

# Health, migration and border management: analysis and capacity-building at Europe's borders

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## Abstract

**Objectives** Three key elements were analysed in Hungary, Poland and Slovakia as a basis for strengthening the capacity of staff and structures related to health, migration and border management: public health concerns linked to migration, health needs and rights of migrants and the occupational health of staff.

**Methods** This IOM project was implemented through an in-depth situation analysis as well as the development of training modules and public health guidelines.

**Results** Findings indicate a paucity of existing data, gaps in the health care for migrants and few existing tools for border officials and health professionals. Sets of training modules were developed for each of these groups, including common modules on migration and the right to health and intercultural communication, as well as targeted health modules. The guidelines promote good practices in the context of border management and detention.

**Conclusions** The EU is working towards a common immigration policy and integrated border management; however, a harmonized approach to migration and health is still lacking. Further research and piloting of the developed

materials is needed to fully establish an adaptable, common toolkit.

**Keywords** Migrant health · Public health · Occupational health · European Union · Border management · Detention

## Introduction

In preparation for the eastward Schengen enlargement of December 2007, the European Union (EU) and the acceding Member States invested substantially in infrastructure, capacity-building and organizational restructuring to support their additional responsibilities for border management. As part of this process, the International Organization for Migration (IOM) was invited by Slovakia to participate in a review of the related health dimension in 2005, during which an initial partnership was established to bring needed attention to the links between health, border management and detention of irregular migrants.

Three key elements for analysis and capacity building were identified: public health concerns linked to migration, health needs and rights of migrants and the occupational health of staff. While an increasing number of reports have examined the detention conditions of migrants and one regional study has since been published on border checkpoints (IHF 2006a, b; EP 2007; JRS 2007, 2010; Kindler and Matejko 2008; MSF 2009), the relevance for health concerns was an under-researched field, with limited or no data on the issues, recommendations or tools for improvement. European legislation (Pace 2007), standards and core training for border management and detention staff focused rather on plant and animal health standards than human public health.

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IOM jointly developed the “Increasing Public Health Safety Alongside the New Eastern European Border Line” (PHBLM) project with Hungary, Poland and Slovakia in 2006 and was awarded financial support from the EU’s Public Health Programme and subsequently from the Hungarian Ministry of Health. Partnership was established with the EU’s External Borders Agency (Frontex) and the European Centre for Disease Prevention and Control (ECDC). Universities from Hungary (University of Pécs) and Spain (Andalusian School of Public Health—EASP) contributed as associate partners, with the collaboration of additional local research institutions.

Over a three-year period, the project sought to support partner countries in their accession to the Schengen area and work towards a harmonized approach to migration and health in Europe. The overall objective was to increase the public health safety of EU member states and promote appropriate health care provision to migrants in the border area as a fundamental human right.

In this context, the present article aims to outline the project findings for Hungary, Poland and Slovakia and the related development of training materials and guidelines on health and border management.

## Methods

### Situation analysis

The situation analysis aimed to capture data from a wide variety of sources on public health concerns linked to migration, health needs and rights of migrants and the occupational health of staff. For this purpose, an extensive consultation process was initiated with the project partners and stakeholders in order to develop the methodology and review the preliminary results. The methodology included desk reviews, data collection and two sets of site visits based on tailored instruments:

- A desk review was conducted to provide an overview of the international, European and national legal instruments, standards and studies regarding the rights of migrants to health and access to health care following UN tools and IOM reviews (Pace 2007, 2009) on the topic. Complementary questionnaires were developed and then completed in collaboration with local counterparts, covering the following topics: standards and procedures for identification and processing of migrants; right to healthcare of different categories of migrants; safeguards and standards for vulnerable groups with special needs; standards for material and hygiene conditions in facilities for migrants and asylum seekers and for medical/facility staff.

