MÉDECINS SANS FRONTIÈRES (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, healthcare exclusion and natural disasters. MSF combines the provision of emergency medical care with a commitment to speaking out about the suffering people endure and the obstacles encountered in providing assistance. MSF offers assistance to people based only on need and irrespective of race, religion, gender or political affiliation.

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The illness of migration

Ten years of medical humanitarian assistance to migrants in Europe and in transit countries

A report by MÉDECINS SANS FRONTIÈRES

MEDECINS SANS FRONTIERES

MEDECINS SANS FRONTIERES

Contents

Niger © Sven Torfinn/Hollandse Hoogte

"Dignity has no nationality."

François Crépeau, United Nations Special Rapporteur on the human rights of migrants

Executive summary

When states close their borders to keep unwanted migrants away, they contribute to illness and suffering.

In this report, MÉDECINS SANS FRONTIÈRES (MSF) looks back at 10 years of medical humanitarian assistance for migrants in the European Union and in transit countries. Our experience shows that restrictive immigration policies make it harder and much more dangerous for people to seek safety and a better life for themselves and their families. When migrants lack safe and legal routes, they become vulnerable to exploitation and abuse and are forced to take risks which put their health and safety in danger.

Over the past decade, MSF has assisted men, women and children at various stages of the migration process:

We have treated men, women and children with symptoms related to the harsh conditions under which they are forced to travel. Many of our patients survived violence along the way and saw others die on their journey.

In transit countries, MSF treated migrants with a range of health problems related to their precarious living conditions. In some transit settings, our teams have recently seen an increase in the number of patients with violence-related injuries. MSF heard testimonies of patients who survived capture, detention and torture while living in transit.

At European borders, our teams witnessed serious shortfalls in assistance for new arrivals, many of whom are exhausted, traumatised and sick.

In European detention centres, MSF saw conditions that were far below standard and caused illness or actively aggravated symptoms.

In cities and rural areas inside the European Union, our teams treated patients with medical and psychological problems directly and indirectly related to their experience of migration. Because in all these settings, our patients came from the same populations we serve in countries of origin, we know first-hand that migrants can gradually become more vulnerable as a result of the difficulties they experience at home, during migration and when they arrive in Europe.

Based on our experience, we are extremely concerned that restrictive immigration policies and shortfalls in assistance are putting migrants' health and lives in danger. We have therefore developed the following recommendations:

- Men, women and children in life-threatening situations must receive immediate assistance, regardless of their legal status.
- Basic healthcare should be available to all migrants.
- New arrivals must receive appropriate medical and psychological assistance from qualified medical personnel, especially if they are ill or have suffered traumatic experiences.
- Migrants must have access to vulnerability assessments and asylum procedures and should not be sent back to countries of origin or transit if they face ill-treatment there.
- States should consider the impact of detention on the health and well-being of migrants and seek alternatives to detention. While migrants are being detained, states should provide dignified living conditions and make medical care and psychological support available to detainees.
- Special attention should be paid to the medical and humanitarian needs of vulnerable people. They should not be detained and must be met with minimum standards of living and medical support when they arrive in Europe. This includes children and young people, pregnant women, survivors of sexual violence, torture and trafficking and people with severe and chronic medical conditions.

Map of countries included in this report

Countries in which activities with migrants are ongoing
Countries in which MSF has previously worked with migrants in the past decade
* MSF is monitoring arrivals on the island of Lampedusa and may intervene according to needs

1. Introduction

"The right to receive humanitarian assistance, and to offer it, is a fundamental humanitarian principle which should be enjoyed by all citizens of all countries."

Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief

With this report, MSF aims to contribute to a better public understanding of the health risks faced by men, women and children in migration.

The report opens with an overview of restrictive government policies and then analyses the effects of these policies on migrants' health and well-being as seen by our teams at various points of the migration process over the past decade. This includes: during the journey, in transit, when they arrive at the borders of the EU, in detention and in European cities and rural areas. In all these settings, we witnessed medical and psychological problems that were directly and indirectly related to our patients' experience of migration.

Over the past decade, besides providing medical care, MSF has lobbied authorities in European and transit countries to improve medical and humanitarian assistance for migrants and ensure that basic healthcare is available for them. This report is based on previously published advocacy papers which are listed in the bibliography section.

Throughout this report, we use the term "migrant" widely: it includes victims of human trafficking as well as asylum seekers and refugees, who have specific rights. It also includes those who left their country voluntarily in search of a better life. As a medical humanitarian organisation, MSF focuses on medical needs independent of any political agenda and does not differentiate between patients based on their legal status. As we also work in countries of origin, we know first-hand that some lives are so vulnerable and destitute that the distinction between forced displacement and voluntary migration can sometimes lose its meaning.

