Ministry of Health of
the Republic of Moldova

MOLDOVAN MIGRANTS' HEALTH

IMPACT OF THE SOCIO-ECONOMIC WELFARE

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Moldovan Migrants' Health

Impact of the socio-economic welfare

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Members of the study coordination team were: Simion Terzioglo, Project Coordinator on behalf of the International Organization for Migration, Ion Jugau, Executive Director of CBS-AXA, Vasile Cantarji, Project Coordinator and author of the report, project manager of CBS-AXA, Natalia Vladicescu, project manager of CBS-AXA, with contribution to the report, Andrei Rotaru and Veaceslav Batrinescu, managers of CBS-AXA operators network.

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IOM Mission to Moldova
36/1 Ciuflea St.
Chisinau, MD-2001
Republic of Moldova
Tel. + 373 22 23-29-40; + 373 22 23-29-41
Fax: + 373 22 23-28-62; www.iom.md

CBS-AXA Sociological Research and Marketing Center
of. 202, 98 31 August St., Chisinau
Tel. (+373) 22 203 464, fax +373 234 987
office@cbs-axa.org, www.cbs-axa.org

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INTRODUCTION

Background

From the oldest times the history of mankind has been marked and shaped by major flows of population. Inter-country and intercontinental circulation of people still remains an essential characteristic of today's globalized world, becoming probably even more important in the shaping of the global social reality.

The disparities in the social and economic development of various countries and regions, together with the liberalization and intensification of capital, goods and services flows, as well as the increased efficiency of communication systems facilitates the mobility of persons, and implicitly of the workforce.

The latest data show that in the recent decades the number of people living outside their native countries has grown constantly and currently exceeds 190 million persons.

In the national context workforce migration from Moldova to other countries has become an immense reality in the independence period, and it once again shows that from the historical perspective the intensification of migration is a process associated with periods of any form of transition.

The experience of workforce emigration is shared not only by post-socialist countries, for which massive emigration has been and still is a reality since the 1990's, but for many other countries as well, some of which (Ireland, Italy, Turkey) have already overcome this phenomenon, while in others (Mexico, the Dominican Republic, El Salvador, etc.) it persists for longer periods of time.

Moldova, as part of the former USSR, has known various forms of workforce emigration since the soviet times when planned workforce migration within the Union was promoted ("Ground Breaking", "BAM" (Baikal-Amur Mainline), "Komsomolsk-on-Amur", forest exploitation in Siberia, etc.).

At present, Moldova is one of the countries most affected by the emigration of its citizens for work, whether seasonal or for a longer term. The phenomenon with its current characteristics emerged immediately after the dissolution of the USSR with all its economic, political and social implications. Migration reached its peak, both in terms of the number of citizens involved in the process and as the amount of remittances (money transferred by migrant workers to the country of their provenance), already in the first mid-decade of the 21st century, and by now the scale of migration tendencies seem to remain stable as well.

Project History

These processes have an enormous, multi-dimensional and lasting impact on all areas of the country's social, economic, cultural and political life. At the same time the effects of migration are widely discussed and studied in the attempt to forecast the impact and try to avoid the most acute consequences of mass emigration on the social and economic dimensions of the country. Opinions become more and more unanimous regarding the fact that if the current migration tendencies continue for a medium and long period, they can bring about more complex and acute problems for the country, rooted in this very process.

Migration leaves marks on a great number of social and demographic processes, affecting such aspects as workforce, family, the destiny of migrants' children, as well as on economic and financial processes – the impact of remittances, i.e. financial resources earned by migrants and sent to Moldova, on various aspects of the lives of theses people and those left at home.

This investigation was brought forth by the need for a more profound study of this correlation, especially of the connection between migration and the health area. Risks involved with migration for migrants' health; migrants' attitude to the national healthcare system and the healthcare systems of the countries where they work; the extent to which remittances increase or reduce the accessibility of medical services

for the people receiving these remittances; ways to improve the use of remittances for a more efficient access to medical services in the country – these and many other issues make the focus of this research.

The study is aimed at investigating the impact of migration and of migrants' social and economic situation on their health.

Specific objectives include evaluating the target group's situation by:

- Describing migrants' profile from the social, economic and psychological points of view, including their families' profile;
- Determining the interrelation between migrants' state of health and their social and economic situation;
- Identifying means of predicting worsening state of health of migrants;
- Evaluating behaviour patterns dangerous to migrants' health, including those related to HIV infection;
- Evaluating access to healthcare services;
- Evaluating migrants' involvement in the compulsory medical insurance system and identifying obstacles, if any;
- Recommending implementing a systematic approach / model for the collection, processing and dissemination of data on migrants' state of health;
- Recommending changing/adjusting administrative statistic procedures for the group of migrants;
- Performing an adequate analysis of data to provide for the development of migrant health protection and improvement policies.

I. METHODOLOGICAL ASPECTS OF RESEARCH

Proceeding from study goal and objectives, the collection of primary data followed a complex approach from the point of view of the methods applied, being a combination of the quantitative and qualitative methods.

In terms of quantity the study is based on a comparative survey focused on three groups distinct from the point of view of migration characteristics:

- Migrants – persons who have been abroad for work, having returned to the country at least 24 months before the interview date;
- Family members that receive remittances – families that in the past 12 months received remittances from citizens of Moldova working abroad, be it family members, relatives, friends, acquaintances, etc.;
- Family members that do not receive remittances – families that in the last 12 months did not receive remittances.

Survey methodology

Descriptive study.

Sample size is determined according to the following statistic formula:

$$n = \frac{Nt^2Pq}{N\Delta x^2 + t^2Pq} \quad (1),$$ where

n – representative sample size
N – general collectivity size according to official data – 309.8 thousand migrants in Moldova in 2008
t – probability factor equal to 1.96, corresponding to a probability of 95%;
P – phenomenon emergence probability, and "q" – counterprobability. Taking into account that **q=1-P**, the product "P*q" is maximum when **P=q=0.5**;

The margin of error (Δx) equals 0.03 (3%) for lot I and 0.044 (4.4%) for lots II and III.

Lot I – migrants, period of exposure – 24 months – 1100 respondents
Lot II – families with migrants – 600 respondents
Control lot (Lot III) – includes families without migrants – 600 respondents

Selection parameters

Sub-sample of migrants:

- *Sample:* multilayer, three-stage, by quota;
- *Stratification criteria:* 12 geographic regions coinciding with administrative territories existing before the return to division by regions; residential environment; size of urban/rural localities;
- *Stratification basis:* taking into account that migration rates are not the same throughout the country (wherefore statistical data on territorial distribution of population cannot be used), the migrants sub-selection was based on data provided by "2008 Migration and Remittances" research by IOM/CBS-AXA.
- *Establishment of quotas:* based on the results of "2008 Migration and Remittances" research by IOM/CBS-AXA migration quotas were determined based on sex, age and country of destination for emigration.

- *Randomization stages:*
  - *Locality*: localities randomly selected within adjusted layers based on a table of random numbers.
  - *Family*: Households to be included in the research will be selected at random.

If a member of a household has come back from work abroad within the last 24 months, this person was respondent, otherwise the next household was contacted, retaining the statistic tempo;

The use of quotas in case of migrants implies a definite structure of respondent selection (e.g. 4 out of 10 respondents are female, 6 are male, 7 have migrated to the CIS, 2 to EU and 1 to another country etc.).

New households have been contacted until the use-up of determined quotas.

Sub-sample of migrants' family members receiving remittances:

- *Sample:* multilayer, probabilistic, three-stage;
- *Stratification criteria:* 12 geographic regions coinciding with administrative territories existing before the return to division by regions; residential environment; size of urban/rural localities
- *Stratification basis:* sub-selection based on data provided by "2008 Migration and Remittances" research by OIM/CBS-AXA
- *Randomization stages:*
  - *Locality*: localities randomly selected within adjusted layers based on a table of random numbers.
  - *Family*: Households included in the research selected at random.
  - *Person:* If there are several adults (without any migration experience) in the selected family, the person whose birthday is nearest was selected as respondent.

Sub-sample of family members not receiving remittances:

- *Sample:* multilayer, probabilistic, three-stage;
- *Stratification criteria:* 12 geographic regions coinciding with administrative territories existing before the return to division by regions; residential environment; size of urban/rural localities
- *Stratification basis:* sub-selection based on data provided by "2008 Migration and Remittances" research by OIM/CBS-AXA. Stratification identical to the one for households with migrants.
- *Randomization stages:*
  - *Locality*: localities randomly selected within adjusted layers based on a table of random numbers.
  - *Family*: Households included in the research selected at random.
  - *Person:* If there are several adults in the selected family, the person whose birthday is nearest was selected as respondent.

In terms of quality the study covered 4 group discussions and 5 in-depth interviews. The quality component aimed at in-depth research of the phenomenon, the investigated aspects having been decided upon after the analysis of quantitative data.
Participants in the study were persons recently returned from work abroad (in the last 6 months).

Study design:

	Category of respondents	**Number of participants**
1FG	Migrants	**6**
2FG	Migrants, women	**7**
3FG	Migrants, young people (18-30 years old)	**8**
4FG	Migrants' family members	**8**

In selecting participants for group discussions theoretical samples have been used, participants being selected by snowball method. In setting samples the following criteria were given priority: sex, age, living environment, emigration experience, and host country in case of migrants.
Focus groups had an average duration of 2 hours. Discussions were audio recorded with participants' permission.

Migration Profile of Migrants' Sub-sample

In setting quotas for the migrants' selection, stratification was made on the basis of three characteristics:

1. migrant's sex;
2. migrant's age;
3. direction of emigration;
4. residence environment in Moldova.

Finally, the resulted sample is almost identical with the projected one, maximum deviation on the combined structure between the first three characteristics (sex, age, direction of emigration) being of 0.8%, and that of residence environment – 1.3%.

Table 1) **Structure of migrants' sub-sample according to characteristics of quota projection**

Direction of emigration	Age	Sex	Projected selection	Realized selection
CIS	under 35	male	28.8%	29.5%
		female	9.8%	9.8%
	36 and above	male	25.0%	24.3%
		female	9.5%	9.7%
EU	under 35	male	5.9%	6.6%
		female	5.0%	5.0%
	36 and above	male	4.1%	3.9%
		female	7.2%	6.4%
OTHER	under 35	male	0.8%	0.6%
		female	1.7%	1.7%
	36 and above	male	0.6%	0.6%
		female	1.7%	1.7%
Residence environment		Urban	21.0%	22.3%
		Rural	79.0%	77.7%

II. SOCIAL AND DEMOGRAPHIC ASPECTS

This chapter will follow a somewhat descriptive note, being in tangency with methodological aspects described above. Before starting the analysis of the subject of investigation, it is appropriate to list parameters of population (samples) that serve as information source and on whose basis we will further try to build the image regarding various aspects of the subject of research within the entire population, represented by one sample or another.

In this context, the chapter will list 1) the description of sub-samples depending on various social and demographic characteristics, 2) aspects regarding the households' income and expenses, 3) the structure of the migrants' sub-sample, and 4) a special attention will be given to remittances, aspect listed only in general, because the remittances factor will be taken into consideration each time we will attempt to emphasize the impact of migration on the practices of population referring to the health sector.

Social and Demographic Structure of Sub-samples

The listing of parameters of the social and demographic structure of sub-samples will be aimed for comparison. Since the social and demographic profile can itself be a factor of impact on the practices connected with the health services consumption, and the sub-samples of the study represent populations somewhat differing from each other, while comparing indices between sub-samples consideration will be also given to the different social and demographic structure of lots.

The gender structure of sub-samples is differentiated both among lots and with regard to the gender structure of the country's adult population according to official statistics (see table). According to the data of the National Bureau of Statistics, on January 1, 2009 stable population above 18 years old was made of about 47% of men and 53% of women.

The sub-sample of migrants is the most differentiated, being represented by two thirds (65.6%) of men and one third (34.4%) of women, a ratio in favour of men, the fact traditionally registered by all studies in the field in the past years.

In the case of family members receiving remittances the ratio is almost exactly opposite to that among migrants, 34.4% men and 65.7% women.

In the case of families without direct tangencies with the migration process, the gender ration is closer to the average per country, the sub-selection being represented in the proportion of 41.3% men and 58.7% women.

In the case of Lot I (migrants) and II (family members receiving remittances) there is an interdependence between the gender ratio, which is explained by the fact that migration involves men to a greater degree, which results in a greater number of women representing families affected by migration, since men are not present.

As for Lot III (family members not receiving remittances), the significant difference to the general gender ratio is connected with age aspects. In the group of families that are not affected by migration there is a greater number of older persons, and the group is mostly represented by women on the account of higher life expectancy among women.

In fine, we saw that in this study the gender factor is to be taken into consideration every time when performing comparison of lots. It is because the previous studies in the field show that at least the consumption of medical services is greater among women. For example, the *Population health and population access to health services in Moldova* study by the National Bureau of Statistics in 2009 shows that "The greatest number of visits to doctors is registered among the women population (except people less than 24 years old and 75+ years old)"[1].

[1] *"Public Health and Access to Health Services in Moldova"*, National Bureau of Statistics, Analytical Note No.02-11/105, 2009, page 5

In terms of age, the lot of migrants is much younger than the other two lots; two thirds of migrants are aged less than 40 years old. The average age is 36 among migrants, while among family members receiving remittances it is 43, and in Lot III – 47 years old. The same study shows that "the least number of requests for medical services is characteristic for 25-34 year olds (14.1%), and this rate increases with age, making 34.0% among people over 65 year old"[2], therefore the age factor is to be taken into consideration so as not to have situations when the value of certain indices is considered a result of migration, while in fact it is age-determined.

The structure of lots according to education level seems to be relatively balanced, except for the fact that among migrants the number of persons with the lowest level of education (gymnasium / primary / uneducated) is smaller (12.9%) than among other sub-samples (18.4% and 22.8% respectively).

In relation to the labor market, the migrants' group at the moment of the study registered the highest rate of employment, 77.3% of them being fully or partially employed. Another differential aspect is the fact that most of them identified themselves as working abroad (61.9%). In contrast, the rate of employment of family members not receiving remittances is 43.6%, and the lowest rate is among family members receiving remittances – 38.5%.

Distribution according to residence environment is almost identical among sub-samples, rural environment being strongly over-represented (77.7%-80%). It arises from the stratification strategy at the moment of selection, having been realized an environment distribution similar to that of migrants.

Table 2) **Social and demographic profile of respondents**

		Migrant	Member of a family receiving remittances	Member of a family not receiving remittances
Person's sex:	Male	65.6%	34.3%	41.3%
	Female	34.4%	65.7%	58.7%
Age group:	Under 30	32.7%	24.6%	17.2%
	30-39	33.8%	17.5%	16.2%
	40-49	22.1%	18.5%	21.7%
	50 and above	11.5%	39.4%	44.9%
	Average age (years old)	36	43	47
Level of education:	Gymnasium/primary/no education	12.9%	18.4%	22.8%
	Secondary school and lyceum	29.1%	31.4%	29.0%
	Professional school	31.3%	20.3%	22.0%
	Higher education, college	26.7%	29.9%	26.3%
Occupation:	Employed (not in agriculture)	10.0%	26.3%	29.9%
	Agricultural worker	3.3%	8.4%	9.6%
	Occasional jobs	2.1%	3.8%	4.1%
	Unemployed	18.6%	30.7%	23.7%
	Pupil, student	.9%	7.4%	4.1%
	Pensioner/disabled	1.1%	19.4%	24.3%
	Maternity leave	2.0%	4.0%	4.4%
	Work abroad	61.9%		
	Employed population	*77.3%*	*38.5%*	*43.6%*
Residence environment:	Urban	22.3%	20.0%	21.1%
	Rural	77.7%	80.0%	78.9%

[2] Idem

Income and Expenses

Under the conditions when the national healthcare system provides paid services to the population or offers the possibility of medical insurance, financial capabilities of households inevitably influence the amount of medical services consumed, so that the resources available can influence the consumption of medical services.

Generally, households that don't receive remittances spend in average 18% per adult equivalent less than households that do.

Structural distribution is very similar; about 40% of expenses in both groups are related to food items, with two special aspects:

- The most important finding directly related to healthcare is that households that do not receive remittances spend 105.4 lei per adult equivalent for drugs, which is about 40% more than in case of households that do. This is the only item of expenses on which households that not receiving remittances spend per average more. At the moment we do not have solid proofs but we can assume that households „unaffected" by migration due to their demographic features (e.g. older people) require a bigger amount of medical services and drugs. However, due to having limited possibilities of accessing professional healthcare or receiving them within the insurance system, they spend less on services but more on drugs than the other group does;
- Remittance receiving households spend twice as opposed to those not receiving remittances for leisure, alcohol drinks and tobacco products;

As for healthcare costs, the difference between the compared groups is almost invisible, both in terms of absolute value and part of total expenditures.

Table 3) **Amount and structure of average monthly expenditures per adult equivalent**[3]

	Migrants' families and families receiving remittances		**Families not receiving remittances**		**Households without remittances to households with remittances average expenditure ratio (%)**
	MDL	**%**	**MDL**	**%**	
Food	536.9	39.7	441.3	39.8	82.2
Clothes	210.4	15.6	148.8	13.4	70.7
Public utility services	214.1	15.8	201.6	18.2	94.2
Transport and telecommunications	91.2	6.8	73.2	6.6	80.3
Drugs	76.1	5.6	**105.4**	9.5	**138.5**
Medical services	33.2	2.5	27.9	2.5	84.0
Education	35.4	2.6	30.5	2.8	86.2
Investment of any kind	26.6	2.0	18.9	1.7	71.1
Leisure	81.7	6.1	40.9	3.7	50.1
Alcoholic beverages, tobacco	29.6	2.2	14.1	1.3	47.6
Other	15.6	1.2	6.3	0.6	40.4
Total	**1350.9**	**100.0**	**1108.9**	**100.0**	82.1

The volume of expenditures made by migrants abroad is almost triple the spending of a household in Moldova, constituting 3775 lei per month in average. The structure of expenditures is also different. Firstly, a migrant abroad spends a larger share of his/her total income for food – 45.9% as against 40% in

[3] To ensure comparability of households of different sizes and composition we have used the equivalence scale of OECD countries, whereby the first adult (family head) of the household is scored with 1.0, other adults are scored with 0.7, and each child aged under 15 years is scored with 0.5.

case of a Moldovan household. As for the costs of drugs, their amount is comparable to that spent by migrant families in Moldova, and for medical services migrants spend in average more than they do on drugs (118.1 lei per month or 3.1% of the total income), thus it is a situation opposite to the one found in Moldovan families.

