



IOM-OIM

INCREASING **PUBLIC HEALTH**  
SAFETY ALONGSIDE THE NEW  
EASTERN EUROPEAN BORDER

An Overview of Findings  
from the Situational Analysis





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# Acronyms

|                |  |
|----------------|--|
| <b>AIDS</b>    | > Acquired Immunodeficiency Syndrome   |
| <b>APT</b>     | > Association for the Prevention of Torture  |
| <b>BBAP</b>    | > Bureau of Border and Aliens Police   |
| <b>BCPs</b>    | > Border Checkpoints   |
| <b>BG</b>      | > Border Guard   |
| <b>BGHSS</b>   | > Border Guard Health and Safety Survey  |
| <b>BLHSS</b>   | > Border Line Health and Social Services Survey  |
| <b>CESCR</b>   | > Committee on Economic, Social and Cultural Rights  |
| <b>CMW</b>     | > International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families                    |
| <b>CoE</b>     | > Council of Europe  |
| <b>CRC</b>     | > Convention on the Rights of the Child  |
| <b>DC</b>      | > Detention Centre   |
| <b>DepA</b>    | > Deportation arrest   |
| <b>DPT</b>     | > Diphtheria- Pertussis-Tetanus (vaccine)  |
| <b>EAHC</b>    | > Executive Agency for Health and Consumers  |
| <b>EC</b>      | > European Commission  |
| <b>ECDC</b>    | > European Centre for Disease Prevention and Control   |
| <b>ECtHR</b>   | > European Court of Human Rights   |
| <b>EP</b>      | > European Parliament  |
| <b>ERF</b>     | > European Refugee Fund  |
| <b>EU</b>      | > European Union   |
| <b>EWRS</b>    | > Early Warning and Response System  |
| <b>Fedasil</b> | > Federal Agency for the Reception of Asylum Seekers   |
| <b>Frontex</b> | > European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union |



**FYROM** > Former Yugoslavia Republic of Macedonia  
**GIRBP** > General Inspectorate of the Romanian Border Police  
**GP** > General Practitioner  
**HIV** > Human Immunodeficiency Virus  
**HQ** > Headquarters  
**ICCPR** > International Covenant on Civil and Political Rights  
**ICD** > International Statistical Classification of Diseases and Related Health Problems  
**ICESCR** > International Covenant on Economic, Social and Cultural Rights  
**IHR** > International Health Regulations  
**JRC** > Joint Research Centre – European Commission  
**JRS** > Jesuit Refugee Service  
**KAP** > Knowledge, Attitude and Practices  
**MHD** > Migrant Health Database  
**MoIA** > Ministry of Interior and Administration  
**MoI** > Ministry of Interior  
**MoH** > Ministry of Health  
**MOU** > Memorandum of Understanding  
**MS** > Member States  
**NGO** > Non-Governmental Organization  
**NPHMOS** > Hungarian National Public Health and Medical Officer Service (ANTSz in Hungarian)  
**OIN** > Office of Immigration and Nationality  
**OECD** > Organization for Economic Co-Operation and Development  
**PH authority** > Public Health authority  
**PHBLM** > Increasing Public Health Safety alongside the New Eastern European Border Line  
**PTSD** > Post-traumatic Stress Disorder  
**PPE** > Personal Protective Equipment  
**RABIT** > Rapid Border Intervention Teams  
**RC** > Reception Centre  
**RIO** > Romanian Immigration Office  
**SIS** > Schengen Information System  
**SPSS** > Statistical Package for the Social Sciences  
**STD** > Sexually Transmitted Diseases  
**FSU** > Former Soviet Union  
**TB** > Tuberculosis  
**TEC** > Treaty Establishing the European Community  
**UAM** > Unaccompanied Minors  
**UDHR** > Universal Declaration of Human Rights  
**UN** > United Nations  
**UNHCR** > United Nations High Commissioner for Refugees  
**VoT** > Victim of Trafficking  
**WHO** > World Health Organization





## **Introduction | 1**



## Concern over the potential health risks associated with migration is a long-standing political and policy issue.

Some of the earliest legislation and international agreements relating to the control of population movements and travellers relate to these fears of 'imported disease', and a key role of frontier police and customs official is to regulate the movement of people and goods that may pose a threat to public health and safety<sup>1</sup>. Some of the earliest writings on 'migrant and minority health' in the contemporary academic and practitioner literature were primarily concerned with 'port health' and the need to recognise and manage imported or exotic diseases such as TB and leprosy<sup>2</sup>. During the two World Wars, there were many reports and policies in all states relating to the risk of the spread of venereal (sexually transmitted) diseases associated particularly with the movement of military personnel and refugees. As recently as 2003 the British Medical Journal carried an editorial criticising the response of 'populist' newspapers and some politicians to suggestions that the opening up of European borders to migration either from the so-called 'third world' (less developed countries) or states of Eastern Europe might create risks of 'plagues'<sup>3</sup>. That editorial quoted a newspaper report from the Mail on Sunday which suggested that the UK Government was passing legislation to give 73 million eastern Europeans, "who also suffer high rates of disease, the right to immigrate and be given free medical treatment" (*Mail on Sunday* "Madness of Blair's imported plagues" 26 January 2003). Doubtless similar reports and discussions could be located in any other national press.

At the same time as there are pressures to restrict migration because of the potential risk to public health, there are pressures to increase the ease of travel and encourage the movement of workers across national borders to support economic development and growth, reflecting an increasingly 'globalised' world economy. There are also, especially in the 21<sup>st</sup> century, pressures to ensure that the human rights of not only citizens but also residents, travellers and migrants (irrespective of their citizenship status) are observed. The 'Amsterdam Treaty' of the European Union, and subsequent legislation and regulations, and declarations made at the Lisbon Conference, have all attested to the centrality of respect for human rights and a need to observe the stipulations of the ECHR and UN Declaration of Human Rights. This means that former approaches of border control, which were essentially less respectful of the rights of non-citizens and primarily aimed at control, rather than care, are no longer as acceptable.

As an earlier initiative of the Council of Europe, concerned with human rights issues, a survey was undertaken in 1994-5 of member states, which revealed that a number of countries were then delivering 'human rights' training to police forces, including information and skills advice on issues of legislation, ethnic cultural diversity and 'courtesy', sometimes allied with 'cultural mixing events': these included examples from Denmark, Hungary, Luxembourg, Norway, Switzerland, Turkey and Austria. A very few mentioned the inclusion of security or border

control staff in such events, and others (notably newer autonomous states such as Lithuania) referred to the problem of developing a curriculum for these purposes<sup>4</sup>.

Finally, it should be observed that there is also a movement to recognise the need to pay greater attention to the health and wellbeing of workers, and to manage 'occupational health' risks, arising both from the pressures of worker militancy (as reflected in the role of trades unions and other civil society partners) and the self-interest of employers (including the state) who invest significantly in the training and welfare of their workforces.

## Project Outline: Structure and Objectives

The enlarged European Union (EU) faces increased and more complex migration flows. Approximately 7.6% of the total EU population is foreign born, and it is estimated that between 2.6 million and 6.4 million migrants are in irregular status.<sup>5</sup> While the migration pressures and detention conditions on the southern EU external border require continued attention, the enlargement of the Schengen zone also brings new migration-related health challenges to the Member States on the new EU eastern frontier. Health systems and border services need to be prepared to address public health concerns, health needs and rights of migrants, as well as ensure staff's occupational health.

Developed by IOM in 2006 in response to these challenges, the "Increasing Public Health Safety Alongside the New Eastern European Border Line" (PHBLM) project seeks to support partner countries in their accession to the Schengen area and work towards a harmonized approach to migration health in Europe. At present, the European legislation, regulations (including Schengen) and core training for border management and detention do not comprehensively address this human public health element.

The PHBLM project launched activities in June 2007 with co-financing from the European Commission's Public Health Programme 2003-2007, IOM and subsequently the Government of Hungary. IOM has collaborated in this part of the initiative with public health and border authorities of the Governments of Hungary, Poland, Slovakia and Romania<sup>6</sup>, the European Centre for Disease Prevention and Control (ECDC), Frontex, as well as with local universities and the University of Pécs as associated partner.

While alternatives to long-term detention, and uniform mechanisms to protect the basic human rights of irregular migrants<sup>7</sup> should be sought and developed, the project's general objective was to promote appropriate health care provision to migrants in the border area through the development of training materials and guidelines for public health in border management and detention procedures on the basis of assessment of the magnitude and nature of the current health/public health hazards in border management.

The present public report is a summary of the assessment, i.e. situational analysis report (SAR). The SAR itself was the culmination of the Project's situation analysis phase drafted with the primary goal of developing a comprehensive evidence base for the subsequent project components. As the first study of this kind, the SAR compiled data from a wide variety of sources and has generated a large quantity of new data using both quantitative and qualitative methods in the primary target countries of Hungary, Poland and Slovakia.

This Report begins with a review of relevant studies on the topic of migration and health before outlining the methodology of the data collection, limitations, processing, and analysis. The results section is then structured by data collection instrument. Starting with a desk review of relevant legislation and retrospective data, the results include: a feasibility analysis for a Migrant Health Database; Knowledge, Attitudes and Practices surveys for both border officials and health professionals; checklists of site conditions and procedures, as well as field visits results from workshops, observations and interviews. The summary and discussion section links findings in a thematic analysis, leading to the conclusions and recommendations.

## **1. Relevant studies on the topic of irregular migration<sup>8</sup> in the Schengen border region of Poland, Hungary and Slovakia**

The majority of publicly available reports<sup>9</sup> of international organizations, donors and experts in the field of irregular migration focus on the assessment of the general conditions in detention and/or reception facilities with respect to Council Directive 2003/9/EC of 27 January 2003 laying down the minimum standards for the reception of asylum seekers and respective international and regional core instruments of the United Nations (UN) and Council of Europe.

Comparing the reports since 2002/2004, one can trace the changes, achieved in the process of preparation for the Schengen accession in each of the three countries as a result of visits, inspections and assessments from international organizations working in the fields of migration and asylum, such as the Helsinki Committee, United Nations High Commissioner for Refugees (UNHCR), Caritas International, local Non-Governmental Organizations' (NGOs), and delegations from the European Commission (EC) and European Parliament (EP). In general, the assessment reports' overview of the legal framework and conditions of detention/reception follow the structure and components of the EC directive with respect to the following asylum seekers' human rights: access to information; documentation; residence and freedom of movement; families; medical screening; schooling and education of minors; employment; vocational training; general rules on material conditions and health care; modalities for material reception conditions; and health care.<sup>10</sup> In the same time, a limited number of studies target the topics of irregular migration and the application of minimum standards when a foreign national is retained at the border and before being transferred to a long-term detention/reception facility or the application of readmission/deportation procedures. Again the health focus covers mainly the exercise of migrants' legal rights, such as access to information, contact with the outside world, accessibility of health care for vulnerable groups and assistance to VoTs<sup>11</sup> (victims of trafficking).

As an outcome of the recommendations, significant investments have been made to improve the conditions of detention/reception to comply with the international regulations. Yet the governments of Poland, Slovakia and Hungary face challenges in transforming their reception/detention system in response to the increased migration flows and their new role of EU external border gatekeepers.

## 2. Health in detention and reception facilities

As a crucial part of the minimum standards for the reception of asylum seekers, medical screening and access to health care services have been discussed in detail in the country reports of the European Refugee Fund (ERF) and later summarized in the Joint Research Centre – European Commission (JRC) report on the detention conditions in Europe.<sup>12</sup> According to their observations, basic medical screening is performed everywhere, however the access to health care services is limited and related to emergency health care and hospitalization for people in need. Similar problems regarding irregular migrants' health are reported in the three countries: poor or lacking psychological and/or psychiatric care, communication problems between medical staff and migrants; mental health state of migrants deteriorated from prolonged stay in reception/detention; and lack of adequate multicultural training of staff. The studies' further address the situation of vulnerable groups<sup>13</sup> and the insufficient health care provided by local health systems. For example, in Hungary, the studies find that traumatized or mentally ill people have been treated with tranquilizers and only in cases of serious mental disturbances transferred to a hospital unit. Lack of specific regulations governing the work of staff in cases of psychological/psychiatric problems of detained population<sup>14</sup>, limited psychological assistance and no specialized care for persons with special needs and/or victims of torture were further noted in the country reports for Hungary and Poland<sup>15,16,17</sup>. The same situation is valid for Slovakia as well: basic health care, communication problems, lack of specialized psychological/psychiatric care and inadequate general standard of care<sup>18</sup>, insufficient presence of NGOs, no specialized treatment programs for victims of torture and violence.<sup>19</sup>

Again, the assessments so far do not cover the health aspects and respect of the right to health during the initial step of apprehension at the border and rather stipulate the actual procedure of providing emergency care and in case of need transfer to hospital settings.<sup>20</sup> The studies on border management focus on the conditions in which passenger traffic takes place<sup>21</sup> and general information/ statistics on any major violations of the border crossing procedure, international activities, legal and illegal migration.<sup>22</sup> The health of staff and host communities seems neglected in the assessments, as well as the staff preparedness for emergency response and the state of occupational health services.





# Methodology for Assessment | 2



**T**he present section provides an overview of the objectives, contents, sampling, and limitations of the assessment tools. This review is followed by a section discussing the general limitations and strengths of the assessment tools and data processing.

## 1. Desk review of legislation and protocols

The purpose of the desk review was to provide an overview of the international and European legal instruments and standards regarding the rights of migrants to health and health care<sup>23</sup>. Information was collected by standardized templates and the following topics are covered in the SAR public report: standards for detention and reception procedures and conditions in facilities and regulations for public health and border management.

## 2. Retrospective data collection

Retrospective data for the period 2004-2006 was collected by a standardized template with the aim to provide country profiles of:

- > the number, nationality, gender and age composition of irregular migrants and asylum seekers;
- > overall border crossing caseload; registered critical events either with health impact or violence; statistics of health service activity for assistance provided to migrants and/or border staff;
- > morbidity and mortality statistics of sending and receiving countries.

An overall bridging goal of the retrospective data collection was to also identify and describe the gaps in existing data collection practices and if needed, provide recommendations for their improvement.

## 3. Migrant health database (MHD)

The objective of the MHD is to improve the knowledge base on the health of migrants and travellers in order to (1) contribute to understanding the magnitude of potential public health risks and (2) plan for and foster adequate and appropriate health services for migrants, staff and communities in the border areas. Specifically, 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/commuters in need of health care.

The proposed draft template included the following five forms:

1. **“Primary Screening Form”**: This form contains basic symptom-based information, ideally to be filled by border officials or, where available, local professional health staff at the first encounter or apprehension of a migrant, serving as a reference to the next level/stage in terms of medical care (General Practitioner (GP), emergency, detention/reception centre, readmission/deportation or departure/release).
2. **“Secondary Screening Form”**: This form contains more complex health information, including diagnosis, treatment, and laboratory tests, and is to be used by health staff from the detention/reception centre. It further functions as a “checklist” when conducting the medical examination and screening.
3. **“Tertiary Screening Form”**: This form contains other health conditions of concern, including chronic diseases, mental health, obstetrics/gynaecology, Tuberculosis (TB) and Human Immunodeficiency Virus (HIV) testing. As with the secondary form, this should be used by the health staff/specialized service.
4. **“Emergency Form”**: This form contains the basic registration data on the migrant, as included in the above forms, and provides a field for use by the Emergency Services to record medical findings and treatment.
5. **“Summary Form”**: This form would be completed by the health staff responsible for the overall care of the migrant and contains an overview of the medical diagnosis (with International Statistical Classification of Diseases and Related Health Problems (ICD) coding), diagnostic tests, treatment, determination of fit to travel/fly, and information on the closure of the migrant’s file.

Written feedback from stakeholder on the MHD was primarily generated. Consultations during field visit with the limited number of onsite staff were also done. The former explains some misunderstanding of the need and role of such template. On several occasions, “concerns” were expressed that BOs (border officials) would be meddling in medical matters and accessing health information, where in fact, their role would be and is in reality noting symptom of health conditions, a practice performed, but not documented, nor one for which they are trained for at the moment in case of need to call the doctor/emergency services and perform first aid.

## 4. Border guard health and safety survey (BGHSS)

The BGHSS questionnaire aimed to assess knowledge, attitudes, and practice (KAP) of border officials and detention centre staff in order to identify needs of further training and recommendations on improving the public health services in the targeted border sectors. Following consultation with project partners, the final version of the questionnaire consisted of the following five themes:

- A. Work conditions and perceived health risks (work conditions, perceived health risks at work).
- B. Health knowledge, attitudes and practice (training, health awareness and self-protection).

- C. Case management of migrants (knowledge and practices, identifying and helping victims of human trafficking).
- D. Subjective health and use of health services.
- E. Personal data (education and training, marital status and living conditions, multicultural competence).

As a semi-structured format, the standardized questionnaire was developed in English and then translated into the three local languages (Hungarian, Polish and Slovakian). An informed consent form was further developed and added to the questionnaire, where the goals of the survey were presented, the voluntary character of the study and the respect of anonymous nature and confidentiality of the answers.

As per the project proposal methodology and sampling, the project aimed to cover at least 50% of Schengen land border checkpoints and detention centres in Hungary, Poland and Slovakia. In coordination with local Ministries of Interior and on the basis of three criteria (border checkpoints most exposed to irregular migration, points with high general traffic, and sectors which include detention centre), the BCPs were identified and respective permissions to visit the facilities were issued.

The target sites included:

- > Two detention centres (out of 3 in the entire country, and only two at the Schengen border) and 20 BCPs (out of 30) at the border with Ukraine (4), Romania (11), and Serbia (5) in Hungary;
- > Seven BCPs (out of 19) at the border with Ukraine (4), Belarus (2) and Russia (Kaliningrad) (1) and 1 deportation arrest and 4 detention centres and deportation arrests in Poland (out of 5 in the entire country and all four at the Schengen border);
- > Four BCPs (out of 5), 5 green<sup>24</sup> border sites, and 1 detention centre (out of 2 in the entire country, the only one at the Schengen border) and HQ of regional BOs at the Schengen border in Slovakia.

The profile of respondents included staff from national border guards/police at land border checkpoints, green/water borders (between checkpoints), branch offices/duty stations, regional border headquarters, and detention centres. Their participation in the survey was randomized depending on the shift schedule, workload and personal interest to take part in the study. At some sites, respondents were referred before or after shifts to participate in the study.

The data has been further weighted to reflect the actual number of checkpoints and staff employed at different sites in all three countries and on the basis of the actual number of sites and population of BOs.