2.
Closing borders, externalising responsibility: how states keep unwanted migrants away

MIGRATION IN NUMBERS

42.5 MILLION people are forcibly displaced worldwide [2]

4 OUT OF 5 of those are hosted by developing countries [3]

CLOSE TO 1 MILLION people crossed the border from Libya into Tunisia between February and September 2011 because of the Libyan conflict [4]

60,000 people fleeing Libya sought safety in Europe in the same period [5]

AROUND US$ 16 MILLION paid by Italy in 2009 to the United Nations High Commissioner for Refugees (UNHCR) to assist worldwide refugees [6]

US$ 200 MILLION invested by Italy in Libya per year since 2009 in exchange for measures to stop migration to its shores [7]

55,000 undocumented people crossed into Greece in 2011 [8]

MORE THAN € 253 MILLION received by Greece from the EU over the past five years to secure its borders [9]

LESS THAN € 19 MILLION received by Greece over the same period to set up a system to process asylum claims and support asylum seekers [10]

Recently, states have been preoccupied with controlling migration – particularly in the West and including the USA, Australia and EU countries. As a result, they have introduced a number of restrictive immigration policies and practices. These include: stricter border controls, restrictive interpretations of refugee law, obstacles to accessing asylum procedures, limited access to basic services for migrants, including health care, and the increased and prolonged use of detention.

Besides these measures, states are increasingly externalising immigration controls outside their territories.[1] This is achieved through bilateral and multilateral cooperation agreements with countries of origin and transit. It has included, for instance, the EU financing the construction of detention centres in countries outside the European Union, like Ukraine and Turkey. At the bilateral level, for example, Spain has cooperated with Morocco and Italy with Libya to stop migrants from reaching Europe. EU states are also cooperating with countries of origin and transit to allow migrants to be readmitted if they are sent back. They have carried out border patrols outside their territories to prevent migrants from reaching Europe. For instance, Italian national border guards patrolled international waters with the assistance of Frontex, the EU border control agency, intercepting migrants in the high seas.

As a result of these measures, men, women and children are forced to take longer and more dangerous journeys which put their health and safety at risk. And because many of them have to use smugglers, which are often part of criminal networks, they become vulnerable to exploitation and abuse. Restrictive immigration policies therefore have a clear and negative impact on the health and well-being of migrants and our experience in a range of settings over the past decade demonstrates this.

3.
MSF: supporting the health of migrants from country of origin to destination

PROTECTING MIGRANT HEALTH FOR 30 YEARS

MSF first set up large-scale medical programmes for hundreds of thousands of men, women and children fleeing conflict and violence in South East Asia in the 1970s. Today, one in ten of MSF's worldwide programmes is designed especially for displaced people. Most of these programmes run in developing countries, because that is where the vast majority of them live.

Restrictive policies do not stop people seeking safety and a better life from trying to reach Europe. We know this from working with migrants in countries of origin or transit and in Europe.

MSF started setting up medical projects for migrants in and around Europe in the late 1990s. Since then, we have developed expertise in delivering medical care in many settings along the migration route: *

- MSF addresses health problems that result from the harsh conditions under which migrants are forced to travel, for instance by treating men, women and children over large stretches of coast in Yemen (Chapter four).
- Our teams assist migrants in transit countries: for example by helping them access medical care in Morocco (Chapter five).
- At land borders and shores in Italy, Greece and Spain, MSF has examined and treated more than 100,000 migrants over the past decade. We have repeatedly criticised the lack of adequate medical care and humanitarian assistance that is available to migrants in countries of arrival (Chapter six).
- MSF has visited and worked in detention facilities in several European countries. We have witnessed the negative impact of detention on migrants' physical and psychological health (Chapter seven).
- MSF has offered medical care to migrants in cities as well as rural settings inside the European Union. Our teams found that many migrants there survive with very limited access to health care and suffer from diseases related to their poor living conditions (Chapter eight).

In all these settings, our patients came from the same populations that we serve in countries of origin: because we have first-hand experience of the violence, destitution and lack of healthcare that people face in many settings in these countries, we are in a good position to understand the accumulated vulnerability of migrants, address their health needs and call for better healthcare for them.

* This classification is intended for descriptive purposes: to reveal that migrants face specific health risks in different settings. In reality, many migrants do not progress straight from country of origin to destination. Some stay in "transit" for a long time; for others, transit is a short part of their journey (see Chapter five). Also, migrants do not always have control over their journeys.