Table 4) **Amount and structure of migrants' average monthly expenditures abroad**

	MDL	%
Food	1731.4	45.9
Clothes	506.0	13.4
Public utility services	587.5	15.6
Transport and telecommunications	358.5	9.5
Drugs	72.7	1.9
Medical services	118.1	3.1
Education	17.3	0.5
Investment of any kind	75.6	2.0
Leisure	98.9	2.6
Alcoholic beverages, tobacco	118.2	3.1
Other	91.4	2.4
Total	**3775.4**	**100.0**

The structure of income shows that both in households of interviewed migrants and in the ones receiving remittances, the remittances constitute considerable support, being the most important source of income. Thus, 41.2% of the total amount of income in migrants' households is covered by remittances, and in case of families receiving remittances it constitutes 38.5%. Employment income only holds the second place by amount – 31.9% and 25.6% respectively, and other sources of income were weighted as less important, except pensions maybe, which constitute 11.2% of income in case of families recipient of remittances.

In case of households not receiving remittances the salary provides almost half of the revenue (45.7%), comparable with the situation in the whole country – 44.3% (third quarter of 2009, BNS source), and a quarter of revenues comes from the pension (25.2%).

Table 5) **Structure of expenditures (%)**

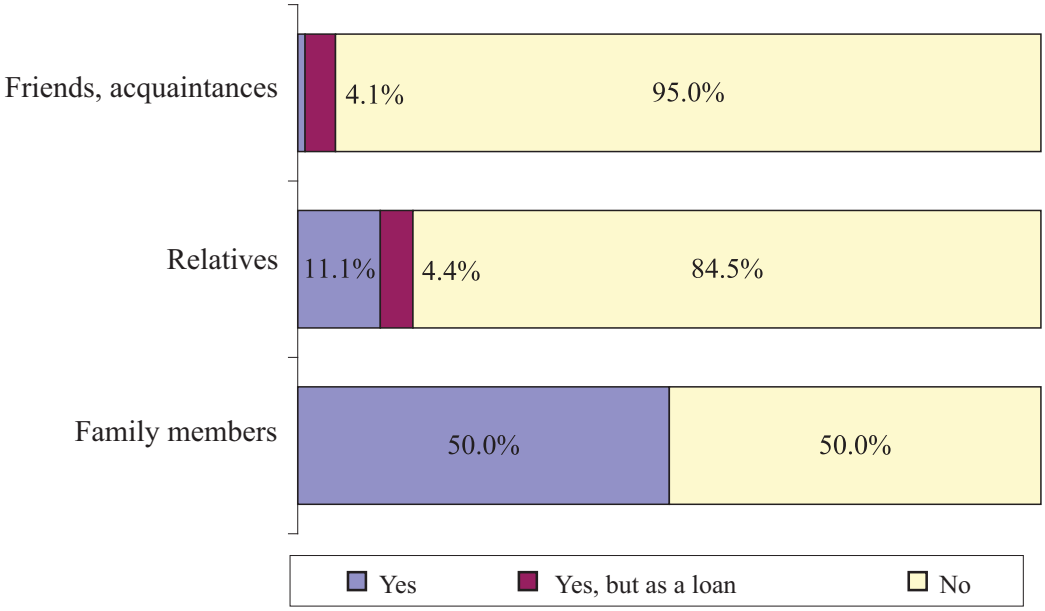
	Migrant	Member of family receiving remittances	Member of family not receiving remittances
Salary	31.9	25.6	45.7
Day labor or occasional income	6.7	7.3	11.6
Allowances	2.6	1.6	3.1
Dividends, rent, interest	0.3	0.6	0.4
Income from individual land work	2.5	4.6	7.7
Income from land lease	0.5	0.8	1.7
Income from own non-agricultural business	4.5	6.3	0
Remittances from family members	38.4	33.4	0
Remittances from relatives, friends	3.4	5.1	0.3
State subsidies in agriculture	1.2	0.3	0.4
Savings	3.6	1.8	1.6
Loans	0.6	1.6	2.4
Pensions	3.7	11.2	25.2

Remittances for Healthcare Purposes

Previously we have learned that remittances constitute an important source of income in the households that receive them. There are also widespread practices to send money specifically for solving health problems. Alt least every second migrant has sent money from abroad to be used specifically for this purpose.

This practice refers not only to migrant's families but also to persons outside the household. Thus, 11.1% of migrants have donated money to relatives and 4.4% have lent them, 1% of migrants donated money to friends or acquaintances for this purpose and 4.1% lent them.

Figure 1) **Remittances sent to solve health problems**



III. STATE OF HEALTH AND ATTITUDE TOWARDS HEALTH

The population generally manifests negligence towards their own health without mentioning the causes of such attitude. Most respondents in all sub-samples only apply for medical services in extreme cases, when the visit to the doctor can no longer be postponed. At the first glance migrants are somewhat more "careless" about their own health as compared with the other groups, although the difference is not very pronounced. Only 19% of migrants stated taking prophylactic medical check-up at least once a year or going to the doctor immediately with the slightest health problem. In case of respondents in other sub-samples the percentage of those regularly accessing health services for prophylactic purposes is around 25%.

Every second migrant goes to the doctor only in serious situations when the visit can no longer be postponed.

Table 6) **Accessing medical services in relation to necessities**

	Migrant	Family receiving remittances	Family not receiving remittances
I take a prophylactic medical examination at least once a year / I go to the doctor whenever I have the slightest health problem	19.0%	25.1%	25.1%
I go to the doctor when I notice a worsening of my health state	30.9%	30.5%	28.0%
I go to the doctor only when I have a serious health problem / I call the doctor only in emergency cases	50.1%	44.4%	46.8%

On the other side we can expect that migrants, compared to the rest of the population, will require a smaller volume of health services due to age difference. At least they appreciate their health state more positively.

Group discussions confirm this hypothesis given the fact that younger persons working abroad mostly declare that they fell well and that is why they rarely go to the doctor. Usually they postpone the task of solving their health problems (most frequently dentistry and gynaecological consultations) for the period when they return to Moldova. They only go to the doctor abroad in emergency situations. When those who left the country to work abroad return to Moldova, they go to the doctor to fix health problems they ignored while being abroad. Sometimes migrants cannot afford to pay the costs of health services in the host country even in emergency cases.

"My friend broke his arm and in Russia the operation costs 60 thousand rubbles, i.e. 2000 euro. So he's coming home to put it in plaster, and anyway it's cheaper... He called the emergency there, they made an X-ray and told him he needed a surgery and also to consult an orthopaedist, a surgeon, because the bone was broken, they told the surgery cost this much and they would just put the hand in plaster as first aid, so it didn't swing move this or that way" (F, 26, rural, Russia)

Moreover, some migrants are aware that changes in their body identified at a certain stage require urgently examination by a doctor, but due to circumstances, especially lack of financial resources, they do not go to a doctor and face enormous psychological stress, if we take for example a suspicion of cancer.

"I've been through so much and worried so! Something appeared above my breast, I don't know what, and I thought it was over now... it was like a small egg when I touched it, I didn't have money and didn't go to the doctor because I just started working, and so it passed by itself, I massaged it with soap or cream... I was so worried thinking I was never going to see my child 'cause he was small then." (F, 44, Russia)

Yet, even in Moldova not all migrants declare that they can afford to access different health services, declaring that at the moment they have other priorities and the money they earn abroad is insufficient.

> *"When I got married I went to the doctor because we needed a certificate for the marriage, for registration… and the lady from the district family health and reproduction centre, something like that, asked my wife to come more often to the gynaecologist, but how can she if we can't pay for it?"* (M, 25, Russia)

More than half of the migrants (52%) gave the qualification "good" or "very good" in assessing their health status, while for the members of families receiving remittances this indicator constitutes 41%, and in the third sub-sample even less – 33,4%.

Table 7) **Subjective assessment of health state 1**

	Migrant	Family receiving remittances	Family not receiving remittances
- Very good	**7.2%**	**5.7%**	**2.4%**
- Good	**44.8%**	**35.6%**	**31.0%**
Neither good, nor bad	37.8%	36.8%	39.7%
Bad	8.9%	18.3%	21.8%
Very bad	1.3%	2.9%	4.2%
DK/NA	.1%	.6%	.8%

The situation among migrants looks better at other indicators as well, meant to measure the assessment of their own health, in case of which the difference between groups is even more pronounced.

Thus about 30% of migrants claim having physical pains that prevent them from working and that they would need medical treatment to be able to lead a normal day to day life. It is obviously a high percentage, but much lower than in other groups where such assessment was given almost by every second respondent.

Table 8) **Subjective assessment of health state 2**

		Migrant	Family receiving remittances	Family not receiving remittances
Do you feel that physical pain prevents you from doing what you need to do?	Yes, sure	**6.6%**	**13.9%**	**15.2%**
	Rather yes	**23.7%**	**33.7%**	**33.2%**
	Rather not	43.0%	32.4%	33.2%
	No	25.9%	18.7%	17.0%
	DK/NA	.8%	1.3%	1.3%
Do you need medical treatment to be able to lead a normal day to day life?	Yes, sure	8.3%	17.7%	16.8%
	Rather yes	20.4%	30.5%	30.6%
	Rather not	42.8%	31.6%	33.2%
	No	27.8%	18.7%	18.3%
	DK/NA	.8%	1.5%	1.1%

The assumption that especially acute negligence among immigrants may be due to their specific group age is supported by data. Comparing practices of accessing medical services only among respondents under 40 years we see that the difference between the compared groups is diminishing to 18% for migrants and to 20-21% for the other two groups.

Age however does not seem to be the main determinant factor of the difference. In the following table the indicator is distributed only among those who view their health as bad or very bad. Nevertheless (despite negative assessment of health state), migrants again are the ones who avoid attending medical institutions regularly; only 25% of them go to the doctor immediately after they notice some health problems, while 38.9% of them visit a doctor only in serious situations.

Table 9) **Accessing medical services in relation to necessities**
(persons who view their health as poor)

	Migrant	Family receiving remittances	Family not receiving remittances
I take a prophylactic medical examination at least once a year / I go to the doctor whenever I have the slightest health problem	25.0%	31.0%	35.6%
I go to the doctor when I notice a worsening of my health state	36.1%	39.0%	24.4%
I go to the doctor only when I have a serious health problem / I call the doctor only in emergency cases	38.9%	30.0%	40.0%

Meanwhile most migrants admit that they do not lead a healthy lifestyle, something also confirmed by family members who have emphasized that people working abroad are more risk-prone: *"They don't know what awaits them there when they leave"*. The perception of a healthy lifestyle is different, but can be summarized in the following:

- *Physiological state of the body* primarily implying, in the vision of those interviewed, an appropriate diet, personal hygiene, leisure, sport activities, prophylactic medical examination etc., as well as avoiding harmful practices such as alcohol abuse, smoking, etc. To be noted that most affected by this are those working in the CIS countries, particularly in Moscow. In order to save money they live in individually built or renovated premises, in adverse health conditions. Some of them have no conditions for daily hygiene (shower), although they do physical work.
- *Working conditions:* the existence of a workplace, moderately strenuous physical work, hygiene at workplace, 8 hour workday and at least one day off a week. But most often migrants are forced by circumstances to work in poor conditions and more than 8 hours a day. Some women working as carers have to work 24 hours a day, 7 days a week, i.e. all the time.
- *Psychological aspect:* primarily referring to stress, particularly affecting migrants. The process of emigration has been an enormous stress for many of those left to work abroad. The experience of staying in a foreign country, far from loved ones, missing the children represents another extremely stressful factor for migrants. Psychologically Moldovans feel inferior in the host country. At the same time migrants do the toughest and dirtiest jobs works, although many of them have higher education degrees and held some social status in Moldova; worked as doctors, teachers, etc., and held executive positions.

> *"I have a cousin in Italy – their whole family lives there and they still say they're not treated the same way as Italians are; they are still considered inferior despite working as accountants, doctors, and they are still not treated like Italian citizens"* (F, 27, rural, a brother in Russia, more relatives in other countries)

- *Cultural and moral issue* refers to relations between people, based on respect and affection; culture consumption, the opportunity to go to the theatre, cinema, concerts. Also access to quality education, leisure and entertainment services, travel etc.

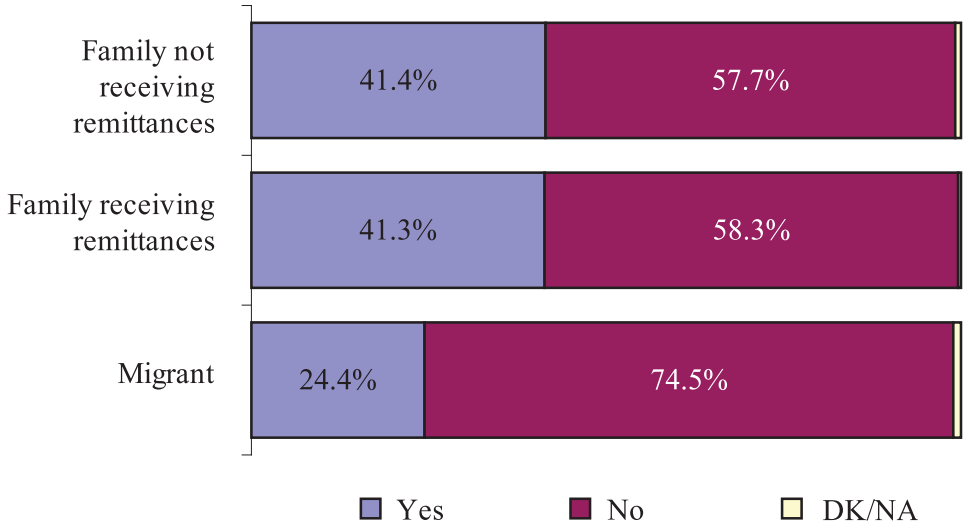
In group discussions it was also noted that the environment pollution, promotion of synthetic products and products with different preservatives contribute to the worsening of health and birth of sick generations in an unhealthy environment.

Incidence of Chronic Diseases

Migrants record a far lower morbidity rate compared to their family members or members of households not receiving remittances. Only one in four migrants (24.4%) states that he/she currently suffers from a chronic disease.

Apparently, receiving remittances does not stop households from having chronic diseases. The incidence of chronic illnesses in households receiving remittances and among respondents from households that do not receive remittances is at the same level, around 41%.

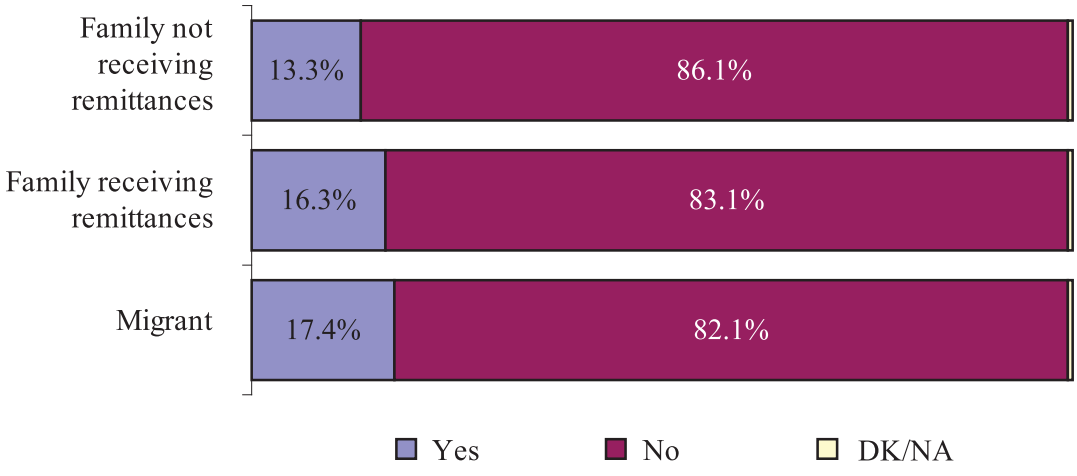
Figure 2) **Incidence of chronic diseases**



Meanwhile, data suggest that the status of a migrant does not influence the incidence of chronic diseases either, and previously attested difference between migrants and people not involved in the migration process is entirely due to the fact that migrants are slightly younger than the rest of the population. Group discussions with migrants revealed, however, a tendency among migrants suffering from chronic diseases to go to the doctor more frequently, including for preventive controls.

Among respondents aged under 35 years there is no differences between the groups in terms of incidence of chronic diseases; moreover, among migrants the percentage of those having chronic diseases is a little higher than in the other two groups, representing 17.4%.

Figure 3) **Incidence of chronic diseases among respondents aged under 35 years**



The most common chronic conditions specified by the population are diseases of the cardiovascular, osteoarticular, gastrointestinal and nervous system.

The disease hierarchy according to prevalence is almost similar in the compared groups, except that remittance recipient families more often have nervous system disorders.

Table 10) **Specified chronic diseases**

	Migrant	**Family receiving remittances**	**Family not receiving remittances**
cardiovascular	5.5%	14.1%	15.2%
osteoarticular	5.0%	8.2%	7.7%
gastrointestinal	5.1%	6.3%	7.7%
nervous	4.4%	8.0%	6.2%
respiratory	3.7%	5.5%	5.4%
endocrine (hormonal)	1.3%	5.5%	3.8%
urogenital	2.5%	3.6%	3.1%
eye and year	1.3%	1.9%	3.1%
infectious	0.4%	1.3%	1.4%
cancer	0.1%	0.2%	0.7%

IV. FAMILY MEDICINE

1. Appeals for Primary Medical Services

Applying for Medical Services

Data regarding appeals to the medical system within a certain period of time (the last 12 months) immediately emphasize two basic moments:

1. migrants much rarely contact the healthcare system compared to people not involved in migration. In the last 12 months 41.9% of migrants interviewed have never contacted the healthcare system, 37.7% - once or twice, and only one in ten migrants contacted the healthcare system more than 10 times. A migrant contacted the healthcare system twice more rarely (1.5 visits on average), compared to 3.2 contacts for members of households receiving remittances and 3.5 contacts on average for households not receiving remittances. This means that migrants contact the Moldovan medical system because of long absences from the country, and respectively do not contact the medical system in host countries;
2. receiving remittances does not seem to enhance access to health services among the population not involved in migration. The difference in the average number of contacts is not very big (although still in favour of members of households not receiving remittances – 3.2 for remittance beneficiaries and 3.5 for non-beneficiaries), and if we exclude respondents aged over 40 years, then the indicator is practically equal – 2.8 to 2.7.

