaniarako itzultzaileak erabili ziren. Kasu batean, itzulpena erabili zen swahilitik frantsesera. Itzultzaile guztiak, parte-hartzaileek beraiek eskainitakoak izan ziren.

Datu analisia

Elkarrizketa guztiak transkribatu eta zehaztasuna egiaztatzeko, errepasatu ziren. Gaztelaniaz eta ingelesez egindakoak, hitzez-hitz transkribatu ziren eta frantsesez egindakoak, gaztelaniara itzuli ziren transkribatzerako momentuan. Testu guztiak *Open Code 4.03 Qualitative data analysis* (74) programan sartu ziren, informazioaren egituraketa eta kodifikazioa errazteko. Datuak, bi modu desberdinetan analizatu ziren:

Lehenengo, datuen analisia, analisi tematikoa metodologia jarraituz egin zen (93), Steven Lukes-en gizarte erlazioetako boterearen analisia jarraituz (94) (3. Kutxa). Teoria honen erabilera, Watters-ek osasun zerbitzuetarako sarbidea eta Lukes-en bi lehenengo botere dimentsioen artean egindako erlazioan oinarritzen zen (54). Tesirako egindako analisian, Lukes-en hirugarren dimentsioa ere barneratu zen.

Transkripzioetan, esanahi unitateak identifikatu ziren, ikerketa galderarekin erlazionatutako informazio zatiak direlarik. Hauek, kodetan laburtu ziren eta kodeak, Lukes-ek ezarritako hiru botere dimentsioetan oinarrituz sailkatu ziren, kode taldeak eratuz. Kode talde bakoitza sakonago aztertu zen, hiru tema sortuz. Tema bakoitzaren barruan, azpi-temak garatu genituen, hauen barneko informazioa antolatzeko helburuarekin.

Bigarren, behin datu guztiak tema eta azpi-tematan sailkaturik, metodologia kualitatiboak ahalbidetzen duen eraldatzea dela eta, kode guztiak berrantolatuak izan ziren, edukiaren analisi kualitatiboa metodologia jarraituz (73). Hortik, hiru kategoria garatu ziren.

3. Kutxa. Lukes-en gizarte erlazioetako boterearen analisia eta gaiarekiko erlazioa

Lukes-en gizarte erlazioetako boterearen ikuspuntua honakoa da: Norbaitek beste baten gaineko boterea gauzatzen du, lehenengoak bigarrenaren interesen kontra doan jarrera daukanean (94,95). Lukes-en arabera, botere mota honek, hiru dimentsio ditu:

Lehenengo dimentsioan, boterea era aktibo eta nahitasunez gauzatzen da (95) eta erabakiak hartzeko prozesutan oinarritzen da (94). Testuko sarbiderako legeen eraginari lotutako parteak, dimentsio honetan sartu ziren.

Bigarren dimentsioan, gizarte baloreak, balore politikoak eta erakunde-praktikak eraldatzen dira boterean dauden gizarte-taldeen interesak babesteko (94). Osasun sistemarekin eta langileekin izandako elkarrekintzatik sortatuko oztopo eta bideratzaileak dimentsio honetan sailkatu ziren.

Hirugarren dimentsioa informazioaren kontrolarekin eta sozializazio prozesuekin estu erlazionaturik dago eta gizartean boterean dauden gizarte-taldeen praktikak barneratzen ditu (94). Dimentsio honetan, arrazismoagatik eta dokumentaziorik gabekoak izateagatik parte-hartzaileek adierazitako oztopoak sailkatu ziren.

Emaitzak

Hirugarren ikerketan, parte-hartzaileek sarbiderako oztopo estrukturalak eta hauei aurre egiteko bideratzaile indibidualak aurkeztu zituzten. Kategoriek, emakume immigranteak osasun zentroetara hurbiltzeko edo bueltatzeko adierazi zituzten oztopoak eta bideratzaileak biltzen dituzte. Lehenengo kategoria, *Immigranteentzako lagunkoia ez den osasun sistemara hurbiltzeko beldurretan*, sarbidea oztopatu dezaketen estatus legalari eta sozialari lotutako faktoreak barnebiltzen ditu. Bigarrenak, *Arretan, profesionalek ezartzen dituzte komunikazio arauak*, komunikazioaren papera osasun zerbitzuetarako sarbidean aurkezten du. Hirugarrenak, *Arreta desberdindua jasotzea: arrazismoa edo zorte txarra?*, beltza eta immigrantea izateak arreta jasotzerakoan duen eragina aztertzen du.

Immigranteentzako lagunkoia ez den osasun sistemara hurbiltzeko beldurretan

Lehenengo kategoriak, beldurra eta informazio faltak sarbidean daukaten eragina deskribatzen du, batez ere dokumentaziorik gabeko immigranteetan eragiten dutelarik. Sarbidea arautzen duten legeei eta sarbiderako prozesuei buruzko ezaguera ezak, immigranteak osasun zentroetara ez hurbiltzea eragiten duela adierazi zuten parte-hartzaileek. Aldiz, osasun txartela edukitzeak, eskubideak erabiltzeko laguntza kontsideratu zuten. Tamyk, dokumentaziorik gabeko parte-hartzaile batek esan zuen bezala:

Txartelarekin, ez dago arazo gehiagorik. Hizkuntza ondo menperatzen ez badut ere, txartelarekin askoz ere errazago daukat osasun zerbitzuak lortzeko (Tamy)

Parte-hartzaileen aburuz, immigranteak orokorrean, baina batez ere dokumentaziorik gabekoak, osasun zentroetara joateko beldur dira, bertako langileengandik beheramendua jaso dezaketela pentsatzen dutelako. Are gehiago, dokumentaziorik gabekoek osasun zentroak ekiditen dituzte, informazio falta eta haien legez kanpoko egoera direla eta, immigrazio erakundeetan salatuak izan daitezkelaren beldur direlako. Gainera, eskakizun legalak ez betetzeagatik osasun zerbitzuak ordaindu behar dituztela esaten dietenean, hauen prezioari aurre egin ahal ez izateak, haien deportazioa eragin dezakeela uste dutelako.

Bai, hasieran beldur dira (dokumentaziorik gabeko immigranteak). Ni lehenengo aldian, beldur nintzen. Mmmm… nire beldurra bazen… medikuarengana heltzea eta berak esatea: "non daude zure dokumentuak? Zuk ez daukazu hemen egoteko eskubiderik!" (Maureen)

(Osasun sistema) Espainiako gobernuarekin komunikatu daiteke eta estatutik kanpo botako gaituzte. Gainera, dirurik ez badaukagu, osasun sistemarekin daukagun zorrak, prozesua azkartu dezake (Carol)

Horregatik, osasun zerbitzuak ordaintzeko eskaerak, sarbidearako oztopo bezala aurkitu zuten, Arjanak esan bezala:

Imajina ezazu: Oso gaixo nengoen, baina ez zidaten arretarik eman nahi. Horko gizonak (administratiboak), esan zidan: "Barkatu, baina ezin dut ezer egin". Zerbitzua jasotzeko ordaindu nezakeela ere esan zidan, baina nik esan nion: "Ordaintzea? Ez dut dirurik, ez dut laguntzarik, ez dut ezer ez". Oso zaila izan zen. Hortik alde egin nuen (Arjana)

Gainera, parte-hartzaileek adierazi zuten administratiboek ez dutela beti immigranteen osasun zerbitzuetarako sarbidearen legearen ezagutzen, batzuetan, informazio kontraesankorra ematen dute eta.