4.
The impact of harsh travelling conditions on migrants' health and well-being

"For nine days I was packed among many others on this truck"*

MSF Patient in Tunisia, 2011 [17]

"We were travelling with a group of four men. At the Ethiopian/Somali border, we paid a truck driver to take us to Burao, a town in Somaliland. On the way, we were stopped by robbers in a small car. They were armed with pistols and knives. They ordered us to get out and [...] took our money. We ran into the bush. We were shot at, but finally we managed to escape."

MSF patient in Yemen, 2008 [18]

YEMEN © MSF

CROSSING THE MEDITERRANEAN: A DEADLY JOURNEY

According to the United Nations High Commissioner for Refugees (UNHCR), 69,000 boat migrants landed at European shores in 2011.[20] At least 1,500 of them died, making 2011 the deadliest year since UNHCR started recording these statistics in 2006.[21] But the actual numbers are likely to be much higher still, as many bodies are never recovered.

MSF has assisted migrants during their journey in various contexts: over large stretches of coast in Yemen; in Morocco, where we treated sub-Saharan men, women and children who had travelled through the desert in Algeria, many of them en route to Europe; at the land border between Turkey and Greece; and on the shores of Italy, Greece and Spain.

In all settings, many MSF patients described travelling under difficult conditions, facing many hardships, having to use smuggling networks and often being exposed to abuse and ill-treatment.

"A woman who has just arrived in Maghnia becomes the property of whoever wants her; she can't refuse, she can't leave, everything is paid for with sex. Even if she is with her baby or child, every woman must go through the same thing."

Sub-Saharan migrant in Morocco, 2010 [19]

Common physical symptoms associated with harsh travelling conditions

Our teams witnessed the following:[11]

- **dehydration**, because the migrants travelled for days and did not have enough water to drink;
- **hypothermia**, from being exposed to the cold during long journeys at sea;
- **musculo-skeletal complaints**, which were mainly related to migrants having to stay in the same position for long periods of time, unable to move in overcrowded boats or trucks;
- **traumas and traumatic lesions** which were often the result of abuse by smugglers.

A large number of patients in all settings had **headaches and general body pain**: these were often physiological manifestations of traumatic travelling experiences.

On the Italian island of Lampedusa, signs of temporary **post-traumatic reactions** were common among new arrivals. In Yemen, many presented with a series of **depressive symptoms** after their journey, including sadness, hopelessness and sleep problems.

Medical symptoms associated with violence and abuse while travelling

In Yemen, between 2007 and 2008, MSF treated many migrants who had bruises, body pains and lacerations after their journeys across the Gulf of Aden.[12]* A total of 14 per cent of diagnoses were for violent trauma,[13] often resulting from patients being beaten by smugglers with sticks, pipes, rifle butts and knives.

In Morocco, MSF surveyed 63 female migrants in 2010. Almost half the women interviewed (45 per cent) said they were subjected to sexual violence during their journey. Alarmingly, nearly a quarter (21.5 per cent) were under 18 and one in 10 were under 16.[14] Also, more than a third (35 per cent) had physical symptoms related to sexual violence, including reproductive tract problems and infections. A third (33 per cent) experienced psychological symptoms associated with sexual violence, including insomnia, anorexia, depression and suicidal thoughts.[15]

Deaths while travelling

Our staff heard many testimonies of patients who saw others dying during their journey:[16]

In Tunisia, in 2011, when our teams assisted sub-Saharans that had fled from Libya when violence and conflict erupted there, we encountered patients who had travelled through the desert and seen others die from dehydration or asphyxiation in overcrowded trucks.

In Yemen, MSF treated patients who spent days crossing the Gulf of Aden in small and unseaworthy vessels and witnessed others dying of thirst or from asphyxiation.

Many patients travelling by sea also witnessed others drowning. This was either because their boats capsized and sank, or because smugglers forced them to jump into the water in high seas to avoid coastal guard patrols and radars closer to the shore.

* In 2011, the United Nations High Commissioner for Refugees warned that violence against migrants en route to Yemen was increasing. At the same time, a record number – more than 103,000 – risked their lives by making the perilous journey from the Horn of Africa across the Gulf of Aden. See endnote 12.

5.
Medical needs and lack of access to healthcare in transit countries


MOROCCO © Anna Surinyach

MSF IN MOROCCO

MSF has provided medical humanitarian assistance to sub-Saharan migrants in Morocco since 2003 and focuses on improving their access to healthcare services, their living conditions and their dignity.

