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EDITORIAL

Disgrace at EU's external borders

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The planks measure about 5 feet (1.5 m) in length. They were once painted in dark and light blue and in red colours. Now the paint has chipped off, the wood is splintered; the nails are loose and rusty. The planks belonged to what must have been a small fishing vessel. They were washed ashore in Sicily. It will probably never be known how many people perished when the boat sank, but it is likely that it was overcrowded with men, women and children of all ages, attempting to reach Europe from North Africa.

The planks have been set up in a church in Noto in the south-east of Sicily, in front of a painting depicting the nativity scene. Mary, Joseph and their infant found at least some shelter, unlike the occupants of the boat. At the foot of the planks, the church congregation has fixed a sign citing Pope Francis: "Chi piangerà per questi morti?"—who will cry for the dead?

More than 1600 refugees drowned in the Mediterranean between January and April 2015, according to UNHCR estimates (UNHCR 2015). It is far easier to decry this disgrace than to offer realistic solutions. Integrating refugees into EU societies poses great challenges. Some of those arriving fled from war and terror, others from economic distress and hopelessness. Some have decent education and marketable skills; others never had the chance to acquire these. Some are active and healthy, others deeply traumatised. But we must meet this challenge.

First, public health and human rights do not end at national borders, and neither does our responsibility for the health of others (Ooms and Hammonds 2014). And yet, efforts to salvage refugee boats in distress were reduced in November 2014 when the 'Mare Nostrum' operation by the Italian marine wound up because of lacklustre support by northern EU states. It needs to be reinstated. EU states without external borders need to accept far larger numbers of refugees who landed in the southern European member states. They need to move from sovereignty to solidarity to meet the challenges of interdependency (Frenk et al. 2014). The current ten point action plan of the European Commission, however, merely "securitizes" the emergency governance response (Joint Foreign and Home Affairs Council 2015)—a short-sighted approach which has proven as trap in other global health contexts (Hanrieder and Kreuder-Sonnen 2014).

Second, detaining refugees and asylum seekers in camps for months and leaving them passive and disengaged will ultimately be far more expensive to receiving societies than incorporating them straight away. Detention is not only an appalling waste of human potential; is also likely to incur long-term social cost due to marginalisation. We need to invest more, and sooner, in the health care, language and vocational training of refugees—there is no societal benefit in denying these rights (Grove and Zwi 2006).

Third, underlying causes of refugee movements need to be tackled. EU states need to implement their Global Health Strategies which often exist mainly on paper (Bozorgmehr et al. 2013). This involves less emphasis on their own economic interests (Gagnon and Labonte 2013; De Ceukelaire and Botenga 2015) and more support for building reliable support structures.

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Politicians seem reluctant to take the necessary steps, fearing that this would affect their chances for re-election. They need to show more courage, and should realise that there are not only vociferous anti-immigration movements in their electorate. The congregation of Noto, long confronted with the disgrace of the EU external border, has sent a different signal.

Fourth, the public health community has to raise its voice to develop and implement sustainable solutions to protect health and other human rights of refugees in the prevailing political climate of EU. This includes building the infrastructure to improve collection of routine health data on migrants and asylum seekers; such data are not available (or only in a highly aggregated format) in most EU member states. In the absence of reliable data, the full extent of human suffering and health tragedies remains invisible. Public health professionals also need to develop strategies to address health threats and health care needs of refugees across the continuum of peri- and post-migration phases. This includes effective protection from infectious diseases (Takla et al. 2012; de Valliere et al. 2011), access to comprehensive primary care (Feldman 2006), particularly for vulnerable groups with mental (Robjant et al. 2009) and maternal (Van Hanegem et al. 2011) health needs, and last but not least decent coverage of existential human needs.

Globalisation is not reversible. Globalisation means that people will continue attempting to move between countries and continents, irrespective of laws and patrol boats, of oceans and deadly perils. So offering charitable responses or relying on faith-based and civil society initiatives alone will not suffice—we need to create appropriate structures accessible to refugees. Moreover, we will have to create societies that accommodate people's free movement and share resources more fairly, based on universal rights and duties (Frenk et al. 2014).

We do not have much time to do so. One day we will be asked what we did to stop this continuing tragedy. As of today, what we have done is far too little.

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