Faktore bideratzaile bezala, gizarte erakundeetan informazioa lortzea edo osasun zentroetara informazio osoa daukan norbaitekin joatea identifikatu zituzten. Horrez gain, profesional batzuek, legeak araututakoari kontra eginez, immigranteen sarbidea ahalbidetzen dutela esan zuten. Hala ere, laguntza hau, normalean, modu eraginkorrean komunikatzeagatik, tematzeagatik edo profesionalaren ezaguna izateagatik eskaintzen dela uste zuten, Teresak esan zuen bezala:

Ezagutzen nauen erizain bat, ni administratiboarekin hitz egiten nengoela, etorri zen eta esan zion: "Zein da emakume honekin dagoen arazoa?" Eta niri esan zidan: "Etor zaitez nirekin, medikuak ikus zaitzala eta gero pentsatuko dugu nola justifikatu dezakegun kontsulta" (Teressa)

Arretan, profesionalek ezartzen dituzte komunikazio arauak

Bigarren kategoriak osasun zentroetako langileekin emandako elkarrekintzan sortutako komunikazio oztopoak eta hauen ondorioak deskribatzen ditu. Bertako hizkuntzaren ezjakintasunak, sarbiderako oztopo oso garrantzitsutzat hartu zen.

Administratiboekin komunikazio eraginkorra ez edukitzeak, sarbiderako posibilitateen gutxitzea dakarrela adierazi zuten parte-hartzaileek. Gainera, profesional hauetako gutxik bertakoak ez diren hizkuntzak menperatzen dituztela uste zuten. Aldiz, osasun langileek hizkuntza gehiagotan komunikatzeko gai direla uste zuten. Nahiz eta hala izan, osasun langileekin komunikazio arazoak izan zituztenean, diagnostikatuak izateko arazoak edo tratamenduak hartzerakoan akatsak eduki zituztela adierazi zuten.

Nire lehengusua gurekin eraman nuen medikuaren kontsultara, nire semea gaixorik baitzegoen. Medikuak azaldu zigun, umeak 3 alditan arnastu behar zuela medikamentua, 10 segundoko tartearekin. Baina nire lehengusuak, 10 alditan 3 segunduro zela ulertu zuen. Imajina ezazu! Berak medikazio hartu zezan, estu hartu behar nuen eta gaixoak ezin zuen arnastu… benetan, nire semea hil egingo zela pentsatu nuen… Azkenean, ospitalera eraman nuen eta akatsaz ohartu ginen (Arjana)

Orokorrean, parte-hartzaileek zioten profesionalek ez dutela esfortzu handirik egiten haiekin komunikatzeko, immigranteekiko duten jarrera negatiboa arrazoi posible bezala azalduz. Gainera, bertako hizkuntzak ez hitz egiteak, egoera zaurgarrian ipintzen dituela zioten, profesionalen edo beste erabiltzaileen komentario arrazistei aurre egiteko ezinean egoteagatik.

Hizkuntza menperatzea abantaila bat da. Jendeak modu txarrean begiratzen zaituenean, esan dezakezulako: "Zergatik begiratzen nauzu modu horretan?" Baina hizkuntza ez badakizu… mugaturik zaude eta aurre egiteko beldur zara, ez dakizulako zer edo nola esan (Carol)

Ahhh... oso zaila da, bertan (osasun zentroetan), jendeak ez dakielako ingelesez. Ez bazaituzte ulertzen, bada… arreta eman nahi ez dizutela dirudi. Esaten didate: "Euskadin zaude, gaztelaniaz hitz egin behar duzu" (Jessy)

Bai profesionalek zein immigranteek, komunikatzeko estrategiak garatzen dituztela zioten. Adibidez, osasun zentroetara beste norbaitekin joatea, immigranteek sarritan erabiltzen duten estrategia da, batez ere lagun bat, senarra edo ondorengo bat eramaten dutelarik. Hala ere, arazo etikoa suposatu dezakeela identifikatu zuten, konfidentzialtasun eta pribatutasun falta direla eta.

Askok ez doaz osasun zentroetara komunikazio arazoak dituztelako. Edo baldin badoaz, norbaitekin doaz. Eta askotan, beste batek zure osasun arazoak ezagutu ditzan ez duzu nahi (Jessy)

Arreta desberdindua jasotzea: arrazismoa edo zorte txarra?

Hirugarren kategorian, immigrantea eta beltza izateak osasun zentroetan jasotzen duten arretan daukan eragina aztertzen da. Kasu honetan ere, parte-hartzaileek administratiboengandik eta osasun langilengandik jasotako arretan desberdintasunak sumatu zituzten:

Administratiboek, bertokoak eta immigranteak modu desberdinean tratatzen dituztela adierazi zuten. Aldiz, osasun langileen bokazioa, arrazista izatearekin bateraezina zela adierazi zuten parte-hartzaile batzuek.

Arrazismoa existitzen dela badakit, baina medikuak ez dira arrazistak; ezin dira izan, hortxe jendea laguntzeko daudelako... ez, ez, ezin dira izan (Yemi)

Hala ere, hauengandik jasandako jarrera desberdinduak ere deskribatu zituzten: Adibidez, parte-hartzaile batek gizarte zerbitzuekin arazoak izan zituen emakume baten kasua kontatu zuen, berari galdetu ezean, bere umea ondo zaintzen ez zuela egotzi ziotelarik.

Maliko emakume bat pediatrarenagana joan zen bere umetxoarekin eta honi arropa kentzeko esan zion. Gu, karité olioa botatzen diegu umetxoei, eta gazta bezalako usain txarra dauka, baina ona da beraien osasunerako. Medikuak gizarte langilea deitu zuen segituan: "umea ondo zaintzen ez duen emakume bat daukat kontsultan, umeak kriston usain txarra dauka eta". Emakume horrek arazo asko-asko eduki zituen, umea kendu nahi baitzioten! (Fatima)

Beste parte-hartzaile batek, historia klinikoan beltza zela ipini zutela ikusterakoan, txarto sentitu zela esan zuen. Azkenez, medikuek immigranteei buruz zituen estereotipoek diagnostikoan eragina izan zuten kasuak aurkeztu zituzten. Adibidez, parte-hartzaile batek esan zuen bezala, ospitaleratua zegoen bitartean, osasun langileek susmoarekin begiratzen zuten, Ebola eduki zezakeela pentsatuz, nahiz eta azken urteetan Euskaditik ez zen irten. Beste batek, medikuak diagnostikoa egiteko frogak egin nahi ez zizkiola kontatu zuen, bere sintomak moldatze faltagatik zirela adieraziz.

Medikuari azaldu nion luze neramala gaixo, hilerokoa, hilerokoa, hilerokoa... baino ez nuelako. Eta aitzakia ematen ari zidala ulertu nuen… Neukana, ez zen bakarrik moldatze faltagatik! Bi hilabete neramalako horrela. Eta berak, hotzari moldatuta ez nengoelako zela esaten zuen, baina ez zen horregatik, oso gaixorik nengoen (Mariam)

Gizarte-erakundeetan lanean zeuden parte-hartzaileek, pertsona beltzek osasun sisteman jasotzen duten arreta desberdindua eta kolonialismoaren arteko erlazioa egin zuten.