In Rabat, the capital city, MSF teams provided medical and psychological care to migrant survivors of sexual violence until December 2012, when activities were handed over to a Moroccan organisation.

In Oriental region, which is an entry and exit point for sub-Saharan migrants en route to Europe, MSF works to ensure migrants have access to public health facilities in the city of Oujda. MSF also provides psychological care, distributes basic shelter materials, hygiene and cooking kits and carries out water and sanitation activities. In Nador, MSF provides primary healthcare, psychological support and humanitarian assistance to migrants during monthly mobile clinics. MSF will hand over its activities in Oriental region in early 2013, but will retain the capacity to respond to emergencies.

The term "transit" implies temporary residence and does not adequately reflect the reality of most migrants in so-called "transit countries":* MSF teams have found that migrants often get stuck there, unable to continue their journeys for long periods of time.

Precarious living and working conditions

Migrants in transit countries often work under hazardous conditions for weeks, months or years in order to pay for the next stretch of their journey. While they wait, they often live without proper housing, toilets or showers and do not have enough food and drinking water. MSF saw people in transit settings with a large number of health problems related to these difficult and unsanitary conditions. From 2010 to 2012, MSF teams carried out 10.500 medical consultations in Morocco. Almost half of the medical problems diagnosed, including respiratory tract infections, musculoskeletal problems and skin diseases, were linked to poor living conditions.[22]

Vulnerability to criminal networks

Because of their undocumented status, migrants are an easy prey for human trafficking and smuggling networks. Testimonies gathered by MSF teams in Morocco and Tunisia indicate that many migrants suffer violence and sexual exploitation on a systematic basis. In Morocco, two out of five (39 per cent) female migrants interviewed by MSF for its 2010 report reported having suffered some form of violence. These migrants included young girls.[23]

In Tunisia, nearly a quarter (23 per cent) of migrants treated by MSF for mental health problems in Choucha refugee camp, near the Libyan border, in 2011 said they had survived physical violence while living in Libya. Another five per cent said they had been victims of human trafficking (see Chapter 6).

"[In Iran] I had to work for a smuggler for four months to pay for my trip [to Turkey]. I was kept in a house for 10 days with only water and bread. In that place it was very bad. The smuggler would whip anyone who protested. After four months I was transferred to Turkey. I was in Istanbul locked up in a basement for 40 days. The smugglers were asking for more money. They threatened us all the time saying that they would kill us. Once they hit me on the head and my arm with a thick piece of wood. I couldn't move my arm for two weeks. A cousin of mine paid the money so after 40 days I was released."

MSF patient in Greece, 2010 [26]

"I went to the hospital but I was turned away."

MSF patient in Tunisia, 2011, talking about transit in Libya [27]

Increasing violence in some settings

Migrants are also at risk of violent attacks by common criminals: MSF teams heard testimonies of men and women who had been kicked, beaten and harassed on the streets of Morocco or Libya. These crimes mostly go unpunished: migrants don't ask for help because, as a result of their undocumented status, they are afraid of being arrested and deported.[24]

In Morocco, in the northern border areas, MSF teams have seen a recent increase in violence against sub-Saharan migrants. Between April and July 2012, the percentage of patients treated for violence-related injuries by MSF mobile clinics in Nador almost doubled. Many patients said they were injured during raids, others said they were beaten by security forces during attempts to cross the border to Spain. In Oujda, also in North-Eastern Morocco, MSF medical teams have assisted over 600 people with violence related injuries in 2012, a quarter of whom required emergency assistance. The number of victims of violence assisted by MSF more than doubled between April and October 2012.[25]

Lack of access to healthcare

Medical care is often not available for migrants in transit countries. Reasons for this are common across countries and include:**

- fear of arrest and deportation, resulting in migrants not seeking medical help;
- language and cultural barriers;
- lack of financial resources to cover the cost of examinations and treatment;
- lack of information about entitlements and where to find medical care;
- the discriminatory attitude of some health workers who exclude migrants from care.

Moreover, in all the settings where MSF worked, appropriate mental health services, including intercultural mediation, were not available.

* Some transit governments use the term as an excuse to avoid adequately supporting migrants. But it is useful in that it shows that Europe is the desired destination of most migrants, and any adequate analysis of the impact of European immigration policies must take that reality into account.

** Migrants in Europe experience similar problems when they need medical care, see Chapter 9.

6.
Torture and abuse of migrants in Libya


Choucha refugee camp in TUNISIA © Mattia Insolera

"Detainees without money are encouraged to ask relatives and friends to collect enough money to pay for their release. Nobody is released without money."