## 5. Border line health and social worker survey (BLHSS)

The BLHSS questionnaire aimed to collect information on the knowledge, attitudes and practices of health professionals and social workers working with apprehended migrants and in detention and reception centres.

The final version of the questionnaire covered the following six themes:

- A. Organizational characteristics and services usage (organizational characteristics, services usage).
- B. Public health safety of resident population (perceived risks of infectious diseases, physical and mental health risks, health safety programs).
- C. Services and assistance for at-risk groups (perceived risks of human trafficking in the region, work with victims of trafficking, work with unaccompanied minors, cooperation with humanitarian organizations).
- D. Training needs (training experience in migration health).
- E. Quality assessment of border facilities and services (health safety standards: expected vs. perceived).
- F. Personal data (education and training, marital status and living conditions, multicultural competence).

Similar to the BGHSS survey instrument, the BLHSS was developed as a semi-structured standardized questionnaire. Further testing and piloting of the survey was also performed.

As the overall population of health professionals, working with migrants is very low and difficult to identify (no relevant numbers were reported during the retrospective data collection), the initial approach consisted in covering all the sites visited for interviews with BOs and performing interviews with the health personnel in selected targeted sites (detention centres, hospitals and other health care facilities, reception centres, etc.): 2 DCs in Hungary; 1 DC and 3 RCs in Slovakia; and 1 DepA, 4DCs and 6 RCs in Poland.

## 6. Border checkpoint and detention/reception centre checklists

The objective of the border checkpoint and detention/reception centre checklists was to assess in the form of a standardized template, the site profile, physical environment, available health facilities, hygiene conditions, and health and hygiene-related procedures at the targeted facilities.

The Border Checkpoint Checklist was designed to cover four areas:

- > General information (number of staff, annual traffic, availability of health care facilities, location of nearest emergency services/ambulance station, etc);
- > General hygiene conditions at the border checkpoint;
- > Hygiene conditions in onsite detention facilities; and
- > Hygiene conditions for staff.

The Detention/Reception Centre Checklist similarly covered four areas:

- > General information (number of staff, average number of persons in the centre and average time spent, availability of health care facilities, location of nearest emergency services/ambulance station, etc);
- > General hygiene conditions at the detention/reception centre;
- > Hygiene conditions for staff; and
- > Living conditions for the detainees/residents.

Checklists were completed in all the sites visited during the survey fieldwork in Hungary (except two sites), Poland, and Slovakia. Overall 31 BCPs have been surveyed with checklists: 18 in Hungary, 7 in Poland and 6 in Slovakia covering green border sections, checkpoints for different modes of vehicle traffic for cars/trains/cargo, and pedestrians, etc. In addition, 17 checklists for DCs/RCs and DepA (12 sites in Poland, 3 sites in Hungary and 2 sites in Slovakia) were also filled in during field visits.

## 7. Field visits

The objective of the project team field visits was to build on, qualify and validate preliminary findings from the above-detailed assessment tools.

Data was collected primarily by means of site dossiers, site rapporteur templates, team member report templates, and voice recordings of selected meetings and interviews. Observations were performed at the border checkpoints and at the detention centre facilities and served to complete, qualify and reassess information collected to date by the Project.

The planning aimed to visit 20 sites, however more were visited: Poland – 4 BCPs and 3 DCs, Hungary - 10 BCPs and 2 DCs, and Slovakia – 2 BCPs, 1 DC, 1 RC and BO HQs. The border checkpoints were identified in cooperation with local partners in Hungary, Poland and Slovakia on the basis of the following criteria: location (all Schengen land borders<sup>25</sup>), type of checkpoint, traffic, availability of on-site detention facility, and previous observations of critical issues from checklists of site conditions and operating procedures. Detention centres were selected based on proximity to the border checkpoints and recommendations of BOs. An additional closed reception centre was visited in Slovakia, given its particular function as a short-term quarantine for asylum seekers.

## 8. Framework of limitations

During the assessment phase, a number of limitations were faced: lack of existing comprehensive research on health and border management, few relevant tools to guide the development of the instruments and scarce statistical information to be used for the planning of the field visits and surveys – particularly on the number and type of

staff; structural changes of the law-enforcement agencies to enter the Schengen family; available human resources/ response rates for review and consultation from national and European stakeholders and budget constraints. Issues such as language barriers and translation of assessment instruments from English into three national languages as well as cultural differences between countries and local institutional history and practices were also faced.

Recognizing these limitations and the fact that the results from different assessment components follow similar patterns (both quantitative and qualitative), the discussion of preliminary findings from survey instruments with local stakeholders during national workshops at field visits, the circulation of draft SAR to local counterparts for comments and feedback, and re-discussion of results at national stakeholder meetings validate the study findings and recommendations.

## 9. Data processing

Data entry for the quantitative sections of the PHBLM project – BGHSS and BLHSS and the border checkpoint and detention centre checklists was completed through the use of the Statistical Package for the Social Sciences (SPSS) Data Entry System.

Confidentiality - anonymous and personal protection of the data was carefully observed: names and/or personal identifier were not collected during field visits and security measures were undertaken for the proper storage and handling of the filled surveys and consent forms.





## Results | 3



## 1. Desk review of legislation and protocols

The legal basis for the right to health and specific healthcare provisions for migrants crossing the border or in places of detention is defined in international, European and national instruments. In the following sub-sections, an overview of the standards for detention and reception procedures and conditions in facilities and the regulations for public health and border management from a European perspective are provided.

### 1.1. Standards for detention and reception procedures and conditions in facilities

While alternatives to detention must be developed, adequate attention to health considerations in detention and reception procedures and facilities is particularly important for guaranteeing migrants the full enjoyment of their right to health as defined in international and European human rights law. The following section illustrates the existing legal provisions related to health care in the context of detention and reception, as well as material and hygiene conditions in places of detention.

#### A. Detention and reception procedures

The practice of detention remains as a major concern and particularly for migrants' health and well-being. Besides the serious mental health impact, the practice of detention and inadequate reception conditions pose physical health risks and may lead to serious health problems.<sup>26</sup> In this regard, States are under direct responsibility to thoroughly process and identify asylum seekers, refugees and vulnerable groups of migrants during the reception and detention procedure and guarantee safeguards to address health needs for the enjoyment of the individuals' fundamental rights.

Further to the provisions on the "*right of everyone to the highest attainable standards of physical and mental health*" as outlined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)<sup>27</sup>, Article 3 of the ECHR and Articles 2, 7 and 10 of the International Covenant on Civil and Political Rights (ICCPR) provide for the prohibition of torture and inhuman or degrading treatment or punishment, while the case law of the ECtHR also addresses the standards of conditions in detention centres.

The case law of the European Court for Human Rights has, in particular, shown that inadequate procedures and conditions affecting the health and well-being of detained migrants and asylum seekers can constitute a violation of the above prohibitions and that States have certain obligations in this field. In *Dougoz v. Greece* (2001),<sup>28</sup> the ECtHR ruled that migrants subject to immigration detention enjoy the right to safe and humane detention conditions in conformity with Article 3. In the *Greek Case* (1969), the European Commission for Human Rights concluded that the detention conditions constitute a violation of Article 3 ECHR, if there are conditions like overcrowding, inadequate heating, inadequate sleeping and toilet facilities, insufficient food, recreation and contacts with the outside world. In *Cyprus v. Turkey*<sup>29</sup>, it was determined that not providing enough food, water and medical assistance in detention centres constitute inhuman treatment contrary to Article 3 ECHR.

## B. Material and hygiene conditions in facilities for migrants and asylum seekers

In order to enhance the well-being of migrants within reception and detention facilities, international and European instruments have identified basic principles and recommended standards to further guarantee the health of individuals in places of detention. International and European standards require that the material conditions for all persons in any form of detention—including persons subject to immigration control measures that include detention—must meet basic minimum standards that guarantee health (both physical and mental), safety, and access to social services.<sup>30</sup>

The U.N. Standard Minimum Rules for the Treatment of Prisoners (Standard Minimum Rules) and the European Prison Rules serve as binding guides on how to comply with international and regional obligations to protect the human rights of persons held in all forms of detention regarding the general material conditions and basic access to services.

## 1.2. Regulations for public health and border management

The above-mentioned minimum standards are important to reduce health risks and prevent spread of diseases within and from the centres. Prior to potential detention or reception, the standards and procedures at points of entry and on-site detention facilities at border checkpoints further play a key role for the health of migrants and staff as well as the public health of host communities. The International Health Regulations 2005 are the current international standards agreed by the World Health Assembly and binding all EU MS in order to enhance public health security and prevent epidemic disease spread. In the European Union, the primary instrument is the Schengen agreement and related protocols.

### A. International health regulations (IHR)

The IHR is a measure to enhance global epidemic intelligence. The purpose of the IHR is to provide international standards including how to protect, control and prevent for spread of diseases implying international public health risks. It is a legal framework for the WHO and its MS to manage defence and protection for emerging public health threats that may jeopardize the international economy and public health security.<sup>31</sup> Furthermore, the regulations provide a framework for assessment to improve national capacity building.

In relation to border management, the IHR are connected to the in-time recognition of a disease or its symptoms as a starting point for the process of diagnostics and reporting a health event at a border checkpoint or place of detention and to accumulate information on the travellers' route to ascertain potential contact with an affected area or contamination before arrival. The MS assign WHO the authority to decide public health risks that may induce IHR measures, including advising on restrictions on entry and travel as well as closure of the borders.

Recent international outbreaks such as SARS and pandemic influenza have demonstrated that prevention measures at border entry points and close cooperation between border and public health authorities represent key components of the IHR response. As the IHR 2005 is currently in an early implementation stage in the EU, the role of border authorities in response to public health threats and the particular needs of persons crossing

the EU external borders, both regularly and irregularly, will require particular attention in future training and standard setting for border officials.

#### B. European regulations: schengen agreement and early warning and response system

The Schengen agreement is a cooperation instrument between MS to cover issues of border control, data protection, police and judicial cooperation, as well as visa and consular cooperation. In terms of health-related provisions, the regulations seek to prevent any potential public health threat to the MS.<sup>32</sup>

MS may be allowed to refuse entry of people who might pose a threat to the public health. In accordance with the International Health Regulations, the meaning of threat to public health refers to any “infectious disease or contagious parasitic diseases” that can cause an epidemic threat for the Member States.<sup>33</sup> Guidelines on the notion of threat to public health for the purpose of refusing entry are, however, defined in very general terms at international and European levels. For example, the Schengen Handbook for border guards states that refusal of entry should be applied for those who are “a threat to public policy, internal security, public health or the international relations of one or more Schengen States.”<sup>34</sup>

Overall, it can be concluded that border management procedures as regulated at the EU level, place importance on the prevention of public health threats identified by the Community Network. Aside from provisions regulating the movement of goods and basic health components of the Common Core Curriculum, specific regulations and tools to support border authorities in their role of protecting human public health are, however, lacking at the European level.

## 2. Retrospective collection of data on statistics of irregular migrants

The retrospective collection of data on statistics of irregular migrants covers the years 2004, 2005 and 2006. The main topics of interest were the caseload of irregular migrants and respective migratory trends, the incidence of critical health events in the border region before the accession to the Schengen zone and detention/reception centres, as well as the types and number of border and centre staff.

### 2.1. Caseload – number of migrants, breakdown by gender, age group and reported country of birth

In general, statistical information on the irregular migration in the region is provided from the Migration Offices within the ministries of interior.<sup>35</sup> Furthermore national administrations use country-specific templates for statistical data collection and vocabulary of irregular migrants<sup>36</sup>, which complicates cross-country comparison. Structural reforms related to the Schengen agreement<sup>37</sup> and the integration of the border police into the national police further obscures the process and responsibilities of data collection on irregular and regular<sup>38</sup> migration in the region.

Table 1 provides comparative information on the types of data requested from national Border Police/Guards headquarters. As shown, the total number and the country of birth of irregular migrants are registered by all the surveyed states, even though different types of records are kept (total number of irregular migrants, apprehended on the territory of the country; total number of issued expulsion decisions; total number of irregular border crossings, etc.). Gender and age breakdown of irregular migration, aggregated centrally was provided only in Poland. Similar is the case with the total border crossing caseload (including regular), where a country of origin breakdown was available only in Poland and Romania.

The system of security and border control in Poland, Slovakia and Hungary is based on both short<sup>39</sup> and long-term detention facilities, while in Romania no short-term detention facilities were reported to exist. Detailed information on detained migrants by age, gender and country of origin is collected only in long-term detention facilities. In Poland, because of restructuring and change of responsibility over long-term detention centres after 2006, no data is available concerning the numbers and group of migrants detained for the period of reporting. However, the Polish BGs were the only surveyed border authority to gather and provide a breakdown by age, gender and country of origin of all migrants detained at short-term detention facilities. In Hungary and Slovakia, this information is available only at the local branch offices/border duty stations.

Statistical information on the population in reception centres is not collected by the alien police, except in Slovakia and partially in Romania (by age and country of birth). As asylum institutions are not under the authority of BOs, the Border authorities in Poland and Hungary do not possess information on the number and profile of asylum seekers in the country once transferred to the next step of the administrative procedure.

Major sending countries of irregular migrants to Hungary, Poland, Slovakia, and Romania are: the Former Soviet Union (FSU) - Ukraine, the Russian Federation (Chechnya), Moldova, Georgia; Asia - Vietnam, China, India, Bangladesh, Pakistan, Afghanistan and Iraq; Africa - Somalia, Nigeria; others – Kosovo. Yet the main group of irregular migrants apprehended on the territories of the countries under review originate from neighbouring countries: Ukraine, Moldova and Russia to Poland and Slovakia; Serbia<sup>40</sup> and Ukraine to Hungary, Moldova to Romania. The citizens of these countries are also amongst the ones most often apprehended in illegal crossing of the border and consequently issued expulsion decisions from the territory<sup>41</sup>. Overall, if the figures of irregular apprehensions and international traffic are to be compared, irregular migrants form a very small proportion of the total border caseload at the new eastern Schengen border, used mainly for inter-regional travel.

## 2.2. Health related information in border areas and border detention centres

The data review, provided in this section presents the types and frequency of health events at the border and in the border region; types and cases of diseases recorded for migrant population; number and general information on the people who needed medical attention at the border; occupational health of staff; coordination between border police and regional health authorities.

Table 1. Comparison of data availability (2004-2006)

| Item   | Hungary | Poland | Slovakia | Romania                       |
|--|---------|--------|----------|-------------------------------|
| <b>Total number of irregular migrants (apprehended)</b>            | yes     | yes    | yes      | yes                           |
| Gender   | NA      | yes    | NA       | NA                            |
| Age  | NA      | yes    | NA       | NA                            |
| Country of Birth   | yes     | yes    | yes      | yes                           |
| <b>Border crossing total caseload (including regular migrants)</b> | yes     | yes    | yes      | yes                           |
| Gender   | NA      | NA     | NA       | NA                            |
| Age  | NA      | NA     | NA       | NA                            |
| Country of Birth   | NA      | yes    | NA       | yes                           |
| <b>Number of short-term detention facilities</b>                   | yes     | yes    | yes      | No short-term det. facilities |
| <b>Short-term detention facilities total caseload</b>              | NA      | yes    | yes      | No short-term det. facilities |
| Average length of stay   | NA      | yes    | NA       | No short-term det. facilities |
| Gender   | NA      | yes    | NA       | No short-term det. facilities |
| Age  | NA      | yes    | NA       | No short-term det. facilities |
| Country of Birth   | NA      | yes    | NA       | No short-term det. facilities |
| <b>Number of long-term detention centres</b>                       | yes     | yes    | yes      | yes                           |
| <b>Long-term detention centre total caseload</b>                   | yes     | NA     | yes      | yes                           |
| Average length of stay   | yes     | NA     | NA       | yes                           |
| Gender   | yes     | NA     | yes      | NA                            |
| Age  | yes     | NA     | NA       | yes                           |
| Country of Birth   | NA      | NA     | yes      | yes                           |
| <b>Number of reception centres</b>                                 | yes     | yes    | yes      | yes                           |
| <b>Number of asylum seekers</b>                                    | yes     | yes    | yes      | yes                           |
| Average length of stay   | NA      | NA     | yes      | NA                            |
| Gender   | NA      | NA     | yes      | NA                            |
| Age  | NA      | NA     | yes      | yes                           |
| Country of Birth   | NA      | NA     | yes      | yes                           |

Table 2 below lists the information requested from the Border authorities. It shows that being responsible for the safety/security of the borders and gathering general health related information on the critical health events in the border region is not part of the competences of the border police. In this regard, statistical data on the number and types of critical health events at the border is not collected centrally. However, the Polish BGs requested and received information from their local units, meaning that such information is available and can be collected centrally. However, it would require the involvement and cooperation of several institutions:

- > the hospital/emergency services,
- > border police/guards,
- > the administration of the detention and reception centres,
- > and the local public health/sanitary divisions.

Further to critical events at the border, information on the communicable and non-communicable diseases among irregular migrants was provided except in Poland, where as mentioned, BGs overtook the authority of detention facilities after 2006. Similar trends were observed in the region: a few registered cases of TB, HIV and Hepatitis. Non-communicable diseases were also reported, however no systematic and centralized data collection exists at DCs, RCs and BCPs.

The number/listing of allied organization was provided by all the countries, except Poland. A record of medical referrals is kept centrally only in Slovakia.

The number of staff in the border region changed drastically between 2004 and 2006, because of the restructuring for adhesion to the Schengen Area in 2007. Only in Poland the staff at the border increased by almost 50% between 2003 and 2006. In the same time the BGs organigram includes very few health professionals in detention centres. In case of emergency, an ambulance is called at the border premises and, if needed, the services of off-premise facilities are used.

Vaccinations of border staff depend on the risk assessment related to the job profile. The vaccinations most often provided were for Hepatitis A and B, tick-borne encephalitis and flu.

The available information on sick leave events and sick leave days is very scarce, and there is no comparative data on the sick leave events and number of sick leave days between the overall national and the police, the military and the health staff except in the case of Slovakia, where comparative figures were provided for the national average sick leave events/days and the police. No data on cross-border outbreaks or in-country outbreaks is collected by the border police and/or public health authorities, neither regarding the number of emergency services requests at the border.