Jendeak, hizkuntza ez jakitea beltzekin erlazionatzen du. Gizarte imajinario bat dago beltzen inguruan, animaliak bezalakoak, ikasgabeak, zakarrak, primarioak, eta abar direla. Historiak beltzengan ezarri dituen etiketa horiek guztiek, gaur egun (osasu sistemarako) sarbidean eragiten dute (Elizabeth)

Parte-hartzaile hauek, osasun zentroetako langile askok immigranteei buruzko estereotipoak jarraituz, osasun zerbitzu asko eskatzen dituztela eta hauek merezi ez dituztela uste dutela adierazi zuten. Azkenez, historia koloniala, immigranteak haien burua behe-mailakoa sentitzearen arrazoia dela uste zuten, haien eskubideak defendatzea zaila eginez.

(Behe-mailakoak sentitzea) barneraturik daukate esklabotasun urte asko eta gero. Kolonizazioa, esklabotasunaren jarraipena baino ez zen izan. Eta orain, immigrazioa beste jarraipen bat baino ez da. Komunikabideetan ematen zaion tratamendua baino ez da ikusi behar. Horregatik, behe-mailakoak direla barneraturik daukate eta balio gutxiago daukatela uste dute (Elizabeth)

(Osasun zentroetan), batzuek ez dizkizute gauzak azaldu nahi. Immigrantea zara, hona zatoz baliabideak eskuratzera, hemen gogaitzeko baino ez zaude... Jarrera... betiere txarra da immigranteekiko (Anne Marie)

Parte-hartzaile batzuek desberdinkeriaz tratatuak izatea arrazismoarekin eta kolonialismoarekin erlazionatu zuten bitartean, beste batzuek desberdinkeria anekdotikoa, bakarrik beltzei gertatzen ez zaiena eta profesionalak momentu txarrean hartzeagatiko egoera kontsideratu zuten.

Profesionalek akatsak egiten dituzte, baina ez dauka zerikusirik azalaren kolorearekin. Ez, ez, ez, ez, ez, kolorearekin ez, nik ez dut inoiz hori aurkitu. Esperientzia hori eduki duten batzuk ezagutzen ditut, baina ez nik. Esaten dute: "medikuak ez nau ezta ukitzen ere!". Ez zaituzte ukitzen. Behin, baneukan mediku bat gurekiko nazka sentitzen ez zuena: ukitzen gintuen eta gero eskuak garbitzen zituen (Precious)

Discussion

Our findings suggest that Sub-Saharan African immigrant women need to overcome numerous barriers to get appropriate healthcare in the Basque Public Health System, which were explained by some of the participants as related to structural racism. That is why, the barriers found in the third category, which represents the influence of a racist shared social imaginary on immigrants and black people, influence on their access to appropriate healthcare, so also reinforces the barriers in the first and second categories. That is, these shared stereotyped preconceptions negatively affect the attention given by staff at health centres, same as health systems' and staff's unwillingness to be organized for considering the needs of a culturally, linguistically and socially diverse population.

Healthcare policies construct human beings as *not* equal in rights, stablishing different entitlement between immigrants with different social conditions and migration status. For vulnerable populations, such as undocumented immigrants and asylum seekers, entitlement is considered to be a benevolent action or a privilege rather than an exercise of their rights, for being considered undeserving of those services and perceived as an

economic burden (39,54,75,96). As seen in our study, social vulnerability of undocumented immigrants, induced by their legal situation, made them more difficult to get a source of income and pay for accommodation to be registered as a resident (39,75), which is a sine qua non condition to get the healthcare card in Spain.

In addition, undocumented immigrants suffer from stigma on the basis of documentation status (90) and as a result, are reported to have more problems than the documented ones to access healthcare, for fearing to be rejected by the health centre professionals or reported to immigration authorities, even if the absence of obligation for it (21,29,34,37,39). In other studies, as appearing in our results, access for undocumented immigrants was also described as variable and dependent on the goodwill of individual professionals (21,39). Therefore, undocumentedness acts as a great barrier not only for their entitlement to rights to healthcare, but for maintaining good health and mental health outcomes (26).

Similarly to our results, previous studies showed that the lack of entitlement to the right to healthcare is an important barrier for immigrants to access healthcare (39,86). The complexity of administrative procedures, as obtaining the healthcare card in the Spanish National Health System, is also considered in the literature as difficult to understand and to follow for immigrants (34,75), same as the demand to pay for the healthcare services is considered as a factor that prevents immigrants to access (21,34,39,75,77). However, contrary to immigrants' reported experiences, healthcare workers and managers in Catalonia and Andalusia perceived that immigrants do not have any difficulty or barrier in the process to get the healthcare card (97,81) and considered their access easy and on equal conditions to natives (97). However, professionals working at free clinics in the Basque Country perceived that immigrants have several difficulties on accessing healthcare services due to multiple barriers (84).

Like in our participants' narratives, lack of awareness of the legal entitlement among both immigrants and the staff at the health centres has also been extensively described in other studies as an important access barrier for immigrants (21,34,39,75), resulting in avoiding to access or receiving mislead information about their rights at the first point of contact with health services (39,54). In Spain, 4755 cases have gathered on which immigrants have been denied access to healthcare despite having legal rights to access, especially after the law reform of 2012 (98).

Therefore, entitlement is not the only barrier in order to access an appropriate healthcare. Like our participants stated, the language barrier has also been extensively described in the literature as one of the main barriers to an effective access to healthcare for immigrants (21,34,39,54,75,77,99), but few times the unwillingness of the staff to provide attention in a not local language has been pointed as a problem (39). As seen in our results, ineffective communication compromised the biomedical care and the received attention (99). Even if using interpreters is a usual strategy for immigrants to communicate in the health system,

their use does not mean that patients' needs and concerns are heard (39,99). On top of that, the use of relatives and/or non-professional interpreters can lead to ethical problems in terms of misunderstandings, confidentiality and privacy (75).

Out of a shared language, there are some other factors that can favour the communication and relationship between patients and professionals, like a receptive attitude or the efforts made by professionals to meet and attend patients' necessities and to understand their cultural characteristics (99). In contrast, lack of cross cultural knowledge and different beliefs about health and disease complicate healthcare providers' understanding of the reason of consultation and the therapeutic approach to be undertaken (100).

Further than professionals' knowledge and willingness to provide an appropriate attention, racism also appears during the professional-patient interaction, as structural racism is deeply enrooted in social institutions, including the health system, its culture and norms (101). Especially in times of crisis, immigrants have been pointed out as "over users" of healthcare services (97). Even if it has been repeatedly stated that immigrants use in general the healthcare services in a minor proportion than native population (8,9,11,102), usually health centre staff share this vision of the disproportionate use of healthcare services by immigrants. Consequently, access disparities, delays or avoidance of accessing healthcare, and mistrust of the health system among immigrants can increase (27,101).

Same as it was identified by two of our participants, a study in France revealed how the caregivers also projected inherited representations of colonialism on Africans, marking them either as violent or as naive, which provoke differentiated healthcare practices (103).

The paradox of expressing overall satisfaction with healthcare services despite of having perceived discrimination or bad treatment that arose in our study was also found in a research about immigrants' perceptions of healthcare attention in the Spanish National Health System. Almost all the participants expressed having been treated respectfully, while at the same time, 60% also perceived discrimination towards immigrants and almost 70% answered that cultural differences negatively affected the quality of received attention (104). Expressing overall satisfaction despite of perceiving discrimination, have been explained based on a better consideration of the health systems at the host country, in comparison with a more limited or not for free attention in their country of origin (79,97). Same as the denial of having experienced racism, or considering it as a random experience as appeared in our results, can be seen as a strategy to "take over" the consequences derived from those situations, such as accepting being oneself in a disadvantaged social position (105).

The health system organization and the practices of the staff at the health centres have the capacity of transforming or preserving the power relations within the health systems (92). Even if barriers coming from them were identified, some facilitators, mainly related to professionals' good practices were also found.