MSF psychologist in Tunisia, 2011, talking about conditions in Al Khatroun prison in Libya's capital Tripoli as described to him by his patients

Large numbers of migrant workers were living in Libya prior to the 2011 conflict,[28*] many of them undocumented migrants from sub-Saharan Africa. When violence and war erupted in Libya in February 2011, about 600,000 sub-Saharans were among those who fled the country.

MSF provided medical and psychosocial support to the refugees in Italy and mental health support in Choucha refugee camp in Tunisia. Between February and June 2011, our teams carried out more than 3,400 consultations,[29] mostly with sub-Saharan African migrants. The consultations revealed that our patients had endured unimaginable hardship in Libya prior to and unrelated to the conflict. In Choucha camp, nearly a quarter (23 per cent) of people we treated with mental health problems said they had survived physical violence; more than a quarter (28 per cent) reported witnessing violence, killings or threats; 11 per cent said they had been incarcerated, kidnapped and/or taken hostage and five per cent said they were victims of human trafficking.

These patients' experiences were for the most part directly related to their status as migrants. The testimonies collected by MSF reveal an economically-driven system in which migrants were captured, detained or held hostage and then released for ransom only to be captured and detained again.

We are very concerned about the mental health of those who endured these traumatic experiences. An MSF exploratory mission along the Libyan-Tunisian border near Choucha in 2011 revealed potentially unmet medical and psychological needs. In one evening alone, we met two people with serious mental health problems: one was a severely traumatised young woman in a catatonic state who had escaped months of sexual bondage; the other was a male patient who had suffered severe brain and mental trauma from beatings while in detention in Libya.[30]

HARMFUL DEALS? BILATERAL AGREEMENTS BETWEEN ITALY AND LIBYA

In 2009, Libya signed a bilateral agreement with Italy, the Treaty of Friendship, Partnership and Co-operation, in which Italy promised Libya investments of US$200 million per year over 25 years in exchange for Libyan efforts to stop migration to Italy. As part of the deal, Italy funded radar systems and provided boats for Libyan border controls.[33]

The agreement successfully reduced the numbers of men, women and children reaching Italy until the conflict broke out in February 2011, when thousands fled Libya across the Mediterranean Sea. In June 2011, Italy and the Libyan National Transition Council signed a new agreement to cooperate in the struggle against "illegal immigration", including repatriating migrants and intercepting them at sea. MSF at the time strongly emphasised that sending migrants fleeing Libya back at sea would constitute a violation of international law, which protects individuals from being returned to areas of conflict.[34**]

No person anywhere should have to endure atrocities like those reported by MSF patients in Tunisia who had previously stayed in Libya. MSF will continue to work to better understand the experiences of migrants in transit countries and address their needs. Men, women and children who make it to Europe should not be sent back to countries of transit or origin if they face ill-treatment there.[31]

In our 2011 report, *Torture, Exploitation and Abuse of Migrants in North Africa*, we documented the experiences of patients who had suffered violence and abuse in Libya and escaped the country during the 2011 conflict. Extracts from these testimonies collected in Choucha camp, Tunisia, in 2011, are reprinted on these two pages:[32]

"Upon arrival at the Libyan border at Azdabyia, we were intercepted by Libyan men. We women were brought to [a] house. In this house, we were forced to remove all our clothes. There were a number of men, all with their faces covered with forage caps. We were told that if we wanted to go to Tripoli, we would need to pay US$400. 'If you don't have this, you will be our slaves,' they said."

MSF patient in Tunisia, 2011

"I was caught and imprisoned. They took me to a Tripoli prison because I had no passport; no matter that I was a political refugee, I was treated as a criminal. They woke us up every morning with a beating, fists on the head and body."

MSF patient in Tunisia, 2011

"Sometimes one, or several of us at a time, were sent to a room to be raped and sometimes beaten by the head of the centre, and sometimes by other soldiers too. Women who protested were beaten."

MSF patient in Tunisia, 2011

* Accurate estimates do not exist, but sources indicate that between 1 and 2.5 million migrant workers were living in the country before the conflict, see endnote 28.

** The principle of "non-refoulement" enshrined in Article 33 of the 1951 Refugee Convention states that "No Contracting State shall expel or return ("refouler") a refugee in any manner whatsoever to the frontiers of territories where his [or her] life or freedom would be threatened on account of his [or her] race, religion, nationality, membership of a particular social group or political opinion."