Table 11) **Frequency of appeals to the healthcare system**

	Migrants	Family receiving remittances	Family not receiving remittances
Never	41.9%	27.2%	28.0%
1 – 2 times	37.7%	38.1%	33.0%
3 – 5 times	9.5%	17.1%	16.2%
More than 5 times	10.8%	17.7%	22.8%
Average number of appeals	1.5	3.2	3.5
Average number of appeals for respondents under 40 years	1.5	2.8	2.7

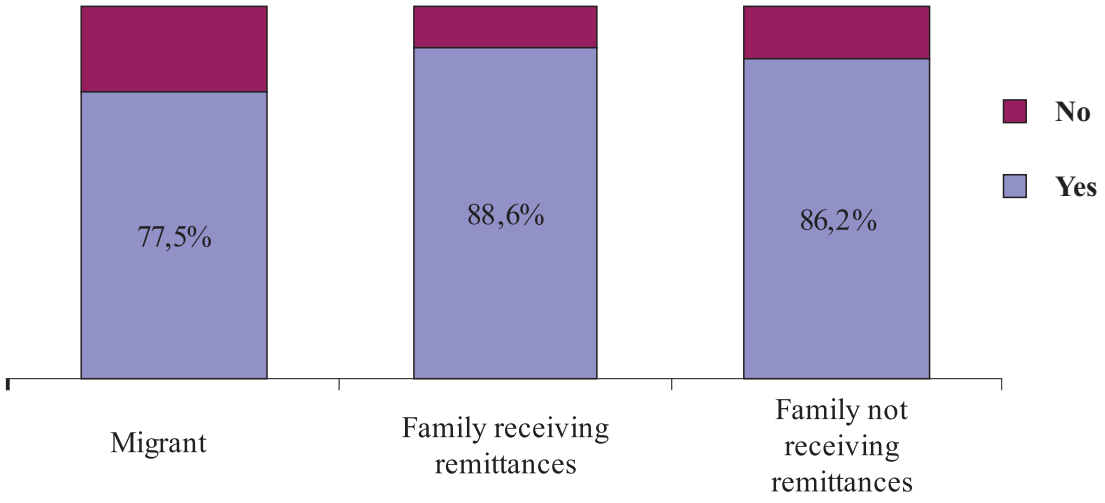
Interaction with the Family Doctor

Fewer appeals to the healthcare system also explain why more migrants currently do not know their family doctor (22.5%). This percentage is double compared to remittance recipient families (11.4%) and 11 percent higher than in the third group (13.8%).

A very important aspect of this case is related to gender. Generally, women are familiar with their family doctor more frequently. But in case of migrants female respondents record a level of knowledge of their family doctor significantly lower compared with a similar group of other sub-samples. 16.8% of women involved in migration do not know their family doctor, compared to 6.8% in case of women from remittance beneficiary households and 8.6% from households not receiving remittances. As for the male group, the difference though existing is not so pronounced: 25.9% for migrants, 20.4% and 21.9% respectively.

And this aspect is not entirely determined by differences in age distribution of the analyzed groups. If we confine ourselves only to respondents under 40 years, for men the highest percentage of those who do not know their family doctor is found in families not receiving remittances (33.8%), while migrant women again have the largest share of the compared groups (15.9%).

Figure 5) **Knowledge of the family doctor**



Migrants much less often visited the family doctor (33.4% have been to the doctor less than six months ago, 15.4% – 7-12 months ago). One in four (27.4%) have never been to the doctor or have done so such a long time ago that they cannot remember exactly when the last visit took place. This percentage is double compared to the comparison groups where these figures are 13.2% and 13.6% respectively.

The youth and males visit the family doctor more rarely. Almost one third of male migrants and only 19.7% of female migrants have never been to the family doctor in the past three years. This gender difference is also relevant for the population not involved in migration, among which the percentage of males that have not visited the family doctor in the last three years is double the number of females.

Another issue suggested by the data is the fact that migrants in need of medical services more often access them directly, without the family doctor's mediation. In their case 22% of those that have accessed a medical service at least once in the last 12 months did not contact their family doctor. For other groups this proportion is twice as small – 8% and 10% respectively.

Table 12) **Last visit to the family doctors**

When did you last visit the family doctor?	Migrants	Family receiving remittances	Family not receiving remittances
Less than 6 months ago	33.4%	52.8%	52.3%
7-12 months ago	15.4%	17.7%	18.5%
1-3 years ago	12.9%	9.1%	7.6%
More than 3 years ago	8.5%	6.1%	6.1%
Never	13.8%	4.6%	5.6%
I don't remember	13.6%	8.6%	8.0%
DK/NA	2.4%	1.1%	2.0%

Group discussions especially marked the attitude of doctors towards patients, emphasizing in this regard that there is a very big difference between doctors from EU countries and those from Moldova. It was largely noted that doctors in host countries are respectful and every patient regardless of his/her status receives special attention of the health workers. In Moldova, according to those interviewed, the doctor's attitude is directly correlated with the amount of money paid to them. Although there were also respondents dissatisfied with the way they were treated abroad, noting that the local population is nevertheless more advantaged and even if you stay legally you are still an alien to them. *"I had my child in Italy, the delivery was very difficult, and because an Italian was having a child too all the doctors were with her. They left me with a nurse and when I was almost in labour the doctor came and was shocked, she was reprimanded. Afterwards about 6 doctors came, and if it lasted 10 minutes more my baby would have died. I didn't like how things were there at all... and I was staying legally, I had a San Giorno staying permit"* (F, 29, has worked in Italy, Romania, intends to go to Ireland)

"They say British medicine is one of the best, but a real case happened to me. I broke my arm… within 2 weeks I went to the doctor and showed him my case, he told me to come in a month. After a month the bone was already grown back together and the doctor told me they'd have to break it again. But I didn't want to singe it had already grown together so I left it the way it was. Another case, I had some problems with glands and once again I couldn't go there… because it was expensive and I was scared. It's better at home anyway" (M, 27, UK)

There are also migrants with chronic diseases who say they were unable to replace the doctors who have been treating them in Moldova for years with people from abroad, since they are in fact satisfied with the services provided by physicians in Moldova.

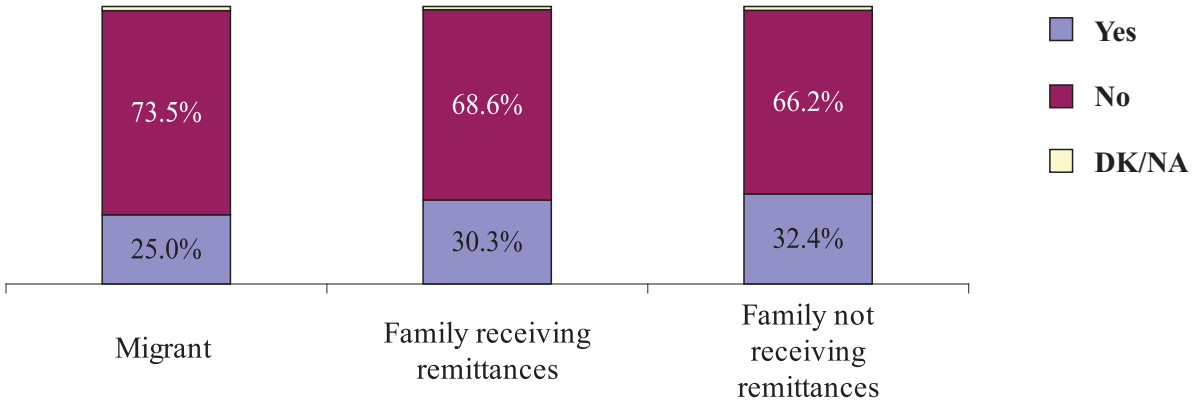
Migrants' family members also believe that the attitude of doctors towards patients is much better abroad. Some have made this finding even from their own experience while working abroad, remarking that *"doctors there serve citizens, not like here when it you always feel like you owe the doctor something"*.

2. Accessibility of Primary Medical Services

Practices of avoiding medical services despite the need are quite popular among the entire population, including migrants, 25% of who said that in the last 12 months there have been cases when they did not go to medical institutions although they needed to. Compared to the groups this is the lowest percentage.

Among remittance recipient households avoidance of medical institutions was reported by 30.3% respondents, and in households not receiving remittances by 32.4% respondents.
From the gender perspective, female migrants find themselves unable to access health services more often than migrant men – 28.8% against 23.1%, as well as women from households who do not receive remittances – 36.2%, as compared to 27 % among men in the same group of households.

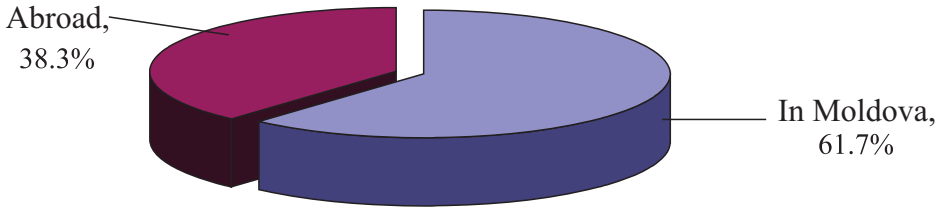
Figure 5) **Incidence of failures to apply for medical assistance**



Have there been cases in the last12 months when you neededmedical assistance but did not appeal for it?

Migrants are unable to access health services for different reasons, both in Moldova and abroad. Such cases reported by migrants largely took place abroad – 38.3%.

Figure 6) **Where failure to appeal for medical assistance took place**



Failure to access health services is caused by several factors, of which two most important are: careless attitude, when people do not appeal to the system because they consider the problem is not a very serious one, and lack of time. These causes are typical for all the groups analyzed. Comparison between the population not involved in migration only shows that members of households not receiving remittances more often face lack of financial means necessary for travelling to medical institutions – 21.3%, versus 13.9% in case of the population receiving remittances.

In the case of migrants more specific moments are observed. First of all there is the first sign of "marginalization" due to lack of medical insurance. Thus, lack of a health insurance has prevented one in five migrants to access health services. This is equally true for Moldova and for host countries. Lack of time to visit a doctor is much more topical for migrants abroad (33.7%) than in Moldova (18.8%).

Lack of money for transport to medical institutions represents an obstacle for migrants as well, but only when they are in Moldova (12.8%).

The qualitative research confirmed some migrants' statements that they are afraid to seek a doctor's advice because they consider them largely incompetent. On the one hand, some consider that old doctors continue to use outdated treatment schemes that in some countries have long been abandoned and/or challenged, and on the other hand some indicate that young doctors study by paying merely fees (including unofficial *"purchase of grades")*. Also many of the focus group participants considered that doctors in Moldova mainly aim at "*squeezing money"* and not curing the patient. This occurs even more in case of migrants who are in their opinion viewed by professionals as a financial source.

"If you come and don't want to take a penny out of your pocket, they look at you like you're a lost person, they reproach, yell, behave rudely, throw the bandage in front of you, and then the technical personnel the same, and the nurse too - you have to give to everyone… we feel more like a source of money" (F, 33, Russia)

Migrants participating in focus groups also revealed that medical institutions in Moldova are under-funded and therefore the buildings are in a poor condition, sanitary conditions are not met, drugs and human resources are insufficient, etc. All these factors taken together cause most migrants to have little confidence in the Moldovan state funded medical system.

"Last year I was in hospital because I am disabled. I went there and they didn't have droppers, I spent 1000 lei to buy all the drugs because they didn't have anything besides analgin, glucose and saline solution and phuracylin… they have a lot of that, but beside this they have nothing, not even bandages" (F, 46, Russia)

"…because I'm from the country, my parents also live in a village, and my sister. Well, that family doctor isn't a doctor at all… he comes with treats everything with a single pill, so you have to give him 20 lei every time you want him just to sign anything. And it's everywhere like this, in all districts, at least in Cantemir district for sure. And there's one family doctor for 7 villages, someone has to come and see the situation, there's nothing to talk about, it's a very difficult situation with family doctors here" (F, 33, Russia)

"I can't possibly know my family doctor, from what I know there's one family doctor for several villages. Our family doctor is 8-9 km away. But there's a kind of nurse here in the village" (M, 21, Russia)

"We don't' have enough equipment. Maybe in other countries you come and they perform the diagnostic with equipments, even the same ultrasound shows if one has internal bleeding in the stomach or elsewhere, but what can we do? We have only palpations..." (F, 30, Russia)

Migrants have more confidence in medical services abroad, particularly in the EU; they say there is a significant difference, starting from interior design, material and technical provision and employees' attitude towards patients.

"The difference is very big: 1. You don't pay for the bed-place separately, it is included in the medical assistance fee. 2. Beds strictly comply with health requirements and have orthopaedic mattresses. 3. The food is very good, you don't need to bring your own food from home; if you are on diet they give you diet food, very tasty and healthy, with meat and everything; they don't allow you to bring your own food. 4. There are very good conditions for taking a bath, going to the toilet, there is water, you don't go have to carry basins, it doesn't smell like chlorine etc. (F, 36, Italy)

Several respondents emphasized that they only require medical services in Moldova for certain formalities. It was noted that medical certificates required at the work place or for other purposes are issued without a proper examination of the patient.

"Half a month ago I took a medical examination in Moldova. I went through all rooms, waiting in lines and getting nervous and they asked me: are you healthy? And then wrote: healthy. I needed a document, they didn't check me but just asked and I lost a day, he could have come himself to sign it or not... (M, 24, Russia)

"When I worked here in Chisinau at a furniture company, I needed a certificate that I was able to work. I called home and talked to my mother, she knew a district doctor. I sent the certificate and they put the seals on it, I didn't go to the check-up and they accepted me for work, otherwise I didn't have the time nor the money to go." (M, 21, Romania)

Migrants to a greater extent express doubts referring to the professionalism of Moldovan physicians – 12.8% of respondents have avoided accessing health services for this reason.

When a migrant is abroad, another obstacle is the legal issues related to his/her official status in the host country. 6.5% of those who have avoided visiting a doctor abroad did it because they did not want to be seen by anyone going to the doctor, most likely by representatives of authorities. Migrants, especially those working illegally, also fear that the employer having learned of their health problem will no longer employ them or will fire them. Another aspect relates to money – not just lack of funds to access medical services, but also the fact that going to the doctor means losing a day (or a few days) of work that a migrant cannot afford to miss, since his/her main purpose is financial gain. In addition to this, migrants say that by going to the doctor they risk losing their job because they will be absent from work and the employer does not care about the reasons of their absence.

Table 13) **Causes of failure to appeal for medical services**

	Migrant		Family receiving remittances	Family not receiving remittances
	In Moldova	Abroad		
The problem wasn't serious	39.6%	40.2%	46.5%	42.2%
I had no time	18.8%	**33.7%**	22.9%	21.7%
I don't have a medical insurance	**20.8%**	**20.7%**	6.3%	4.3%
I have no money for transport	**16.8%**	5.4%	13.9%	**21.3%**
I don't trust doctors	**12.8%**	1.1%	7.6%	7.0%
I have no money to pay for the medical services	7.4%	7.6%	8.3%	8.3%
I didn't want anyone to see me going to the doctor	2.0%	**6.5%**	0.7%	1.3%
Other	7.4%	10.9%	11.9%	12.9%
DK/NA	4.0%	9.8%	3.5%	2.6%

The language of communication is often a barrier for some migrants in applying to a doctor in the host country. Some of those working abroad declare that although they know the language at a communication level, it is difficult for them to talk to doctors because most of them use specific language.

Assessing Accessibility of Primary Medical Services and medical Assistance in Moldova and Abroad

Medical care in Moldova is rather considered by the population as inaccessible. Every second citizen believes it would be difficult to receive medical care when they needed it, and between 8% and 14% stated that it would be "very difficult".

The population receiving remittances (not to be confused with migrants themselves) are noted to have a somewhat more positive view on the accessibility of health services compared with migrants and people who do not receive remittances. A negative assessment among families receiving remittances was given by 59% compared with 64% by migrants and 66% by people not receiving remittances.

In fact, group discussion with migrants' family members confirms that receiving remittances substantially increases their opportunities to access health services. Many of the respondents whose relatives are working abroad have admitted that they personally or some of their relatives have received medical services only due to remittances.

> *"I could only have treatment due to the money from abroad. It was about 300 dollars, only from abroad, here it's not possible"* (F, 26, urban, husband in Russia)
>
> *"Our cousin has diabetes and if it wasn't for his mother who is working in Italy and sending him money for treatment and stay in the hospital every half a year I don't know what would have happened. He has insurance, stays in hospital No. 3; he keeps paying the nurse and everybody else and the attitude towards him is completely different from that towards those who stay in the same hospital and don't pay that much"* (F, 27, rural, several relatives working abroad)
>
> *"I needed a surgery and they sent me money for it"* (M, 51, urban, wife and daughter in Italy)
>
> *"Our sister-in-law helped us a lot when my mother-in-law was sick. It's all we have for a living; my husband left to Italy and I have to go next week, we live only on the money sent from abroad."* (F, 37, France)
>
> *"I am retired and if the daughters don't send me anything I'll die; my costs are practically acceptable, but only with the income from over there"* (F, 60, Italy)

Some participants in the study showed that health problems of one of the family members was actually the main factor that determined their departure for working abroad, they being aware that there was no other way to ensure the appropriate treatment.

Some participants in the study noted that it is only the thought that there is someone working abroad whom they could call for help in an emergency gives them confidence in the future, a certain sense of stability. If anything would happen they will surely send money to solve the health problems. It is further confirmed by migrants who declare they could waive other expenditures, but when it comes to the health of their loved ones they sacrifice everything.

> *"If he is part of my family I will spend as much as it is needed, a thousand Euros, two, three if necessary. I spent more than I expected for my parents' surgeries"* (F, 36, Italy)

Migrants also noted that doctors already know that people who have left to work abroad can provide financial support to relatives or that they may come to the doctor themselves.

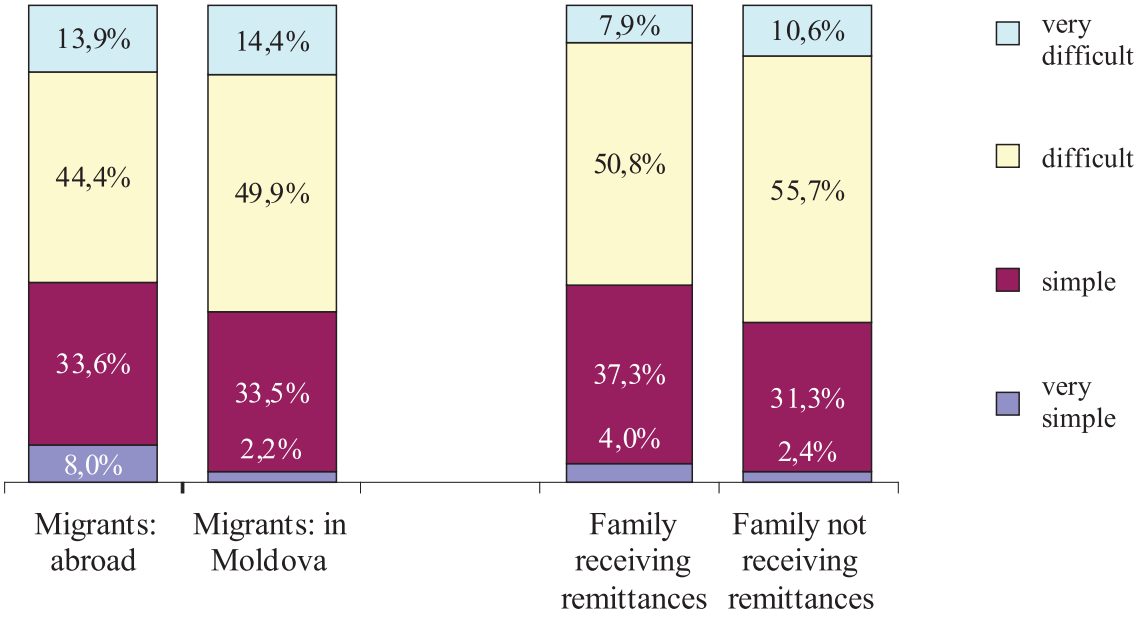
> *"Not so long ago I heard a case about a lady who was admitted to the hospital and they asked her from the start: "Do you have anyone abroad?", and the lady died in about 3 days*. (F, 44, Russia)
>
> *"I was in the Republican hospital, and they didn't come to ask you where it hurt, but how many more days you had to pay. The first question was "for how many more days can you pay?"* (F, 60, Italy)

Several participants in group discussions emphasized that the medical system in Moldova is supported (informally) by remittances, otherwise it would go bankrupt and doctors would not withstand in the conditions provided by the state. In fact, in different contexts, some respondents specified that doctors are actually forced by the economic and political context to practice bribery, otherwise they could not survive.