Methodological considerations

For the recruitment, differences in power relations between researcher and participants may have influenced the willingness to participate and contribute to participants´ socially desirable responses. At the time to recruit the women in the waiting room of the free clinic, the first author presented herself as a researcher at the regional university and a nurse volunteering at the free clinic in order to increase participants' confidence and therefore, their predisposition to participate. The place of recruitment, which was considered friendly for immigrants as it was a well-known NGO free clinic, presumably increased the confidence of the immigrant women to participate. However, the acceptance of participation could have also been related to expectations of getting a differentiated attention at the free clinic where they were recruited.

During data collection, even if the topic was not related to personal health issues, participants may have had to recall situations of discrimination in the health system, which may have put them in a vulnerable situation in front of the researcher.

Most of the interviews were made in Spanish. Interviewer's first language is Spanish, while it is not for any of the participants. Likewise, some language nuances could have been missed when translating the interviews from French into Spanish.

In order to analyse the data in the most rigorous way possible, due to the absence of familiarity with the topic, authors performing it were constantly consulting each other during the process. The narrative of the results was repeatedly shared with all authors in order to ascertain that the way women's experiences were interpreted remained grounded on the data.

EZTABAIDA OROKORRA/GENERAL DISCUSSION

Eztabaida orokorrean, ikerketetan agertutako emaitzarik nabarmenenak literaturako emaitzekin alderatzen dira. Hauek, Watters-ek ezarritako sarbiderako mailetan klasifikatuko dira; hau da, osasun zerbitzuak jasotzeko eskubidea, hauetarako sarbidea eta hauen egokitasuna (54).

Osasun zerbitzuak jasotzeko eskubidea

Immigrazio eta osasun politikak, immigranteekiko praktika instituzionalak gidatzeaz gain, hauekiko gizarte onarpena eta babes legala neurtzeko tresnak ere badira. Europako herrialde anitzetan, Giza eskubideen eta dokumenturik gabeko immigranteak osasun zerbitzuak jasotzeko eskubidearen artean desberdintasun nabarmena dago (34).

Herrialde Europarrek, bakoitzak modu desberdinean aitortzen die immigranteei osasun zerbitzuak jasotzeko eskubidea. Espainia, 2018ko uztailean aplikatutako legearen ostean, Europako herrialdeen artean, immigranteei zerbitzu gehien eskaintzen dien herrialdeen artean dago (106). Hala ere, immigrante guztiak ez dira berdin tratatuak legearen aurrean; adibidez, Europar Batasuneko (EB) beste herrialdeetatik datozenak, ez dute oztopo legalik haien sarbidean (107). Halaber, konpentsazio historikoa dela eta, Latino Amerikako immigranteak, beste EB-tik kanpoko immigranteekin konparaturik, nazionalizazioa lortzeko baldintza errazagoak dauzkate (80). Honek, beste batzuen artean, osasun sistemarako sarbidea lortzea errazten die.

Gure ikerketetan agertu den bezala, literaturak osasun zerbitzuak jasotzeko eskubiderik eza, immigranteen sarbiderako oztopo nabarmena dela dio (39,84). Azkenengo krisialdiaren garaian egindako ikerketa batek, eskubide honen murrizteak immigranteen hilkortasuna handitu zuela dio; Espainian, 2012ko osasun legea aplikatu zenetik, hauen hilkortasuna %16.82, %15.08 eta %22.6 igo zelako 2013, 2014 eta 2015. urteetan, hurrenez hurren (108).

Prozesu administratiboen betetzea, informazioa edo osasun txartela lortzea bezala, immigranteentzako zaila kontsideratu zen (34,75). Gainera, dokumentaziorik gabeko immigranteentzako, haien gizarte eta bizi baldintza okerragoak direla eta, errolda lortzea oztopo garrantzitsutzat eman zen (39,54,75), hau osasun zerbitzuak modu jarraian jasotzeko beharrezkoa den osasun txartela lortzeko baldintza izanda. Gainera, Espainian modu ilegalean sartzen diren immigranteak, askotan identifikazio dokumenturik gabe heltzen dira, migrazio prozesuaren baldintzak eta sufritutako indarkeria direla eta.

Osasun eskubidea betetzeko, gizarteko populaziorik zaurgarrienei osasun zerbitzuak eskaintzea nahitaezkoa da estatuentzat. Beraz, diskriminaziorik-eza eta erantzukizun printzipioak errespetatu behar dituzte.

Osasun eskubideko erantzukizuna eta diskriminaziorik-eza printzipioak Espainiako testuinguru legalean

Hunt and Backman-ek dioten bezala (58), osasun eskubidearekiko estatuen erantzukizuna bi zutabeetan oinarritzen da: Lehenengo, osasun eskubidea lege nazionaletan agertu behar da. Bigarren, eskubideari buruzko informazio argia eskaini behar zaie bai osasun zerbitzuak eskaintzen dituzten profesionalei zein erabiltzaileei, legitimikoki eskatu dezaketena ezagutu dezaten.

Espainia eta Euskadiko legeria azaltzen den atalean ikusi den bezala, immigranteen osasun zerbitzuetarako sarbidea Espainia osoan, 2012. urtera arte, unibertsala kontsideratzen zen. Ordura arte, osasun sistema nazional osoan, osasun zerbitzuak, Espainiako edozein herritan 90 eguneko errolda zuen edonori eskaintzen zitzaizkion. Gainera, betiere atentzioa ziurtatuta zeukaten honako kasuek: adingabekoek, emergentziek eta jaio aurreko, erditzeko eta erditu eta osteko zainketak behar dituzten emakumeak (1. Taula ikusi).

Krisi garaian, RDL 16/2012 onartu zen, lege aldaketa egiteko nahitaezkoa den justifikazio ekonomikoa eta gizartean izango duen eragina neurtzeko txostenik gabe (44,45). Nazioarteko Giza eskubideak babesteko erakunde askok[6] ardura adierazi zuten lege berriak immigranteen osasunean eduki zezakeen eragina zela eta. Hala ere, araua ez zuten aldatu, 2018ko uztailean gobernu berri batek egin zuen arte.

Estatuak osasun eskubidea guztiontzako bermatzeko erantzuleak dira. Beraz, estutasun ekonomikoa ez da neurri atzerakoiak hartzeko justifikazio legitimoa (55,56). Neurri atzerakoiak hartzeko beharretan, estatuak alternatiba posible guztiak kontuan izan dituela frogatu behar du (56). Hala ere, RDL 16/2012-a onartzeko, ez zen ebaluazio txostenik aurkeztu (48). Auzitegi Konstituzionalak berak diru publikoaren aurrezpena behar bezala justifikaturik egon ez zela adierazi zuen (45).

Dokumentaziorik gabeko immigranteak osasun zerbitzuetatik kanpo uztean, RDL 16/2012-a, argi eta garbi jo zuen osasun eskubideko diskriminaziorik-eza printzipioaren kontra. Printzipio honek, estatuek osasun zerbitzuak guztiontzako bermatzeko, diskriminazio modu guztiekin bukatzeko obligazioa daukala esaten du (55).