7.
Gaps in addressing the medical and humanitarian needs of migrants at arrival


ITALY © Mattia Insolera

"All we have left is the clothes that we are wearing."

Afghan family: MSF patients in Greece, 2012 [39]

"I arrived this morning; I was in the boat that sank. I was injured in the face when the boat took water. I really struggled to survive. [...] Many people did not make it."

Somali boy, MSF patient in Italy, 2011 [40]

TEN YEARS' EXPERIENCE OF PROVIDING MEDICAL CARE FOR MIGRANTS LANDING IN ITALY

LANDING SITE	PERIOD	ACTIVITIES	NUMBER OF CONSULTATIONS	MAIN MEDICAL PROBLEMS
Lampedusa Island	2002–2009** 2011	• First aid, including psychological first aid • Medical evaluations and referral to health facilities • Vulnerability assessments • Distribution of blankets, clothes and water • On call 24x7 system	Around 115,000	• Traumas and musculo-skeletal complaints • Hypothermia • Seasickness • Dehydration • Skin problems • Respiratory tract infections • Temporary post traumatic reaction
Coast of Sicily (Ragusa, Siracusa and Mineo)	2003 2005–2007 2011			

Over the past decade, medical assistance by MSF to men, women and children arriving at the EU's external borders has included medical triage, first aid, psychological support and vulnerability assessments. Our teams also referred patients to hospital if they needed it and distributed water, food, blankets and warm clothes.

Our staff found that new arrivals' medical conditions were mainly related to difficult travelling conditions, abuse by smugglers and violence experienced along the migration route. But despite migrants' health needs, MSF found that reception conditions at European borders were unacceptable in many settings.

Lack of medical examinations

Adequate medical examinations were lacking in most settings. Police and administrative staff without any medical qualification were in charge of evaluating medical needs. The authorities prioritised administrative procedures over health care and did not leave enough time for examinations. Interference by police and other authorities was frequent.

During its intervention in Greece between 2009 and 2010, for instance, MSF found that no standard protocol was in effect for the medical screening of new arrivals. As a result, practices varied. On Lesvos Island, new arrivals were sent to hospital for a chest X-ray but did not receive a general medical examination, with the exception of infants and pregnant women.

On the Greek mainland, in the northern border regions of Evros and Rodopi, new arrivals were immediately transferred to detention centres, where medical screenings weren't always performed because of the lack of medical staff. When medical examinations were carried out, they did not include interpretation services.[35*]

In Malta, medical examinations on arrival were superficial and carried out in a police station. They did not include interpreters.[36]

Limited emergency assistance

Not distributing blankets, food and water at arrival points can aggravate health conditions such as dehydration and hypothermia.

In Lampedusa, during the 2011 Arab spring emergency, MSF found that 3,000 migrants were left at the dock without shelter and basic living commodities for several weeks and they only received 1.5 litres of water per person.[37]

In Greece, during the winter months of 2011, our teams gave sleeping bags and warm clothes to migrants who had been left exposed to freezing temperatures because the authorities did not have an emergency reception system in place and not enough shelter. The people left out in the cold included pregnant women and young children.

Limited identification of vulnerable groups

European Council Directive 2003/9/EC establishes minimum standards for the reception of asylum seekers. It explicitly states that the "reception of groups with special needs should be specifically designed to meet those needs." This requires professionals to assess people's needs at arrival and provide adequate care. Victims of torture and sexual violence, for instance, need specialised health care and psychological support. But in most settings that MSF has worked in over the past decade, all new arrivals were funnelled into the same inadequate system on arrival. This was also true for children and young people travelling alone and pregnant women, who also have special needs and require adequate support.

Lack of psychological support

In some settings, initial mental health assessments carried out by our teams pointed to the risk of widespread depression and hopelessness.[38] But mental health services to identify those who needed further assistance were not available in most settings.

Our teams also found that gaps in legal services at landing sites, including information on migrants' rights and prospects, caused uncertainty among new arrivals and aggravated psychological symptoms.

* Since 2010, medical teams of the Hellenic Center for Disease Control are based in Evros and Rodopi and provide medical care to migrants arriving in detention facilities. Some of these now do include interpreters.

** The data was only systematically collected after 2005.

8.
The impact of detention on migrants' physical and mental health

THE SYSTEMATIC DETENTION OF MIGRANTS

Many migrants are systematically detained at arrival in Europe, some for long periods of time. In Malta, for instance, new arrivals can be detained for 12 months and this can be extended to 18 months. In Greece, detention is usually for six months and can be extended to 12. In Italy, the maximum period was extended to 18 months in 2009.