> *"We speak negatively about doctors and teachers, but if we put ourselves in their place I personally can understand them; they also have small salaries and they want to live. This is where it all starts – everything comes from the government..." (F, 21, Russia)*

Accessibility of healthcare for migrants abroad is assessed somewhat more positive, compared with healthcare in Moldova, although negative feedback still prevails: 44.4% assessed access to medical services as difficult and 13.9% as very difficult.

Figure 7) **Perception of healthcare accessibility**



Accessibility of healthcare abroad depends on the direction of migration, in particular on the migrant's legal status in the host country.

The most restricted access to health care abroad is faced by migrants working in the CIS countries and those with a less "advanced" legal status.

Every second migrant in the CIS assessed access to professional healthcare services as "difficult", and 15.5% as "very difficult". In comparison, in the EU these ratings were given by only 28.4% and 10.9% respectively.

The easiest access to medical care abroad is available to Moldovan migrants who managed to obtain the citizenship of their country of stay, those who have Bulgarian or Romanian nationality and those with residence and work permits.

In the issue of accessibility of health services abroad, holding a residence permit as well as temporary registration does not offer any obvious benefits in relation with illegal status. 42.8% of the latter believe it would be difficult for them to access health services and 23.1% - very difficult.

Table 14) **Perception of medical assistance accessibility abroad by emigrational characteristics**

If you need medical care abroad, how simple it is to receive it?		Very simple	Simple	Difficult	Very difficult
Emigration direction:	CIS	5.0%	29.0%	50.5%	15.5%
	EU	14.2%	46.4%	28.4%	10.9%
Residence status in the host country:	citizenship of the host country	12.5%	58.3%	16.7%	12.5%
	Romanian/Bulgarian passport	13.0%	41.3%	43.5%	2.2%
	residence and work permit	12.3%	39.3%	38.7%	9.7%
	only residence permit	3.9%	30.3%	50.0%	15.8%
	temporary registration	4.8%	28.0%	52.8%	14.4%
	no official status, illegal	5.2%	28.9%	42.8%	23.1%

Qualitative research confirmed that a migrant's staying status is an important factor in accessing health services. Those staying in the host country illegally generally avoid public places for fear of being expelled, so travelling to medical institutions exposes them to this risk, and also for fear that doctors could to denounce: *"As far as I know, those who are staying illegally and go to the doctor, are afterwards turned in to the police"* (F, 49, Italy). However, there were more migrants stating they did not think that medical

workers were capable of doing anything like that and no one has confirmed any case when any Moldovan citizen or another migrant had been expelled after going to the doctor.

> *"There has been a law adopted this Spring imposing some new conditions on doctors – when an alien comes to them they must denounce him, but I don't think any doctor has done this, no, I don't"* (F, 33, Italy)

Obstacles in Accessing Medical Services in Moldova and Abroad

The number of obstacles hinder the population's access to health care in Moldova is as large as could be.

The acutest problem is related to the financial aspect, i.e. the cost of medical services, which makes these services inaccessible for the public. The financial issue is almost as sharp for migrants as well.

Second by importance is the absence of medical insurance, most pronounced in case of migrants - 44.9%, compared with 32% in case of members of households receiving remittances and 29.3% for households not receiving remittances.

Table 15) **Obstacles in accessing medical services in Moldova**

	Migrant	Family receiving remittances	Family not receiving remittances
High costs of healthcare	59.3%	62.7%	64.1%
Lack of medical insurance	**44.9%**	32.0%	29.3%
I don't have confidence in doctors' professionalism	29.2%	28.4%	24.5%
Need to get a referral from the family doctor	19.1%	**24.2%**	**23.8%**
I don't know whom to contact	14.4%	13.1%	13.8%
Medical institution is in another location	11.1%	11.4%	11.8%
I don't know my family doctor	8.1%	3.8%	6.5%
Other	6.3%	10.3%	6.3%
DK/NA	11.7%	10.3%	7.2%

The set of obstacles in accessing health services abroad is different from the one in Moldova.

The problem of medical insurance is also topical for migrants in host countries; it was most frequently (34%) mentioned as making it difficult to access medical care abroad. The second obstacle is illegal staying status which made it difficult for 28.7% of migrants to access healthcare, or the general perception that health services are unavailable for migrants abroad – 11.1%.

Financial constraints are only in the third place – every fourth migrant (25%) stated that the costs of medical services abroad were beyond his/her financial possibilities.

A very important aspect is related to the labour market that has mechanisms of restraining access to medical services, either through prohibition to leave the workplace during working days (14.7%) or through fear of job loss (20.5%).

Distrust in medical professionalism, which with reference to the medical system in Moldova is placed on the third place (29.2%) in the set of obstacles, is a fairly insignificant factor abroad – 6.1%.

Table 16) **Obstacles in accessing medical services abroad**

No health insurance	34.0%
Illegal staying status	28.7%
High costs of healthcare abroad	25.0%
Fear of losing the job	20.5%
Not knowing whom to contact	17.2%
Prohibition to leave the workplace during working days	14.7%
Trip to medical institutions that are located at a distance	11.1%
Impossibly of receiving medical care by migrants	11.1%
Need to get referrals from the family doctor / another authority	9.3%

3. Consumption of Medical Services Abroad

The degree of Moldovan migrants' accessing health services abroad is very low. Only 6.5% of migrants were recorded in the foreign public health system throughout the period they have been involved in the migration process, and it is the service most frequently accessed compared to other types of medical services. Only 6.1% of migrants have consulted a specialized public doctor, 5.7% visited a general practitioner / family doctor.

The private healthcare system is even less accessed at the level of advisory services: only 4.8% of migrants have consulted a doctor from the private system. As for surgeries or treatment, paid services are accessed more often. 3.6% have received paid treatment (hospitalization) and 1.8% - unpaid; 2.8% of migrants have paid for a surgery and 1.5% had a surgery free of charge.

Emergency medical services, apparently most affordable abroad (55% of migrants are sure they could access this service if needed) are not among the most accessed, so that only 3.9% have applied for this service.

Migrants participating in the focus group largely claim being much more satisfied with emergency services in countries where they work compared with the ones in Moldova. Many perceive that the ambulance in Moldova arrives late and unprepared for the intervention. Although some respondents said that situation has changed in the last few years, others stated that there have been recent cases (last year) when the ambulance came within more than half an hour or without the necessary first aid kit. In contrast, emergency services abroad are viewed positively, which is supported by specific examples. The speed of intervention is primarily appreciated.

> *"My sister-in-law called the ambulance, her daughter's foot was ran over by a car. They even came in a helicopter very quickly and took her"* (F, 37, France)
>
> *"I was visiting my mother when she had a strong allergy, it really happened. They didn't ask her for any documents, they just gave her first aid and told her to go to the doctor, but my mother felt better and didn't go… So, my mother doesn't have any documents and they still provided her first aid"* (F, 26, Italy)
>
> *"The girl I lived with in America called the ambulance and they came very quickly and gave her first aid, but here you have to wait for the ambulance for a very long time"* (F, 21, USA)

Less positive experiences, however, were recorded in the Russian Federation; migrants state that emergency services intervene very promptly, provide assistance, but require the payment of certain fees. However, it should be mentioned that most respondents were referring to other persons, such as colleagues or friends.

> *"I haven't called the ambulance for myself, but there was a guy that worked in the same place with me who fell and broke his arm, and to tell you frankly they asked for money right away. The ambulance took him and applied plaster*" (F, 44, Russia)
>
> *"A friend from Chisinau called the ambulance, they operated him, but they said the service was paid for Moldovans, so he had to call his acquaintances and friends to borrow money and pay"* (M, 20, Russia)
>
> *"A friend in Russia had a brain concussion and paid a lot because he was in a serious condition"* (M, 25, Russia)

Private medical services (against a fee) are seen as more affordable abroad.

Table 17) **Consumption of medical services abroad**

	Accessed	Not accessed, but available
Registration with a doctor in the public system	6.5%	33.4%
Advice by a specialized doctor in the public system	6.1%	36.1%
Visit to a general practitioner / family doctor	5.7%	35.3%
Advice by a specialized doctor in the private system	4.8%	40.6%
Call for an ambulance	3.9%	55.0%
Paid treatment in hospital	3.6%	44.9%
Registration with a doctor in the private system	3.0%	35.1%
Paid surgery	2.8%	42.5%
Free treatment in hospital	1.8%	27.6%
Free surgery	1.5%	26.4%

The amount of consumed of medical services varies substantially among different groups of migrants, distinct in terms of migration profile. The same as for directions of emigration, the highest level of healthcare services consumption is attested in the EU countries. The average for types of medical services accessed by migrants in the EU is 0.68, while in the CIS this indicator is 0.31, i.e. twice smaller.

Female migrants access substantially more medical services abroad – 0.54 services on average, compared to 0.32 for men. The degree of medical services consumption abroad increases with age, from 0.3 in the youngest group to 0.55 for migrants aged over 50.

Differences at this aspect are even more pronounced depending on the migrant's legal status and duration of emigration. Most types of medical services abroad were accessed by migrants who have the citizenship of the host country (average 1), almost double of those holding Romanian or Bulgarian citizenship (0.55) and those who had residence and employment permits abroad (0.54). The lowest degree of consumption is attested among illegal migrants and those who stayed abroad with temporary registration – 0.26 in both cases.

As for duration of stay in the host country, it appears that short-term (seasonal) migrants access on the average far fewer medical services – 0.31. For comparison, long-term migrants (over 12 months) accessed on the average 0.92 types of medical services.

Table 18) **Average number of types of medical services accessed abroad**

		Total migrants
Emigration direction:	CIS	0.31
	EU	0.68
	Other	0.42
Sex of the migrant:	Male	0.32
	Female	0.54
Age group:	Under 30	0.30
	30-39	0.40
	40-49	0.46
	50 and above	0.55
Staying status:	citizenship of the host country	1.00
	Romanian/Bulgarian passport	0.55
	residence and work permit	0.54
	only residence permit	0.43
	temporary registration	0.26
	no official status, illegal	0.26
Duration of the last trip:	Under 6 months	0.31
	6-12 months	0.54
	Over one year	0.92

Persons working abroad often resort to self-treatment to solve their health problems.

> *„ "I know what medicine I need to take and I took a whole bag with me. So when the time comes, I already know, in spring and in fall, when things get more serious, I just take them and that's it, so my condition doesn't get worse and I can work*" (F, 49, Italy)

Colds are most often treated by migrants with natural traditional recipes. However, young migrants have been noticed to have little trust in popular remedies and self-treatment.

Many migrants' family members said that they send drugs from Moldova to relatives working abroad for various reasons:

- migrants have certain chronic illnesses and have become accustomed to these drugs and already know their medication;
- migrants have no time or money to go to the doctor. In these circumstances their relatives describe their symptoms to doctors those prescribe treatment in the absence of patients and their relatives buy the drugs and send them abroad;
- drugs in Moldova are considered to be cheaper;
- certain drugs that migrants are used to are not found in EU countries. Most often migrants require medication for migraine: citramon and analgin, but also other drugs such as valerian and paracetamol.

> *"Citramon, valerian, paracetamol, such emergency drugs, if you have fever or something. In more serious cases we consult doctors and ask them what we should send from here, without the patient's presence. We just call, tell about the problem and ask for advice. For example, my cousin had problems, something with his leg, so I called a doctor and asked what to buy him and sent it there"* (F, 27, rural, brother in Russia, more relatives in different countries)
>
> *"Minor aches: liver, pancreas – you drink a pill or two and it passes. It all just comes from nerves, but in case of nerves you take some sedatives and that's it"* (F, 33, Italy)

Also some migrants send drugs to relatives in Moldova. Those who have sent some some drugs home from Russia said they were cheaper in Russia than in Moldova. In their turn those who work in the EU have sent home medications noting that they were of higher quality and more efficient in treating different diseases. Some have mentioned that there were no such drugs in Moldova. Also some migrants after coming back home for a longer period of time ask their relatives, acquaintances or friends left to work abroad to send them medicine because they have greater confidence in drugs produced in the EU, but they are very expensive in Moldova.

> *"My sister was in Italy and now if she needs some drug she calls her sister-in-law there and asks her to send it from there, for example some kind of aerosol for breathing. I don't know if we have it here, and even if we do it's very expensive, so she sends her several of these"* (F, 32, rural, more relatives in Italy)

Forced by circumstances and working conditions migrants wait for their return to Moldova to have treatment. In this regard seasonal migrants are more advantaged.

> *"I come home every two or three months. I have a very difficult job and we are two Moldovans with Romanian passports and we shift every 2-3 months, in this way we manage to stay with our families here. We shift, and now I am home and she remained... I'll wait, three months will pass quickly, and then I'll go to see doctors, make an ultrasound or remove a tooth or something...* (F, 49, Italy)

Although most migrants try to postpone solving their health problems for the time when they return to Moldova there have been positive examples of treatment practices in the host country. These refer in particular to cases of emergency, and the emphasis was placed by respondents on the fact that the service was free.

> *"A friend of mine left to the Czech Republic and there she had an emergency and was operated – free of charge, and it was very successful. She stayed there half a year and then came back home*" (F, 58, rural, daughter in Italy)

Respondents noted that even some residents of countries where they work prefer to seek medical, recovery or beauty services in Moldova due to the price to quality ratio. In this respect dental services are the most requested.

"I worked at Rublyovka, a very rich district, you've heard of it. It's funny but I heard it myself that a person from there bought an air ticket to come to Moldova to repair his teeth" (F, 44, Russia)

"My friend from Italy came with an X-ray of her teeth, she went with the X-ray, the doctor did her teeth and then made an appointment for the Italian" (F, 60, Italy)

V. COMPULSORY MEDICAL INSURANCE

1. Medical Insurance Coverage in Moldova and Abroad

Compulsory Medical Insurance Coverage in Moldova per Categories

According to the statistical data available on the web site of the National Health Insurance Company, during 2008 about 2568.6 thousand persons of the total of 3424.4 thousand registered persons were insured, which is a 75% coverage.

Data reveal no significant development during the year. Insurance rate among households not receiving remittances (the largest represented group from the total population) remained the same 75%.

Table 19) **The number of persons insured in 2008, per groups**

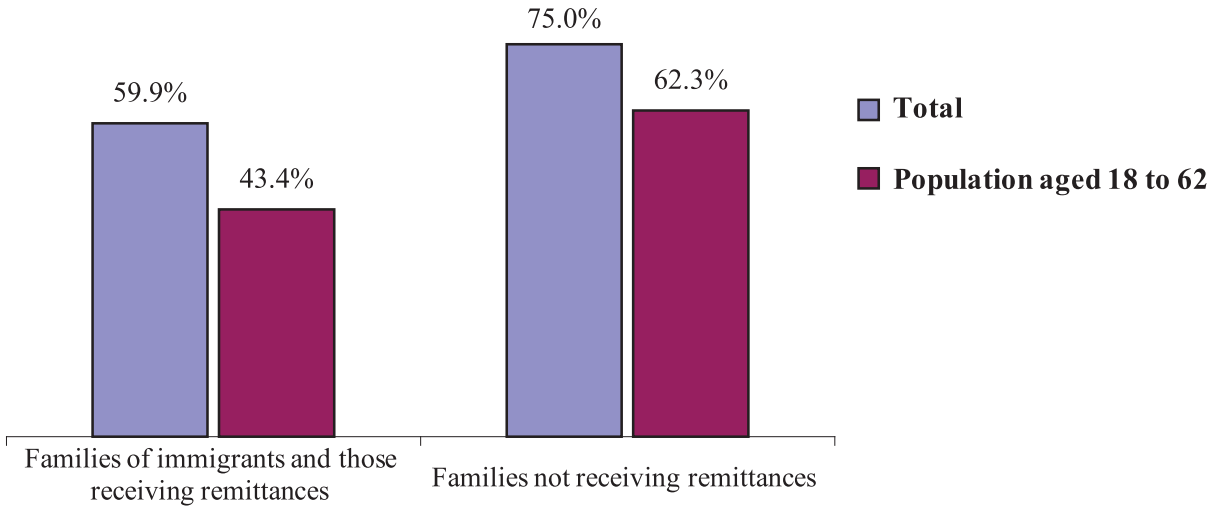
	Number of insured persons (thousand persons)	Percentage of the total number of insured persons (%)
State insured persons	1,733.2	67.5
Employed persons	800.1	31.1
Personally insured individuals	35.3	1.4
TOTAL	**2,568.6**	**100.0**
Population of the Republic of Moldova	3424.4	

Source: REPORT on the usage of means from the compulsory medical insurance funds for 2008

Despite expectations, receipt of remittances does not motivate and / or provide greater opportunities for medical insurance. On the contrary, medical insurance coverage rate among migration-affected families is about 15% lower than average.

The reason of the above phenomenon is not that the number of the elderly or children among migration-affected households is smaller, since if we only consider people aged 18-62 the insurance coverage rate decreases for both compared groups, while the difference between the groups rises to 19%.

Figure 8) **Medical insurance coverage rate**



Another reason behind the lack of medical insurance policies, especially the insurance rate difference between the compared groups, is the financial aspect, which has been mentioned most frequently by both groups.

At the same time households not affected by migration mention financial constraints as the main reason for non-insurance at a higher rate than the other group (51.9% compared to 32.9%).

On the other hand, among households receiving remittances subjective factors are of greater importance, such as refuse to purchase a medical insurance policy on account of considering it unnecessary since the person has no health problems (31.3% compared to 16.7% of the control group), or because the cost of the insurance policy is higher than current health expenses (14.1% compared to 8.6%).

Table 20) **Reasons behind non-insurance**

	Families of migrants and those receiving remittances	Families not receiving remittances
I cannot afford it	32.9%	51.9%
It cost more than my healthcare costs	14.1%	8.6%
I do not need it, I have no health problems	31.3%	16.7%
I don not know where to buy it	.5%	.5%
My employer has not provided me a health insurance policy	2.3%	1.0%
I am not (officially) employed	12.6%	14.8%
DK/NA	6.6%	6.5%

Separate sub-samples analysis[4] shows that migrants themselves are the most responsible for the low rate of insurance among the population affected by migration. Just as expected, most of them are outside the compulsory medical insurance system, with a much more lower insurance rate than the other two sub-samples. Of the total number of migrants, people that worked abroad two years ago at the earliest, only one of four currently have a medical insurance policy. Coverage rate among migrants is very small as compared to the population not involved in migration.