Gobernuak, beste neurrien artean, 873,000 dokumenturik gabeko immigranteen osasun txartelak baliogabetu zituela onartu zuen (5), lehen mailako arreta zerbitzuetatik kanpo utziz. Literaturak behin eta berriro erakutsi duen bezala, lehen mailako arreta mugatzeak,

[6] Besteak beste, osasun lege berria aldatzeko edo kentzeko gomendioak hauek egin zituzten (48):

Eskubide ekonomiko, sozial eta kulturaletarako komitea
Nazio Batuetako Intolerantzia, xenofobia eta arrazismo forma desberdinetarako erreportaria
Nazio Batuetako guztiontzako osasun eskubiderako erreportaria
Nazio Batuetako migratuen Giza eskubideetarako erreportaria
Europar Batasuneko Giza eskubideetarako batzordea
Europar Batasuneko gizarte eskubideetarako batzordea
Nazio Batuetako Giza eskubideetarako eta muturreko pobreziarako erreportaria
Nazio Batuetako pertsonen trafikorako erreportaria

emergentzia unitateak gehiago erabiltzera darama. Honek, kostu gehiago suposatzeaz gain, osasun publikorako arriskua suposatzen duelarik (44).

Jarraipen eta ebaluazioan, erakunde publikoez gain, gizarte erakundeek rol erabakitzailea daukate. Adibidez, 2012ko lege aldaketan, osasun langileen sareak sortu ziren, lege berriari desobedientzia egiteko euskarria eskaintzen zituztenak (109).

Nahiz eta osasun eskubideak estatuek populazio zaurgarrien osasun zerbitzuetarako eskubidea bermatu behar dutela esan, printzipio honekin ez betetzeak ez du ondorio legalik. 2012. urtean gertatutako legearen aldaketa, hau baieztatzeko kasu paradigmatikoa da.

Erantzukizunaren bigarren oinarria aintzat hartuz, lege aldaketak immigranteen osasun zerbitzuetarako eskubidearen gainean informazio nahastea sortu zuen; bai osasun zentroetako langileetan zein erabiltzaileetan (21,34). Profesionalen informazio ezak, osasun zerbitzuetarako eskubidearen urraketa gehiago egon dadila eragiten du. REDER-ek, RDL 16/2012-aren aurkako erresistentzia sareak, 2014ko urtarriletik 2019ko urtarrileraino, 4755 eskubide urraketa bildu ditu. Hauen artean, eskakizun legalak betetzen zituztenei arretarik ez eskaintzea, osasun zentroan informazio okerra jasotzeak edo osasun zerbitzuen fakturatze okerrak daude (98). Médicos del Mundo Euskadi-ko dohaineko klinikan, 2014ko irailetik 2018ko ekainera, Euskadiko osasun sisteman gertatutako 106 eskubideen urraketa bildu dira.

Dohaineko klinikak: aho biko baliabideak

Lehenengo ikerketaren emaitzetan ikusi den bezala, lehen mailako arreta eskaintzen duen dohaineko klinikan, urtero 700-1000 osasun kontsulta inguru ematen dira. Sexu eta ugalketa osasun dohaineko klinika batek, 2014. urtean, 517 emakume immigranteri arreta eman ziotela adierazi zuen honen arduradunak.

Alde batetik, dohaineko klinikak beharrezkoak direla agertu da gure ikerketetan, osasun sistematik kanpo dauden immigranteei informazioa eta osasun arreta ematen diotelako. Gainera, osasun publiko arazoa izan daitezkeen kasuak identifikatzen dituelako. Hala ere, hauen lanarik nabarmenena, osasun eskubideari buruz egiten duten intzidentzia politikoa kontsideratu zen.

Hala eta guztiz ere, aho biko ezpatak bezala ere kontsideratu ziren, edo baliabide arriskutsuak, osasun sistema paralelo baten eraketa ahalbidetzen dutelako, immigranteen sarbidearenganako botere publikoen arduragabekeria sustatu dezakeena (20). Gainera, osasun eskubidearen interpretazioan, adituek ordezko osasun zerbitzuak garatzearen aurka aurkezten dira, arrazoi berbera dela eta (60).

Osasun zerbitzuetarako sarbidea

Watters-en modeloan adierazten den osasun zerbitzuetarako sarbidea mailan eragiten duten oztopo eta faktore bideragarriak, Levesque-k ezarritako dimentsioetan klasifikaturik hobeto aurkeztu daitezke (28):

Gerturatze dimentsioarekin erlazionaturik, osasun zerbitzuen identifikazioa eta hauek erabiltzeko modua, gaixotasuna eta osasunari buruzko kontsiderazio sozial eta kulturalekin erlazionaturik daudela ikusi da (75,76). Gainera, osasun sistemari buruzko informazioa edukitzeko eta hauetara hurbiltzeko, sistemak berak populazio zaurgarrietara hurbiltzeko egiten dituen esfortzu eskasak oztopo bezala azaldu zen (29). Informazioa, osasun zentroetan eta web orrialdean baino ez da ematen. Beraz, baliabide hauek aurrez ezagutu behar dira, informazioa jaso ahal izateko. Tesian ikusi den bezala, administratiboak osasun zentroetan informazioa emateko arduradunak dira (66), baina immigranteen osasun zerbitzuetarako sarbiderako informazioa ez dute beti behar bezala ezagutzen. Horregatik, dohaineko klinikek eta beste gizarte erakundeek eskaintzen duten informazioa eta aholkularitza dela eta, hauekin harremanetan egotea sarbiderako faktore bideragarri bezala azaldu zen (20,21,25).

Osasun zerbitzuen onarpenaren dimentsioan, dokumentaziorik gabekoa izatea, osasun zerbitzuetarako eta osasun fisikoa eta mentala mantentzeko oztopoa dela aurkitu zen (20,26,77). Lehenengo, dokumentaziorik ez edukitzea dakarren estigmagatik (90) eta haien eskubideei eta osasun sistemaren funtzionamenduari buruzko ezagutza faltagatik (21). Bigarren, osasun zentroetara gerturatzea ekidin dezaketelako, baztertuak izateko edo zentroetako langileak immigrazio erakundeei haien presentziaren berri eman dezaketelako beldurra dela eta (21,29,34,37,39). Horregatik guztiagatik, dokumentaziorik gabeko immigranteek, dokumentazioa daukatenek baino oztopo gehiago dituzte osasun zerbitzuetarako sarbidean (21). 2015. urteko ikerketa batek dio, azkeneko urtean Europako herrialdeetan, dokumentaziorik gabeko bost immigrantetatik batek, osasun zerbitzuetarako sarbidea alde batera utzi zuela aurkitutako oztopoak zirela eta (110). Faktore bideragarri bezala, sare sozial pertsonal zabala eta harrerako herrialdean denbora luzea egotea adierazi ziren (21,78), osasun sistemarekiko ezagutza eta konfiantza handitzen dutelako.

Erabilgarritasun dimentsioan, bai tesiaren emaitzetan zein literaturan, eskakizun legalak ez betetzea, sarbidea oztopatzen duen faktore erabakigarri bezala agertu zen (29). Prostituzioan jarduteak edo genero indarkeria sufritzeak, osasun zentroetara hurbiltzeko emakumeen autonomia gutxitzen duela ikusi da (19,82). Kasu hauetan, dohaineko klinikak, immigranteen osasuna eta osasun zerbitzuetarako sarbiderako sustatzailetzat eman ziren (20,21,25), hauek emandako osasun zerbitzu, aholkularitza legala eta intzidentzia politikoa dela eta.

Ordaintzeko ahalmenarekin erlazionaturik, jasotako osasun zerbitzuengatik ordaindu behar izateko beldurrak sarbiderako oztopoa zela adierazi zen (77). Tradizionalki, Espainiako osasun sisteman jasotako zerbitzuak dohainekoak izan dira. Hala ere, RDL 16/2012 aplikatu zenetik 2018ko uztailera arte, bai Espainian zein Euskadin, eskakizun legalak

betetzen ez zituztenen zerbitzuak ordaindu behar zirela ezarri zen (43,50). Lana edukitzea, aldiz, zerbitzuak ordaintzeko ahalmena handitzen duenez, sarbiderako faktore bideragarri kontsideratu zen.