"We were told we were coming to a camp. This is not a camp, this is a prison. Why are we here? We are not criminals. What law have we broken?"

MSF patient in Greece, 2010 [46]

GREECE © Yannis Kolesidis/Reuters

Many men, women and children who make it to Europe are systematically detained, often for long periods of time. MSF has worked in European detention facilities in Belgium, Greece, Italy and Malta. In Italy, MSF surveyed more than 20 detention, reception and open centres for asylum seekers. In all settings, we found that conditions were below standard. Often, they were so bad that detention had a very negative impact on migrants' physical and mental health.

Lack of appropriate housing, overcrowding and poor sanitary conditions

In many instances, inappropriate facilities were used as detention centres: the Maltese authorities used barracks with broken windows which left detainees exposed to poor weather conditions including the cold and rain. Some areas had only one toilet per 40 people and one shower for every 100 people.* Most areas were permanently flooded with water leaking from broken sinks and toilets. Wastewater escaped from damaged pipes, leaving residents exposed to human waste.[41]

In Greece, both Venna and Pagani detention centres were housed in old, run-down warehouse buildings without enough insulation.[42]** In Evros, near the Greek/Turkish border, we worked in border police stations that were unsuitable to hold large numbers of people and operated at two to three times their capacity.[43]

Illnesses related to detention

In all settings, MSF found that the majority of diseases could be linked directly or indirectly to poor living conditions.

In Evros, MSF doctors found that two-thirds (63 per cent) of the most common physiological diagnoses were caused or exacerbated by conditions in detention. They included:

- **upper and lower respiratory tract infections**, from exposure to the cold;
- **musculo-skeletal problems**, related to the cold, uncomfortable environment and lack of exercise;
- **diarrhoea and gastro-intestinal disorders**, related to low quality food, lack of exercise and stress;
- **skin diseases**, reflecting overcrowding and poor sanitary conditions.[44]

These same conditions were also the most frequent health problems in the Maltese barracks. There, cases of accidental trauma were also repeatedly seen, mainly caused by falling due to wet floors, poor lighting and broken floor tiles.[45]

"My son's first home was the detention centre, where they sent us soon after the delivery in hospital. I never expected this kind of treatment in Europe. I have nothing a mother needs to take care of her baby. I tore one of my dresses into six or seven pieces to make small nappies."

MSF patient in Malta, 2009 [47]

"In October it started getting cold. There were three of us sleeping on two mattresses, but in our room it was still too cold because of the broken windows."

Nine-year-old Ethiopian boy, MSF patient in Malta, 2009 [48]

* According to the World Health Organization, the minimum ratio of functioning latrines and showers per person, even in an emergency, is one latrine per 20 people and one shower per 50.

** The Greek government closed down Pagani detention centre in 2010, following harsh criticism by MSF and others.

MALTA © Olmo Calvo

A HUMANITARIAN DILEMMA: ASSISTING MIGRANTS DETAINED UNDER DISASTROUS CONDITIONS IN MALTA

In March 2009, MSF suspended its activities in three Maltese detention centres. This was because we found that inadequate housing, poor sanitary conditions, delays in the dispensation of drugs and inadequacies in isolating patients with infectious diseases were causing illness and suffering among migrants.

During our seven-month intervention, we carried out more than 3,000 consultations in the centres and found that the majority were for diseases related to the poor living conditions. We were saddened to leave patients without adequate medical care, but found that, as an independent humanitarian organisation, we could not effectively alleviate suffering or provide for the medical needs of patients under these conditions.[54]

Diseases spread quickly in detention

Lack of hygiene and isolation rooms often caused diseases to spread. In Pagani detention centre in Greece, for instance, infants and children who shared an overcrowded room were frequently ill with upper respiratory tract infections, fever and scabies.

In Malta in 2009, MSF saw infectious diseases like chicken pox, gastroenteritis and respiratory and skin infections in more than a third (35 per cent) of consultations. In a group of 60 people who were healthy on arrival, over the course of five months, MSF diagnosed 65 cases of illnesses that were transmitted within the group during detention.

Overall, detention centres lacked appropriate isolation facilities: in Malta in 2008, we saw 13 chicken pox patients sharing an area with 80 healthy migrants. This resulted in an on-going outbreak of chicken pox with over 120 cases identified.[49]

"I am inside here and I cannot provide help for my family in Iraq. I am worried about my children. I feel weak and hopeless."