- *Retrospective data* were compiled based on official public and non-public data from partner countries (principally Ministries of Interior and Health) based on a standard questionnaire for the period 2004–2006. The resulting country profiles included available data on migrant caseloads, registered critical events at the border; statistics of health service activity for assistance provided to migrants and/or border staff; and morbidity and mortality statistics of sending and receiving countries.
- *Two knowledge, attitudes, and practice (KAP) surveys* were undertaken based on semi-structured questionnaires for border officials working with migrants as well as health and social work professionals. In developing the questionnaires, existing and tested scales and other relevant methodologies were utilised and, in some cases, adapted (Goldberg 1978; Goode 2000; IOM 2004; IOM 2008; University of Athens and IOM 2005; WHO 2005a, b; U.S. Department of Health and Human Services 2007).

The survey for border officials covered: work conditions and perceived health risks; training, health awareness and self-protection; case management of migrants, identifying and helping victims of human trafficking; and subjective health and use of health services. The survey for health professionals targeted the organizational characteristics and services usage of health facilities; public health safety of the resident population; services and assistance for at-risk groups; training needs; and health safety-standards of border facilities and services. Administered by local teams of trained interviewers, the survey was completed with 2356 border officials of diverse profiles within the national border guards/police at land border checkpoints, green/water borders, branch offices/duty stations, regional border headquarters and detention centres. Seventy-seven health and social work professionals were also interviewed from the national border guards/police or national health service providers of health and/or social care to migrants apprehended at border checkpoints or placed in detention or reception centres. Sites were selected to cover at least 50% of border checkpoints, detention centres for irregular migrants and reception centres for asylum seekers.

- *Two checklists* were completed on-site during the survey process—at border checkpoints (31 assessed) and at detention and reception centres (17 assessed). The instruments assessed the site profile, physical environment, procedures/facilities for highly vulnerable groups, available health facilities, hygiene conditions and health and hygiene-related procedures.
- *Field visits* were conducted by international and local experts over a 5-week period in the three target countries. The ATP Monitoring Guide of Places of

Detention (2004) served as a methodological framework for the assessment. The assembled expert team observed conditions in 21 sites (14 checkpoints, 6 detention centres, and 1 closed reception centre), discussed with health and non-health staff, interviewed migrants, met non-governmental organizations, led workshops with local border and public health authorities and initiated collaboration with border guard/police training schools.

The data entry and analysis of the quantitative part of the research were completed through the use of the Statistical Package for the Social Sciences (SPSS) Data Entry System and the Stata statistical package.

A Situation Analysis Report (IOM 2010) assessed data collected through the above methods and elaborated recommendations for the development of the training modules and guidelines.

### Training modules

Two sets of training modules for border officials and health professionals were developed, aiming for a multidisciplinary approach that would include common and specific modules for each group. Similar to the situation analysis, experts were identified from the project partners having border management, training and/or public health expertise.

A collaborative approach was used throughout the material development, starting with an international partner meeting to select the priorities, teaching methodologies and respective time allocations for individual units. Authors were proposed from IOM and the Andalusian School of Public Health staff, and drafts were discussed at national stakeholder meetings in each of the three countries. Based on the feedback provided, the training modules were adapted, piloted and evaluated during a 5-day international seminar with partners and experts from the participating countries. After the seminar and based on oral and written evaluation, the materials were finalized.

### Guidelines

A set of public health guidelines for border management and detention procedures involving migrants was elaborated in parallel to the development of the training modules. While alternatives to long-term, administrative detention of irregular migrants should be sought, the guidelines were designed to promote good practices and standards as well as to support the capacity of border management personnel to deal with health concerns of relevance for the public, staff and migrants.

An international meeting for project partners was organized to agree on the scope and structure of the

guidelines based on the findings of the situation analysis and existing international and European standards on detention and reception of third-country nationals. Due to similarities in the infrastructure, environment and administrative procedures of prisons, the more extensive international and European standards for these facilities were another important reference (UN 1998; CoE 1998, 2006; WHO 2007). As done for the training materials, the draft guidelines were presented and revised at national stakeholder meetings in Hungary, Poland and Slovakia prior to finalization.