Osasun zerbitzuetako egokitasuna

Komunikazioa

Gure emaitzetan sarritan agertu den bezala, literaturak hizkuntzaren ezjakintasuna sarbiderako oztopo oso garrantzitsu bezala ezarri du (21,34,39,54,75,77,99). Ezaugarri kulturalen ezagutzak eta jarrera harkorra izateak ere komunikazioan modu positiboan eragiten dute, profesional eta erabiltzailearen arteko erlazioa hobetuz. Horregatik, ulertzea eta ulertua izateak, informazioa era eraginkor batean lortzeko faktore gakoa da. Aldiz, komunikazio ez-eraginkor batek, jasotako osasun zerbitzuak konpromisoan ipini ditzake (99).

Euskadiko osasun sisteman, osasun arreta eskaintzen ez duten profesionalak, (administratiboak barne), hizkuntza ez-lokalak ezagutzeagatik ez dira sarituak izaten. Gainera, osasun zentroetako langileek eskura dituzten itzultzeko tresnak ez dituzte era egokian erabiltzen; osasun zentroetan komunikazio arazoak eduki dituzten parte-hartzaileekin, batekin ere ez dutelako Osakidetzak eskaintzen duen aldibereko itzulpenerako tresna erabili. Honen arrazoiak, erabiltzaile bakoitzari arreta emateko denbora eskasa eta beste lehentasunen agerpena izan zitezkeela adierazi da (16). Bitartekari kulturalen erabilera, egoera hau hobetu dezake (75), familiakoak edo adingabekoak itzultzaile bezala erabiltzeak, arretaren kalitatea konprometitzeaz gain, gatazka etikoak ere sortu ditzakelako (4).

Arrazismoa

Arrazismo estrukturala gizartean, osasun sisteman eta honen kultura eta arauetan erroturik dago (101). Bereziki krisialdietan, immigranteak osasun zerbitzuen gehiegizko erabilera egiten dutela kontsideratu egin da (97). Aldiz, literaturak behin eta berriro frogatu egin du immigranteak, pertsona lokalekin konparaturik, hauek proportzio txikiagoan erabiltzen dituztela (8,9,11,102). Premisa honek, immigranteak osasun eta gizarte prestazioak merezi ez dituen “bestea” bezala kontsideratzen duen gizarte arrazoibidea indartzen du (54). Bestearen eraketarako prozesu honek, gizarte botereen desoreka mantentzen laguntzen du (111).

“Ilegal” bezala ikusiak diren pertsonak, dokumentaziorik gabekoak edo asilo-eskatzaileak besteak beste, gizarteko kide ez-legitimo bezala kontsideratuak dira. Ondorioz, haiei osasun zerbitzuak eskaintzea borondate oneko ekintzatzat eta zama ekonomikotzat ematen da, haien eskubideen partetzat baino (39,54,75,96).

Arrazismo estrukturala profesional eta pazientearen arteko erlazioan ere agertzen da (101). Osasun zentroetako langileek ere, sarritan, immigranteek osasun zerbitzuen gehiegizko erabilera egiten dutenaren pertzepzioa badaukate (17). Horrela, osasun sistemaren barnean botereen desoreka mantendu dadila ahalbidetzen dute (19). Hala ere, nahiz eta desberdinkerian oinarrituriko arreta eskaintzen duten, askotan ez dute nahita egiten, gizartearen baloreak jarraituz baino (112) eta horregatik, osasun sisteman ematen diren praktika arrazistak, ikusezin irauten dute (113). Osasun zentroetako langileen jardunbide egokiek, beraz, osasun sistemarekiko pertsona indibidualek dauzkaten esperientzietan eragina izan dezakete, baina osasun sistema eta gizartearen antolakuntzan ere eragingo dute.

Osasun langileen gida etikoek, kode deontologikoak barne, legeen eduki aldakorrak aldera utziz, pertsona guztiei diskriminaziorik gabeko arreta eskaintzeko beharra adierazten dute. Osasun sistema barneratzaileagoa garatzeko, eskubideetan oinarritutako arretaren baloreak indartu, profesionalen ezagutza garatu eta bitartekaritza kulturala bezalako neurriak hartu beharko lirateke.

ONDORIOAK/CONCLUSIONS

Emakume immigranteen Euskadiko osasun zerbitzuetarako sarbidea oztopatzen duten faktoreak, lau motatakoak izan daitezke: 1) immigranteen ezaugarri pertsonalak, haien jatorriarekin estu erlazionaturik daudenak; 2) osasun zentroetako langileen immigranteenganako jarrera; 3) osasun sistemaren ezaugarriak eta funtzionamendua eta 4) eskakizun legalak. Aurreko faktorez gain, arrazismo estrukturalaren eraginak ere immigranteen osasun zerbitzuetarako oztopoa suposatzen duela aurkitu zen. Gainera, hau gizartean oso erroturik dagoenez, osasun sisteman barne, eskakizun legalak, osasun sistemaren funtzionamendua eta immigranteekiko imajinario sozialean ere eragina dauka.

Maila legalean, osasun zerbitzuak jasotzeko eskubidea sarbide egokia ahalbidetzen duen faktore erabakigarri bezala agertu zen. Maila honetan gehien errepikatutako oztopoak, zerbitzuak jasotzeko eskubiderik eza, eskakizun legalak betetzeko zailtasunak eta dokumentaziorik gabekoa izatea izan ziren.

Sarbiderako mailan, hizkuntza lokala ez ezagutzeak, dakarren komunikazio ez eraginkorrarekin batera, immigranteen sarbidean eta osasunean negatiboki eragiten duela aurkitu zen. Beste faktore batzuek, informazio falta edo baztertua izateko beldurra bezala, immigranteak osasun zentroetara ez gerturatzea eragiten dutela azaldu zen.

Osasun zerbitzuen egokitasunaren inguruan, osasun zentroetako langileen kultur aniztasunean arreta emateko ezagutzarik eta prestutasunik eza, immigranteen sarbiderako oztopo bezala adierazi zen. Kasu batzuetan, arrazismoa profesional eta pazientearen arteko erlazioan agertzen zela identifikatu zen, osasun langileek ere gizartean dagoen immigranteekiko imajinarioarekin bat egiten dutelako.

Bitartean, profesionalengandik, gizarte erakundengandik edo sare sozial pertsonalengandik informazioa, akonpainamendua eta sostengua jasotzea sarbiderako faktore bideratzaileak kontsideratu ziren. Halaber, dohaineko klinikak immigranteen osasuna eta osasun zerbitzuetarako sarbidea hobetzen duten baliabideak kontsideratu ziren. Gainera, populazio osoaren babesean laguntzen dutela aurkitu zen, osasun publiko arazoak izan daitezkeen kasuak identifikatzeko gai direlako. Hala ere, egindako intzidentzia politikoa haien indargunea dela kontsideratu zen.

Populazio zaurgarrienen osasun zerbitzuak jasotzeko eskubidea indartzea nahitaezkoa da haien osasun zerbitzuetarako sarbidea bermatzeko. Horrez gainera, osasun eskubidean oinarritutako arreta, bitartekaritza kulturala eta informazio iturri eskuragarriagoak sustatu beharko lirateke diskriminaziorik gabeko eta barneratzaileagoa den osasun sistema bat garatzeko.