### 2.3. National health profiles of sending countries as compared to the four receiving countries, i.e. Hungary, Poland, Slovakia, Romania

This section presents a brief snapshot of selected morbidity and mortality statistics of the four receiving countries, i.e. Hungary, Poland, Slovakia, Romania, as compared to these statistics in the sending countries. For each



Table 2. Comparison of data availability in the target countries (2004-2006)

| Item   | Hungary                 | Poland | Slovakia                            | Romania    |
|--|-------------------------|--------|-------------------------------------|------------|
| Number of critical events on the border  | NA                      | Yes    | NA                                  | NA         |
| Number of critical events in detention centres   | Yes                     | Yes    | Yes                                 | Yes        |
| Number of critical events in reception centres   | NA (only 2008)          | NA     | Yes                                 | NA         |
| Communicable diseases among irregular migrants (in DCs)  | Yes                     | NA     | Yes                                 | Yes        |
| Non-communicable diseases among irregular migrants   | Yes                     | NA     | Yes                                 | Yes        |
| Number needing medical attention   | Yes                     | NA     | Yes                                 | Yes        |
| Number with medical conditions (diagnosed)   | Yes                     | NA     | Yes                                 | Yes        |
| Number treated   | Yes                     | NA     | Yes                                 | Yes        |
| Number of referrals to local health facility   | Yes                     | NA     | Yes                                 | Yes        |
| Number of allied organizations (e.g. NGOs, foundations, associations, neighborhood watch)              | NA                      | NA     | Yes                                 | Yes        |
| Number of referrals to allied organizations (e.g. NGOs, foundations, associations, neighborhood watch) | NA                      | NA     | Yes                                 | NA         |
| Number of staff in border region   | Yes (only for 2006)     | Yes    | Yes                                 | Yes        |
| Number and type of health facilities   | NA                      | NA     | Yes                                 | NA         |
| Number and type of health staff in health facilities   | NA                      | NA     | Yes                                 | NA         |
| Vaccinations given to border health personnel  | NA                      | NA     | Yes                                 | NA         |
| Vaccinations given to border guards staff  | Yes                     | yes    | Yes                                 | Yes        |
| Sick leave events among border staff   | NA                      | yes    | NA                                  | Yes (2006) |
| Sick leave days among border staff   | NA                      | yes    | NA                                  | Yes (2006) |
| Sick leave events (comparison between national, policy, military and health staff)                     | Only national available | NA     | Yes for national average and police | NA         |
| Sick leave days (comparison between national, policy, military and health staff)                       | Only national available | NA     | Yes for national average and police | NA         |
| Number of staff in detention centres   | Yes                     | NA     | Yes                                 | Yes        |
| Sick leave events among detention centre staff   | NA                      | NA     | NA                                  | Yes        |
| Sick leave days among detention centre staff   | Yes                     | NA     | NA                                  | Yes        |
| Number of staff in reception centre staff  | NA                      | Yes    | Yes                                 | NA         |
| Sick leave events among reception centre staff   | NA                      | NA     | NA                                  | NA         |
| Sick leave days among reception centre staff   | NA                      | NA     | NA                                  | NA         |
| Number of cross border-region outbreaks  | NA                      | NA     | NA                                  | NA         |
| Number of outbreaks in country   | NA                      | NA     | NA                                  | NA         |
| Number of emergency service requests in border   | NA                      | NA     | NA                                  | NA         |

of the four countries, five major sending countries were selected based on the statistics obtained regarding the number of illegal border crossings to each.

Data on the selected health status indicators was obtained from the World Health Organization's publications on Global Burden of Disease<sup>42</sup> and the annual World Health Statistics report<sup>43</sup>.

As can be foreseen from the previous sections, majority of the individuals crossing borders to enter Hungary, Poland, Slovakia and Romania in 2004 - 2006 came from countries with varied health profiles, sometimes similar, but most often very different from that in the receiving countries.

In 2004-2006, the five major countries of origin for illegal crossings to Hungary were Ukraine, Moldova, Serbia, Romania and Turkey. Then the sending countries had a higher proportion of loss of life-years due to communicable diseases, as compared to Hungary. This is further reflected in the much larger prevalence and incidence of tuberculosis in the sending countries, as compared to Hungary. The data on HIV prevalence among adults also highlights this concern, in which case, whereas Hungary had an adult HIV prevalence of <100 (per 100000 population), this prevalence was 1036 and 815 (per 100000 population) respectively in two major sending countries - Ukraine and Moldova.

Similar is the situation for Poland, where the five major sending countries were Ukraine, Moldova, Russia, Vietnam and the Czech Republic. For most of the selected health status indicators, the Czech Republic and Poland seem to have a comparable health profile in the years 2004-2006. On the other hand, a review of infectious disease health indicators in Ukraine, Moldova, Russia and Vietnam again shows that the prevalence and incidence of Tuberculosis and HIV was much higher in these sending countries, as compared to Poland. For example, among adults, prevalence of HIV infection in Poland was 78 per 100 000 population in 2004. This was much higher at 1036/815/775/421 per 100 000 population respectively in Ukraine, Moldova, Russia and Vietnam. Parallel to the prevalence, the mortality burden caused by HIV infections in these four sending countries was also much greater than in Poland.

The five major sending countries of irregular migrants to Slovakia were Russia, Moldova, India, China and Georgia. Again, there were huge discrepancies in the health status indicators, especially for infectious diseases, between the sending countries and Slovakia. Morbidity and mortality caused by Tuberculosis and HIV/AIDS were much higher in Russia, Moldova and India where majority of the irregular migrants originated from.

### 3. Migrant health database

During the visits, the updated version of the forms – shorter and in a different format – was presented to health staff and re-discussed with project team to discuss the feasibility of the instrument, the legal aspects of implementing the system, health professional's willingness to use it on daily basis, and their overall impressions. The finalized MHD template consists of three forms:

1. **“Primary Screening Form”**: This form contains basic symptom-based information, ideally to be filled by border officials or, where available, local professional health staff at the first encounter of a migrant requiring emergency health assistance or at apprehension/detention of a migrant, serving as a reference to the next level/stage in terms of medical care (GP, emergency, detention/reception centre, readmission/deportation or departure/release).
2. **“Secondary Screening Form”**: This form contains more complex health information, including diagnosis, treatment, and laboratory tests, and is to be used by health staff from the detention/reception centre. It further functions as a “checklist” when conducting the medical examination and screening.
3. **“Summary Form”**: This form is to be completed by the health staff responsible for the overall care of the migrant and contains an overview of the medical diagnosis (with ICD coding), diagnostic tests, treatment, determination of fit to travel/fly, and information on the closure of the migrant’s file. Closure could result from deportation, granting of refugee status, release, resettlement, voluntary return to country of origin, death, or other (to be specified).

## 4. Border guard health and safety survey

Following the structure of the BGHSS KAP survey, this section provides a summary of major findings in Hungary, Poland and Slovakia.

**Characteristics of the BGHSS KAP Survey**

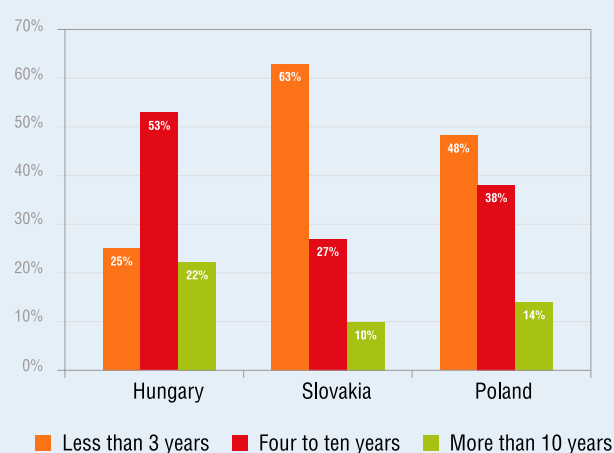
|   |   |
|---|---|
| <b>Period of visit</b>                  | 19 May – 25 July 2008   |
| <b>Method of registration</b>           | Semi-structured interviews  |
| <b>Sample</b>                           | 2356  |
| <b>Distribution of BGHSS by country</b> | Hungary > 1603<br>Poland > 389 (+47 <sup>44</sup> )<br>Slovakia > 364 |

### 4.1. Work conditions and perceived health risks

Starting the research findings’ overview from the work conditions and perceived health risks at BCPs and detention facilities, the data reveals that the majority of border officials in Slovakia have been recruited in the last three years (63%), almost half of the staff in Poland (48%) and one fifth in Hungary. The generation change is more visible in Poland and Slovakia where persons with more than 10 years of work experience as BOs are respectively

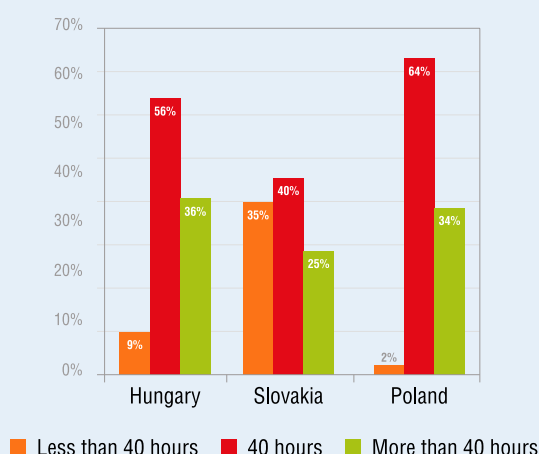
14% and 10%, while in Hungary one fifth of staff has worked for more than 10 years. (Graph 1) The majority of women in Slovakia and Poland were also recruited in the last three years in comparison to around one third in Hungary. Aside from this gender parity trend, the newly recruited staff is very young, being predominantly aged between 18 and 33.

**Graph 1. Number of years of work at present work site by country**

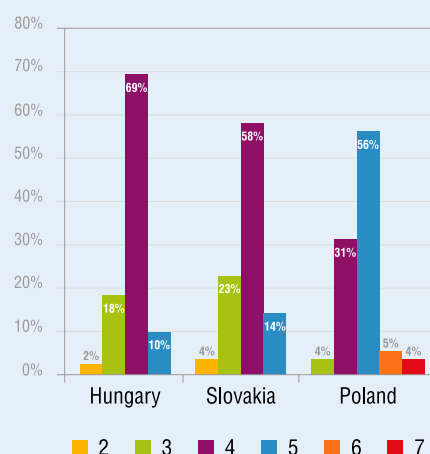


The majority of BOs work 40 hours a week – in Hungary, 56% of the respondents declare to have a 40-hour work week, while this percentage in Poland is 64% and in Slovakia – 40%. (Graphs 2, 3) More than forty hours per week is declared to be the working schedule for around one third of the employees in Hungary and Poland and one fifth of the staff in Slovakia. In terms of gender differences, only in Slovakia is there a significant disparity in the number of working hours between men and women: one third of women report to work more than 40 hours weekly in comparison to 24% of men. The majority of border officials in Hungary (69%) and Slovakia (58%) report working four days a week, while in Poland the working days for 58% of the respondents are five. More days a week (6 and 7 - 9%) are also declared in Poland.

**Graph 2. Number of hours per week usually worked (excluding lunch breaks and time spent travelling to work) by country**



**Graph 3. Number of days per week usually worked by country**



For the majority of respondents in Hungary (66%) and Slovakia (57%), the number of night shifts varies between six and seven, while 45% of Polish respondents state they don't have night shifts. Sixty-three percent of women in Poland declare they do not have night shifts at all in comparison to 10% in Hungary and 13% in Slovakia.

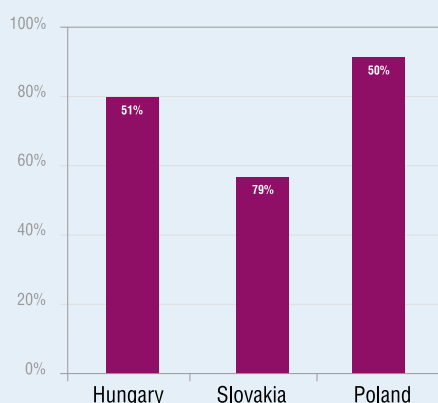
Resting facilities, bathing facilities and an employee association are available on all sites. Sport/recreation facilities are reported by only 30% of Polish staff; 37% of the Polish BOs also state that they do not have occupational health services easily available on their worksite.

Women tend to be more satisfied with the available conditions in Slovakia and Poland than in Hungary. The sport facilities receive significantly different answers from men and women only in Poland, where twice as many women than men are not satisfied with the possibilities for practicing sports. Moreover, BOs working at the green border in Slovakia and Poland are less satisfied than the ones working at BCPs and DCs with the availability and access to these services.

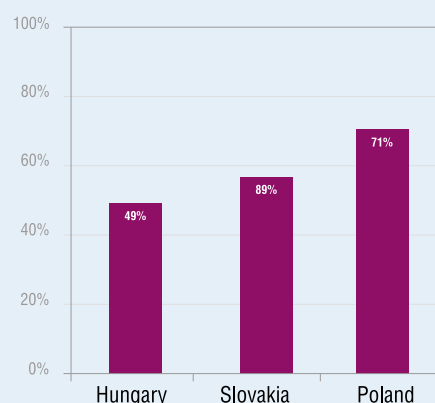
Regarding physical health hazards, BOs in the three countries face similar challenges. The majority complain of regular exposure to computers, TV, electronic screen work, draught, dust and dirt, and noise. Harsh weather and geographic conditions seem to be a bigger problem for the Slovakian border officials, while high room temperature, unpleasant smell, passive smoking and stuffy bad air are the subject of more complaints in Poland. Very rarely BOs are exposed to chemicals, pesticides, animals, human samples, dyes or potential carcinogens, radioisotopes or static electricity. On the other hand, they rather suffer from poor lighting, glare/reflection/exposure to ultraviolet light and the use of latex gloves. As for the gender differences observed in the three countries, in general, women tend to perceive of less risk their exposure to chemicals, pesticides, animals, radioisotopes and carcinogens, while they are more sensitive towards stuffy bad air, smell, variation in room temperatures, dust, dirt and noise.

The staff recall being vaccinated from Hepatitis A and B, influenza, TB and against ticks. However, only half of BOs in Poland and Hungary report possessing a record of vaccinations related to the job, while 79% of interviewees in Slovakia note they have. Similar is the situation regarding the monitoring of vaccinations by superiors or health professionals – 89% of the staff in Slovakia answer that their vaccinations are monitored against 49% in Hungary and 71% in Poland. (Graphs 4, 5)

**Graph 4. Possession of a record of vaccinations related to the job, by country**



**Graph 5. Superiors/Health professionals monitor vaccinations, by country**

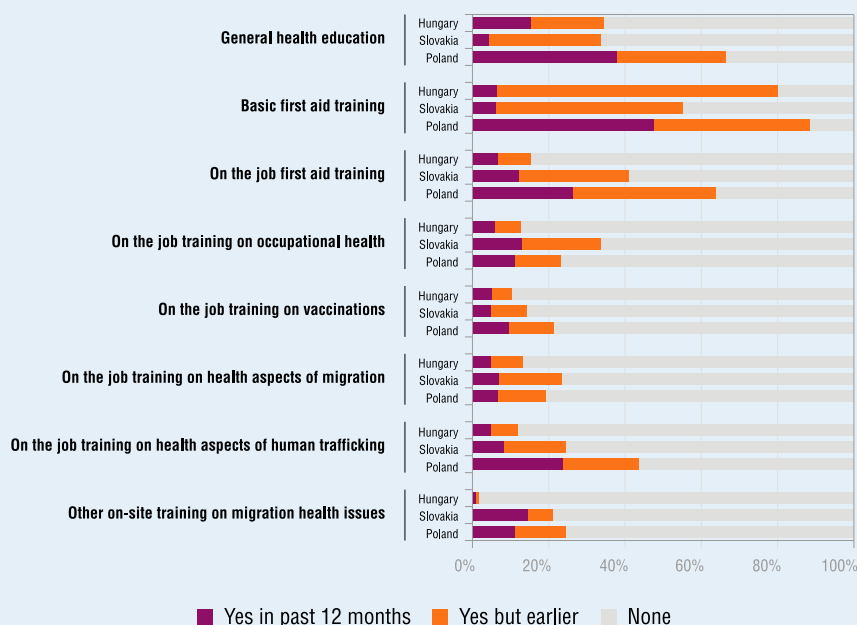


In addition to the physical health hazards, the KAP survey investigated the mental health hazards that BOs face in their daily work. In this respect, Slovakian border officials note less mental health stress at work compared to their colleagues in Poland and Hungary, where on average one fifth of the staff complained about monotonous and unpleasant tasks and verbal violence from travellers. The Polish respondents also add to this picture the irregular workload and lack of professional recognition. Discrimination linked to gender, age or personal attribute and unwanted sexual attention are reported as rather rare events, yet women report facing sexual discrimination or unwanted sexual attention at work more often than men. In terms of witnessing traumatic events at work: 38% of the Hungarian, 44% of the Polish and 16% of the Slovak respondents note that they have had at least one case in their work environment in the previous six months. BOs at the green border appear to be more exposed to traumatic events than at BCPs and DCs.

## 4.2. Health knowledge, attitudes and practice

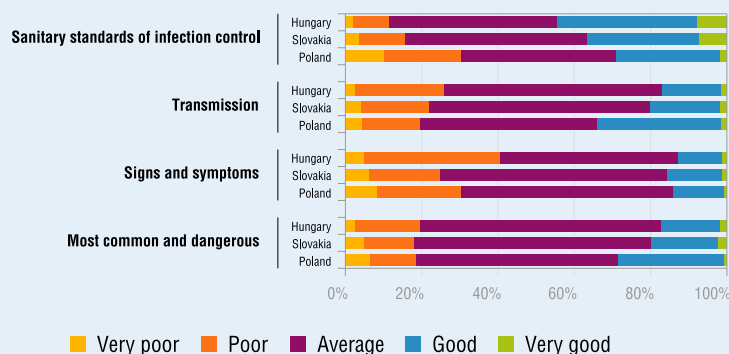
BOs have had basic first aid training (90% in Poland, 56% in Slovakia and 81% in Hungary) – mainly when undergoing driving lessons, as well as general health education (around one third reported such in Hungary and Slovakia and two thirds in Poland) and on-the-job first aid training (64% in Poland, 41% in Slovakia and 15% in Hungary). No specialized trainings on health aspects of migration and human trafficking, vaccination and/or occupational health are present in the training curricula for border guards. (Graph 6) More often women and staff at DCs report having had basic first aid training and professional first aid training. DCs staff report being better informed on vaccinations and occupational health as well.