## Results

### Situation analysis

The findings of the situation analysis were structured according to the project's three main areas of interest: the health of migrants crossing the land border and in detention; the occupational health, health knowledge, attitudes and practices of border officials; and the emergency preparedness and public health situation in the border regions.

Detained migrants access health care services mainly after being transferred to a detention centre, although a health professional can be called to a border checkpoint in case of emergency or request of the migrant. The medical screening of migrants is basic and non-standardized within two of the three countries, and not comparable across countries. Lacking mental health assessments and social workers in detention centres were found to be important gaps. With regard to the quality of care, it was found that border guards generally do not have the necessary skills and refresher courses on first aid. Shortages of interpreters and health professionals (particularly mental health professionals) are common barriers in all of the countries studied. Specific procedures and/or facilities to support vulnerable groups such as minors or pregnant women were absent, while staff interviewed were unaware of provisions in place for victims of trafficking, even when such were provided for by national law.

Systematic and standardized data collection on the health of detained migrants was found to be available only in Slovakia. Interviewed health professionals reported, however, a low frequency of communicable diseases (tuberculosis, gastrointestinal diseases and hepatitis), as well as non-communicable conditions (drug abuse and physical injuries). Discussions with migrants and non-governmental organizations suggested that a number of migrants are under mental distress without an adequate support system.

Based on difficulties encountered during the retrospective data collection phase, IOM proposed a template for a

*Migrant Health Database* and discussed the draft with European and local stakeholders during the field visits. The database concept aims to enable the participating countries to systematically collect comparable data on symptoms, medical diagnosis, testing, treatment, follow-up and case closure for migrants apprehended, transferred and/or detained by border authorities, as well as travellers in need of health care.

The border guard and police staff working at checkpoints and in detention centres in the three countries are mainly young men who have passed both physical and psychological tests before entering the service. No data on health status and sick leave were made available; however, officials assessed their own health as good to excellent. Although regular visits to a mental health professional are compulsory (on average every 2 years), the assessment team found that the rigidity of the law enforcement work culture did not facilitate discussing mental health and well-being, despite complaints of stress and burn-out from staff.

Staff members reported unsubstantiated fears of diseases transmitted by migrants during interviews, but demonstrated limited knowledge of the vaccines or personal protective equipment made available to them. In some of the border checkpoints visited, the stock of personal protective equipment was inadequate or not of appropriate quality (i.e. plastic instead of latex gloves), and first aid supplies included expired products. Aside from basic first aid training, no health-specific training was available in the three countries. Insufficient exchange of information between local border and public health authorities was identified during the field visits, and good examples of training or cooperation initiatives seemed to depend on the initiative of individual staff rather than standard operating procedures. None of the health professionals interviewed had received specific training on working with migrants or occupational health issues specific to border/police officials.

As a result of the significant investment in infrastructure along the Schengen border, the border checkpoints and detention centres assessed were found to be in good physical condition. Although new or recently renovated, the buildings at some checkpoints were found to have been poorly designed from a public health perspective (e.g. isolation rooms located in the same corridor as snack bars or rooms reserved for interviews or medical assistance lacking washbasins). Basic hygiene supplies, blankets and food were provided to migrants detained up to 24 h at the borders, but clothing was not systematically available, and supplies relied on donations.

The living environment in the detention centres visited had a bare prison-like atmosphere with bars on the windows, widespread cameras and no decorative elements or references (calendars, clocks). The lack of social or sporting activities, strict daily routines and minimal contact

with the outside world further deteriorated the fragile mental health condition of detained migrants.

In terms of public health and emergency response, no major epidemiological threats in the border regions were reported aside from isolated outbreaks of measles, hepatitis A, influenza; however, comparative data between border regions and national figures were not made available.