Comparison between families receiving remittances and those not receiving remittances shows that receipt of remittances diminishes the motivation to purchase medical insurance policies. Thus the rate of medical insurance among families receiving remittances is lower than among households not receiving remittances (61.9% compared to 69.2%).

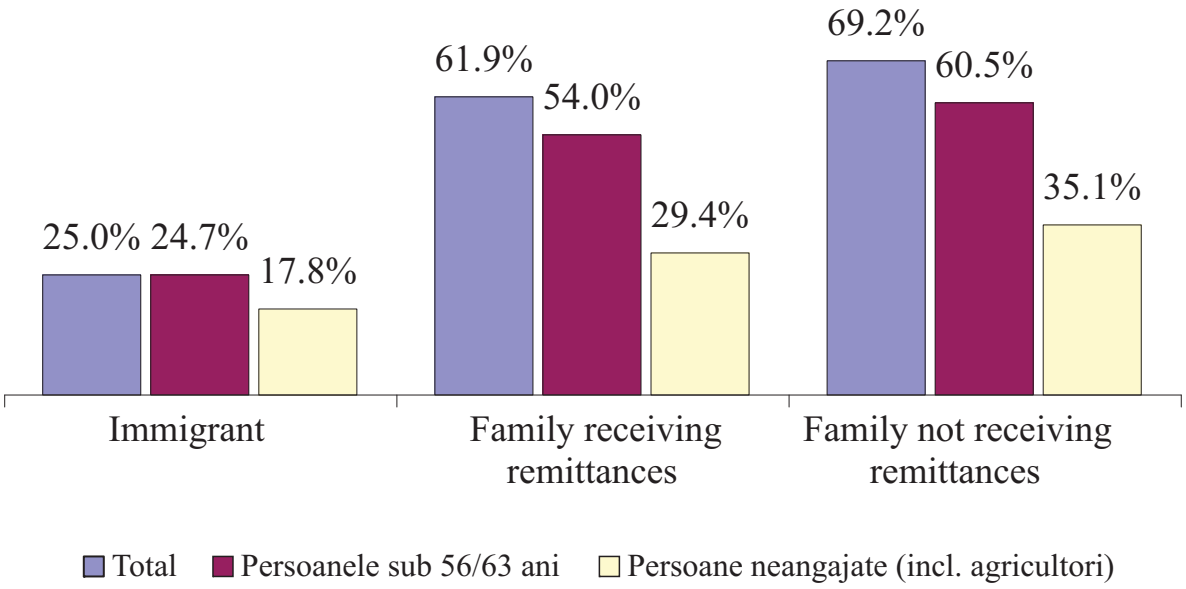
Taking into account that migrants are a relatively young age group as compared to the rest of the population, we exclude from calculations persons over the retirement age (women over 56 and men over 63 years old). In the group of people under the retirement age the medical insurance rate among migrants (24.7%) is practically equal with the average rate, whereas coverage rate among other groups diminishes considerably, retaining a significant difference between the population receiving remittances and the population not receiving remittances (54% compared to 60.5%).

At the same time, besides the retired population receiving free insurance, we will see later on that to a significant extent people are insured through monthly contributions from salaries, and only a relatively small part of the population purchases insurance policies independently. For this reason the last comparison shall be done among respondents not receiving free insurance policies and not insured through monthly contributions, which shall demonstrate more precisely differences in motivation for medical insurance. Thus, the medical insurance policies purchase rate among migrants not receiving free insurance (i.e. are not retired, invalids, pupils, students, or on maternity leave) and not insured through monthly contributions from the salary constitutes 17.8%, among respondents from families receiving remittances – 29.4%, and among those from families not receiving remittances – 35.1%. So the difference

[4] Data are presented regarding respondents only, not the entire household

between migrants and the other two groups, as well as the difference between groups not involved in migration remains significant. This fact clearly indicates that remittances do not lead to increased purchase of medical insurance policies; on the contrary, the population receiving remittances (whether migrants or members of their families) avoid the state medical insurance system.

Figure 9) **Medical insurance coverage rate per categories of respondents**



During group discussions migrants mentioned that the medical insurance policy does not offer any benefits. People without a compulsory medical insurance policy are treated with much more respect and courtesy by doctors who perceive them as possible sources of income.

"I've worked in medicine and I know it. Those who with policies wait at the door and are told to come back tomorrow and those who pay cash are admitted first." (F, 30, Russia)

"From my own experience I can say that there are different reactions from doctors and nurses. If you don't have medical insurance they treat you better because they know you'll pay them, and if you have the policy you are treated with aggression. If you have insurance they are not interested in examining you, there's no attention towards a person with a policy" (M, 24, Italy)

"I once paid a lot for my husband's surgery; I thought there'd be only one, but in fact there were two surgeries. One was an emergency and the second was two weeks later, and I paid for both, and they didn't want to perform the surgery until I paid. They were trying to send him home for money and it was Sunday night" (F, 57, Italy)

As for the access to medical services, policy holders are required to undergo a bureaucratic process involving a compulsory visit to the family doctor followed by registering for appointments and waiting in queues. For money the patient is served by the doctor *"here and now*" and some policy holders need to pay in order to immediately receive certain medical services.

"I didn't buy it because, you know, it's all the same: you pay when you go to the hospital, you pay in clinics, you pay for tests, so I don't see any reason..." (F, 33, Italy)

"I didn't buy it because it's pointless. I've bought one for my mother and when she went to hospital she paid a lot of money and they said they didn't care if she had the policy. I simply don't trust these policies" (M, 24, Italy)

"Last August I came home and wanted to go to my regular doctor at the infections hospital. I called her and said: "I want an appointment", and she replied: "You may come but the funds allocated to the infections hospital for your policy have come to their limit"... If these policies were already invalid in August, then what's the point? I paid and was admitted to hospital. Now, just this Monday I came with my brother... to the Republican Hospital: do you have insurance? Yes, my brother had it because he works in the village, but he had no referral from Nisporeni. And they said: since you don't have a referral, we'll figure out something... Of course we paid" (F, 49, Italy)

"The queues are huge and if you feel bad and you can't just stand and wait, there are no tickets, see? You have a heart attack or something and you can't get to a doctor for a week, how's that? You just die at home and that's it, so whether you want it or not you go to a place with no queues" (F, 46, Russia)

"If you want to see the family doctor you have to go Thursday afternoon, and if you go Monday, Tuesday, or Wednesday that very week you have no chance to see the doctor. You only have to go Thursday afternoon to get an appointment for the next week." (F, 42, Russia)

Even medical policy holders recognize that in case you have an appointment to the doctor for a certain hour, the time is not observed, priority being given to those who pay, those with relations, etc. Some respondents declared that they "establish personal relations" with the family doctor and then the quality of the medical services improves: *"once a month you pay the family doctor 100 lei and when the doctor sees you he comes around and asks how you are, and there's no problem"*.

Migrants mentioned that abroad appointments are strictly respected; everybody appreciates their time and in case of any deviations from the appointed time the doctor feels guilty and apologizes. In Moldova however, doctors even get angry with the patients who mention they have an appointment.

Another disadvantage of medical insurance policies is the impossibility for the patient to choose the doctor they want to address for advice or treatment.

"We go to a doctor that we've heard is good, while with the policy we can only go to the family doctor and then to those doctors he refers us to. And if I know that doctor isn't qualified enough it's not worth seeing him, so I find myself a good one" (F, 33, Italy)

*"Why should my health and the health of my child depend on some incompetent community doctor? I go where I want, where there's an expert" (*F, 27, Russia)

"*I take distant learning in Chisinau while I reside in Ungheni, and I went to the community family doctor here in Chisinau, who is responsible for the given hostel. The doctor refused me and told me to pay for everything, although I had a student identity card. I had pneumonia, fever. I got very angry, stressed, it was January and she was sending me to my place of residence to see a doctor"* (F, 30, Russia)

Some respondents said that since they spend most of the time abroad, there is no use in purchasing a medical insurance policy because the probability they will have the chance to use it to receive medical services is very small. Nevertheless, some migrants (exceptions, mostly elderly persons) declared that they purchased medical insurance policies for fear that in case they need to stay in hospital the costs will be much higher than the cost of the policy. Some respondents said that the current system is not well-thought-out, the policy should be issued for life and not for a year, i.e. beneficiaries should be stimulated: e.g. by contributions or at least a part of them accruing each year; by transferring these contributions in certain cases to other members of the family, etc.

"I think it's mockery to buy a policy for a year. In Europe the policy is issued for life and you have a personal code. Even if we pay 800, 900 lei per year, this year I've paid about 1300 lei, but I went to the doctor twice, and as for the rest..." (F, 41, Greece)

Currently, the contributors of the Moldovan medical insurance system are highly state-dependent. In 2008 of the 2.6 million insured persons 67.5% were insured by the state (retired persons, children, invalids etc.), and only 32.5% made effective contributions to the budget of the National Health Insurance Company, with just 1.4 % individual contributions.

The research data indicate a smaller dependency rate, in proportion of 1/1 (state-insured to individually insured) in the case of sub-samples 2 and 3, and of 1/5 in case of migrants.

Only 21.3% of migrants are currently insured by the state; about two thirds (58.7%) are employed, and 20% of migrants have an individually purchased insurance policy; most of the latter (15.6%) purchased the policy personally. This percentage is the highest per groups and is incomparably higher than the general percentage of the personally insured population.

Table 21) **Practices of purchasing compulsory medical insurance policies in Moldova, per categories**

	Migrant	Family receiving remittances	Family not receiving remittances
Personally insured individuals	15.6%	2.1%	3.6%
Individuals insured by the household members	4.4%	2.8%	.6%
Employees	58.7%	45.6%	46.1%
State-insured persons	21.3%	49.5%	49.3%
Other			.4%
Dependency rate	*1/5*	*1/1*	*1/1*

Insurance conditions brought forward by non-insured persons:

1. Possibility to be insured occasionally, in case of illness. This condition is favoured by 32.8% of migrants, 30.6% persons from families not receiving remittances and 25.4% from families receiving remittances;
2. Combating corruption. A significant part of the non-insured persons refuse purchasing the policy because it does not protect against corruption;
3. Reduction of the cost of the medical insurance policy is a condition required mostly by the population uninvolved in migration and less by migrants.

The idea of giving the possibility to be insured for a period shorter than a year does not seem to be a mechanism appropriate for increasing the rate of medical insurance.

Table 22) **Conditions of health insurance rate increase**

In which case would you purchase a medical insurance policy?	Migrant	Family receiving remittances	Family not receiving remittances
Only if I fall ill	**32.8%**	25.4%	**30.6%**
If it gets cheaper	16.3%	**26.5%**	**27.4%**
If I'm sure that with the policy I won't have to pay more for medical services	**28.9%**	**28.7%**	23.3%
If private medical services get more expensive	5.4%	4.4%	3.2%
If I can buy a policy for less than a year	3.7%	6.6%	5.5%
Only if I fall ill	13.0%	8.3%	10.0%

Medical insurance coverage rate of migrants in the host country is lower but close to the rate registered in Moldova. Thus, every fifth migrant (20.6%) was insured during his last travel abroad, as compared to 25% in Moldova.

When considering social and demographic characteristics and characteristics of the migration profile, a very low insurance rate is registered among migrants to CIS (13%), short term migrants (15.9%), illegal migrants, those with temporary registration or residence permit, those working in constructions (13.7%), male migrants (17.5%). Among age groups the variation in the medical insurance coverage rate is not very pronounced.

Table 23) **Medical insurance abroad (G21)**

General		20.6%
Directions of emigration:	CIS	13.0%
	EU	**40.4%**
	Other countries	**48.0%**
Duration of the last emigration:	Less than 6 months	15.9%
	6-12 months	**34.6%**
	Over a year	27.3%
Residence status in the host country:	Citizenship of the destination country	**50.0%**
	Romanian/Bulgarian passport	**36.4%**
	Working and residence permit	**37.2%**
	Only residence permit	9.9%
	Temporary registration	12.6%
	Illegal residence	3.7%
Sphere of activity abroad:	Household	**30.1%**
	Construction	13.7%
	Agriculture	24.4%
	Hotels	**43.2%**
	Trade	19.3%
	Transport	25.4%
	Industry	**44.9%**
Gender of the person:	Male	17.5%
	Female	**26.7%**
Age group:	Under 30	18.8%
	30-39	22.0%
	40-49	17.0%
	50 and above	28.8%

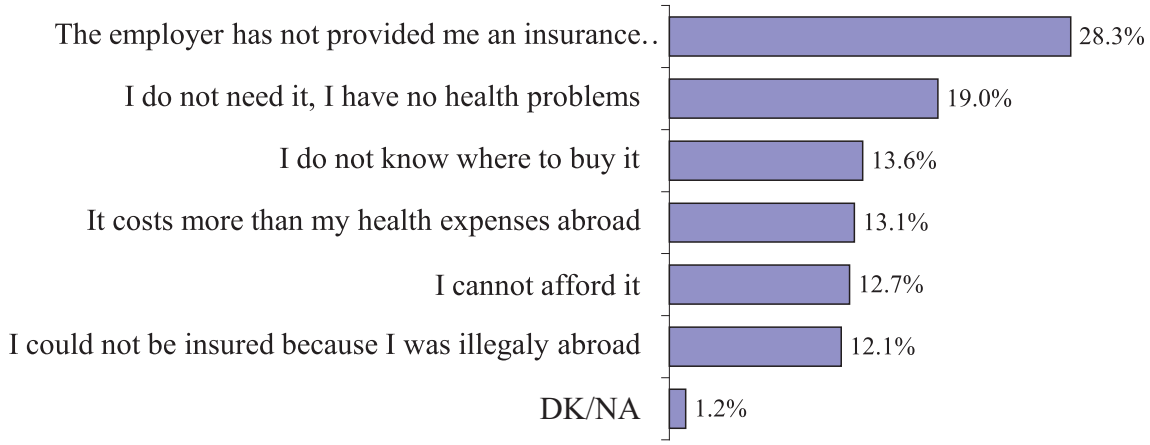
Employers' and employees' negligence is the main reason behind Moldovans not having a medical insurance in the destination countries.

Most often employers avoid legal employment of non-residents, and so medical insurance contributions are not paid. Because of this about 28.3% of non-insured migrants were not insured during their last travel. Some of the participants at group discussions with migrants, however, said that despite working illegally, their stay in the country was legal, and they, having paid a certain fee, had medical insurance. Also, illegal migrants in Europe may benefit of medical services provided by charities: Red Cross and Caritas.

One in five (19%) invoked a reason valid for Moldova as well, which is lack of need in medical insurance because of not being ill.

The next reasons in order of importance are lack of knowledge about practices (not knowing where to buy), financial aspects and problems connected with illegal residence in the host country.

Figure 10) **Reasons behind lack of medical insurance abroad**



Most participants in the qualitative study mentioned that medical insurance abroad depends on contractual conditions with the employer and on the host country policy regarding medical insurance. So, most medical insurance policy holders received their policies from employers. In certain situations employers request migrants to undergo medical investigations, especially if they work in public catering, and sometimes in constructions.

The modality of insurance abroad is similar to that in Moldova, except the fact that the number of state-insured migrants abroad is very small. Most migrants are insured by paying monthly contributions from their salary – 85.8%, very few purchasing insurance policies personally.

Table 24) **Practices of purchasing compulsory medical insurances abroad per categories**

	Migrant
Personally insured individuals	7.6%
Individuals insured by household members	4.0%
Employed	85.8%
State-insured	1.3%
DK/NA	1.3%

2. Knowledge of the Medical Insurance System

Degree of Awareness about the Compulsory Medical Insurance System in Moldova

Generally, the lack of knowledge of the principles of the medical insurance system in Moldova is highly pronounced and widely spread; moreover, it is recognized. Important segments of the population consider that they do not know the functioning principles of the medical insurance system in Moldova, specifically its essential element – the set of medical services provided to a medical insurance policy holder from the medical insurance budget. There are differences between the groups compared in the research, differences to the detriment of migrants. Finally, among the population not directly involved in migration the number of "those who know" (in terms of self-evaluation) is greater than those "who don't know", while among migrants the situation is reverse – 57.2% say they do not know about medical services covered by their insurance policy.

Table 25) **Evaluation of the degree of awareness about the set of medical services covered by the health insurance policy**

Do you know about the free medical services covered by the compulsory insurance policy in Moldova?	Migrant	Family receiving remittances	Family not receiving remittances
Yes	37.6%	59.6%	58.5%
No	57.2%	36.4%	37.2%
DK/NA	5.1%	4.0%	4.4%

Assessment of Medical Insurance Costs in Moldova and Abroad

In 2009 the cost of the compulsory medical insurance policy in Moldova equalled 2,637.9 lei.

It is clear that not all beneficiaries and potential beneficiaries of medical insurance know the exact cost of the policy. Generally, the cost of the policy is considered to be somewhat lower than it actually is, about 2,000 lei, and only 16% of respondents were closer to reality.

It is impossible to establish the exact cost of medical insurances in the host countries because only 5.4% of the interviewed migrants could provide an answer in this regard, which denotes very little interest and knowledge regarding medical insurance abroad. Only one in four migrants insured abroad could name insurance costs.

The most vulnerable and disapproved of aspect of the medical insurance system in Moldova is its cost. Most of the population consider that the cost of the policy is too high for the volume of services provided by the medical insurance system. When compared, positions of the groups proved to be rather similar, with every second respondent of each group considering the cost of the policy "very high", and a quarter of respondents – "high".

On the other hand, disapproval of the cost-benefit ratio is not determined by the level and volume of the consumed medical services. It is because we could not find substantial differences between appreciations given by persons who had at least one contact with the healthcare system during the last 12 months and appreciations of persons who had no such contact.

Group discussions with migrants revealed a negative attitude towards the operation of the compulsory medical insurance system in Moldova. Respondents consider the insurance policy is a formality and when you have a real health problem, whether you hold a policy or not, you have to pay for services, mostly unofficially. Some participants in the study mentioned that the medical insurance policy offers only the possibility to stay in hospital for free, without paying *"for the bed",* and that patients still need to pay for all other services.

"The only difference is that when a person is hospitalized he doesn't pay for the bed, for the place, because each place in the region costs 110 lei and not every person has these 110 lei, so he presents the policy. There are actually some people who buy the policy and stay in hospital for 3 months a year. The policy is only this and nothing more; not even the food playa a role" (F, 41 years old, Greece)

"There's not a big difference whether you have the policy or not. The situation is the same as it was before; maybe just the medical service is better – for doctors themselves… The policy is of no use to people, since it was made in a way to benefit the state, not people" (F, 46, Russia)

"The family doctor says I have to see all doctors in the clinic to get 5 stamps so as to come here (in Chisinau) to the hospital, to stay in queues… I already have some relations, my own doctors who put their stamps; I don't take any tests as I should do, they already know me" (F, 26, Italy)

During group discussions policy holders themselves recognized the fact that for the elderly and those with serious health problems the medical insurance policy is necessary and useful, but for the young people and for those involved in more than one activity the policy does not facilitate access to healthcare services.