**Graph 6. Health education during professional training in the previous 12 months or earlier, by activity and country**



Border officials assess their health literacy as average and do not feel confident in their knowledge of the most common infectious diseases signs and symptoms and modes of transmission (even though women assess their health literacy better than do men). At the same time, they assess the risk of contracting certain infectious diseases at the worksite, such as Bronchitis, Pneumonia, Diarrheal diseases, Tuberculosis, Meningitis, or Hepatitis, as high. In the same time, BOs appear confused when requested to connect different modes of transmissions with specific communicable diseases such as HIV/AIDS, Hepatitis A/B/C and Meningitis and often mix the modes of transmission, causing additional fears and stress.

**Graph 7. Self-assessment of personal knowledge and understanding of most common infectious diseases, by disease factor and country**



As regards the methods for self-protection, BOs report to follow the instructed measures for self-protection and usage of self-protective devices (from all the self-stated answers: 62% in Hungary, 92% in Slovakia and 84% in Poland) such as masks and gloves. Respondents take care of their personal hygiene (from all the self-stated answers 57% in Hungary, 28% in Slovakia and 32% in Poland) by washing the hands and using disinfectants though less people report following the immunization calendar and going for medical examinations. When dealing with a person suspected of carrying a contagious disease, BOs in Poland report phoning a doctor for advice, calling emergency services or using a standard health screening questionnaire to a much smaller extent than in Hungary and Slovakia, where the percentage of staff referring directly to health authorities is twice as high. A possible explanation for this difference is the organization of work in Poland, where the chief on duty decides and contacts the health authorities in case of emergencies.

Regarding the warning signs and symptoms that alert BOs to initiate a medical intervention, the interviewees self-declare these to be general signs and symptoms (Hungary - 48%, Slovakia - 64%, Poland - 60%), skin signs (Hungary - 48%, Slovakia - 56%, Poland - 60%) and respiratory/breathing conditions (43% in Hungary and Slovakia and 49% in Poland). Additional, rather medical conditions confirmed by all the respondents are jaundice, syncope, stupor, and skin rashes; however, BOs note that there are also a lot of other signs and symptoms which can be alarming in some cases such as nausea, excessive anxiety, or somnolence.

### 4.3. Case management of migrants

This section investigates the knowledge and practices of border officials in identifying and helping the migrant population. According to the findings on knowledge of key concepts, BOs seem to be generally well informed on the terminology used in migration with the exception of two concepts: assisted migration (correctly described by 42% in Hungary, 23% in Slovakia and 24% in Poland) and cultural orientation of migrants (2%, 1%, 12% respectively). The majority of Slovakian BOs appear less knowledgeable of migration terminology such as asylum seeker, irregular migration, displaced person, primary inspection, secondary inspection and trafficking in persons.

Border staff are required to intervene in critical events in their job performance; however, around one fourth of the respondents, and even less in Hungary, indicate that they have had such cases, which are mainly non-health related, non-violent events.

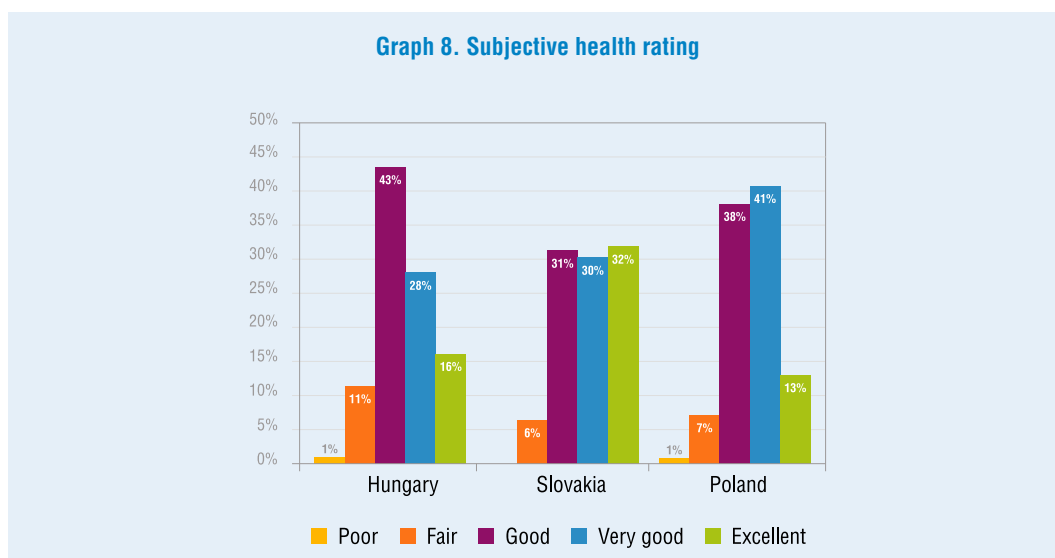
Information about organizations helping migrants is scarce. On the one hand, BOs do not have regular contact with such organizations and do not know them, but also NGOs and international agencies are not visible/ active in the border region by working mainly in the capitals of Hungary, Poland and Slovakia. The most known organizations on a country level appeared to be UNHCR, the Red Cross, Helsinki Committee, and IOM.

### 4.4. Subjective health and use of health services

According to respondents' self-assessment, their health is good to excellent – only some 12% in Hungary, 6% in Slovakia and 8% in Poland assess their health as poor. No difference in their personal assessment of



their current health as compared to the previous years is observed – more than 60% in the three countries state it is the same. (Graph 8)



In terms of health check-ups, border officials state that they have obligatory health screening once a year (90%). Seventy-five per cent of Hungarians, 88% of the Slovakian and 87% of the Polish interviewees have been at least once to the doctor in the past 12 months. Most respondents have had appointments with a GP, optician and/or dentist; a few have had other specialized health consultations with a therapist or visited the hospital. In terms of work-related accidents in the last 12 months, the staff reported accidents are the highest in Poland (7% of respondents had such in comparison to around 2% in Hungary and Slovakia).

#### 4.5. Education and training

In terms of education and training undertaken at the initiative of staff, Polish BOs have been the most active with 50% having had specialized training outside of work, in comparison to 21% in Hungary and 23% in Slovakia. Regarding on-the-job training, 80% of the Slovakian border officials report to have had such, while this percentage is 60% in Hungary and 52% in Poland. Most of the on-the-job training has been specialized (such as weapons or recognizing false document) or general (on new legal provisions). Very few report having had health-related training at work (none in Hungary, 8% in Slovakia and 3% in Poland).

In terms of language competences, the main foreign languages spoken by BOs in the three countries are Russian, English and German. BOs speak other languages besides the country's official language at home rather rarely (17% in Hungary, 44% in Slovakia and 85% in Poland report that they have done it at least once).

## 5. Border line health and social worker survey

Following the structure of the BLHSS KAP survey, this section provides a summary of major findings in Hungary, Poland and Slovakia. Overall 74 interviews were included in the final dataset with health professionals, from which 30 in Hungary and Poland<sup>45</sup> and 14 in Slovakia. (Table 3)

As elaborated in the methodology section of the report, the profile and number of interviews in the three countries differ according to duty station and specialization. In Hungary, the data covers mainly health professionals<sup>46</sup> working in hospitals; the majority of Polish respondents were interviewed in RCs; while in Slovakia, interviewees are from DCs and RCs. Most of respondents are nurses (44%), followed by medical doctors (23%) and social workers (22%). In Hungary, there are no social workers or psychologists in the group of respondents, while in Slovakia, no psychologists were interviewed. In Poland, there are no interviews with respondents working outside of DCs and RCs. The majority of respondents work in organizations, affiliated to the MoI or MoH, with the exception of Hungary, where the health staff interviewed works primarily in hospitals, affiliated to the MoH. (Table 4) The services provided by interviewees' organizations are primary care (out-patient) (78%), hospital care (42%), public health services (39%) and emergency services (35%).

### 5.1. Work conditions and service usage

#### A. Work conditions

Across the country samples, the findings show that, even within diverse organizations, the majority of respondents have similar daily work routine: 40-hour work week over 5 days (Graph 9 below), without weekend and night shifts. Part-time work among health and social worker staff is most common in Poland (36.7%) and Slovakia (21.4%).

**Graph 9. Number of hours per week usually worked (excluding lunch breaks and time spent travelling to work) by country**

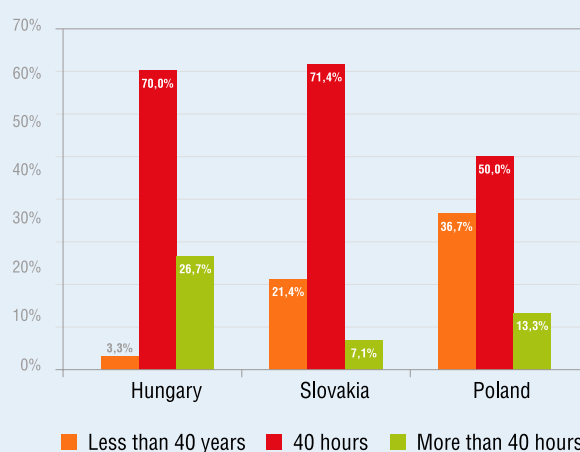


Table 3. Distribution of BLHSS by country

|  | Total | Hungary | Slovakia | Poland |
|--|-------|---------|----------|--------|
|  | n=74  | n=30    | n=14     | n=30   |
| Detention centres (long term)          | 18%   | 17%     | 14%      | 20%    |
| Detention centres (short term)         | 7%    | 0%      | 36%      | 0%     |
| Reception centres (for asylum seekers) | 42%   | 0%      | 50%      | 80%    |
| Hospital                               | 26%   | 63%     | 0%       | 0%     |
| Other health facility                  | 8%    | 20%     | 0%       | 0%     |
| Total                                  | 100%  | 100%    | 100%     | 100%   |

Table 4. Characteristics of the organization

|  | Total | Hungary | Slovakia | Poland |
|--|-------|---------|----------|--------|
|  | n=74  | n=30    | n=14     | n=30   |
| <b>Affiliation</b>   |       |         |          |        |
| Affiliated to Ministry of Interior   | 55%   | 23%     | 64%      | 83%    |
| Affiliated to Ministry of Health   | 43%   | 77%     | 29%      | 17%    |
| Private not-for-profit provider (e.g. humanitarian, charitable organization) | 1%    | 0%      | 7%       | 0%     |
| <b>Services provided</b>   |       |         |          |        |
| Primary care (out-patient)   | 78%   | 60%     | 85%      | 93%    |
| Secondary care (specialist out-patient)                                      | 21%   | 14%     | 15%      | 32%    |
| Hospital care (inpatient, long term)   | 42%   | 62%     | 15%      | 33%    |
| Emergency services (medical)   | 35%   | 38%     | 39%      | 29%    |
| Public health services (infectology/ epidemiology)                           | 39%   | 14%     | 46%      | 65%    |
| On-site health services at border checkpoint                                 | 0%    | 0%      | 0%       | 0%     |
| On-site health services at long-term detention centre                        | 23%   | 14%     | 31%      | 30%    |
| On-site health services at detention centre (short-term)                     | 9%    | 0%      | 43%      | 0%     |
| On-site health services at reception centres                                 | 25%   | 7%      | 57%      | 29%    |
| Social services (social work)  | 19%   | 3%      | 0%       | 50%    |
| <b>Reports directly to authorities at</b>                                    |       |         |          |        |
| National level (Ministry, National HQ)                                       | 60%   | 18%     | 86%      | 89%    |
| Regional level   | 29%   | 64%     | 0%       | 7%     |
| Local level  | 4%    | 11%     | 0%       | 0%     |
| Independent  | 4%    | 0%      | 14%      | 4%     |
| Other  | 3%    | 7%      | 0%       | 0%     |

### B. Services usage

The main clinical diagnostic technologies and procedures reported to be routinely available for migrants on-site or through referral are chest X-ray in TB diagnosis (76%), general blood test (82%), and general urine test (84%). Tests for viral hepatitis (e.g. HBsAG) (62%), infectological counselling (65%), consultation with a specialist on internal diseases and /or cardiology (63%), and psychiatric screening and counselling (63%) are also reported to be available.

The most frequent migrants users of medical services in the previous 12 months, according to the country of origin were reported to be Romanians (27% of all answers), Pakistani (22% of all answers), Russians (20% of all answers) and Ukrainians (18% of all answers); and in smaller extent individuals coming from India, Moldova, Croatia, Afghanistan, Serbia, China, Belarus, Georgia, Somalia, Iraq, Kosovo, Lebanon, Vietnam, and Nigeria. Main vulnerable groups served from health professionals were reported to be pregnant women (60%), minors (50%), unaccompanied minors (20%), and elderly (35%) distributed along the categories of asylum seekers, refugees, UAMs and smuggled migrants. No cases of trafficked persons for sexual and/or labour exploitation were known.

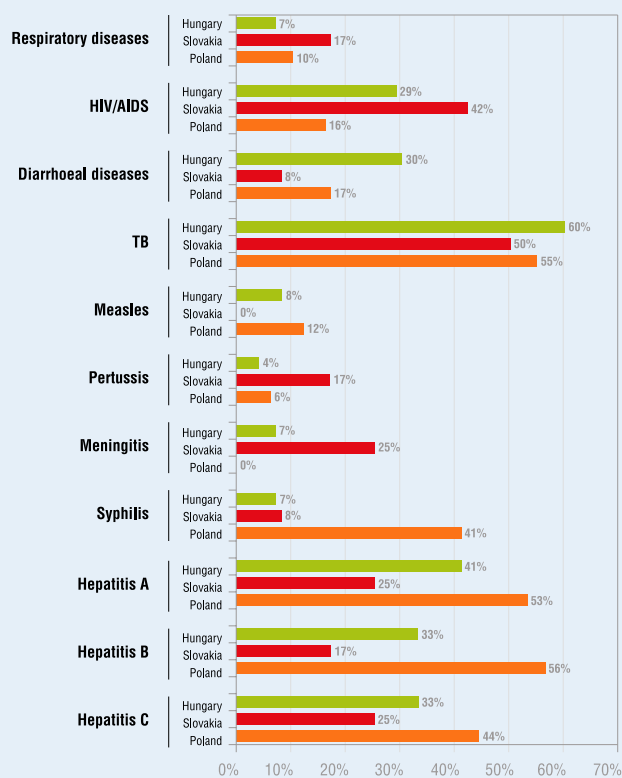
## 5.2. Public health safety of the resident population

Interviewees generally agree that the overall rates of infectious diseases in the border region correspond to their share of the total population. Major infectious diseases being of risk to the resident population as a result of cross-border migration are considered to be TB and Hepatitis A/B/C. In Slovakia, the respondents also rate as high risk HIV/AIDS and meningitis, in Poland – syphilis, and in Hungary - diarrheal diseases. (Graph 10)

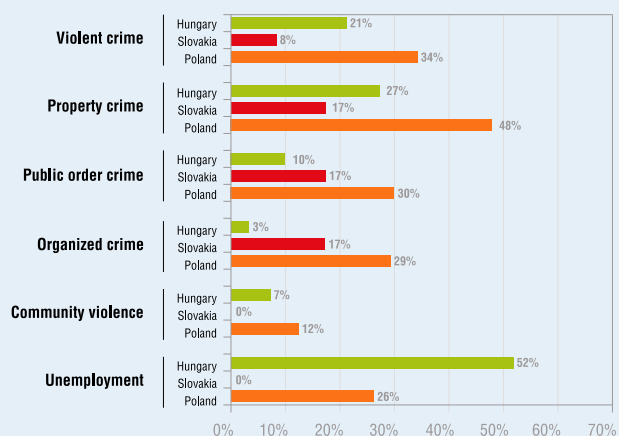
When investigating the perception and fears of migration as potentially threatening the physical and mental health of resident population, the respondents appear rather skeptic. Except for unemployment rates in Hungary (52% state that migration is a risk factor) and property crime in Poland (48%), migration is not associated with higher rates of violent crime, organized crime, public order crime and/or community violence at the border. (Graph 11)



**Graph 10. Infectious diseases considered to represent the most risk to the resident population as a result of cross-border migration<sup>47</sup>**



**Graph 11. Perception of migration-related risk factors (i.e. increase in rates) as threatening to the physical and mental health of the resident population in the long run<sup>48</sup>**



Diverse public health and security measures<sup>49</sup> concerning migrants are planned or implemented in the border region according to the health professionals that participated in the study, ranging from screening programs to education and promotion activities. However, the variety of answers, i.e. “none considered”, “implementation in progress” and “have been implemented” reveal lack of knowledge and clarity about the actual measures implemented and/or planned.

### 5.3. Services and assistance for at-risk groups

The perceived risk of trafficking in persons is assessed to be low to medium. The risk level of organized crime is perceived the same as for non-border zone populations (51%) or higher (43%). The majority of respondents have not worked with VoTs. In terms of diagnostic tests, procedures and specialists’ counselling services available to VoTs, the answers vary: in Slovakia and Poland, the majority of respondents note that they offer a variety of services to VoTs, while in Hungary these services are not routinely used for screening of migrants.

When investigating whether the respondents have worked with unaccompanied minors, Slovakian respondents confirm to have worked with UAMs, while few Hungarian and Polish health professionals report to have had such cases or have heard of referrals to their organization in the last 12 months.

With regard to cooperation with humanitarian organizations, most respondents in Slovakia and Poland note that they have had contacts with organizations helping refugees/asylum seekers, UAMs, VoTs and regular migrants in general. The Hungarian respondents do not have such contacts. The services known to be offered to migrants are legal services (92%), services associated with job finding, family and child care, social work services, vocational training/education, and psychological counselling (65%).

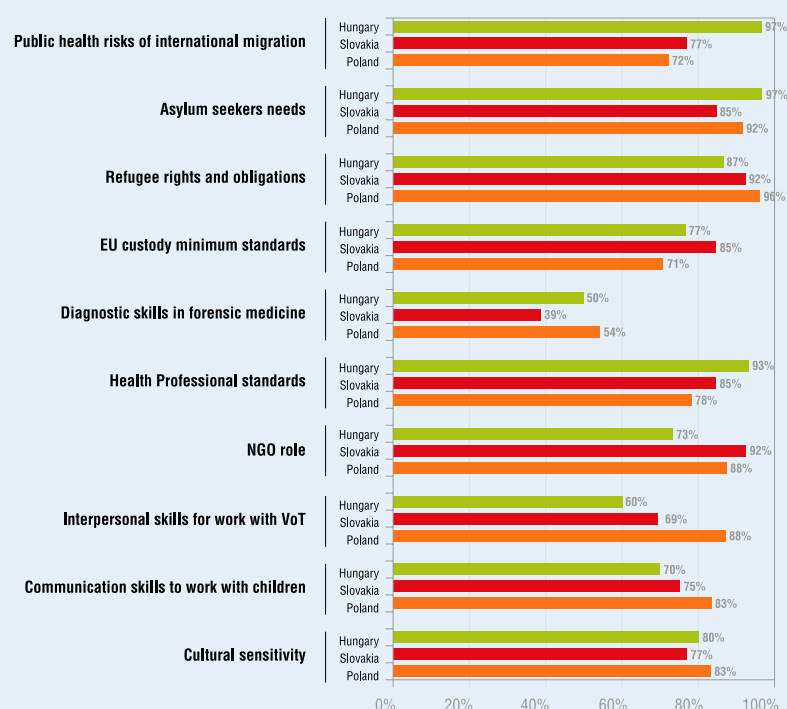
### 5.4. Training needs and language competences

Few respondents have had training on migration health issues in the previous 12 months or earlier. Only the Polish health professionals reported courses on legal aspects of migration and health (52% of staff), health safety alongside the external borders (33%) and health issues for trafficked or smuggled migrants (30%).