IMPLICATIONS FOR FURTHER RESEARCH/ IKERKETARAKO ARLOAK

To date, available evidence analysing the access to healthcare services of immigrant populations has mainly focused on the entitlement and access level. However, little is known about the appropriateness of the healthcare services. Hence, it would be interesting to explore the role that racism and social stereotypes play on hindering the access and appropriateness levels of the access.

Related to entitlement, a lot of work with very novel approaches has already been done. Even then, inequalities in strategies, health plans and laws need to be continuously monitored to make sure that the non-discrimination principle is fulfilled for populations on vulnerable situation. Future studies should deepen on creating evidence on relating immigrants´ accessibility to healthcare services, immigrants' health and social determinants of health, using quantitative and qualitative data.

The quasi-universal coverage of the actual Spanish law ruling the access for immigrant populations, is a good starting point to further develop policies to improve access and ensure quality and appropriateness of healthcare for a culturally diverse population.

The policy change occurred in 2012 is a great opportunity to assess how immigrants' health outcomes and access to healthcare were affected after its implementation in the different autonomous communities. Likewise, law change in 2018 provides the opportunity to compare and improve on the found areas of concern.

CHALLENGES OF DOING RESEARCH WITH IMMIGRANTS/ IMMIGRANTEEKIN IKERTZEAREN ERRONKAK

The researchers' social position, cultural standard, personal characteristics and experiences shape the research process (114). In this thesis, none of the signatories have Sub-Saharan origin nor are immigrant in the Spanish context, so they had an outsider-perspective on the topic, which has advantages and disadvantages for the research process and outcomes:

As the authors were not familiar with the study topic, the participant were considered to be in the position of experts, which could be part of an empowering process for them. Likewise, the researchers approached the topic with an open viewpoint that may lead to identifying disguised associations and considering the topic from a broader perspective than the experiential.

However, the absence of familiarity with the study topic, which may lead to inability to fully comprehend the participants' experience or reflect it appropriately, also posed some challenges.

The recruitment of immigrants, especially when they are undocumented, is difficult to complete. A very recurrent strategy is to resort to associations or NGO that work with immigrants, or to catch them in the health system, which was not very useful considering the topic of this thesis. However, those persons who are not organized in social organizations, are difficult to reach, so their experiences remain more invisible.

At the moment of recruitment, one of the African women who was workers at a social organization, refuse to participate as she was not in agreement with the perspective of being interviews as an African immigrant woman, instead of as a professional in migrants' issues.

During the interviews, the type of questions to pose also supposed something to seriously consider before. Even if personal questions were limited to the maximum, answers recalling situations of undocumentedness and illegal migrant status, gender based violence, racist attacks and violence during the migration process appeared. Treating this kind of topics could be hard not only for the participant, but also for the researcher.

Related to the language, participants and researcher may not share the same mother tongue. Inevitably, some language nuances could have been missed during interviews. In the cases translators are used, there is need to make sure that for the participants is does not suppose a potential problem and we need to recall translators about the importance of keeping confidentiality and discretion with the information treated during the interview.

GLOSSARY/GLOSARIOA

Access to healthcare/*Osasun zerbitzuetarako sarbidea***:** The opportunity to reach and obtain appropriate health care services in situations of perceived need for care (28).

Accountability/*Erantzukizuna***:** The process that enables right-holders to assess how duty-bearers have discharged their obligations, and provides duty-bearers with the opportunity to explicate the level of progress achieved (59).

Administrative professional/*Administratiboa***:** Responsible professionals for attending and orienting the users of public health services. Among others, they provide information in the health centres, protect users' and patients' rights, process the complaints presented by the users and supervise the compliance of the responsibilities and norms towards the patients (66).

Basque Public Health System/*Euskadiko osasun sistema***:** The constitution of the Department of Health, being the organization responsible for the planning, funding and regulation and Osakidetza as the Basque Public Healthcare Entity, which provides healthcare services (65).

City council register/*Errolda***:** The register that gathers all persons living in a municipality, after presenting a residence evidence. The inscription is the proof of settlement for immigrants to get allowances from public institutions (115).

Discrimination/*Bazterketa***:** any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms. It is linked to the marginalization of specific population groups and is generally at the root of fundamental structural inequalities in society (55).

Free clinic/*Dohaineko klinika***:** A private, non-for-profit, community-based organization that offers services such as primary and secondary medical and dental care [...] These services are offered for no cost or a small fee to low income, uninsured, or underinsured people (25).

Health system/*Osasun sistema***:** People, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health (116).

Healthcare professional/*Osasun langilea***:** Health centre staff who have the knowledge, skills and attitudes to provide healthcare, and which are organized in professional associations officially recognized by the public authorities. It is their responsibility to actively participate in projects that can benefit the health and well-being of people in health and illness situations, especially in the field of disease prevention, health education, research and the exchange of information with other professionals and with the health authorities, to better guarantee these purposes (68). Healthcare professionals referred to in this thesis are nurses and physicians.

Healthcare service/*Osasun zerbitzua***:** any service (i.e. not limited to medical or clinical services) aimed at contributing to improved health (116) through promotive, preventive, curative, rehabilitative and palliative interventions, whether directed to individuals or to populations (67).

Immigrant/*Immigrantea*: Person moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family (117).

Immigration/*Immigrazioa***:** A process by which non-nationals move into a country for the purpose of settlement (117).

Medical tourism/*Osasun turismoa***:** Travelling across international borders to receive some form of medical treatment (51).

National Health System/*Osasun sistema nazionala***:** A coordinated set of health services from the Central Government Administration and the autonomous communities that integrates all healthcare functions and benefits for which public authorities are legally responsible (64).

Nurse/*Erizaina***:** A person who has completed a programme of nursing education and are qualified and registered or authorized to provide responsible and competent service for the promotion of health, prevention of illness, the care of the sick and rehabilitation (67).

Physician/*Medikua***:** A graduate of medicine whose work entails the indication and realization of activities aimed at the promotion and maintenance of health, prevention of diseases and diagnosis, treatment, therapeutics and rehabilitation of patients, as well as the prognosis of care processes (68).

Primary healthcare centre/*Lehen mailako arreta zentroa***:** A centre that provides services which are usually the first point of contact with a health professional. They include services provided by general practitioners, community nurses, pharmacists and midwives, among others (67).

Racism/*Arrazismoa***:** the types of behaviours, practices, beliefs and prejudices that underlie systemic and avoidable inequalities in social power and opportunities across groups in society based on race, ethnicity, culture or religion (118).

Registered immigrant/*Erregistratutako immigrantea***:** In this thesis, it refers to an immigrant who is registered in any city council registration in the Basque Country

Right to health/*Osasun eskubidea***:** The right to health is not limited to the right to receiving healthcare as timely and appropriate medical care. It also includes "underlying determinants of health", which are factors or conditions that protect and promote health beyond health facilities, goods and services and that can help lead a healthy life: access to safe water and adequate sanitation; adequate supply of safe food, nutrition and housing; healthy occupational and environmental conditions; access to health-related education and information, including on sexual and reproductive health and gender equality (55,56).

Structural racism/*Arrazismo estrukturala***:** Ideologies, practices, processes and institutions that operate to produce and reproduce differential access to power and to life opportunities along racial and ethnic lines, creating "undesirable others" or "threats of a nation" (85).

Undocumented migrant/*Dokumentaziorik gabeko immigrantea***:** A non-national who enters or stays in a country without the appropriate documentation. This includes, among others: a person (a) who has no legal documentation to enter a country but manages to enter clandestinely, (b) who enters or stays using fraudulent documentation, (c) who, after entering using legal documentation, has stayed beyond the time authorized or otherwise violated the terms of entry and remained without authorization (117).