"I've had medical insurance ever since 2000 and I'm satisfied. Certain tests are more expensive, but the rest are free. And I also had a tomography for free, and it costs a lot. I have a spinal tumour and I wouldn't say, so I have to spend something. Maybe those with a whole lot of diseases, who see the doctor more often, are pleased, but not the healthy people" (F, 60, Italy)

"I have it because I was employed, and now I'm retired. I think the policy is not worth buying because when you get to see the doctors you have to pay them personally. The policy is useful when you take tests, but if you need to have the liver scanned, for example, you have to pay 100 lei or wait for 3 months for your turn" (F, 57, Italy)

Regarding the costs of medical insurance abroad, we need to first mention the high rate of avoidance to answer (64.5%). As for those who answered, we again detect a predominantly negative appreciation among migrants of the cost-benefit ratio regarding medical insurance abroad, though the general impression seems to be more positive as compared to the same aspect in Moldova. Thus, 11.7% of migrants declared that in the country where they worked last time the cost of the medical insurance is too high for the provided healthcare services. This percentage makes one third of the total number of migrants who gave an appreciation in this regard, as opposed to one of two migrants who gave an answer regarding the same aspect of the national medical insurance system.

Ten percent of all migrants (about 30% of those who gave an answer) declared that the medical insurance cost abroad corresponds to the services included in the policy.

Table 26) **The cost of policy as compared to the package of services included in the policy**

Do you think that in comparison with the services included in the policy its cost is…?	Migrant		Family receiving remittances	Family not receiving remittances
	In Moldova	Abroad		
Very high	49.5%	11.7%	47.4%	51.4%
High	25.0%	10.4%	32.8%	23.2%
Corresponds to the services included in it	8.1%	10.9%	9.5%	9.3%
Low	1.7%	1.5%	1.5%	3.0%
Very low	.8%	1.1%	.8%	3.4%
DK/NA	14.8%	64.5%	8.0%	9.7%

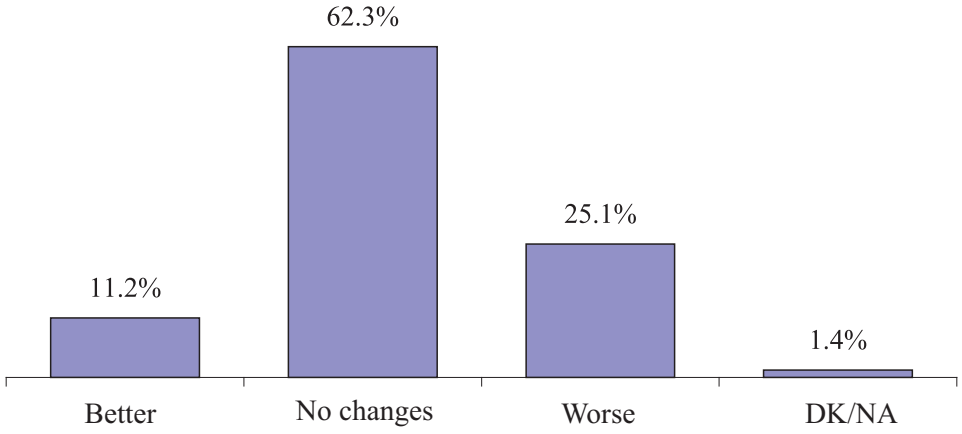
VI. HEALTH PROBLEMS CAUSED BY MIGRATION

Long stays far from home, emotional intensity connected with migration and stays abroad, as well as the risks connected with illegal activity on the labour market are reasons enough to expect worsening of the health of those involved in migration.

However, judging upon the migrants' estimations, we cannot say that the hypothesis is true. Being asked to appreciate the current state of their health as compared to the period before the first emigration, worsening was mentioned by 25.1% of migrants, quite a big proportion.

Worsening of the state of health is more often reported by female migrants (31.5%), over 40 years old, who immigrated to other countries than EU and CIS and worked in households.

Figure 11) **Current state of migrants' health compared to the period before emigration**



Hypothetically speaking, health risks implied by migration may arise as a result of the following:

1. Migration, change of the living environment, the stress connected with living abroad, away from the family;
2. Living conditions abroad;
3. Working conditions, accidents at the working place;
4. Risks based on illegal residence in the host country, implying, for example, forcing and exploitation of migrants.

Below is an evaluation of each of them.

Emigration Process, Change of Living Environment and Stress of Staying in a Foreign Country, away from Family

This aspect has been addressed mostly in the qualitative study, migrants mentioning psychological and emotional difficulties which they faced during emigration and their stay in the host country.

Illegal emigration especially affects people's health. Some of them declared that the effects of emotions and stress they underwent were felt later in time as difficulties with concentration, sleep, communication, migraines, etc. Others said that during migration their chronic diseases worsened.

Longing for their children, for the loved ones, for the native land is a factor of depression for people working abroad. Family separation is an important stress factor, but respondents declared that they had no other choice. Also, in the host country they feel as foreigners and very often experience humiliation.

"I've worked in Russia for many years, my son stayed with my relatives, you know how it is. Half of the way from home I was crying and when I was back home I thought that I'd never go abroad again. But I needed money; I had to raise him all alone. He graduates from the Academy of Economic Studies this year" (F, 44, Russia)

"First, culture differences; second, no relatives near; third, it's not like everyone abroad is welcoming you with open arms. They see you as a stranger, sometimes even worse. Psychologically you definitively lose; we often joked that animals abroad are treated better than strangers" (F, 27, Italy)

"My health was most affected by the fact that I left my native land, my country and my child to go abroad. The last was the biggest trauma, but the conditions and the life there are wonderful" (F, 36, Italy)

Many of the people working abroad used to have a certain social position, are people with higher education who, forced by circumstances, perform non-qualified jobs. Some people said that they could not get used to these jobs and returned home.

"I was in Italy, for no more than 3 months. My mother has been there for about a year and I also went there to work but I couldn't. I stayed a night with an old woman and on the second day I quit – just apologizing and asked them to let me go back home" (F, 26, Italy)

At the same time illegal residence and/or work is a permanent stress for migrants, especially when they are in public places, but also in every minute. The uncertainty is a characteristic for such people, they do not know what to expect the next day, the stress that they came to work and gain money always follows them, especially that risks are many: inability to find a working place, work accidents, non-payment of the salary, etc.

"When you think you can go there and earn money, it's not always true. Even in Moscow it happens to go and come back without money. I've stayed there for 3 months and returned with some money, and then I went there for the second time and came home with noting but 5000 rubbles" (M, 21, Russia)

Migrants' Living Conditions Abroad

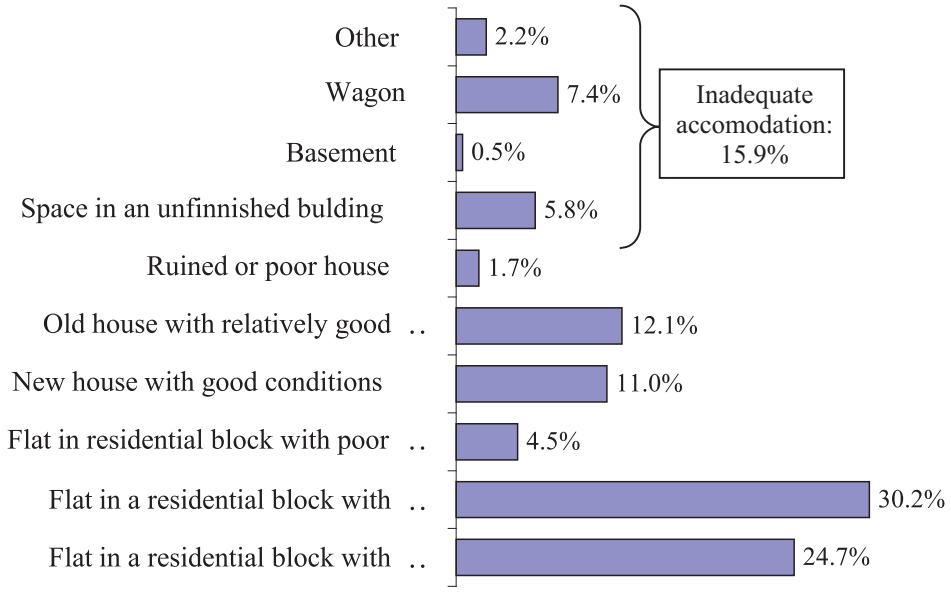
First we will refer to the type of migrants' accommodation abroad. At first glance the situation is not very bad. The fact that migration flows are directed to cities explains the predominance of migrants who lived in blocks of flats – 59.4%.

Eight of ten migrants live abroad in flats or private houses in relatively good conditions, and the proportion of migrants who considered their living conditions bad was only 4.5% of those who lived in flats and 1.7% of those who lived in private houses.

At the same time during their last travel abroad about 16% of migrants lived in inadequate spaces, adapted locations. It becomes evident that this situation is mostly common to migrants who work in constructions. So, 5.8% of migrants lived in unfinished buildings and 7.4% in a wagon.

In general, every fifth migrant (22%) does not have an appropriate and secure accommodation abroad.

Figure 12) **Types of accommodation**



Mostly because of inadequate accommodation a part of migrants are exposed to cold, insufficient lighting and wetness, factors that can have negative effects on health.

Between 9.6% and 17.4% of all migrants are exposed to such factors. It is clear that better quality of accommodation diminishes such factors. Of the migrants living in adequate accommodations only 4.6% mention wetness (compared to 9.6% of all migrants), 10.2% mention poor lighting, and 12% – poor heating.

Living conditions in locations with poor conditions (both in flats and houses) are as bad as in inadequate, adapted locations, with the percentage of migrants exposed to cold, poor lighting and wetness being at least three times greater than of those who lived in adequate accommodations in acceptable conditions.

Table 27) **Living conditions**

	Total	Adequate accommodation in acceptable condition	Adequate accommodation in unacceptable condition	Inadequate accommodation
Insufficient heating	17.4%	12.0%	37.3%	38.9%
Insufficient lighting	14.4%	10.2%	31.3%	30.2%
Too wet	9.6%	4.6%	34.3%	26.8%

Group discussions with migrants revealed that the poorest living conditions were those of migrants working in constructions, who chose to live at their working site. They also showed that a longer migration experience leads to an improvement of living conditions in the host country.

"W*hen I was there last years I even slept on concrete. Our people from Moldova took mattresses from garbage, chose better ones, covered them with bed sheets and slept on them. It was great if you had a place to sleep"* (F, 30, Russia)

"Guys working in constructions build something of a room from plywood put some boards on a couple of bricks and sleep on this "bed". There's no place to wash, to eat. How can we stay healthy?" (M, 25, Russia)

"The place where we lived was very mouldy; we lived like in a cowshed. We didn't sleep there until we renovated the place; we slept outside, thank goodness it was warm" (M, 21, Russia)

Pe lângă condițiile de trai uneori precare, migranții se confruntă şi cu deficitul de spațiu locativ, în unele cazuri în aceeaşi locuință locuind zeci de persoane. Astfel, numărul mediu de persoane per cameră locuibilă peste hotare constituie 2,6, iar numărul maxim – 60! Pentru comparație, în anul 2008 în Republica Moldova unui cetățean îi reveneau în medie 22 m^2 de suprafață locuibilă, deci cu aproximație o cameră locuibilă de dimensiuni medii. Economisirea mijloacelor financiare constituie principalul motiv care determină migranții să locuiască în număr mare în acelaşi spațiu. Migranții declară că locuiesc şi activează în condiții precare, ce le afectează sănătatea, în mod conştient, acesta fiind costul pe care îl plătesc pentru a câştiga bani.

„Deodată (apare) răceală, fiindcă afară e -45 grade, dar eu mă duceam la lucru. În casă era normal, +20. Însă noaptea, pereții erau subțiri, eu puneam perna, dimineața (când) mă sculam, perna era lipită de perete, aşa de tare înghețа. De asta şi am răcit de multe ori." (M., 25 ani, Rusia)

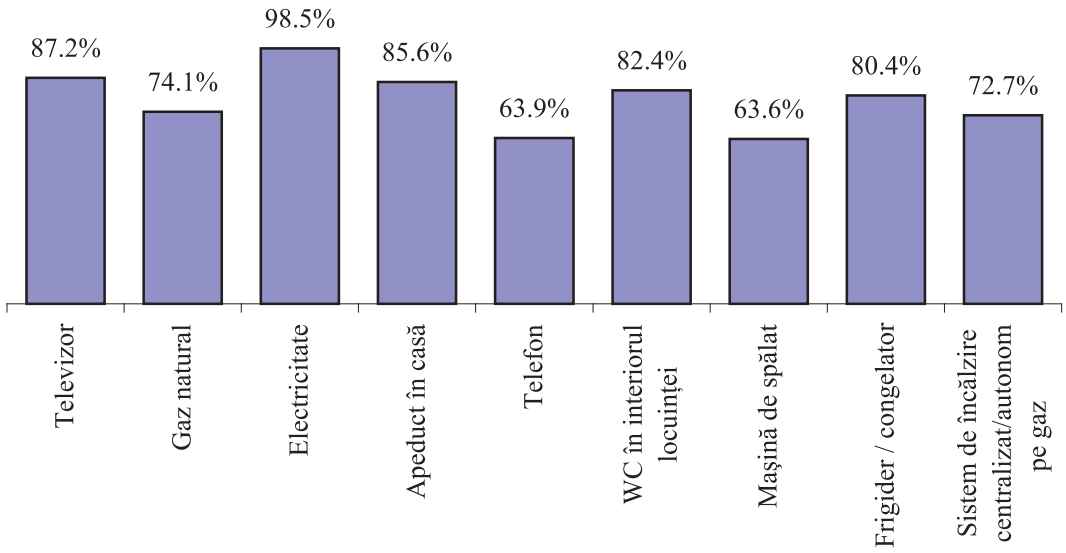
„Trei băieți locuiam în cameră. Se întâmpla că aveam unde trăi, da se întâmpla că singuri ne construiam ca (un fel de) o gheretă, aşa, (acolo) unde lucram... Locuiam câte o lună şi (apoi) ne ducea la un obiect nou. La unii era (câte) o căsuță şi (noi)construiam alta alături." (M., 23 ani, Rusia)

Dotarea locuințelor pare a fi una înaltă şi comparabilă cu cea din Moldova la unii parametri. Deoarece se ştie, din studiile în domeniu, că migrația economică vizează preponderent marile centre industriale şi economice, ar fi mai corect să comparăm cifrele obținute de studiu cu datele statistice pentru mediul urban din Republica Moldova. Astfel, în cazul a 85,6% dintre migranți ultima locuință de peste hotare a fost conectată la un apeduct. În Moldova, în anul 2008 erau conectate la apeduct 79,8% din locuințele urbane.

În schimb conectarea la conducte de gaz înregistrează parametri mai mici – 72,7% față de 93,1% în Moldova, în mediul urban. Asigurarea cu energie electrică este una comparabilă cu situația din Moldova.

Şi asigurarea cu obiecte de uz casnic am spune că este una destul de bună, luând în calcul cota mare a migranților care locuiesc în locuințe inadecvate, improvizate. Au avut un televizor în locuința lor peste hotare 87,2% dintre migranți, un telefon fix – 63,9%, o maşină de spălat – 63,6%, iar 80,4% au dispus de un frigider/congelator.

Figura 13) **Dotarea locuințelor cu servicii comunale şi obiecte de uz casnic**



Migrants' Work Conditions Abroad

Eight working hours per day and five working days per week is the provision of the labour legislation in most countries, including the countries where Moldovan migrants work. This research, however, reveals that most of the Moldovan migrants work in conditions that violate the labour legislation, at least regarding the duration of the working day and of the working week.

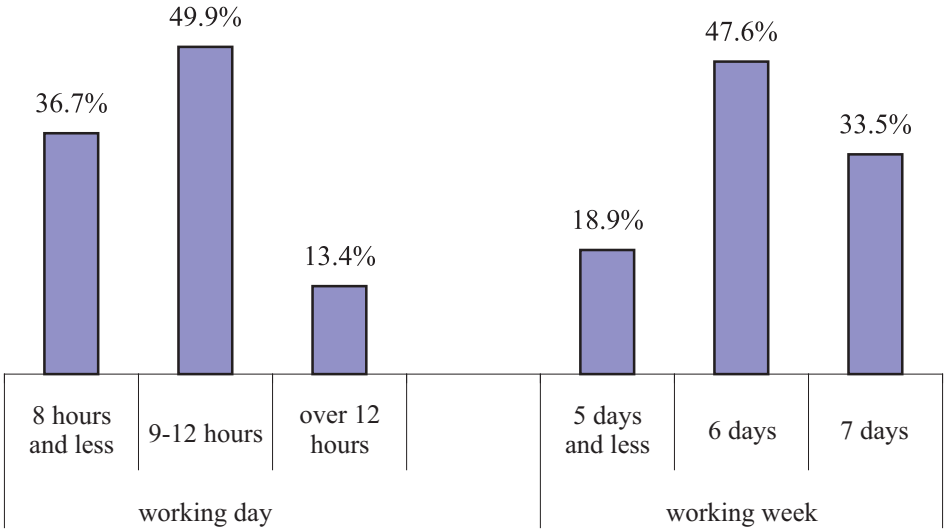
Only 36.7% of migrants during their last travel abroad worked about 8 hours per day or less, and only 18.9% of migrants worked 5 days per week or less.

Every second migrant had a working day of 9 to 12 hours and a working week of 6 days.

One of three migrants (33.5%) worked seven out of seven days per week, and 13.4% worked over 12 hours per day.

So, the average duration of the migrants' working day was 10.3 hours, and the average working week – 6 days.

Figure 14) **Duration of the working day and week abroad**



Data also indicate that female migrants make the highest percentage of those who work over 12 hours (18.2% compared to 10.9% of males), and of those who work 7 out 7 days per week (37.9% compared to 31.2%). On the average, the working day of a female migrant is about 1 hour longer, 10.9 hours as compared to 10.0 hours for males.

The above fact is not, however, determined by the migrant's sex, but by emigrational characteristics, namely the sector of activity abroad and the direction of emigration. Sectors of activity mostly performed by female migrants have the longest working days and weeks. 31.8% of the migrants doing housework work over 12 hours a day and 43% of them work the whole week with an average of 12.6 hours per day. It is followed by the hotel sector with about 11.2 hours per day.

The women engaged in housework and/or people care who participated in the focus group, declared that they are "at the service of the masters" 24 out of 24 hours. Some of them do not have a day off, and some, even if they had it, are there illegally or they simply have nowhere to go and so keep working.