In addition, they were the largest group to report taking courses on their own initiative (88% have had such). As regards language competences, most respondents have studied Russian as their first foreign language, followed by English and/or German.

A proposed number of domains of professional knowledge and need for advancement in the work and overall professional competence were highly valued such as specific health needs, rights and obligations of refugees and asylum seekers, minimum standards and expected role of health professionals, role of humanitarian organizations, interpersonal skills and cultural competence. (Graph 12)

**Graph 12. Importance rating of domains of professional knowledge for advancement in the work and overall professional competence<sup>50</sup>**



## 6. Border checkpoint and detention/reception centres checklists

During the first phase of data collection, 31 land border checkpoints were surveyed with checklists: 18 in Hungary at the borders with Ukraine, Serbia, Romania<sup>51</sup>; 7 in Poland at the borders with oblast Kaliningrad (Russia), Ukraine and Belarus; and 6 in Slovakia at the border with Ukraine. The sites<sup>52</sup> included three green border sections, checkpoints for different modes of vehicle traffic for cars/trains/cargo, and pedestrians, and varying border caseload (including sites with high and low border traffic). (Table 5)

Border regions are diverse in terms of geographical conditions and distance from the closest town/village, natural barriers to irregular migration (e.g. rivers or mountainous landscape), and connections to highways and main national/international roads. One branch office/duty station supervises one or multiple BCP(s), being land, railway or pedestrian, and their respective green border areas. The annual regular and irregular caseload varies between border sections, and depends on the conditions in the border region, size/capacity of individual BCPs, available technical equipment, and fluctuations in routes for irregular migration; thus, neighbouring sectors can experience different flows of regular and irregular migrants and critical events. One shift includes between 10 and 50 staff,

depending on the size of the BCP and respective number of lines of entry and exit; the total number of employees is between 100 and 300 persons at the largest BCPs.

**Table 5. Distribution of BCP checklists by country**

| Hungary                       | Poland                        | Slovakia                                   |
|-------------------------------|-------------------------------|--|
| Zahony (Ukraine)              | Bezledy (Russia)              | Podhorod (green border) (Ukraine)          |
| Vallaj (Romania)              | Dorohusk (Ukraine)            | Ubla (Ukraine)                             |
| Szeged – Tiszasziget (Serbia) | Hrebenne (Ukraine)            | Velke Slemence (Ukraine)                   |
| Szeged – Roszke (Serbia)      | Korczowa (Ukraine)            | Matovske Vojkovce (green border) (Ukraine) |
| Nyirabrany (Romania)          | Kroscienko (Ukraine)          | Vysne Nemecke (Ukraine)                    |
| Tiszabecs (Ukraine)           | Kuznica Bialostocka (Belarus) | Zboj (green border) (Ukraine)              |
| Battonya (Romania)            | Slawatycze (Belarus)          |  |
| Beregsurany (Ukraine)         |                               |  |
| Biharkeresztes (Romania)      |                               |  |
| Csengersima (Romania)         |                               |  |
| Gyula (Romania)               |                               |  |
| Kelebia (Serbia)              |                               |  |
| Kiszombor (Romania)           |                               |  |
| Letavertes (Romania)          |                               |  |
| Mehkerek (Romania)            |                               |  |
| Nagylak (Romania)             |                               |  |
| Barabas (Ukraine)             |                               |  |
| Lonya (Ukraine)               |                               |  |

## 6.1. Health resources of BCPs

BCPs in Hungary, Poland, and Slovakia do not have health care facilities and health care staff either at checkpoints or in the branch offices. As explained previously, in case of health-related issues at the border (green border or BCP), the emergency services and/or the local GP is called. In Hungary this is the local GP, in Poland - the border stations for sanitary and epidemiological control and/or the GP, and in Slovakia the emergency services.

All the BCPs in Poland and Slovakia and most of the border facilities in Hungary confirm having regulations for handling health-related emergencies. At the time of visit, employees were not familiar with the IHR 2005 or their role to coordinate with public health authorities. Protocol or procedures in case of outbreaks (e.g. SARS or pandemic influenza procedures) were reported to exist only in Poland and in one BCP in Hungary. The possibility to quarantine and observe persons displaying symptoms of infectious disease in separate rooms on site at the border was recorded in the majority of Polish and Slovakian sites, however missing in Hungary. The physical distance of the checkpoints from different health care facilities in the border region varies but overall the findings suggest that the sites are well served in need of urgent health care.



## 6.2. General hygiene conditions at BCPs

A series of questions regarding the hygiene and cleaning regulations on-site were asked to Chief Commanders or delegated staff.

All visited sites in Poland and Slovakia claim to conduct scheduled hygiene inspections, whereas only half of the Hungarian facilities report to have such practice. However, the information on the frequency is not very precise in any of the countries and consistent between sites, which suggest that there are no centralized and standardized hygiene inspections. All sites report having cleaning regulations but concrete documents were not provided. Cleaning staff was also reported, except in Slovakia, where an external company is contracted for the cleaning services. The premises are cleaned daily/several times a day. The information on pest control is unclear and difficult to extract – apparently pest control is neither performed, not controlled for centrally.

The standard personal protection measures used by BOs are rubber gloves and protective masks. As far as regulation/training regarding their usage is concerned, it appears that no such training is organized in the majority of sites in Hungary, while the majority of respondents in Poland and Slovakia state they have had training on personal protection. Similar is the situation with the training on personal hygiene, half of the sites report to have had such training, amongst which all the Polish sites, one third of the Slovakian and 44% of the Hungarian. Access to disinfectants for personal use was confirmed in the majority of sites visited in Hungary and Poland, described mainly as bleach and commercially available cleaning materials. They are easily accessible in one third of the places from the facility storage room. Training/regulations regarding the usage of disinfectant substances were confirmed in all Polish sites and one third of the Hungarian BCPs, while in Slovakia the BP is not dealing with cleaning. Training on infection control and prevention was not held, according to the majority of respondents.

Regarding sewage connections, 61% of the sites report to have a local sewage system against centrally connected one, amongst which all the sites in Slovakia. Only one site in Hungary collects the waste in container. Potable water and hot running water are secured and running in the majority of BCPs visited. Usually the lavatories are supplied with liquid soap (bar soap in Hungary and Slovakia), toilet paper and hand dryers, except in Hungary where approximately half of the sites report to have a hand dryer and cloth towels. Paper towels are not reported as common in Hungary and Slovakia, neither are hands-free hand-wash stations. All the sites report separate public lavatories with functional locks for men and women and cleaning of the public lavatories daily or several times a day. However, these descriptions refer to the staff lavatories, as lavatories for travellers are missing regular hygiene supplies.

## 6.3. Hygiene conditions in on-site detention facilities

From the thirty-one BCPs visited, nine BCPs do not have on-site detention facilities and thus direct detained migrants to the nearby police detention facilities. Only twenty three sites describe the hygiene conditions in their short-term detention facilities. The average length of short-term detention is approximately 9 hours in Hungary and Slovakia and 15 hours in Poland. The average number of detainees held in the facility at any point in 2007



was the highest in Slovakia: 18 persons. The Slovakian checkpoints seem to provide larger cells as the minimum area and elbow-room ensured for detainees was reported to be on average 16 m<sup>2</sup>.

The majority of short-term facilities provide access to hot running water and daily showers (in the on-site detention facility at the branch office in the case of Hungary<sup>53</sup>), constant electricity supply in cells (except in Slovakia), ventilation (windows), and regular cleaning of cells (daily/several times a day). Separate lavatories and showers for men and women, hands-free hand wash stations and functional locks were not available in a number of sites, primarily in Hungary and Poland. The cleaning staff disinfects the premises after removal of detainees.

In BCPs with on-site detention facilities, migrants receive a medical examination upon explicit request or if the need is identified by border officials (i.e. in case of clear visible signs). No mandatory screening procedure takes place at the checkpoints.

The main factors reported in separating detainees are health, gender, age, and family status (in order). Nationality and religion are relevant factors in the majority of sites visited in Poland and Slovakia, and less frequently considered in Hungary.

While in detention, apprehended migrants are provided with a plastic dinner set, mug, blanket, bed, soap and toilet paper at most BCPs. In Hungary there are wooden plank beds in place; towels are only available in the toilets. Duvet covers and sheets are provided only in Poland and Slovakia. None of the countries visited provide night clothes, slippers, extra clothes, and toothpaste or toothbrush. Tampons/sanitary napkins are provided in all premises in Slovakia.

The routine for the period of short-term detention at the BCPs consists of time for washing and time for meals. No open-air walks and time for medical examinations are provided in short-term detention facilities in Hungary and Poland. Time for medical examinations is neither included in the routine in Slovakia. In the majority of cases, detainees eat in their cells. The meals served are diverse in origin and preparation: by catering company, by the staff in the on-premises kitchen or cold dishes bought from the local grocery store. No copies of any food preparation regulations were provided during the visits. The cleaning of sheets is performed by different actors in the three countries: from none (no sheets and towels provided) to external laundry services or the BO local division.

#### 6.4. Hygiene conditions for staff

A final part of the checklist questioned the hygiene conditions for staff. In all sites, the detention areas are separated from the staff's premises. The staff have separate lavatories, and generally have separate cutlery and separately cleaned sheets and towels. For a large majority of sites, no separate room for drying clothes was reported to be available on site, neither the possibility to use washing machines for washing the uniforms. The possibility to wash and dry uniforms was identified at only four Hungarian checkpoints. The social area for staff consists of kitchen with basic kitchen supplies: a table, chairs, refrigerator, and a microwave to warm up and prepare basic meals and/or coffee. According to reports, it is cleaned on a daily basis.

## 7. Field visits

The project team field visits took place in Hungary, Poland and Slovakia from 26 January to 26 February 2009. These visits built on the first phase of assessment activities carried out by the Project<sup>54</sup> and covered 21 sites (14 checkpoints, 6 detention centres, and 1 closed reception centre): 10 sites in Hungary, 7 sites in Poland, and 4 sites (plus the BO regional HQ Centre) in Slovakia. More than 21 meetings with local resource persons from the border police and public health authorities, health professionals and migrants were organized and detailed feedback was collected and reflected in the report.

The project team members and observers included representatives from the following institutions/ organizations: IOM Brussels and local IOM country coordinators, IOM Kiev, Migration Health Department, University of Pécs (Hungary), Executive Agency for Health and Consumers (EAHC), representatives from national governments of the country visited, representatives from project collaborating partners: ECDC; Frontex, Training and Rapid Border Intervention Team (RABIT) Units; experts in the IHR as proposed by the WHO EURO, Centre of Migration Research, Warsaw University (Poland), University of Trnava (Slovakia), Federal Agency for the Reception of Asylum Seekers (Fedasil) (Belgium).

In the following sub-sections, a brief overview of the major issues regarding the occupational health of staff (both physical and mental); migrant health (both physical and mental); physical conditions of the site visited; public health in host communities; and good practices to share is provided.

### 7.1. Occupational health of staff

With regards to the occupational health of staff, the findings from the field visits to the three countries confirm regular medical control and physical check-ups of the border police/guards. No major outbreaks amongst staff were reported. BOs undergo regular, psychological check-ups and can access a psychologist on-site, though such self-initiated visits are rare: the organisational and community culture, for one, not being conducive to such mental health seeking behaviour. The range and type of services provided were further judged by the project team as not fully adequate, where both prevention and promotion activities mostly lacking. At the same time, BOs reported facing significant stress in their daily job due to factors ranging from aggressive travellers' behaviour to physical threats and traumatizing events while patrolling the green border. BOs identify the need for more psychological support as essential and yet insufficient.

### 7.2. Migrant health

The overall findings reveal similar trends in the three countries. Not only is the migrant profile similar, but so are the major difficulties that migrants face in receiving adequate and appropriate health care services, in particular while in detention. Migrants undergo some basic, not standardized, medical screening in DCs/RCs upon admission. No major health conditions or infectious diseases amongst migrants were reported to the project team,

except rare cases of TB, Hepatitis and dermatological problems and/or allergies. Statistics on migrants' health were not available and only Slovakia collects such centrally.

It was observed during the visits that limited medical staff availability and communication problems burden the access to appropriate health care. This is even more pertinent in the case of mental health care. Often, psychologists available in DCs are responsible for both staff and migrants, generating problems such as conflict of interest, different training requirements, or competing demands on the psychologist's schedule. Staff has insufficient time to work with migrants, does not necessarily know foreign languages (with professional translation services limited to legal proceedings) and/or has limited knowledge about the cultural particularities of their foreign patients, who might suffer from a wide range of mental health conditions, ranging from confusion to PTSD.

### 7.3. Physical conditions of the sites visited

Although all visited sites at the external Schengen border are new or recently renovated, they exhibit some organizational and infrastructural deficiencies. In all three countries, the sanitary facilities for the general public at BCPs were often in poor condition; some BCPs were lacking medical/isolation rooms, others had the isolation and interrogation/holding rooms in proximity to the staff social or eating areas. DCs appeared clean and new, yet had an intense prison-like atmosphere and lacked sport and recreation possibilities in most cases.

### 7.4. Public health in host communities

No major epidemiological threats in the border region were reported to the project team, except one outbreak of measles, though actual comparative data from border regions and national figures was not made available. Coordination gaps between the border police/guards and the local public health services and in some cases with colleagues across the border resulted in a lack of or insufficiently reliable information on the cross-border epidemiological situation and raised the question of how the border region authorities will react in a crisis situation or in case of emergency.







## Good practices to share

### POLAND

During the visit in Poland, the project team observed the following good practices in DCs and BCPs:

#### For staff:

- > The system of rotation, i.e. regular shifts in some units between BCPs (land, railway, and green border) and DCs of staff is an effective mental and physical health measure, preventing adverse effects of monotonous and/or strenuous tasks that border guards experience in their daily work routine;
- > Rehabilitation recreation system available for staff;
- > Initiatives in Białystok DC: sports competitions, psychologist does outreach at BCP, and anonymous assessment questionnaires on work conditions for staff;
- > Cooperation with the Jagiellonian University in Krakow in development of training programs on communication in a multicultural environment;
- > In Warmińsko-Mazurski Unit, the BGs have initiated collaboration with an NGO on multicultural training;
- > Collaboration with La Strada Foundation on providing training to BGs in identification of VoTs.
- > Procedure for identification of infectious diseases at Przemyśl - highly valued by the provincial health inspectorate.

#### For migrants:

- > Availability of prayer room, own kitchen for preparing meals, library and sport rooms (for playing table tennis) in DCs;
- > Employment of civilian professionals in some detention centres such as the librarian in Przemyśl DC.<sup>55</sup>

#### For border communities:

- > Bilateral cooperation and exchange of information on the epidemiological situation between the Polish and the Ukrainian and Belorussian authorities;
- > At Białystok after the SARS outbreak, an operational plan was developed for emergency preparedness and an agreement with Chief Sanitary Inspectorate describing respective competencies and how to act in case of outbreak;
- > Crisis management group – partnership between Podlaski Border Guard's unit and the Sanitary Inspectorate, which monitors health threats in the border region. The group developed an action plan for crisis situations, which lists procedures to be observed in case of an epidemic or other health threats; different authorities' competences to act; the rules for exchange of information; phone numbers of doctors/institutions in the region and hospitals. In 2005, the Sanitary Inspectorate provided training to 350 BGs in this unit on how to handle possible cases of avian influenza in order to protect themselves and the public health.

#### Photographs from field visits: Poland (26 January – 6 February 2009)

- ① Detention Centre – Medical Room   ② Checkpoint   ③ Detention Centre – Playground   ④ Checkpoint  
⑤ Checkpoint – Tour of Facilities   ⑥ Checkpoint – Discussion with Border Guard Staff





1



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2



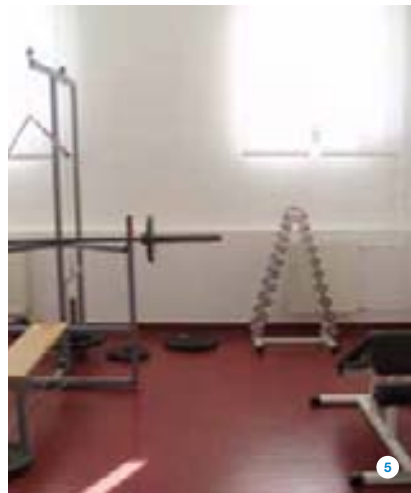
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## HUNGARY

### For staff:

- > Training on protection against infectious diseases (2x2 hours) by the Szeged/Roszké Border Police Branch Office: topics include how to identify symptoms of infectious diseases and primary measures to be taken in case of suspicion.

### For migrants:

- > National and international organizations providing direct services to migrants, including psychological counselling hours in Nyirbator DC by “Kordéllai” Foundation;
- > Families with children are not held in detention;

### For border communities:

- > Excellent 24-hour emergency and GP group practice/ health centre funded by the community at Mako with well-equipped ambulances collaborating with BCPs;
- > Centrally prepared and distributed action plan for extraordinary events (e.g. explosion, fire, bio-terrorism activity, chemical hazards and infectious diseases) is available in every BCP, which includes response plans for different hazards, including infectious diseases and outbreaks (first task is to call the GP). However, these plans should be discussed with public health (PH) authority, exercised, and updated yearly.