MSF patient in Greece, 2010[55]

EUROPEAN COUNTRIES IN WHICH MSF WORKED IN DETENTION SETTINGS

Country	Period
Belgium	2004 – 2007
Greece	2008 2009 – present (including regular presence and visits)
Italy	2003 (assessments only) 2010 (assessments only) 2012 – present
Malta	2008 – 2009 (activities in open reception centres ran on until 2010)


GREECE © Nondas Paschos

The impact of detention on mental health

Not knowing why they were being detained or for how long was a common source of stress and anxiety among migrants.

In Evros, during the winter of 2011, MSF found that 85 per cent of psychological symptoms were provoked or aggravated by detention. In Venna and Pagani detention centres, around a third (31 per cent) of patients seen in individual consultations between 2009 and 2010 had symptoms of depression and three per cent had attempted suicide or self-harm.[50]

When patients were detained for long periods of time, their mental health tended to deteriorate: in Malta, between 2008 and 2009, 94 per cent of patients with suicidal tendencies had been detained for more than four months.[51]

Gaps in the medical provision

None of the European detention settings that MSF worked in between 2003 and 2011 had enough medical personnel or interpreters. Detainees received no mental health support, apart from that offered by MSF. Some settings lacked a pharmacy and MSF often witnessed delays in the dispensation of drugs. Vulnerability assessments were usually not available, and when they were, procedures were slow and often no medical staff were involved. As a result, MSF witnessed pregnant women, mothers with newborns and minors being detained, some for months.[52] In Lampedusa in 2011, for instance, we saw more than 300 unaccompanied children and young people locked up in transit centres for weeks.[53] Other vulnerable people are likely not to be identified if there are no assessments, including survivors of torture, sexual violence and trafficking and people with serious and chronic medical conditions.

9.
Migrants' health needs in European cities and rural areas


ITALY © Mattia Insolera

"We have no water or light, we often lack food to eat and during the winter months we risk dying of cold."

MSF patient in Italy, 2008 [59]

"Sometimes I cannot remember anything; I cannot sleep."

MSF patient in Paris, 2009 [60]


ITALY © Lorenzo Maccotta

Migrants risk their lives coming to Europe. They do so in the hope of finding safety and a better life. But once inside the EU, most face a very bleak reality: they lack adequate housing, work in hazardous jobs and face violence and exploitation. Health care is often not available to them.*

Over the past decade, MSF has provided health services to migrants in the European cities of Athens, Brussels, Madrid, Paris, Patras, Stockholm and Zurich. Teams also supported seasonal migrant workers in the Italian countryside. Interventions typically included primary healthcare, mental health services, referrals to primary and specialised care with accompaniments and cultural mediation.**

Makeshift accommodation can cause illness

In Patras, migrants were living in makeshift and often overcrowded accommodation. Common diagnoses were for upper respiratory tract infections (22 per cent) and skin diseases (20 per cent).[56]

Skin diseases, such as mycosis and dermatitis, related to poor hygiene and overcrowding, accounted for 15 per cent of diagnoses among seasonal migrant workers in Italy: MSF examined 643 migrant workers there in 2007 and found that about two-thirds of them (65 per cent) lived in abandoned structures, 64 per cent had no access to running water and 62 per cent had no toilets. These living conditions also caused and aggravated gastro-intestinal illness, which was diagnosed in 12 per cent of cases. 89 per cent of these were chronic infections.[57]

Mental health problems for migrants in Europe

Poor living conditions, fear of deportation and uncertainty about the future can trigger distress and psychological illness in migrants. At the MSF psychological support clinic for migrants in Paris, for example, 16 per cent of 608 patients who have been followed by the clinic since it first opened in 2007 suffer from depression.

The difficulties these men, women and children experience in European host countries add to previous traumas they endured at home and in migration. Of the 183 people with mental health problems that our team saw at the clinic in Paris in 2011, two-thirds (66 per cent) reported some form of physical violence, just under half (46 per cent) said a member of their family had been killed, and one in three (33 per cent) had suffered torture.[58]

"There are guys here who have been beaten up and we are afraid to go to the hospital and to the police. I have also been beaten up twice, once with a stick and the second time they threw bottles at me from a car."

MSF patient in Italy, 2008 [61]

"Living in these conditions, I cannot begin to imagine a future."

MSF patient in Italy, 2008 [62]

"Having someone to listen to us means a lot – more than life."

MSF patient in Paris, 2009 [63]

* In some cases, like Italy and France, migrants are legally entitled to healthcare but this is not always implemented.

** In Italy, for example, MSF introduced a model for culturally adapted and cost effective healthcare for migrants. In 2009, 35 clinics using this model were successfully taken over by local health authorities across the country.

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