> *"Those three months I work there I have no time off, not even a second, neither Saturdays nor Sundays. Yes, Sundays are paid separately and I have Thursday afternoons off. But I stopped going out because I have no one there, and they don't even ask me: "Pauline, maybe you want to go out; maybe you have to go somewhere?" Even when I have to go for an hour or two to send something home, I see that the host's daughter is not pleased with this"* (F, 42, Italy)

As for migration directions, we find that working day is the longest for migrants to countries other than EU and CIS (an average of 12.3 hours); the shortest day is in CIS – 10 hours, while in the EU the average working day of a migrant is about 10.9 hours. And the CIS countries are the ones where female migrants are in minority.

Apparently, the residence status in the host country is of great importance. Those who hold the citizenship of the host country have the shortest working day and week – 9.6 hours per day and 5.6 days per week. In comparison, illegal migrants work on average 10.9 hours per day and 6.2 days per week.

The duration of the working day in correlation with the economic factor has an impact over the migrants' nutrition.

> *"In the morning I would get up at 6, and I'd rather sleep half an hour more than have breakfast. At 6.30 I went to work. They gave me a 7 minute break every hour and I had no time for lunch... Sometimes I afforded myself to buy something to eat, but then I thought of all the money I spent, so I started having only one meal per day when i would return home in the evening"* (F, 21, Russia)

Moldovan migrants are exposed to still other risk factors connected with labour conditions. The most often risks are works in noise, dust and at height. And in most cases migrants have no adequate equipment to face these risks. Thus, every second migrant worked in conditions of considerable noise at his/her last job, of whom only 21.6% had adequate equipment. Also, every second migrant worked in dust, with 26.8% without adequate equipment.

Every third migrant performed works at height (31.9%), of whom 13.5% without any protection equipment.

Table 28) **Labour conditions, presence of risk factors**

	Yes, with adequate equipment	Yes, without adequate equipment	No
Noise	21.6%	27.3%	51.1%
Dust	22.0%	26.8%	51.2%
At height	18.4%	13.5%	68.1%
Overstrain because of hard work and without sufficient rest	7.0%	16.6%	76.4%
Humidity	10.2%	13.3%	76.5%
Low temperature	6.8%	11.8%	81.4%
High temperature	7.8%	9.7%	82.5%
Gases	8.2%	8.3%	83.5%
Toxicity	4.5%	6.2%	89.3%
Radiation	3.5%	3.8%	92.6%
Threat for life because of people taken care of	2.2%	5.0%	92.7%

Risks and lack of adequate protection increase considerably the number of accidents and of negative effects on migrants' health.

Research data indicate a higher number of work accidents among migrants abroad then on the labour market in Moldova. In 2008 the national statistics showed a ratio of 502 work accidents per 1,251 thousand employed people. Reporting the numbers, we have 0.04 accidents per an employed person. Even if we admit that official statistics do not reflect the real number of accidents (not every accident is reported), the difference between the situation in the country and that of migrants abroad still amounts to hundreds. Falls from height are reported by 2.8% migrants, with only 46 cases registered in Moldova in 2008. For comparison, 28 migrants per one thousand were reported to having fallen from height abroad, while in Moldova the number was 0.037. Such a difference cannot be attributed only to the inaccuracy of national statistics. Falls from height are not the most often traumas. The greatest numbers of migrants suffer from psychological traumas - 8%, caused by leaving the native country and the loved ones, etc.

The next in frequency are injuries caused by falling objects, equipment – 5.3%, hypothermia of certain body parts – 5%, fractures caused by overstrain – 3.3%.

Each activity sector abroad implies certain injury risks.

Psychological traumas are common mostly to migrants doing housework, working in commerce, transportation.

Falls from height are mostly common to migrants working in constructions. The constructions sector also registers a very high rate (7.3%) of injures caused by falling materials and equipment.

In agriculture the most common risk is hypothermia – 8.9%.

Injures caused by road accidents (1.9% of all migrants) are common primarily to migrants working in transportation – 11.3%.

Table 29) **Work accidents per type of economic activities (H9)**

	General	Household sector	Constructions	Agriculture	Trade	Transport
Falls from height	2.8%	1.3%	**4.1%**			2.8%
Injures caused by fallen materials or equipment	5.3%		**7.3%**	4.4%	1.8%	4.2%
Hypothermia of some body parts	5.0%	3.9%	5.5%	**8.9%**	3.5%	4.2%
Scalds or burns of some body parts	1.2%	2.6%	.8%	2.2%	.9%	
Injuries caused by car accidents	1.9%	1.3%	1.8%			**11.3%**
Bone fractures, visceral injuries caused by overstrain	3.3%		4.1%	4.4%	.9%	4.2%
Psychological traumas	8.0%	**11.8%**	6.5%	8.9%	**10.5%**	9.9%

Have you had any of the following during the period you worked abroad?

Besides the risk of work accidents, migrants face difficulties not necessarily connected with work, which endanger their lives.

Psychological traumas are the main problem among migrants. Every fifth migrant had long periods of stress, and 16.3% had nervous breakdowns.

Other risks are connected with migrants' vulnerability in an unknown country, having no people who could help them. So, 10.8% of migrants happened to have nothing to eat for days because of lack of food, 9.3% faced situations of having no place to sleep for more than one day.

Health-related situations, such as failure to visit the doctor or treatment abandonment are relatively rare, though still existing – 3.9% and 2.8% respectively.

Table 30) **Risk incidence**

You were overstressed	19.0%
You had nervous breakdowns	16.3%
You have not eaten for more than one day because you had no food or money	10.8%
You had nowhere to sleep for more than one day	9.3%
You have staid ill in bed for several days without calling the doctor	3.9%
You refused the prescribed treatment because you had no money	2.8%
You wanted to commit suicide	0.8%

Have you had any of the following situations during the period you worked abroad?

Staying in a country without the statute of citizen, often illegally, migrants may easily become victims of exploitation and pressure. 14.8% of migrants became victims of various forms of exploitation and pressure. This phenomenon is common to all directions of migration, though with a wider incidence in CIS (16.4%) than in other countries (about 10%). A wider incidence of exploitation is registered in agriculture (24.4%) and transportation (19.7%).

As for forms, the most often migrants are forced to work hours and days overtime, for pay (8.4%) and without pay (6.2%).

Next is the situation in which migrants are forced to work in severe conditions without adequate protection (6.1%), which partially explains the high rate of accidents.

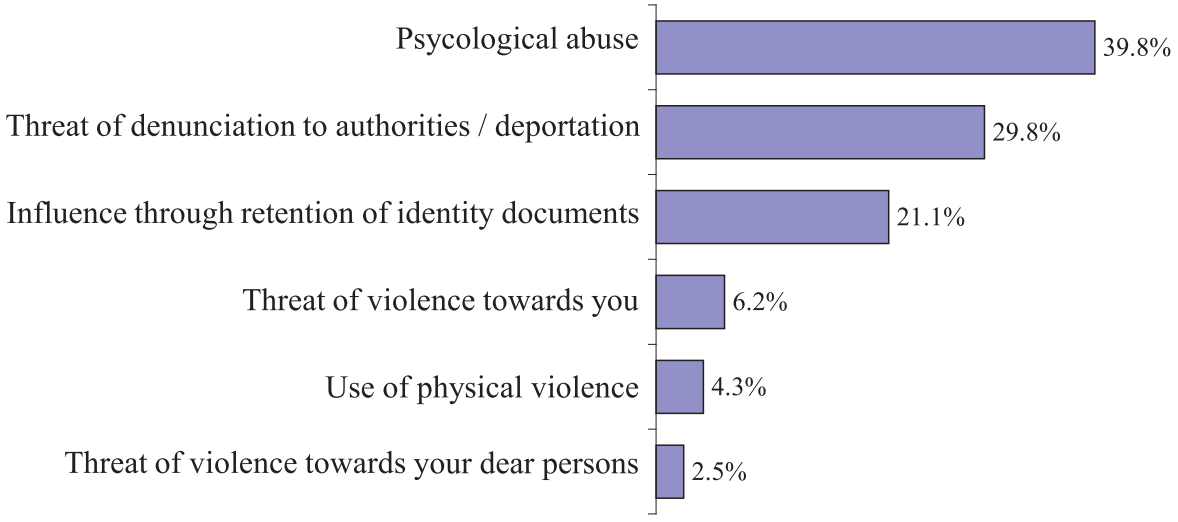
Table 31) **Exploitation and forcing of migrants**

	General	Activity sector abroad					Direction of migration		
		House hold	Construc tions	Agri culture	Trade	Trans port	CIS	EU	Other
Forced to accept an unwanted job/type/task	5.9%	5.9%	6.0%	6.7%	7.9%	2.8%	6.6%	4.2%	2.0%
Forced to work overtime without pay	6.2%	5.2%	7.5%	6.7%	4.4%	2.8%	7.4%	3.3%	2.0%
Forced to work overtime for pay	8.4%	9.2%	7.8%	11.1%	7.9%	12.7%	9.3%	6.3%	6.0%
Forced to work despite some health problems	3.8%	3.9%	4.1%	6.7%	.9%		3.8%	3.8%	4.0%
Forced to provide sexual services	.6%		.7%		1.8%	1.4%	.8%	.4%	
Forced to work in severe conditions without adequate protection	6.1%	3.3%	6.0%	13.3%	6.1%	9.9%	6.8%	5.0%	
In general	14.8%	13.7%	14.7%	**24.4%**	14.0%	**19.7%**	16.4%	10.4%	10.0%

Means used by the people (employers) that exploit migrants are mostly limited to 2 widely used methods – psychological violence (39.8% of exploited migrants) and use of the migrant's vulnerable statute of residence, by threatening the migrant to report to authorities (29.8%) or by confiscating identity documents (21,1%).

Threats of physical abuse and even application of physical violence are relatively rare.

Figure 15) **Means of constraint**



A tragic aspect has been identified during discussions regarding the death of Moldovan citizens working abroad. Usually, these cases are mysterious. Among migrants Moscow is named "the city of deaths". Participants in the study from rural areas (information there spreads easier) mentioned at least one person's death abroad in the last five years.

"We buried our uncle half a year ago. He was 36 and he worked in Moscow on the 5th floor of a building and lived there, too. One evening he fell into a ventilation shaft and died. There was no one to be found, neither the site supervisor, nor anyone. He simply fell down. The guys who saw him pulled him out. They spent 2,500 USD to bring the body home. They couldn't even get any certificate from the doctor. We went to the police and said that the man died and we wanted to return the body to Moldova. Thank goodness there was a man who understood us. He helped us and we could bring the body home by car for 2,500 USD. He stayed there legally but they said: "They were not allowed to live there, why did they? They are not allowed to stay in that building after 7 p.m." The relatives paid all the costs and no one helped us, not even the Moldovan Embassy. After that none of our relatives has gone to work in Moscow, absolutely no one. Now they go to Italy, Spain. We had other incidents, too. My mother got her salary of 5,000 USD. She was robbed and beaten by the police, she lost her hair and had to wear a headscarf. My uncle died there, my cousin died there too. It's a real mess, no respect" (M, 24, Italy)

The above story reveals another aspect – that of the migrants' security, mentioned in other contexts, too. It points out that very often the citizens of Moldova who work abroad feel insecure, they are not protected in the host country neither by host country officials, not by the officials from Moldova.

A Better Life Abroad

Some participants in the qualitative study remarked that their leaving abroad to work has improved their health, this thing being mostly mentioned by migrants to EU countries.
The focus was mostly on better living conditions (access to infrastructure: water supply system, toilet, gas supply, etc.), but on a better nutrition, too.

"When I came to UK I went to an agency that assists migrants and they helped me. I was given a room, practically everything, a doctor, a lawyer. Every week I was given 40 pounds to spend on my living" (M, 28, UK)

"I didn't have health problems. At home I had problems with my liver, gall bladder, pancreas, problems which disappeared there. First of all, the climate is good, and there is possibility to eat healthy. Everything is fresh, without colorants, unfrozen" (F, 57, Italy)

Other migrants mentioned that they feel better working abroad from the psychological and emotional point of view. The stress was greater in Moldova when they had no employment, they could not provide a minimum for living, when they looked with sorrow in the eyes of their children and could not offer them certain things that other children had. Some migrants mentioned that a job gives psychological comfort which they did not have in Moldova, and it increases access to education, healthcare, and better nutrition.

"I could afford anything there, but at home you have to limit yourself. Back there, if I came to a shop and wanted cheese I bought it, if I wanted fruits I bought them. I ate healthy food, but not at home. I buy healthy food for my child, but not for myself..." (F, 29, has worked in Italy, Romania, intends to leave for Ireland.)

VII. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

One of the basic assumptions that gave start to this research relates to more frequent engagement in risk behaviour associated with migration and therefore a more pronounced "vulnerability" of migrants to HIV and sexually transmitted diseases. Allegations of this kind are based on the reasoning that migrants' mobility, break of couples for long periods, or unmarried young people getting beyond their parents' control would lead to frequent involvement of migrants into casual sexual activity.

These aspects will be elucidated in this chapter.

Sexual Behaviour, Vulnerability towards STDs

First of all, sexual behaviour is about the number of sexual partners and their type. In the research questionnaire sexual partners were divided into four categories:

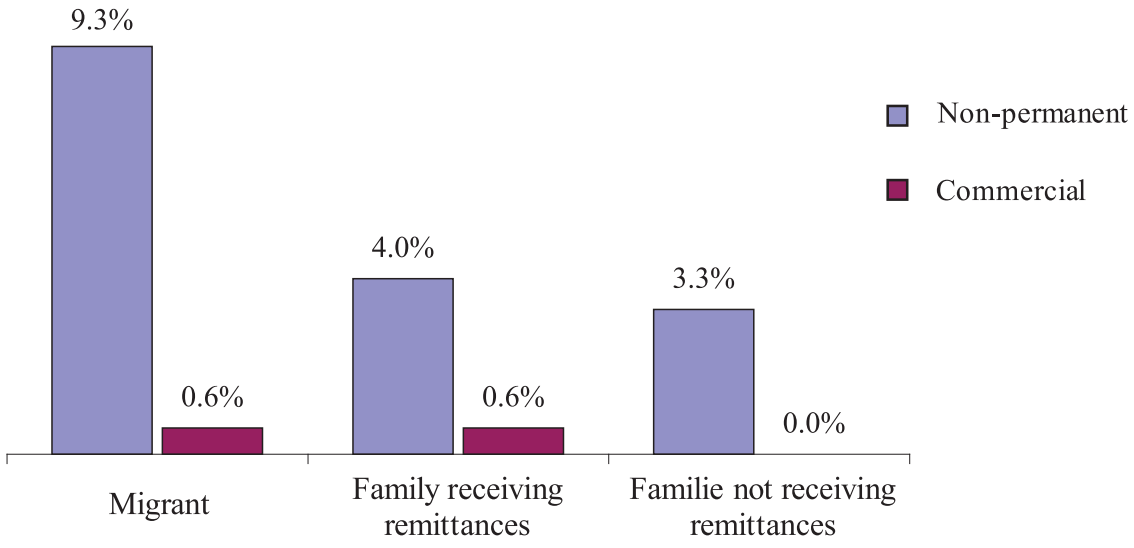
- permanent sexual partners, living in the same household with the respondent;
- permanent sexual partners, not living in the same household with the respondent;
- non-permanent but also non-commercial sexual partners: not spouses or cohabitants, and not paid for sexual services;
- commercial sexual partners (paid): partners paid for sexual services.

The first finding regarding migrants is a much more disordered sex life in comparison with the non-migrant population.

Almost every tenth migrant (9.3%) in the last 12 months had at least one occasional sexual partner (non-commercial), which is more than double compared with the non-migrant population - 4% in the case of families receiving remittances, and 3.3% in the case of families not receiving remittances.

The incidence of sexual contacts with commercial partners is very small, making a deeper analysis impossible. Commercial sexual activity was reported by 0.6% of migrants and members of families receiving remittances, with no recorded cases of commercial sexual contacts among members of families not receiving remittances. Taking into account the allowable statistical deviations, we can not be certain about specific aspects that would distinguish the groups in this sense.

Figure 16) **The share of respondents who had sexual relations with non-permanent sexual partners in the last 12 months**



On the other hand, migrants reveal a higher frequency of condoms use, even as couples, where condoms use is very rare. Thus, 12.6% of migrants used a condom during the last sexual intercourse with a permanent partner living in the same household, as compared to 7.6% in the case of families receiving remittances, and 4.9% in the case of families not receiving remittances.

In non-couple sexual relations (besides sex partners the respondent lives with) the frequency of condoms use is much higher, even with permanent sexual partners (with whom the respondent does not live under one roof). Every second migrant (55.3%) used a condom during the last intercourse with a permanent partner outside the family couple, and 67.8% used a condom during the last intercourse with an occasional partner (non-commercial)[5].

Here we conclude about the vulnerability of migrants, who are much more often engaged in sexual activity with occasional partners without using a condom at least in one third of cases.

As for other groups, and as regards the use of condom in sexual contacts with commercial partners, relatively little records do not allow us to insist on the obtained estimations and to confirm differences between the groups.

Table 32) **Condom use during the last sexual contact** *(number and percentage of respondents who indicated condom use at last sexual contact by type of partners)*

	Migrant		Family receiving remittances		Family not receiving remittances	
	Number	Percentage	Number	Percentage	Number	Percentage
With husband/wife	101	12.6%	22	7.6%	19	4.9%
With another permanent partner	84	55.3%	15	53.6%	16	35.6%
With an occasional (non-commercial) partner	61	67.8%	2	15.4%	8	57.1%
Commercial partner	3	50.0%	1	50.0%		

Knowledge about HIV/AIDS

The awareness of HIV/AIDS is very high now, with the majority of respondents having heard about HIV/AIDS (97.6% migrants, 96.2% of respondents in group 2 and 95.2% in group 3).

No significant differences have been detected between groups regarded from the point of view of involvement into migration or belonging to various social and demographic groups; exception may be people over 50 years old, who claim to have heard about HIV and the disease it causes in the proportion varying between 91% to 93% among groups.

Table 33) **Awareness of HIV/AIDS among the population**

	Yes	No	DK
Migrant	97.6%	2.1%	3%
Member of family receiving remittances	96.2%	3.4%	4%
Member of family not receiving remittances	95.2%	4.2%	6%

Have you ever heard about HIV or AIDS?

The research clearly indicates that migrants are relatively better informed about HIV/AIDS in comparison with people not involved in migration. The table below shows the percentage ratio of respondents who provided accurate assessments on a series of statements on HIV/AIDS.

[5] The percentage is valid for the number of migrants who reported sexual contacts with the respective types of sexual partners during the last 12 months.

First of all, we note the highest rate among indices (but still far from complete) of awareness about the importance of condoms as a method of protection against HIV/STDs and contraception, of ordered sexual life (single uninfected and faithful partner) in preventing infection, as well as the risk of infection through their repeated use. All these statements were appreciated correctly by most groups.

A low degree of awareness (with the percentage of correct appreciations still prevailing) has been recorded in the case of myths on HIV transmission: allegations concerning the risk of infection by using common cutlery and through handshakes, as well as the possibility to identify an infected person by how he/she looks. Thus, significant parts of population still continue to share certain wrong perceptions regarding HIV/AIDS, fact that proves superficial knowledge of a great number of citizens on the subject.