### Photographs from field visits: Hungary (8-20 February 2009)

- ① Checkpoint – Staff Kitchen   ② Detention Centre – Outdoor Area   ③ Detention Centre – TV Room
- ④ Detention Centre – Reading Room   ⑤ Checkpoint – Staff Gym   ⑥ Checkpoint – Medical Room
- ⑦ Checkpoint   ⑧ Detention Centre Cell   ⑨ Detention Centre – Phone for Detainees



## SLOVAKIA

### For staff:

- > Possibility to wash staff uniforms at work;
- > Cooperation with UNHCR on multicultural training (at Sobrance HQ);
- > The health department of the MoI developed a booklet advising protection measures to border police in 2001 (although the material requires an update).

### For migrants:

- > The psychological counselling practice at Sečovce DC and engagement of psychologist is a good initiative, similar is the case with the involvement of the social worker from Goodwill Foundation in Humenné RC;
- > Hands - free sanitary facilities (toilets, sinks and showers) in Humenné RC;
- > Living conditions in RC: decoration, library, freedom of movement in the campus of the facility;
- > Centralized data collection by the health department at MoI on diseases in RC/DCs.

### For border communities:

- > Exchange of information with the Ukrainian authorities on the epidemiological situation;
- > Communication of health status of migrants between the detention centres and the central authorities (Ministry of Interior) – health statistics are maintained and available;
- > The doctor from Sečovce DC organizes regular meetings with other doctors in the region to share experiences (continuous training). Additionally, he meets with the staff regularly to discuss possible cases of diseases.

### Photographs from field visits: Slovakia (22 - 26 February 2009)

- ① Detention Centre – Holding Cell   ② Detention Centre – Family Room   ③ Reception Centre - Library  
④ Checkpoint – Holding Cell (Camera)   ⑤ Detention Centre – Playground   ⑥ Detention Centre – Medical Room  
⑦ Workshop with Local Stakeholders   ⑧ Workshop with Local Stakeholders





## Summary and Discussion | 4





In this section, a brief discussion of the major findings of the situational analysis report will be presented for the three areas of interest as follow: 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 in the border regions.

## 1. Migrant health

In order to better understand the magnitude and nature of migration-related public health hazards in the target border regions, the discussion starts with the profiling of irregular and regular migrants (e.g. travellers) coming to the Eastern Schengen land borders of Poland, Hungary and Slovakia.

The profile of irregular migrants in the three countries, with small variations, is similar: mainly individuals from the Former Soviet Union, Former Yugoslavia (especially in Hungary) and major sending countries in Asia (Vietnam, China, India, Bangladesh, Pakistan, and Afghanistan). The majority of migrants irregularly crossing at the Eastern border originate from the neighbouring countries and are generally using Poland, Hungary and Slovakia as transit countries to their final destination further west. The available statistics suggest that most irregular migrants are young men, although the number of women and children is increasing steadily. Overall, the number of irregular migrants represents a very small proportion of the total border traffic, which is predominantly based on inter-regional travel. The main regular travellers at the Eastern Schengen border are citizens from the neighbouring countries (Russia, Ukraine, Belarus, Germany, Moldova, and Lithuania) and a significant amount from the border region, mainly crossing the border with labour migration, commercial and/or smuggling of goods (cigarettes and/or alcohol) purposes. Nevertheless closer geographical proximity, Russia, Ukraine, Belarus, Moldova, and Georgia suffer from higher morbidity and mortality rates caused by Tuberculosis and HIV/AIDS in comparison to Poland, Slovakia and Hungary.

During the assessment phase, issues related to the health of irregular migrants and factors in their vulnerability were given particular attention. Main topics addressed are access to health care services, the quality of health care services and state of health. Regular migrants crossing the border have limited contacts with border authorities and their health is primarily of concern in emergency situations and outbreak preparedness. These issues will be addressed in the final section of the discussion.

### 1.1. Access to health care

> At border checkpoints, migrants receive medical care from general practitioners or emergency services upon request and/or if border guards/police assesses it necessary. The physician generally decides on-

site whether further referral to a hospital is needed, depending on the conditions of the patient. In case of accident at the green border, BOs are supposed to provide first aid if the person cannot be transported to health facility.

- > Upon admission to detention centre, irregular migrants undergo basic, non-standardized medical screening. Limited medical staff availability<sup>56</sup> and communication problems burden the access to appropriate health care. Prenatal care is insufficient and few pregnant women are informed of their rights to have regular consultations during pregnancy. Specialized health care services are similarly not easily accessible. Usually, specialized services are at some distance from the premises of the centres, and officials have to escort the migrants and guard them during the visit. This represents an additional burden to DC staff's workload and impedes the access to specialized health care.
- > According to surveyed health professionals, migrants in detention centres have access to the main clinical diagnostic technologies and procedures routinely available on-site or through referral, such as chest X-ray in TB diagnosis and general and urine tests. Other tests reported as available are for viral hepatitis (e.g. HBsAG), infectological counselling, and consultation with specialists on internal diseases and/or cardiology, and psychiatric screening and counselling. During interviews, migrants did not report any consultations with specialists except the basic medical exam and general blood and urine tests. The question remains how often migrants are referred for such testing and treatments as relevant statistics were neither available at the level of individual detention centres, nor collected centrally and points out to the need of implementing a centralized migrant health template, where the actual number and referrals would be reflected. Slovakia is an exception in collecting centralized data on certain physical health conditions, hospitalizations and situations of concern (e.g. hunger strikes, alcohol/drug abuse and self-harm).
- > No particular evidence of mental health assessment as part of the general health screening of detainees was noted. Limited or lack of access to psychological assistance and/or preventive mental health services and mental health counselling session was observed in all the countries visited. In fact, problematic cases in DCs are usually detected by staff, not because they have followed specialized training, but because of their work experience and compassionate attitude, attention which comes sometimes with serious delay and should not be relied upon.

## 1.2. Quality of health care

- > Health care provided at BCPs and on-site detention facilities can be either first-aid/ emergency care or PHC. Border officials have some first aid training, but this is generally at a very basic level and not refreshed regularly. Although the cases of need to provide first aid at the border (BCPs or green border) are reported to be few (statistics are not available/kept), BOs do reported having to intervene and provide first aid. They expressed anxiety about their actual preparedness to provide such help. No fatalities were further reported in this respect during meetings; however, a story of a colleague who saved the life of a baby was recalled by different BO units in Hungary.



- > In respect to the emergency services, the only problem potentially could be the average time for arrival of the ambulance to the border, ranging from 5 minutes to 30 minutes in different checkpoints and countries. The lack of data on the number of times GPs and/ or the ambulance is called and on the outcome and continuity of health care (at the hospital and further in DC/RC) makes it difficult to evaluate the readiness to actually provide health care and its quality at the border despite knowing the available procedure in practice.
- > Even though basic medical examination is performed upon entry to detention centre, the quality of the health care is uncertain, and again difficult to evidence and assess due to lack of actual data, on account of: financial constraints and insufficient medical staff to work in DCs; lack of standardized screening and data collection procedure; communication barriers and issues of miscommunication, and preconceptions and cultural gaps. Medical staff have insufficient time to work with migrants and do not necessarily know foreign languages, nor have training on how to work with people from different cultural and at risk backgrounds to interpret signs, symptoms and perceptions of illnesses of their foreign patients. Very often the sole means of communication is through interpreters (which are not available as a matter of regular practice except as reported, in Hungary and when available most often only for English and Russian). More frequently the help of another migrant is solicited or communication is attempted via signs, which can lead to poor understanding of migrant health concerns and inadequate treatment and follow up.
- > In the case of mental health, knowledge about the cultural and experiential particularities of their foreign patients, who might have experienced or suffer from a wide range of mental health issues, ranging from confusion to PTSD is even more crucial and overall lacking. Often psychologists in DCs are not specialized in dealing with vulnerable cases and people with PTSD, which impacts on the health care services provided. A further concern is the adequacy of psychosocial and educational support for children, who are also detained with their families in closed centres in two of the three countries.
- > The limited number of psychologists, physicians and nurses available in DCs, the gaps in necessary competencies/training and the possible conflict of interest rising from their reporting to Mol/detention authorities and being responsible for both the staff and migrants in Hungary and Poland, further impedes the quality of health care.
- > Even in reception centres, which are overall better resourced, the country UNHCR office, has noted the absence of linguistically and culturally accessible care and interpreting services. Refugees have shown difficulty developing trust in, and respect for, physicians and local medicine and, they are often unable to communicate with health professionals and be referred for the right treatment. Furthermore, complaints about xenophobic or discriminatory attitudes among doctors and other staff have been reported to UNHCR. Medical staff also encounters many challenges due to the fact that this group of population in many cases lacks necessary means of communicating their medical history, current needs, and personal health practices and values.



### 1.3. State of health

- > As explained above, no statistical data of health events, their nature and outcome at the border or number of times emergency services were called and/or relevant health statistics are kept. Thus no information on the health status of irregular migrants passing through BCPs and held in short-term, on-site detention facilities is available, incidental such was only provided verbally on site. Cases of TB, hepatitis, scabies and other general health conditions (such as heat issues for travellers facing long line-ups in summer) were mentioned during field visits.
- > Some basic information regarding the health of irregular migrants was provided only during the retrospective data collection: the number of people who needed medical attention and/or with diagnosed medical conditions; the number treated; and the referrals to local health facility. However, in Hungary and Poland, the categories of information collected are not standardized within the country (between detention facilities) and the restructuring of the border authorities was reported to have resulted in some interruptions/gaps in data collection. In Slovakia, data is collected and centralized at Mol's health department from doctors in DCs every three months, mainly indicating low frequency cases of TB, gastrointestinal diseases and hepatitis (communicable), as well as drug abuse and physical injuries (non-communicable).<sup>57</sup> Overall, a low number of cases of TB, Hepatitis A/B/C and HIV/AIDS, and dermatological problems were reported during the retrospective data collection phase for migrants in DCs<sup>58</sup> (no numbers were provided during field visits when such were requested from the health workers).
- > During the field visits in DCs, team members commented that the majority of detained migrants show signs of mental distress as a result of the various ordeals they had experienced and the lack of psychological and network support. The complaints of migrants covered issues related to their living conditions, food, hygiene supplies, communication problems, the lack of social activities and sport facilities among others. Overall, the major distress factor for detained persons seems to be the uncertainty on their stay in detention and the overall lack of information and support, which also increases drastically the health complaints of both physical and psychological nature.
- > Another pertinent issue of concern, observed during field visits is the fact that children are detained in DCs (in two out of the three countries visited) and supposed to live for months in prison-like conditions, which further impacts their already fragilized mental and physical state. In this regard, availability of paediatric care, specialised child psychologist, lack of schooling were problems noted from experts, participating in the visits.

## 2. Occupational health of staff, health knowledge/attitudes and practices and case management of migrants

The profile of border guards/police staff in Hungary, Poland and Slovakia is similar as it reflects the recent restructuring of the national security systems to adapt to the Schengen criteria. The infrastructure and material equipment is renovated or new, and BOs have received related technical training. The implementation of the

Frontex common core curriculum is being planned or in process. The majority of employees are young men - a high proportion of the staff is aged between 30 and 40, recently recruited into the system after physical and psychological examination and respective training.

At the same time, a high turnover of border guard/police staff in the border region was registered and increase<sup>69</sup> in the number of recently recruited employees amongst the border police, especially in one of the three countries, where the newly arrived staff in the last three years amounts to almost 50% of all the border officials. A small number of health professionals are employed by the Border Guards/Police and report to the Mol.

## 2.1. State of health and occupational health services

- > Respondents' health self-assessment varies from good to excellent. Compulsory medical check-ups are performed once a year. Visits to a GP, optician and/or dentist are reported to be regular. Quite few BOs have had any health consultations with special therapist services (e.g. occupational health or rehabilitation) and/or visited the hospital in previous 12 months before the interview.
- > BOs also undergo compulsory psychological check-ups (on average every two years) and can access a psychologist on-site, though such self-initiated visits are very rare: the organisational and community culture not being conducive to such mental health seeking behaviour and the range and type of service provided not being fully adequate, and prevention and promotion are mostly lacking. In this regard, BOs identify the need of more psychological support to cope with stress as essential and yet insufficient. For one, there is a general shortage of psychologists and physicians in service, and second, the concept of mental health is vague and loaded with negative stereotypes, often confused with psychological disturbances (mental illness). Stress management and burn-out identification is not a standard component of the compulsory assessment process. With the exception of some sporadic initiatives and limited access to "rest" centres, little information was provided as to whether any specific mental health prevention measures were in force and/or planned to help staff cope with work-related stress and traumatic events.
- > According to one third of BOs overall, and much more in one of the three countries visited, the occupational health services are not easily accessible at their work site. During the field visits, team members also could not find information on the occupational health services and receive any occupational health data. In addition, need of better social services was noted to be needed for improving the overall health and well being of border staff.
- > No major disease outbreaks were reported amongst staff. Cases of TB and scabies transmitted from migrants, Hepatitis A and seasonal outbreaks of influenza were recalled by some BOs. Major occupational health concerns were reported by the BOs to be motor function and cardiovascular problems; yet, no information and/or actual statistics regarding the major occupational health conditions within the border guards were shared, nor seemed to be available to public health authorities either, with the exception of notifiable diseases to public health authorities.

- > The information on sick leave events and sick leave days amongst border officials is also very scarce. No comparison of data on sick leave days between the overall national and police, military and health staff is collected and analysed centrally and, thus, no comparisons can be inferred for the occupational health of staff in regard to the general population.
- > Where some data was provided, as in Hungary, the available information on the number of national average sick leave days was compared with the average number of sick leave days in DCs and differences were found concerning the number of sick leave days of the two health staff (231 per person in 2006 for 3 HP, whose number decreased from 8 in the previous year) in comparison to the general population, suggesting issues of occupational health concern, explicitly related to the work of health professionals.

## 2.2. Vaccinations

- > In general, vaccinations are not compulsory and are provided on a voluntary basis. In Hungary and Poland, BOs receive obligatory vaccinations against selected infectious diseases based on a risk assessment of the workplace and the region. Mainly vaccinations for hepatitis A and B, tick-borne encephalitis, typhoid fever and influenza are provided. Not all of the staff report possessing a record of vaccinations related to their job and/or have their vaccinations monitored.
- > Generally, uptake is varied across the border checkpoints; however no official coverage rates were reported. Health education overall as well as concerning vaccination is limited. There is no standardized and harmonized procedure by which the importance of vaccination or the dangers of certain infectious diseases would be explained to the staff, so that they could make an informed decision on whether or not they want to be vaccinated.
- > Some of the vaccinations, provided are debatable and not necessarily harmonized with the international standards such as BCG/TB for adults.

## 2.3. Work conditions and perceived health risks

- > BOs face different health hazards depending on their worksite (DCs, BCPs, green border, etc.). Some of them do rotate, so they are exposed to diverse number of health hazards, while other work at one site and face site-specific health risks.
- > Overtime working hours are one of the problems reported by 1/4 to 1/3 of BOs. Regular exposure to computers, TV, electronic screen work, draught, dust/dirt, and noise appear to be the main physical health hazards. Harsh weather and geographic conditions, high room temperature, unpleasant smell, passive smoking and stuffy bad air are main challenges in their working environment as well. Women BOs evaluate their exposure to these environmental risks factors higher than men.

- > In terms of mental health hazards, monotonous and unpleasant tasks and verbal violence from travellers are experienced on a regular basis. Irregular workload and lack of professional recognition burden the work of BOs. Discrimination (linked to gender, age or personal attribute) and unwanted sexual attention are a problem for women working at the border. BOs report facing significant stress in their daily job due to factors ranging from aggressive travellers' behaviour, to physical threats and traumatizing events related to irregular migrants while patrolling the green border. Fear of infections is high and contributes to anxiety and stress.

## 2.4. Health knowledge, attitudes and practices

- > In terms of completed health training, BOs have had general health education, basic first aid training, as well as on-the-job first aid training, which is usually theoretical for 2-3 hours. No specialized training on health aspects of migration and human trafficking, vaccination and/or occupational health were integrated neither in the training curriculum nor, as a general rule, in subsequent service trainings for border guards. Predictably, the self-assessment of BOs health literacy and their knowledge on modes of transmission is average, while their fear of contacting certain infectious diseases at worksite such as Bronchitis, Pneumonia, Diarrheal diseases, Tuberculosis, Meningitis and Hepatitis is, as mentioned, high. A number of BCPs used reference materials on infectious diseases from Internet sources rather than official information as such is provided on request post factum when a critical event raises the awareness at the border.
- > Personal Protective Equipments (PPE), such as gloves and masks, are usually available, but sometimes not in sufficient amount and quality. The use of PPE is voluntary, and there is no written guidance nor training on when and how to use them with the exception of a small number of sites. Disinfectants are available and used regularly for cleaning, but no formal training on proper hand disinfection is provided.

## 2.5. Case management of migrants

- > BOs are overall familiar with the key concepts and interpretations used in the context of international migration, with the exception of a few such as assisted migration and cultural orientation of migrants. In some of the countries, however BOs do not know the concepts of asylum seeker, irregular migration, displaced person, primary inspection, secondary inspection and trafficking in person<sup>60</sup>.
- > While in two of the countries visited BOs have fixed job positions either at checkpoints or in patrolling the green/water border, in the third country BOs rotate and change their duty station on a regular basis between green/water border, train station, airport (if available), checkpoint. This practise was instituted and assessed in the country as a successful mechanism to prevent burn out and reduce stress. As stated, critical events are reported to happen rarely at this external EU border (there is no information kept on their regularity and nature). The question remains whether BOs are prepared to react in a critical situation and take appropriate measures in regards to their health, that of the migrant, and the health of the local community.

### 3. Physical conditions

#### 3.1. Health resources of border checkpoints

- > BCPs have basic or no health care facilities or health staff at checkpoints. First-aid kits are available; however, when checked, the items inside were quite outdated and inadequate, including those for green border patrol.
- > In one of the countries visited, no medical rooms and/or separate facilities, at least with wash basin, were available at the BCPs or nearby branch offices to perform medical examinations. These were performed in the interrogation room or cells, potentially exposing healthy migrants and/or staff to infections.
- > Regulations for handling health-related emergencies were reported to be available and to generally include the procedure for contacting the public health authorities in case of emergency. No preparedness exercises were done.