The discharge of migrants with potential communicable diseases (such as tuberculosis) and transfer of responsibility and medical files between different institutions was identified as another key issue during the assessment. Due to the cost and demands on staff time, border officials noted challenges in ensuring the presence of an escort for migrants transferred to external health facilities. As a result, incidents were reported of patients disappearing from these facilities prior to completing necessary treatment. Both non-health and health local staff were found to be unfamiliar with the International Health Regulations.

### Training modules

Following the pilot and evaluation of the materials, the structure and contents of the modules were finalized using a variety of teaching methodologies: lectures based on powerpoint presentations, individual and group desktop exercises, case studies, simulations and videos. Common modules were developed on migration and the right to health as well as intercultural communication, while the needs and roles of the target groups required tailored modules on public and individual health. Both sets of modules were designed as a 16-h course that can be integrated into continuing education programmes (see Table 1 for Table of Contents).

### Guidelines

As a complement to the training content, guidelines for border management and detention procedures were finalized based on a thorough review of existing standards and recommendations (Council of Europe 1993, 1998, 2006, 2009; EC 1989a, b, 2003; ILO 2006; JRS 2007; MSF 1997,2009; OHCHR 2005; UNODC 2008; U.S. Immigration and customs enforcement 2008; U.S. Army Center for Health Promotion and Preventive Medicine 2006; WHO 2005a, b, 2007, 2008) and feedback from the national stakeholder meetings. Table 2 presents the Table of Contents of the guidelines.

### Discussion

The Council of the European Union (2007) has stressed that addressing the health of migrants is fundamental to

**Table 1** Table of contents of training modules on migration and health, developed within the project (2010)

Health professionals	Border officials
I. Migration and the right to health care	I. Migration and the right to health care
Unit 1. Migration in the EU: introduction and terminology	Unit 1. Migration in the EU: introduction and terminology
Unit 2. Global and European migration trends	Unit 2. Global and European migration trends
Unit 3. Migration and the right to health	Unit 3. Migration and the right to health
Unit 4. Antidiscrimination and ethics	Unit 4. Antidiscrimination and ethics
II. Well-being: public/individual health	II. Well-being: public/individual health
Unit 5. Communicable diseases	Unit 5. First aid
Unit 6. Occupational health: concepts on safety, hygiene, infection control and well-being in the workplace	Unit 6. Basic concepts in communicable diseases and epidemic and pandemic alert and response
Unit 7. Epidemic and pandemic alert and response	Unit 7. Occupational mental health
Unit 8. Caring for trafficked persons	Unit 8. Vulnerability factors and groups
Unit 9. Psychosocial implications of migration	
III. Intercultural competence	III. Intercultural competence
Unit 10. Intercultural competence: concepts, principles and the role of health professionals	Unit 9. Intercultural competence: concepts and principles
Unit 11. Communication skills	Unit 10. Communication skills
Unit 12. Intercultural mediation	Unit 11. Intercultural mediation

attaining the best level of health and well-being for everybody living in the EU. The World Health Assembly (2008) has further called on Member States to promote migrant-sensitive health policies, assess and analyse migrant health data, train health professionals on related issues and strengthen cooperation among countries. Subsequent policy documents at European level reaffirm the need for action in this field (EC 2009, Council of Europe 2010, Council of EU 2010). Although not yet politically well recognized, the particular health situation of irregular migrants detained at the borders and in detention centres requires further attention and commitment on ethical, human rights and public health grounds (JRS 2010, IOM 2010). Ensuring the capacity of border officials, health professionals, and facilities to assess and assist these individuals should be of utmost concern.