Very little knowledge has been recorded in respect of the statements on the risk of infection by sharing toilet and through mosquito bites, where the correct answer (denying the possibility of infection) was given by one third to a half of respondents, ratio varying between groups.

Moreover, we found that knowledge of the specifics on HIV/AIDS among migrants is higher than among members of families receiving remittances, and especially of those not receiving remittances.

The above finding is even more evident in integrated indices. The integrated index of knowledge about methods of preventing HIV/AIDS5 is 70.2% for migrants, approximately 10 percent higher than the index for respondents in the 2nd group, and almost 20 percent over the index for the 3rd group.

The same ranking remains in case of the integrated index of knowledge on HIV/AIDS in general, which is 25.9% for migrants, 24.6% for members of families receiving remittances, and only 17.6% for members of families not receiving remittances.

Table 34) **Specific knowledge about HIV/AIDS**

	Correct answer	Migrant	Family receiving remittances	Family not receiving remittances
Do you think the risk of HIV can be reduced by correct use of condoms during every sexual intercourse?	Yes	**81.2%**	71.2%	64.3%
Can one get HIV from using the same toilet with an HIV-positive person?	No	46.2%	**50.1%**	39.0%
Can one reduce the risk of getting HIV by having a single faithful and uninfected sexual partner?	Yes	**81.7%**	75.4%	67.2%
Can one get HIV by eating from the same dish with an HIV-positive person?	No	**61.3%**	61.0%	51.5%
Can one get HIV by shaking hands with an HIV-positive person?	No	**70.4%**	66.4%	58.5%
Can one get HIV by getting a shot with a needle already used by another person?	Yes	**85.2%**	83.2%	74.6%
Can one get HIV from a mosquito sting?	No	**40.5%**	39.9%	32.4%
Could a person looking completely healthy have HIV?	Yes	**74.7%**	64.7%	62.9%
Integrated index of knowledge of correct preventive methods [6]		***70.2%***	***60.4%***	***51.1%***
Integrated index of knowledge on HIV/AIDS [7]		***25.9%***	***24.6%***	***17.6%***

[6] Includes respondents who gave positive answers to the questions: "Do you think the risk of HIV can be reduced by correct use of condoms during every sexual intercourse?" and "Can one reduce the risk of getting HIV by having a single faithful and uninfected sexual partner?"

[7] Includes respondents who gave positive answers to the questions: "Do you think the risk of HIV can be reduced by correct use of condoms during every sexual intercourse?", "Can one reduce the risk of getting HIV by having a single faithful and uninfected sexual partner?", "Could a person looking completely healthy have HIV?" and negative answers to "Can one get HIV by eating from the same dish with an HIV-positive person?"

It should be noted that migrants in all social and demographic groups record a somewhat higher level of awareness about HIV/AIDS, followed by members of families receiving remittances, with the lowest awareness recorded among respondents in the 3rd group. The single exception in this respect would be people under 30 years old, when the maximal values of the integrated indices were registered among respondents from families receiving remittances (50.4% for the index of knowledge and 78.6% for the index of knowledge about preventive methods), but even they not much exceeding migrants (44.1% and 77.8% respectively).

Our findings show that among migrants the degree of knowledge about HIV/AIDS:

- varies by gender, women being relatively better informed, with the difference more evident especially when considering the integrated index of knowledge - 28.3% versus 24.6%. We have to notice that in the other groups, the values of the indicators are also higher among women (except for the integrated indicator of knowledge regarding HIV/AIDS among the member of the families benefiting from remittances), with differences between the values smaller (max. 2.4%) than in the case of migrants;
- is inversely proportional to migrants' age, with maximal indices of knowledge about prevention and of general knowledge recorded among young migrants (under 30 years old) - 77.8% and 29.8% respectively (of which 78.8% and 29.0% among people under 25 years old), and minimal indices among migrants of older age - 59.2% and 22.2%;
- awareness of HIV/AIDS increases with the level of education. The maximal level of awareness was registered among migrants-holders of university diplomas - 75.8% and 32.9% of the integrated indices;
- a great difference has been identified between people from different living environments, with better awareness among migrants-urban residents. We see that the difference on residence zone is generally maintaining in the gender groups as well, except for the integrated indicator of knowledge about the prevention methods in the urban area, which value is higher among men (with 1.1%) comparing to women;
- categorization of migrants according to level of awareness and involvement in “insecure” sexual relations, i.e. with occasional and commercial partners, revealed a very curious moment. Migrants who had sexual intercourse with such partners in the last 12 months showed an average integrated index of knowledge about prevention methods with about 2 percentage points higher than the opposite group, while the index of knowledge about HIV/AIDS among them is 6 percent lower than among migrants who had no sexual relations with non-permanent sexual partners;
- and, finally, a greater vulnerability because of lower awareness is common to migrants to CIS countries, who show minimal values of integrated indices among migrant groups according to the direction of migration.

To recapitulate, we can say that a more HIV/AIDS-informed migrant is rather a young person, with higher education, originating from a town/city in Moldova, gone to EU or elsewhere, except CIS countries.

Table 35) **Specific knowledge about HIV/AIDS among migrants: social and demographic aspects**

		Integrated index of knowledge about preventive methods	Integrated index of knowledge about HIV/AIDS
General		70.2%	25.9%
Sex	Male	69.2%	24.6%
	Female	72.0%	28.3%
Age group:	Under 30	77.8%	29.8%
	of which under 24 and younger	*78.8%*	*29.0%*
	30-39	70.9%	23.0%
	40-49	63.5%	26.2%
	50 and above	59.2%	22.2%
Level of education:	Gymnasium and below	66.9%	24.6%
	Secondary education and lyceum	68.9%	23.9%
	Professional secondary education	67.8%	22.6%
	Higher education, college	75.8%	32.9%
Residence environment:	Urban	79.4%	32.5%
	from which: men	*79.9%*	*31.9%*
	women	*78.8%*	*33.3%*
	Rural	67.5%	23.9%
	from which: men	*66.5%*	*22.7%*
	women	*69.6%*	*26.5%*
Occasional/commercial sexual relations in the last 12 months	Yes	72.5%	20.2%
	No	70.4%	26.2%
Direction of migration:	CIS	68.8%	24.0%
	EU	73.8%	29.1%
	Other	76.0%	40.8%

HIV Testing

In Moldova, due to the implication and efforts systematically invested by all actors involved in combating HIV/AIDS, the monitoring and epidemiological supervision of HIV/AIDS has been steadily developing. For this reason the population's access to HIV testing also improved. For example, the number of people tested annually almost doubled during 2001 - 2004 (from 116,000 to 217,000 persons tested).

Complete provision of the general population with free access to voluntary and confidential HIV and STD testing is among the objectives of the National Program for control and prevention of HIV/AIDS and STD in 2006-2010.

However, the share of population at least once in their lifetime tested for HIV remains relatively low.

On the other hand, the highest number of persons tested for HIV is registered among migrants (37.8%) – (which would constitute 403 cases per sample). The other two groups show somewhat similar indices – 31.4% in the 2nd group and 29.0% in the 3rd group, significantly smaller than in the case of the migrants.

In general, respondents' answers indicate that the majority of the population gets voluntarily tested for HIV, which probably still does not mean that it is done on their own initiative. Three out of four migrants (74.2%), 78.8% members of families receiving remittances and 81% members of families not receiving remittances got voluntarily tested.

It is legal emigration, which involves preparing a set of necessary documents, which is behind a greater number of HIV-tested persons among migrants. Almost one of the ten migrants (9.6%) had to get tested for HIV just to meet the requirements necessary for legal departure.

Between 14% and 17% of persons ever tested for HIV indicated that they were required to take the test.

Almost every fifth migrant (18.5%) of those tested had taken the last test abroad. To be noted that among migrants tested abroad the percentage of tests made "under pressure" is double (26.7%) compared to those tested in Moldova - 12.5%.

Table 36) **HIV testing, general aspects**

		Migrant	Family receiving remittances	Family not receiving remittances
Have you ever been tested for HIV?	Yes	37.8%	31.4%	29.0%
	No	61.8%	66.7%	69.3%
	DK	.4%	2.0%	1.8%
When you were tested (the last time), did you do it voluntarily or were you forced to do it?	Voluntarily	74.2%	78.8%	81.0%
	I was forced to	15.2%	16.6%	14.1%
	I had to do it so I could leave abroad	9.6%	1.3%	2.4%
	DK	1.0%	3.3%	2.4%
Where were you tested (the last time)?	In Moldova	80.8%	98.0%	96.6%
	Abroad	18.5%		.5%
	NA	.7%	2.0%	3.0%

VIII. THE RESULTS OF APPLYING THE SPIT TEST ON THE MIGRANTS' GROUP

One of the project components included the attempt to measure the HIV prevalence among the migrants (the returned citizens in the last 24 months from abroad, where they left for work).

The testing was carried out by applying to the group of migrants the fast tests of spit.

Overall, from 1090 of the migrants interviewed during the survey, the fast test was applied in 692 cases, the refusal rate was 36,5%.

There was not registered any positive result among the total number of tested migrants.

On the other hand, we can expect that the null rate of prevalence could be determined by the high rate of refusals from test application, which requires the comparison of several characteristics of migrants to which the test was applied and of those that refused its application.

From socio-demographic perspective, we established that the highest refusal rates were registered among aged population (45,6% in the group of those over 50 years old and more comparing to 29,5% among the people under 30 years old), and among the population with high education – 41,5%. Highlighting these groups implies a certain contradiction, meaning that at least on the subject of knowledge regarding HIV/AIDS, the first group (older population) registers the lowest level, while the population with high education has the highest one.

The refusal rate when applying the tests did not register significant variations depending on the type of migrant or the area of residence.

Table 37) **The refusal rate on applying the fast test according to the socio-demographic characteristics of the migrants**

		% refusals
General		36.5%
Sex:	Male	35.8%
	Female	37.9%
Age group:	under 30 years old	29.5%
	30 - 39	38.6%
	40 - 49	39.0%
	50+ and over	45.6%
Level of education:	No education/primary/secondary studies	36.7%
	High school	34.3%
	Vocational education	34.0%
	High education, college	41.5%
Residence zone:	Urban	37.0%
	Rural	36.4%

If we take a look at the refusal rate in connection with the migration characteristics of the migrants, it seems that a group that avoided to a higher extent the tests is emerging. These are the migrants that worked abroad in the household sector (41,2%) or in hotel services (45,9%), the ones that emigrated for periods longer than one year (47%) in the EU countries (40%) or in other countries (50%).

We should take into account the fact that the number of migrants with such characteristics is not large in our sample, which doesn't allow precise measurements. Another thing that does not allow us to affirm that this group is a high risk one, thus avoiding testing from this point of view, is also the fact that such

migration characteristics have more the female migrants, but, while as previously shown, the refusal rate among migrant women is not higher than among migrant men.

The analysis depending on the sexual behavior substantiates the null hypothesis: those that possess risk characteristics (persons that had extramarital sexual contacts during the last 12 months and those that are nor using condoms) have refused the testing more rarely.

Table 38) **The refusal rate on applying the fast test base on migration characteristics and sexual behaviour**

			% of refusals
The activity domain abroad:		Household sector	41.2%
		Constructions	35.3%
		Agriculture	37.8%
		Hotel services	45.9%
		Commerce	36.0%
		Transportation	36.6%
		Industry	30.6%
The length of the last departure:		Under 6 months	35.2%
		6-12 months	38.0%
		Over one year	47.0%
The emigration direction		CIS	34.6%
		EU	40.0%
		Other	50.0%
Extramarital relations in the last 12 months		Had	31.9%
		Did not have	36.2%
Using the condom at the last intercourse	With husband/wife, partner	Yes	40.6%
		No	37.1%
	Permanent partner that does not live with him	Yes	31.0%
		No	27.9%
	Occasional partners	Yes	36.1%
		No	23.1%
Testing HIV previously:		Tested at least one	36.2%
		Did not test	36.7%

RESEARCH CONCLUSIONS

Income and expenses

- Remittances leave a notable mark on the size and structure of families' expenses. Although in all households about 40 percent of expenses are connected with food consumption, as far as health is concerned – households not receiving remittances spend on purchase of medication more than households receiving remittances, both as volume and percentage of total revenue;
- In Moldova, households' expenses for medication are much higher than costs for medical services, this ratio in the structure of migrants' expenses abroad being reverse;

State of health and attitude towards health

- The study reveals a negligent attitude of people towards their health, with most applying for medical services only in serious cases. Migrants show a generally more pronounced level of negligence. At the same time, most migrants recognize that they do not lead a healthy lifestyle.
- According to the perception of participants in the qualitative study, a healthy lifestyle first of all implies healthy eating, doing sports, but also avoiding alcohol abuse, smoking, drug use. Overstrain and works in hazardous conditions are also perceived as important factors that have impact on health. The migrants put a special emphasis on the psycho-emotional aspect, with particular reference to stress.
- Due to the specifics of their age (they are younger than the people uninvolved in migration), migrants' rate of morbidity is two times lower than that of the members of their families or members of the families not receiving remittances. Only one of four migrants (24.4%) mentioned currently suffering from a chronic disease. And the receipt of remittances evidently does not have any impact on the households' incidence of chronic diseases.
- The process of migration subjects migrants to health risks, from the process of emigration, living and working conditions in the host country, to psycho-emotional disorders caused by separation from the loved ones. Yet some migrants declare that the environment in the host country is more favourable for health, the alimentation and living conditions are better than those they had in Moldova.

Family medicine, consumption of medical services

- Migrants appeal twice more rarely to state-provided medical services than the rest of the population. Two out of ten migrants do not know their family doctor; this situation is more characteristic to female than male migrants, which is not applicable for the general population. Participants in focus groups mentioned a number of disadvantages of the compulsory medical insurance system;
- The population involved in migration has apparently a wider access to medical services. Among migrants the percentage of those who happened not to apply for medical services when needed is smaller than among the rest of the population (25% compared to 30% -32%);
- Failure to visit a physician when needed is a common practice in migrants' life, especially when being in a host country. However, if in Moldova it happens to migrants due to the lack of medical insurance or to financial problems, while staying abroad it happens mostly because of the impossibility to leave the workplace to make such a visit;

- Medical care in Moldova is assessed by the population as rather inaccessible. Receipt of remittances in Moldova apparently makes healthcare more accessible. According to migrants, medical care abroad is more accessible than in Moldova from the point of view of cost.
- Access to medical services abroad is the most limited among migrants working in CIS countries and those with a less "advanced" legal status.
- Another finding is that migrants in most cases postpone visiting the physician and solving health problems until their return to Moldova, and apply for medical services in the host country only in emergency cases. The main reason behind the above situation is economic, covering two aspects: high cost of medical services abroad on the one hand and pressure at the workplace (inability to take time off from work, financial loss, fear of losing the workplace, etc.) on the other hand.
- The level of medical services consumption abroad is very low. Eight out of ten migrants did not appeal to any medical service abroad. The least frequent appealing to medical services abroad are male migrants, young people, those with temporary registration and illegal ones, leaving for CIS, seasonal migrants;

Medical insurance

- Despite expectations, remittance receipt does not produce motivation and / or more possibilities for medical insurance; on the contrary, medical insurance coverage rate is about 15% lower among families affected by migration. Migrants mistrust the medical system in Moldova, their scepticism supplied by precarious material and technical equipping of medical institutions, and to a certain extent by the qualification of medical staff. A special emphasis was placed on inappropriate attitude of most Moldovan medical workers towards patients.
- Migrants represent the smallest group included in the medical insurance system. Only 25% of migrants are insured, in comparison with 62% of members of families receiving remittances and 69% of members of families not receiving remittances. Most migrants do not see the benefits of medical insurance; they mentioned only free hospitalization (place/bed), but otherwise only disadvantages;
- In the respondents' opinion the medical insurance system restricts consultation by certain doctors, limiting immediate access to medical services; the doctors' attitude is in favour of those who pay for medical services; free medical services provided according to the policy are often only a formality, etc.
- The low medical insurance rate among migrants in comparison with the general population is determined by the relatively small number of state-insured persons in this group (pensioners, disabled persons), but also by a low employment rate of migrants on the Moldovan labour market;
- Instead, the dependency rate regarding medical insurance among migrants is very different. Among them the ratio between self-insured persons (with policies purchased or granted by employer) and those state-insured is 5/1, while among the general population about 1/1;
- Uninsured persons forward the following conditions for insurance:
  1. possibility to be insured occasionally, in case of illness;
  2. combating corruption in the system, affecting both insured and uninsured persons;
  3. policy cost reduction, condition mostly forwarded by people uninvolved in migration, rather than migrants.
  4. promoting a more attractive, long-term medical insurance system, by at least partial accumulation of payments and/or by possibility of transfer to other family members, etc.

- Migrants' medical insurance rate abroad is 20.6%, being very close to that of Moldova. Medical insurance abroad is mostly held by migrants going to EU and other countries (except the CIS countries), medium-term migrants (for about one year) of standard emigration, those who have a solid legal status (citizenship, residence and work permits), those working in domestic sector, hotels and industry;
- The most vulnerable and disapproved part of the medical insurance system in Moldova is the cost of insurance. Most people consider the cost of the policy too high compared to the volume of assistance provided within the medical insurance system.

Health problems caused by migration

- The research suggests that migration involves a number of risks for the health and psycho-emotional integrity of migrants. Emotions and stress, typical especially to illegal migration, related to the separation from family and children, appear in the state of depression, difficulties in concentration, sleep, communication, migraines, but also in the development of chronic diseases;
- A big part of migrants for various reasons cannot afford an appropriate living environment during their stay abroad. Nearly 16 percent of them live abroad in improvised dwellings - trailers, basements, unfinished constructions. Such practices are especially common to seasonal migrants in constructions. Emigration experience, as well as length of stay abroad, leads to an improvement in living conditions in the host country;
- Working environment represents certain risks as well. Six out of ten migrants during the last stay abroad worked more than eight hours per day, eight out of ten worked more than five days per week;
- Working conditions also expose Moldovan migrants to a number of risk factors. The most common risks of this kind are working in conditions of noise, dust and at height. And usually the migrant has no proper equipment when exposed to such conditions;
- The rate of work-related accidents abroad is tens times higher than on the labour market in Moldova. Psychological traumas, those caused by fallen materials and equipment, hypothermia of some parts of the body are the most common accidents;

HIV/AIDS and sexually transmitted diseases

- Migrants represent a group with an increased risk of HIV and STD infection by means of sexual contact, with a twice bigger number of persons having occasional sexual partners than the general population.
- The integrated index of knowledge about HIV/AIDS shows a satisfactory level of awareness about HIV and AIDS, but with a large number of migrants having wrong knowledge about HIV transmission, which indicates a certain degree of superficiality of migrants' knowledge about this issue. Thus, we can conclude that we could expect a high level of intolerance towards persons with HIV derived from those misconceptions.