#### 3.2. General conditions at BCPs/on-site detention facilities

- > Border checkpoints are new or recently renovated, and their physical and hygiene conditions were assessed as good. The sewage system is local, and potable water and hot running water are secured and running almost everywhere. The lavatories were reported to have liquid soap, toilet paper, hand dryers (in Hungary cloth towels were predominantly in use). Paper towels and hands-free hand-wash stations are not often available. However, these practices even though recommended in general for the public premises on site are mainly valid for the staff facilities.
- > The public toilet facilities in the majority of sites visited had severe deficiencies. As the facilities are the property of the customs service (a different Ministry) the responsibilities were divided between different authorities and the specific hygienic requirements were not considered with necessary weight. Toilets intended for the general public were often locked, sometimes damaged and lacking hygiene products, and/or not cleaned with sufficient frequency. The lack of minimum hygiene standards of public toilet facilities was an obvious critical aspect of the general hygiene conditions observed.
- > At some BCPs, even new renovated, infrastructure was poorly designed from a public health perspective, as for example, isolation rooms located in the same corridor as a snack bar or a lack of separate room at least with washbasin at all on-site and for initial medical examination of detained persons who need medical assistance. The available public health labs at the border checkpoints are intended only for veterinarian and food control.
- > Regular hygiene inspections and pest control were reported to be performed, but their frequency and quality is not clear, neither it is coordinated and controlled. Many times there was no plan of inspections and pest control available on site, when requested.

- > It was reported during the assessment phase that the cleaning staff was self-protecting with rubber gloves and masks and/or protective clothing. Few cleaning staff were seen working during the field visits.
- > At BCPs, the majority of short-term detention facilities were also renovated. In general, they provide access to hot running water and showers, electricity supply in cells, ventilation (windows), and regular cleaning of cells. Separate lavatories and showers for men and women, hands-free hand wash stations and functional locks were not present everywhere. In some facilities in Hungary, only bare wood planks and basic blankets and/or only narrow benches were available in short-term detention facilities. Even though renovated and/or new, again a standardized approach in respect to the general hygiene rules and basic amenities was not prevalent.
- > The main factors in separating detainees in short-term detention facilities are health, gender, age, and family status (in order), as self-reported or assessed by BOs. In some cases, the status of a detainee (for example VoTs) is not considered, in other their nationality and religion. Again, a common approach is not applied everywhere. In Hungary and Poland, BOs at BCP provide different answers, covering all possible categories; while in Slovakia gender/family status/age/unaccompanied minors from adults/nationality/religion/healthy and ill are considered by all sites, thus it appears that there are standard regulation implemented everywhere.
- > In short-term detention at BCPs, generally, apprehended migrants are provided with mug, blanket, bed, soap and toilet paper. Night clothes, slippers, extra clothes, and toothpaste or toothbrush are not provided (often no towels and/or tampons/ sanitary napkins). The staff decides on the type of food and provisions (basic) to be purchased in respect to the limited budget (a few euro) they have to cover such expenses. Cases of bringing diapers, toys, clothes and other items from home were reported during meetings, as well as a desire from some respondents for a standardized approach in availability and purchasing these items for BCPs, especially concerning children.
- > The stringent daily routine comprises mainly of time for meal and time for washing. For example in Hungary, there is no time for open-air walks and medical examinations in short-term detention facilities at the border and very few offer time for washing, providing mainly basic meals; in Poland only open-air walks are not provided, while time for meal, washing and medical examination were listed; while in Slovakia detainees in short-term detention facilities do not have included in their routine medical examinations. These rather different practices in every country need to be standardized and adapted to fulfil at least the basic needs of migrants, kept at the border.
- > In the majority of cases at BCP facilities, detainees eat in their cells and/or in the waiting room. The meals served are diverse in origin and preparation: by catering company, by the staff canteen or cold dishes bought from the local grocery store. Hygiene regulations for food preparation were reported to be in place at some places, mainly standard hygiene rules. No evidence of food preparation regulations was provided during visits. The cleaning of sheets is performed by different actors in the three countries: from none (no sheets, blankets, nor towels provided at all) to external laundry services or the BO local division and/or centrally at HQ.

### 3.3. General conditions at long-term detention facilities

- > DCs are similarly new and/or recently renovated. Most of the ones visited have a TV room and a canteen (plus a yard for open-air walks). In Poland, the newly reconstructed DCs had separate praying rooms, a room for playing table tennis, kitchen for detainees to prepare their own meals; a small play room for kids (where families are detained); a rudimentary library; and outdoor area for walks. The living quarters, toilets and showers are separate for staff and detainees, as well as for men and women. Families are reported to have specific living quarters in the two countries that detain families in closed centres. The medical rooms are new, clean and have basic medical equipment.
- > In this regard, one can conclude that the general hygiene conditions are good; however, deficiencies have been observed with regard to the cleaning. In Poland, migrants are required to clean their living areas on their own, to which they generally object. In Slovakia, even residents of a well-equipped RC complained from the general hygiene conditions on site and especially in the toilet facilities.
- > In detention centres, detainees receive a mug (and/or plastic dinner sets), duvet cover, sheets, blanket, bed, toilet paper, soap toothpaste/toothbrush and towels (items needed for a longer stay). Night clothes, slippers, extra clothes, tampons/sanitary pads are not offered everywhere. Extra clothes are sometimes provided by charitable organizations. Some DCs provide the possibility to migrants to order hygiene supplies (if they have money), and migrants are free to decide what to buy, while others provide the very basic hygiene supplies. Washing by hand of personal belonging was observed during visits at DCs, while sheets are washed by specialized services.
- > In DCs, the stringent daily routine includes time for washing, meals, open air walks and medical examinations. The food is served in the dining room or living quarters (cells/rooms). Meals can be prepared by different providers (catering company, kitchen staff, or cold meals). There is a possibility to order food from outside (if one has money) and in Poland to cook it in the kitchen available on the premises. The food is reported to follow the nutrition standards, but complaints on the quality of food (mainly pasta, bread, potatoes, salami) and diversity of ingredients (less fruits and vegetables) were recorded everywhere during the visits. In one of DCs in Slovakia, a lack of possibility to keep the religious eating customs of detainees and to practise their religious customs (no prayer room) were reported.

### 3.4. General hygiene conditions for staff at BCPs and DCs

- > All detention areas are separated from the staff's premises. Staff have separate lavatories, separate cutlery and separately cleaned sheets and towels. For a large majority of sites (except one country), no separate room for drying clothes was reported to be available on site, neither the possibility to use washing machines for washing the uniforms (which were mainly washed at home). The possibility to wash the uniforms on site was assessed positively by staff, who shared their fears of bringing infections home.
- > The social area for staff consists of a kitchen with basic kitchen supplies, a table, chairs, refrigerator, and a microwave used to warm up and prepare basic meals and/or coffee. In some premises, the staff complained that they do not have a proper social area.



### 3.5. Living conditions at BCPs and DCs

- > The living environment of detained migrants has a bare prison-like atmosphere with bars on the windows and widespread cameras (also in the rooms of detainees in one of the countries and in short-term holding cells at BCPs in another), and no decorative elements (pictures, curtains, plants) nor references (calendars, clocks) are present that would make the areas more human and friendly both for staff and detainees. The daily routine is very stringent at some sites, including even morning checks when the staff is changing (wake up at 6:00 am with breakfast at 9:00 am), while the educational, social and entertainment activities such as sports, games, visual materials, books, newspapers or magazines in different languages, as well as time outdoors, are extremely limited or non-existent.
- > The lack of social activities and a lot of unoccupied time without sport, education opportunities and contacts with the outside world (no more than one TV, no newspapers, radio, Internet) further deteriorate the fragile mental health condition of detained migrants.
- > In addition to the shortages of medical staff, the lack of social workers in DCs further burdens the access to appropriate social support in the daily living of migrants, which has a legal maximum stay of six months to a year depending on the country and can be longer in practice for complex cases. In fact, social workers are only present in RCs, while in DCs there is no such job position opened with the exception of occasional and very few librarians providing some ad hoc support to detainees.
- > Few humanitarian organizations are visible and known at BCPs and especially in detention centres, both local and international, and those that are known are by means of posters or brochures rather than physical presence. The main organizations working in these facilities in the three countries are UNHCR, the Red Cross, Helsinki Committee, and IOM.

## 4. Public health in border communities

### 4.1. Data collection and information

- > Data on the number and types of critical and health-related events is not usually recorded nor kept centrally in the system of MoI. Incidental information is available on place (BOs recall the critical cases they had locally and presented them during meetings). The number of critical events in DCs is available amongst which the health related ones are very few in number.
- > No data on cross-border outbreaks or in-country outbreaks was provided to the team by public health authorities nor such information made available to the border police. On the other hand, the number of emergency services requests at the border and summary of main reasons for calling the ambulance were not collected by BOs or other institutions, nor such statistics kept by health authorities, making adequate plan-

ning of services and public health intervention difficult. Effective collection and appropriate dissemination of all such information would require the involvement and cooperation of different institutions such as the hospital/emergency services, border police/guards, administration of DCs and RCs, as well as local public health/sanitary divisions.

## 4.2. Epidemiological situation and cooperation between institutions

- > No major epidemiological threats in the border region were reported, aside from outbreaks of measles, hepatitis A, influenza, though current comparative data from border regions and national figures was not made available. Coordination gaps between the border police/guards and the national and local public health services, as well as, in some cases, with colleagues across the border result in a lack of or insufficiently reliable information on the cross-border epidemiological situation. This raises the question of readiness of the border region authorities (health and police/guards) in case of a crisis situation.
- > Discharge and transfer of responsibility between different institutions (i.e. MoI and MoH) was particularly evident in the follow-up of migrants with communicable conditions (such as TB). In this regard, one can add that BOs often do not receive feedback on the medical diagnosis (or even information on the lack of health threat) after they have completed their part of the apprehension procedure and a migrant is referred for medical treatment. The lack of feedback contributes to stress and the prevalent fear of infections amongst staff.
- > Insufficient collaboration/exchange of information on good practices/initiatives between different BOs units and between BOs and local public health authorities was identified during the field visits. Such an example of good practice is a training in 2005, on how to handle possible cases of avian influenza, provided from the Sanitary Inspectorate to the BOs in one of the countries visited, however such initiatives are difficult to sustain due to lack of funding and because they are not institutionalized, but depend on the good will and individual's initiative.

## 4.3. Links to international and European regulations

- > Insufficient knowledge on IHR (designated sites, reporting procedures) amongst BOs and HPs was found during the assessment. The in-time recognition of a disease or its symptoms is of crucial importance as a starting point for the process of diagnostics and reporting an event at BCP, DC or RC and to accumulate information of the migrant's route of travel. General obligations for the MS are to ensure the capacity of designated points of entry, to position competent authorities and report to WHO when detecting potential public health risks including relevant information regarding infection or contamination together with vectors and reservoirs which could cause international disease spread.
- > The knowledge on the Schengen agreement and related protocols as relates to the obligation to refuse entry based on a threat to public health was assessed as vague. In discussions, border staff were uncertain how to apply this refusal of entry in practice and hardly recalled any such cases in their practice so far.

#### 4.4. Public health safety of resident population

- > According to the health professionals surveyed, the overall rates of infectious diseases in the region correspond to their share of the total population. Major infectious diseases linked to migration and representing the most risk to the resident population are considered to be TB and Hepatitis A/B/C, and to a smaller extent HIV/AIDS, meningitis, syphilis, diarrheal diseases.
- > The perceived risk of trafficking in person in the region is assessed to be low to medium. The majority of respondents (both health professionals and border guards) have not worked with VoTs and have had few cases of UAMs.
- > Overall insufficient data collection as well as country-specific templates for statistical data collection and variable definitions of irregular migrants burden the collection of comparative, cross-country and even within country data on migrants and appropriate assessment of the public health risk for the local population.
- > The statistical information on caseload of migrants (number of apprehended irregular migrants, breakdown by gender, age group and reported country of birth) is scarce. While the total number of apprehended irregular migrants is known (less than 1% from the total border crossing caseload), their breakdown by age and gender is not collected centrally except in Poland. This type of information is not collected at all in short-term detention facilities at BCPs.

### 5. Migrant health database

IOM received overall positive feedback on the template concept from the national and international experts of the JPT1 as well as local counterparts and the available limited number of health professionals during the field visits to Poland, Hungary and Slovakia. Border officials and health professionals interviewed recognized the importance and benefit of using a standardized instrument to record and collect data from the point of encounter through transfer and the closure of file, on a broader European level and were open to discussions with the project team members on how it could affect their work.

In comparing the forms gathered during the field visits to Poland, Hungary and Slovakia, it can be seen that the Migrant Health Database model proposed by the PHBLM project compiles key fields covered in the target countries, although in a more comprehensive format, with a possible extension from paper to electronic format. At this time, the three countries visited are using different formats for data collection, even inside the same country (e.g. collecting different information), and only Slovakia has summary statistics readily available.

The template proposed fits the needs for medical registration/data collection, providing more data for in-depth analysis and the possibility to compare information between countries of migrants' health in the eastern EU Schengen border. The MHD developed in its electronic format also provides ease of generation of summary

statistics and reports as well as confidentiality safeguards by selected access to type of nominal data (e.g. symptomatic general data inputted by BOs, medical data accessible only to health professionals), as well as the possibility to have non-nominal data.

Building on the above results, it was discussed between involved experts and governmental counterparts to consider the following points in an eventual pilot of the MHD template:

1. Endorsement and proper arrangements with the Border Guard/Border Police HQ and the responsible Ministry.
2. The amount of information to be collected was often re-assessed, in part due to the limited number of health staff and their workload in detention facilities. Over the course of the field visits, the MHD template has been slightly modified based on the discussions in each country. As the suggestion was to have a shorter version of the database – with two pages instead of three or more – the template was reduced.
3. Training for BOs in recognizing and recording symptoms and modes of transmission of common diseases that require immediate attention (or a booklet with some basic knowledge on infectious diseases) was identified during discussions as necessary for BOs general preparation.

The form of data collection – for example paper-based as a start then electronic – should be further considered in the eventual implementation of the MHD.

As the overall feedback from health staff in the centres visited and BOs was positive in terms of piloting the MHD, a next step would be to pilot the template, with the support of national and local authorities, to fine tune the database for further use.



## Conclusions and Recommendations

5





In order to assess public health aspects of border management at the new Eastern Schengen border, a situational analysis was undertaken. The summary report provides an overview of the current situation in Hungary, Poland and Slovakia analysed from a threefold perspective: health of migrants crossing the land border and in detention; occupational health of border officials, and public health and health hazards in the border regions.

## 1. Conclusions

### 1.1. Migrant health

Little attention is directed towards the migrant health needs in short/long term detention facilities. The majority of available reports published under the authorship of international organizations, donors and experts in the field of irregular migration focus on the assessment of the general conditions in detention and/or reception facilities with respect to Council Directive 2003/9/EC of 27 January 2003 laying down the minimum standards for the reception of asylum seekers and respective international and regional core instruments of the United Nations (UN) and Council of Europe from the perspective of migrants' fundamental rights including the right to health care.

EU Member States have committed to the right of everyone to the highest attainable standards of physical and mental health<sup>61</sup> and agreed on the goal of facilitating access to health care for migrants on the basis of international, European and national instruments.<sup>62</sup> In line with the human rights, provision of adequate and appropriate health care to migrants further ensures the protection of the health of European communities and border staff. The public health dimension of migration not only covers the context of spreading infectious diseases, "common" new and re-emerging ones, but also pertains to the problem of vaccine preventable and "imported" diseases spreading to transit and destination countries, where physicians may not have been confronted with such pathologies before and/or do not have the facilities to deal with such diseases. Providing appropriate healthcare services for migrants is an important humanitarian obligation, and also, with growing importance, a public health concern for countries of transit and destination alike. In this respect, addressing the existing gap in migration health issues in broad cooperation with relevant governmental bodies, partner organisations and agencies in the fields of public health and border management was the main objective of the project and situation assessment.

The findings from the analysis suggest that migrants' access to health care is restricted and mainly related to basic health care provisions and/or emergencies services. Even though consultation with a doctor is not refused to migrants, their access and adequate quality of health care provisions are burdened by the limited staff availability; communication problems, financial and distance constraints, as well as xenophobic and discriminatory attitudes. The difficult access to specialized health care and the limited or lacking psychosocial support services

further deteriorate the fragile state of detained migrants, living in closed facilities for months and with uncertain future. This fragile state of mental and physical health is aggravated by the sterile and “prison like” atmosphere of living in detention centres, without the possibility to practice sports, cultural or training activities or receive support from social workers, and limited contact with the outside world.

Moreover, the lack of standardized medical screening of irregular migrants and unavailability of migrant health-related statistics limit the assessment of migrant’s health conditions and the provision of adequate to their needs support, but also increases the related risks for the border population and staff, especially in case of epidemiological outbreak.

## 1.2. Staff and infrastructure

Although border guards are mainly young men who perceive themselves in good health and receive regular checkups from the occupational health services, they face significant environmental and mental health risks at work. Major disease outbreaks have not been recorded on site, but again there is no centralized collection of comparable occupational health related data. BO’s fear of infections is high, however, and contributes to anxiety and stress. The shortages of psychologists and physicians on site and the lack of promotion of mental health services (even though regular mental health checkups do exist), further has a negative impact on the health of BOs.

Even though BOs have access to personal protective equipment such as gloves and masks, they do not have written guidance or training on when and how to use them, neither on personal hygiene (proper hand disinfection) or information on different modes of transmission of major infectious diseases in the region. BOs also lack specialized training on health aspects of migration and human trafficking, vaccination and occupational health.

Similar to BOs, Health professionals also face difficulties in providing health services to migrants ranging from communicational problems and how to handle with prejudices and cultural gaps and work with people from different cultural and risk backgrounds to knowledge on the public health implications of migration, related public and individual health hazards; sensitization to physical and mental health issues of vulnerable persons, including victims of trafficking, smuggled migrants and minors, etc.

Generally, the physical conditions of BCPs and DCs are good (recently renovated or new) and, where available, the health care facilities have proper, though basic, medical equipment. Sites face, however, diverse structural challenges in terms of health-related hazards: no isolation rooms; infrastructure poorly designed from public health perspective; outdated first-aid kits; questionable provisions of hygiene materials; unclean or locked public toilet facilities without clear responsibilities and distribution of tasks between different institutional actors working at the border; as well as a lack of regular and standardized hygiene inspections and pest control. Overall, a unified and standardized approach in respect to the minimum health standards at BCPs and DCs (including also relevant trainings on personal protection and hygiene, minimum cleaning, and food standards) is missing. Few humanitarian organizations are visible and known by BOs and health professionals to be active in providing health and social support.



### 1.3. Public health at border regions

The lack of information on the number of critical events and disease outbreaks burdens the assessment of the epidemiological situation in the border region. Coordination gaps between the border police/guards and the national and local public health services, as well as, in some cases, with colleagues across the border result in a lack of or insufficiently reliable information on the cross-border epidemiological situation. This questions the readiness of the border region authorities (health and police/guards) in case of a crisis situation.