In a period of organizational restructuring and adapting to new methods of work in the context of the Schengen enlargement, occupational health of border staff has not received high priority. At the same time, border guard and police staff do face physical and mental health issues, including irregular work schedules and workload, experiencing emergency and traumatic situations, limited or lack of personal protective equipment and training, and poor understanding of health risks leading to anxiety about communicable disease transmission. Failure to address these health and safety concerns affects the well-being of staff, migrants, and families and the community in large. Tackling issues and cultural taboos related to mental

health, how to cope with stress and traumatic events, as well as fighting prejudice towards different ethnic groups is an important element of the promotion of a human rights-based approach within the border guard and police services.

There is no evidence of major epidemiological threats in the border region for the public health of the population in contrast to popular belief that migrants bring dangerous infectious diseases to Europe. In fact, the percentage of irregular migrants is a very small proportion of the total border caseload at this Schengen border, which is used mainly for local cross-border travel. However, no data were made available on health-related critical events or epidemiological outbreaks to better assess the public health situation. A number of key issues remain to be addressed: the referral mechanisms in place between different institutions and countries to ensure follow-up for migrants with communicable conditions (such as TB); the implementation of the International Health Regulations; and the availability of response plans on preparedness to react in health-related emergencies.

While the migration pressures and detention conditions on the southern EU external borders now warrant Europe's highest priority, the project was developed based on European-level gaps in the approach toward migration and health and has initially aimed to support the EU Member States forming the EU's new eastern frontier. As a follow-up, IOM aims to support the project target countries and the EU's External Borders Agency (Frontex) in institutionalizing the

**Table 2** Table of contents of guidelines for border management and detention procedures involving migrants: a public health perspective (2010)

1. Detained migrants' health and public health related matters
1.1 Recommendations regarding conditions of detention
1.2 Recommendations regarding health promotion, protection and disease prevention for living conditions
1.3 Recommendations regarding health care services
1.4 Responsibilities for health promotion, protection and disease prevention
2. Border officials' occupational health
2.1 Recommendations on health promotion, protection and disease prevention
2.2 Responsibilities on health promotion, protection and disease prevention
3. Health/public health services
3.1 Provision of services
3.2 Health professionals
3.3 Public health professionals/authorities
3.4 Infrastructure
3.5 Communication on public health issues in border communities
4. Infrastructure and environment
4.1 Design criteria considering hygiene and safety
4.2 Operating procedures considering hygiene and safety
5. Role of administration in detention centres
5.1 Inter-institutional communication
5.2 Personnel management
5.3 Health promotion, protection and disease prevention

Migrant Health Database, training materials and guidelines, while also working with its Member States (both within and outside of Europe) to adapt the methodology and tools within its country-level activities.

### Limitations

The main limitations faced during the project are common to most initiatives seeking to collect migration data. There is a variety of governmental actors responsible for asylum, migration and health fields as well as lacking or decentralized data collection and limited exchange of information between involved institutions. For some variables, the official data as provided in publicly available reports on the topic, relevant websites and received by IOM differed, the terminology applied varied both within and between countries, or the requested information was not collected at all. Data availability and/or consistency was a particular issue with regard to disaggregation of migrant caseload by age and gender, critical events (health/non-health/violent/non-violent) at the border, cases of communicable and non-communicable diseases amongst detained migrants,

health service usage of staff, sick leave days/events of staff, local outbreaks of communicable disease and use of emergency services at the border.

At the same time, some of the health-related information on health service providers' statistics (including data from GPs, occupational health services, regional hospitals, sick leave lists, medical occurrence registries, emergency services statistics, death certificates), and registered official complaints were not reported after several rounds of data collection. This task proved to be unfeasible as these data are not collected centrally or exchanged between Ministries of Health and Interior in respective countries. The highly securitized work environment of border guards and police further requires requests for permission for access to information, personnel and facilities.

### Conclusion

Five years since the project conception, the linkages between health and border management remain underexplored. It is the hope of the authors that further research and piloting of the project outputs can elaborate the evidence base and support the establishment of an adaptable, common toolkit to support both border and public health authorities worldwide.

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**Conflict of interest** The authors declare that they have no conflict of interest.

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