Vulnerability/*Zaurgarritasuna***:** A state of high exposure to certain risks and uncertainties, in combination with reduced ability to protect or defend oneself against those risks and uncertainties and cope with their negative consequences" (7).

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La salud es un derecho, no un privilegio

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Annex 2. Interview guide for study 2

1. Experiencias en los centros alternativos:

¿Cuáles son las condiciones para ser atendida/o en el centro donde trabajas? ¿Es necesario tener la tarjeta sanitaria?

Cuéntame un poco sobre el trabajo que hacéis en vuestra consulta con mujeres immigrantes sin tarjeta sanitaria.

¿Qué tipo de mujeres llegan a la consulta? ¿Cuáles crees que no acceden a este centro y por qué?

¿Realizáis derivaciones a Osakidetza?

¿Cómo llegan estas mujeres a la consulta? (recomendación otras mujeres, derivadas de Osakidetza u otros centros…) ¿Cuál es su actitud al acudir a la consulta? (¿Llegan con miedo a ser discriminadas o no atendidas?, participativas…)

¿Cuáles son las principales barreras para acceder a este tipo de servicios?

(Si no salen espontáneamente, explorar): miedo al rechazo o actitudes racistas, dinero, relaciones de poder en la pareja, falta información, Situación administrativa, Tipo de pareja, Lugar de residencia, Desconocimiento del derecho a la prestación sanitaria y de la red asistencial, Tiempo de residencia, Motivos socio-laborales, Barreras lingüísticas, país de origen, Cuestiones culturales o religiosas, Necesidades percibidas diferentes, Necesidades percibidas diferentes acuden a medicina tradicional u otros recursos…

¿Cómo es la relación en las consultas de SSR con mujeres immigrantes? ¿En qué difieren de la relación con otras pacientes?

2. El derecho a la salud y su cumplimiento

¿Crees que en el País Vasco las políticas sanitarias respetan el derecho a la salud de todas las personas? (¿Quiénes son esas personas excluidas?) ¿De qué forma crees que se les excluye?

¿Cómo crees que la existencia de los módulos psicosociales y otros centros alternativos * refuerzan el respeto del derecho a la salud de estas mujeres? *aquellos centros donde no hace falta cumplir los requisitos administrativos de Osakidetza para ser atendida/o

¿Qué consecuencias crees que ha tenido la implementación del RDL16/2012 en el acceso de estas mujeres a Osakidetza?

3. Acceso a los servicios públicos:

¿Cómo ves la atención de SSR en los servicios de Osakidetza para las mujeres immigrantes sin tarjeta sanitaria? (según las experiencias contadas por las pacientes)

¿Cuáles crees que son las principales barreras de las mujeres immigrantes sin tarjeta sanitaria para acudir a las consultas en Osakidetza a las que tienen derecho a asistir?

Explorar (si no salen espontáneamente): miedo al rechazo o actitudes racistas, dinero, relaciones de poder en la pareja, falta información, Situación administrativa, Tipo de pareja, Lugar de residencia, Desconocimiento del derecho a la prestación sanitaria y de la red asistencial, Tiempo de residencia, Motivos socio-laborales, Barreras lingüísticas, país de origen, Cuestiones culturales o religiosas, Necesidades percibidas diferentes, Necesidades percibidas diferentes acuden a medicina tradicional u otros recursos…

¿Cómo crees que las mujeres que sufren violencia de género se ven afectadas en su acceso a los servicios de atención sanitaria?

¿Crees que hay condiciones que facilitan el acceso a los servicios alternativos y a Osakidetza?

¿Qué relación tenéis con estos servicios públicos? ¿Comunicación/relación con otros recursos sanitarios no públicos? (consulta Médicos del Mundo, otros módulos…)

¿Cuál consideras que sería la situación ideal en relación a la atención sanitaria a personas immigrantes? ¿Y en concreto en la atención a la salud sexual y reproductiva?

Annex 7. Interview guide for study 3

EXPERIENCIAS Y PERCEPCIONES EN EL ACCESO Y LA ATENCIÓN

- ¿Cuál es tu experiencia con los servicios sanitarios públicos? (Explorar: Ya ha accedido/ha intentado acceder/no ha intentado acceder. ¿Por qué?)
- ¿Cómo fue tu primera experiencia con los servicios sanitarios?
- ¿Has tenido alguna vez la necesidad de acudir a los servicios sanitarios y no lo has hecho? ¿Por qué?
- ¿Te han negado alguna vez la atención sanitaria que has solicitado? (no atendida y si han dado razones)
- Cuando acudes a los servicios sanitarios… ¿lo haces sola, o acompañada? ¿Por qué? (traducción, apoyo…)

OTROS RECURSOS

- ¿Conoces otros recursos que dan atención sanitaria y que no son parte de Osakidetza? ¿los has utilizado alguna vez? (CASSIN, módulos…)
o ¿Por qué? (no tenías acceso al público, o los has utilizado aun teniendo acceso al sistema público)
o ¿Cómo te enteraste de su existencia?

CONOCIMIENTO DE DERECHOS Y NORMATIVA

- ¿Tienes tarjeta sanitaria o estás en trámites de conseguirla?
o SI: ¿Cómo te enteraste de los trámites que tenías que hacer para conseguir la tarjeta sanitaria? (red social, ONGs, ayuntamiento, centros Osakidetza…)
o NO: ¿Conoces la normativa para acceder a Osakidetza? ¿Sabes si cumples los requisitos? ¿Por qué vías te has informado? (red social, ONGs, ayuntamiento, centros Osakidetza…)

- Si tuvieras algún problema de salud… ¿sabrías hoy en día dónde acudir?
- ¿Conoces el funcionamiento de Osakidetza?
- ¿Cómo crees que el hecho de tener o no tener papeles afecta al acceso a los servicios sanitarios públicos?

Idioma
- ¿Cómo crees que afecta el idioma en el acceso para acceder a los servicios sanitarios?
- ¿No has accedido alguna vez por miedo a q no te entiendan?
- ¿Has tenido problemas para hacerte entender en los servicios sanitarios? (acceso y atención)
- Si fueras… ¿Crees que te entenderían bien?

Situación administrativa estable
- ¿Crees que las personas con situación administrativa legalizada acceden más fácilmente a los servicios sanitarios?

Trato inadecuado y comunicación inefectiva del personal
- ¿Cómo te ha tratado/te trata el personal administrativo en el mostrador cuando intentas acceder a los servicios sanitarios?
- ¿Y el personal sanitario?

Trabajo
- ¿Tener trabajo influye en el acceso a los servicios sanitarios?

Mayor discriminación racial y social
- ¿Crees que las mujeres immigrantes tenéis más problemas para acceder a los servicios sanitarios? (por ser immigrante/por ser mujer)
- ¿Tienes miedo a que te rechacen en los servicios sanitarios por ser immigrante?
- ¿Has tenido alguna experiencia de rechazo en el acceso o en la atención?

Tiempo de residencia
- ¿Crees que con mayor tiempo de residencia se conocen mejor los recursos?
- ¿Cuáles son los factores que pueden aumentar el conocimiento sobre los derechos sanitarios?

Utilización de medicinas alternativas
- ¿Con quién consultas primero cuando tienes un problema de salud?
- ¿Resuelves de la misma manera aquí los problemas de salud que en tu país?

Violencia de género
- ¿Cómo crees que la violencia de género afecta en el acceso a los servicios sanitarios públicos?