Discharge and transfer of responsibility and funding between different institutions (i.e. MoI and MoH) was particularly evident in the follow-up of migrants with communicable conditions (such as TB) in some of the countries visited, i.e. once a person with communicable condition is hospitalized, the Director of the DC might ask the Court to lift the detention, and the migrants may continue treatment or leave at their discretion, which in cases of TB for example raises serious issues regarding their own health and public health in terms of both continuity of treatment as well as further transmission and potential of MDR, XDR. Another issue is that MoH has to pay for uninsured migrants when hospitalised, but often the hospital is reimbursed years after. This and similar structural deficiencies pose risks for the migrant and the public health of the host communities.

Insufficient knowledge on the International Health Regulations (designated sites, reporting procedures) amongst BOs and HPs was found during the assessment. The knowledge on the Schengen agreement and related protocols as relates to the obligation to refuse entry based on a threat to public health was assessed as vague. In discussions, border staff were uncertain how to apply this refusal of entry in practice and hardly recalled any such cases.

## 2. Recommendations

Based on the findings of the Situation Analysis Report, the following recommendations are proposed with the objective to improve the public health aspects of border management in terms of migrant health, occupational health of staff, physical and hygiene conditions of sites, and public health in border communities:

### 2.1. Migrant health

- > To consider the piloting and implementation of a standardized health assessment of apprehended/detained migrants and regular migrants in need of emergency health assistance at the borders (at the BCPs, DCs and RCs), in order to strengthen the collection of migrant health-related data and ensure the follow-up of migrant health from one institution to the next. This collection of data on the health of migrants would further support the planning for adequate and appropriate health services for migrants, staff and communities in the border areas. In this respect IOM developed a Migrant Health Data template, recommended briefly in the data collection recommendations section;

- > To ensure regular access to primary health care provisions by adequately trained staff, independent on the management of the facility; and specialized health care service for detained migrants (incl. pregnancy follow-up);
- > To ensure regular access to psychological care and mental health services and mental health counselling sessions with independent psychologist. Psychologists need to specialize in dealing with vulnerable cases and people with PTSD. Specialized psychological support should be provided to detained children;
- > To establish clear and working procedure for grievances in case of disrespect of migrants' rights;
- > To introduce social workers as staff in DCs as is common practice in RCs. Such presence is very much needed to facilitate communication between BOs, health staff and residents of the facility; to provide migrants with information on procedures and services available; but also to organize social/cultural activities. In this respect, social workers could provide some basic knowledge of the host country and how to communicate their medical history, current needs, and personal health practices and values as well as mediation, personal advice and help in practical matters such as legal issues;
- > To encourage the involvement of humanitarian organizations beyond legal assistance in the areas of health and social assistance, with both presence and information campaigns on their work activities, which would provide other avenues of support, monitoring, and contacts with the outside world;
- > To provide training for health professionals and BOs would be beneficial for providing better health services to migrants: communication skills and how to handle with prejudices and cultural gaps and work with people from different cultural and risk backgrounds; understanding of global migration patterns, push-pull factors and the impact of migration on the European Union (EU); knowledge on the public health implications of migration, related public and individual health hazards; practical skills in recognizing health emergencies and cases requiring transfer to health professionals, as well as self protection and occupational health issues; sensitization to physical and mental health issues of vulnerable persons, including victims of trafficking, smuggled migrants and minors; would be beneficial for better health services to migrants;
- > To provide a possibility for foreign language courses (English, Russian and/or French) for staff. This is urgently needed as the staff often lacks competence in foreign languages and cannot communicate with detainees and/or understand their complaints;
- > To provide more possibilities for sport, cultural events, training courses, media in multiple languages (TV, newspapers, Internet), and access to outdoor facilities for persons in long term detention, as this would drastically improve their fragile mental and physical health.



## 2.2. Occupational health of BOs

- > To consider central collection and analysis of occupational health statistics, sick leave days and sick leave events amongst BOs;
- > To ensure annual refresher courses on first-aid for BOs staff, including practical exercises and simulations;
- > To provide active psychological support as well as health promotion and prevention services to BOs;
- > To improve the working conditions in terms of both physical and mental health risks, considering also the gender aspect of health hazards; to consider targeted training for different lines and duty stations and positions on the basis of different levels of risk exposure; to initiate information campaigns during which the risks of certain infectious diseases are explained to the staff, so that they could make an informed decision whether or not they want to be vaccinated;
- > To consider including in the BOs training curriculum content on: public health implications of migration, related public and individual health hazards; identification of health risks and modes of transmission of infectious diseases that require immediate attention; safety at workplace instructions and/or minimum standards of hygiene and infection control measures (such as washing of uniforms of staff on site); personal protection measures (training/regulation on when and how staff should use PPT and disinfectants); and a general introduction module on the global migration patterns, push-pull factors and the impact of migration on the European Union (EU).

## 2.3. Physical conditions of BCPs and DCs

- > To ensure that first-aid kits are regularly checked and outdated materials removed;
- > To ensure a room, equipped with basic conditions for examinations (or at least with facility for hand washing and examination) as a minimum requirement at the border;
- > To consult with public health experts when designing the infrastructure of public facilities at the border (incl. isolation rooms and/or labs);
- > To ensure the respect of minimum hygiene standards in public toilet facilities at BCPs; to standardize and regularize the hygiene and pest control inspections at BCPs and DCs;
- > To provide minimum hygiene standards for food provision/preparation at BCPs and DCs (including minimum nutrition value and diet diversity);
- > To include training/instruction for hygiene and infection control for cleaning staff; to develop and implement a standardized approach (minimum standards) regarding hygiene and living conditions of migrants;

- > To ensure a humane atmosphere in DCs - with decorative elements (pictures, curtains), plants, references of time (calendars, clocks); more friendly daily routine; a library with news/magazines/books; possibilities for training; outdoor facilities (often are very small and prison-like to allow normal outdoor walks); sport facilities (e.g. gym) for detainees.

## 2.4. Public health in border communities

- > To consider the feasibility of collecting health-related data, including information on the health events in the border area and the epidemiological situation in the border region, number of times emergencies services were called at the border, and outbreaks;
- > To work to improve and institutionalize coordination between the border police/guards and the national and local public health services, as well as with colleagues across the border. In this respect, clear role distribution between institutions in the follow-up of migrants with communicable conditions (such as TB) is needed; as well as a working system of providing feedback from public health authority to the MoI on cases of detained migrants with notifiable medical conditions; to stimulate the exchange of information on good practices/initiatives between different BOs units and between BOs and local public health authorities;
- > To ensure more information about the responsibilities of different national services and on IHR and more knowledge on IHR (designated sites, reporting procedures) amongst BOs and local HPs;
- > To update and rehearse annually the available response plans and to undertake joint exercises for health emergency preparedness for all the parties involved to react in health-related emergencies;
- > To improve the knowledge of BOs on the Schengen agreement and related protocols as relates to the obligation to refuse entry based on a threat to public health as border staff are uncertain how to apply the refusal of entry in practice.

## 2.5. Data collection

Developed with the objective to improve the knowledge base on the health of migrants and travellers and to enable the participating countries to systematically collect comparable data on migrants apprehended, transferred and/or detained by border authorities as well as travellers/commuters in need of health care, the Migrant Health Database as presented in the result section contains three forms (the primary, secondary, and summary forms), which would be simple to use for BO and health staff and could generate statistics more easily than handwritten journals. Considering that the centres visited are already using some kind of medical form developed locally (similar from country to country, although not standardized and relatively basic), and that BO do keep record in secondary inspection/interviews, it seems feasible to envision a transition to the Migrant Health Database.

The instrument was designed to be practical and user-friendly, covering the medical history of the migrant patient, from the point of encounter with border officials to the transfer to medical care, detention and reception centre

(RC), readmission/deportation or departure/release. In its paper version, each form would be produced in triplicate in order to allow for recordkeeping and summary statistics at multiple sites of the migrant's transfer. A copy of the file would also be provided to the migrant.

### 3. Further steps

In respect to the gaps and needs identified during the assessment phase of the PHBLM project, the following deliverables were developed in cooperation with the Andalusian School of Public Health:

*Training course development and regional testing on public health aspects of border management and detention for border officials and for health professionals:*

- > Understanding of global migration patterns, push-pull factors and the impact of migration on the European Union (EU);
- > Knowledge on the public health implications of migration, related public and individual health hazards;
- > Practical skills in recognizing health emergencies and cases requiring transfer to health professionals, as well as self protection and occupational health issues;
- > Sensitization to physical and mental health issues of vulnerable persons, including victims of trafficking, smuggled migrants and minors;

*Development of proposals for minimum public health guidelines and recommendations for structural changes for health/public health services in border regions:*

Comprehensive guidelines for public health and health requirements and country specific recommendation for structural changes to public health services in the targeted border sectors were developed to address gaps in conditions and protocols that were identified by the Situation Analysis Report.

### 4. Conclusion statement

Information, generated via different yet related assessment instruments, confirms the need for more and targeted work in respect to human public health considerations at the Eastern border, but also in the context of addressing public health in other external border regions facing dynamic (both regular and irregular) migration flows at their air, land and sea borders as well as the future enlargement of the Schengen family. In this regard, the assessment tools and Situational Analysis Report, guidelines and recommendations for structural changes for health/public health services in border regions, and training course development for BOs and HPs are developed for recommended implementation in the three countries as well as piloting and adaptation for other settings.



1. Bashford Alison (ed). 2006. *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present* Palgrave, Basingstoke.
2. Dodge JS. 1969 *The Fieldworker in Immigrant Health* Staples Press.
3. Jackson T 2003 'Mystery of the Imported Plagues' *BMJ* 326:342.
4. ECRI 1995 Report summarising the replies received to the questionnaire drawn up by ECRI European Commission against Racism & Intolerance (ECRI), Strasbourg: Council of Europe (Document CRI (95)3).
5. IOM. 2008. "Managing Labour Mobility in the Evolving Global Economy." *World Migration 2008*. Geneva, Switzerland.
6. Romania is a member of the Steering Committee and participates in selected data collection activities, with the aim of sharing information with future Schengen zone countries. No field visits to Romania are included in the project.
7. There is no universally accepted definition of migrant. The term migrant is usually understood to cover persons moving to another country or region to better their material or social conditions and to improve the prospects for themselves or their family. Migration today involves migrants in a regular and irregular situation, as well as asylum seekers, victims of trafficking, refugees, displaced persons, returnees, and internal migrants. For ease of reference, they are all referred to as 'migrants' in this document.
8. According to IOM Glossary on Migration, irregular migration is a movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries it is illegal entry, stay or work in a country, meaning that the migrant does not have the necessary authorization or documents required under immigration regulations to enter, reside or work in a given country. From the perspective of the sending country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfil the administrative requirements for leaving the country. There is, however, a tendency to restrict the use of the term "illegal migration" to cases of smuggling of migrants and trafficking in persons.
9. For more information see: **Poland:** Council of Europe. 2006. "Report to the Polish Government on the visit to Poland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) of 4-15 October 2004." CPT/Inf (2006) 11. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Strasbourg, France.; International Helsinki Federation for Human Rights and Coll. 2006. "Places of Detention in Poland." (Report from the visit of the delegation of human rights NGOs to places of detention Poland on 24 - 26 October 2005.) Vienna, Austria; Caritas Polska. 2007. "Actions in Support of Civil Society in the EU Member States which acceded to the European Union on May 1 2004: Creating and strengthening a sustainable network of civil society concerning administrative detention of asylum seekers and illegally staying third-country nationals across the ten new EU Member States." (Report on Detention of Asylum Seekers and Illegally Staying Third Country Nationals in Poland.); European Refugee Fund. 2007. "Country Report: Poland."; EP. 2008. "Draft Report from the Committee on civil liberties, justice and home affairs on the delegation to Poland." European Parliament Committee on civil liberties, justice and home affairs.; **Hungary:** Hungarian Helsinki Committee. 2006. (HHC) "Alternative Report Regarding the Fourth Periodic Report of Hungary Under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment." Budapest, Hungary.; International Helsinki Federation for Human Rights and Coll. 2006. "Places of Detention in Hungary" (Report from the visit of the delegation of human rights NGOs to places of detention in Hungary on 11 and 12 May 2005). Vienna, Austria.; Mink, J., 2007. *Detention of Asylum-Seekers in Hungary: Legal Framework and Practice*. Budapest, Hungary: Hungarian Helsinki Committee.; European Refugee Fund. 2007. "Country Report: Hungary."; Szigo, T. 2007. *Reception Conditions and the Impact of the EU Directive in Hungary*. Budapest, Hungary: Hungarian Helsinki Committee.; **Slovakia:** Vselkova, M. 2007. *Reception Conditions and the Impact of the EU Directive in Slovak Republic*. Bratislava, Slovakia:



- Slovak Humanitarian Council.; European Refugee Fund. 2007. "Country Report: Slovakia."; **Others:** Caritas Polska. 2007. "Actions in Support of Civil Society in the EU Member States which acceded to the European Union on May 1 2004 : Creating and strengthening a sustainable network of civil society concerning administrative detention of asylum seekers and illegally staying third-country nationals across the ten new EU Member States." (Report on Detention of Asylum Seekers and Illegally Staying Third Country Nationals in Poland.); STEPS Consulting Social. 2007. *The Conditions in Centres for Third Country National (Detention Camps, Open Centres as well as Transit Centres and Transit Zones) with a Particular Focus on Provisions and Facilities for Persons with Special Needs in the 25 EU Member States*. IP/C/LIBE/IC/2006-181. European Parliament Committee on Civil Liberties, Justice and Home Affairs.
10. EC. 2003. Council Directive on Laying Down the Minimum Standards for the Reception of Asylum Seekers, Article 7.4. Official Journal of the European Union 2003/9/EC[L 031].
  11. **Hungary:** Hungarian Helsinki Committee (HHC). 2008. "Asylum Seekers' Access to Territory and to the Asylum Procedure in the Republic of Hungary" (Report on the Border Monitoring Program's First Year in 2007.) Budapest, Hungary.; **Poland:** UNHCR. 2006. *The Monitoring of Access of Refugees and Other Persons of Concern to UNHCR to Refugee Status Determination Procedure in Poland*.; **Slovakia:** Ministry of the Interior, Bureau of Border and Alien Police. 2007. *Yearbook: Slovakia*. Bratislava, Slovakia.; **For all the three countries:** Kindler, M. and E. Matejko, 2008. "Gateways to Europe: Checkpoints on the EU External Land Border." (Monitoring Report) Warsaw, Poland: Stefan Batory Foundation.
  12. European Refugee Fund. 2007. "Country Report: Hungary."; European Refugee Fund. 2007. "Country Report: Poland."; European Refugee Fund. 2007. "Country Report: Slovakia."; C Jesuit Refugee Service Europe (JRS). 2007. "Civil Society Report on Administrative Detention of Asylum Seekers and Illegally Staying Third Country Nationals in the 10 New Member States of the European Union."
  13. Such as minors, pregnant women, elderly, VoTs or people with mental disabilities.
  14. International Helsinki Federation for Human Rights and Coll. 2006. "Places of Detention in Hungary" (Report from the visit of the delegation of human rights NGOs to places of detention in Hungary on 11 and 12 May 2005). Vienna, Austria.
  15. European Refugee Fund. 2007. "Country Report: Hungary."
  16. European Refugee Fund. 2007. "Country Report: Poland."
  17. European Refugee Fund. 2007. "Country Report: Poland."
  18. Vselkova, M. 2007. *Reception Conditions and the Impact of the EU Directive in Slovak Republic*. Bratislava, Slovakia: Slovak Humanitarian Council.
  19. European Refugee Fund. 2007. "Country Report: Slovakia."
  20. International Helsinki Federation for Human Rights and Coll. 2006. "Places of Detention in Hungary" (Report from the visit of the delegation of human rights NGOs to places of detention in Hungary on 11 and 12 May 2005). Vienna, Austria.
  21. Kindler, M. and E. Matejko, 2008. "Gateways to Europe: Checkpoints on the EU External Land Border." (Monitoring Report) Warsaw, Poland: Stefan Batory Foundation.
  22. Ministry of the Interior, Bureau of Border and Alien Police. 2007. *Yearbook: Slovakia*. Bratislava, Slovakia.
  23. This report covers a sample of the legislative review as it relates to the general standards on detention and reception conditions.
  24. Green border is the defined border area between two official border checkpoints .
  25. The only exception was made in the case of Hungary, where the border with Croatia was not visited. As suggested by the Hungarian Border Guards the traffic of irregular migrants is very low and the focus is on the borders with Ukraine and Serbia.
  26. Council of Europe. 2001. Recommendation 1503: Health Conditions of Migrants and Refugees in Europe. Parliamentary Assembly (PACE). Strasbourg, France.
  27. UN. 2000. General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). [E/C.12/2000/4.] 11-8-2000. UN Committee on Economic, Social, and Cultural Rights.
  28. *Dougoz C. Grèce*. 40907/98 (European Court of Human Rights, 2001).

29. European Commission of Human Rights. 1999. "Report of the Commission on Applications 6780/74 and 6950/75."
30. UN. 1988. Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment. 7th Plenary Meeting. A/RES/43/173. General Assembly of the United Nations.; Council of Europe. 1987. Recommendation No. R (87) 3 of the Committee of Ministers to Member States on the European Prison Rules. R (87) 3. Strasbourg, France.
31. WHO. 2005. Revision of the International Health Regulations. WHA58.3 [Fifty-Eighth World Health Assembly]. Geneva, Switzerland.
32. EC. 2008. "External borders control, Removal and readmission: Recommendations and best practices." *EU Schengen Catalogue*. 15250/2/08. Brussels, Belgium.
33. EC. 2006. Regulation (EC) of the European Parliament and of the Council Establishing a Community Code on the Rules Governing the Movement of Persons Across Borders. Official Journal of the European Union 562/2006[L 105/1].
34. EC. 2006. Commission Recommendation Establishing a Common "Practical Handbook for Border Guards (Schengen Handbook)" to Be Used by Member States' Competent Authorities When Carrying Out the Border Control of Persons. C (2006) 5186.
35. Pribytkova, I. and J. Gromovs. 2007. *Migration trends 2004-2006 Söderköping Process countries*.
36. For example, on the website of Söderköping process initiative, the statistics on irregular migration are not cross-country unified.
37. Hungary, Poland and Slovakia joined the Schengen Area on 21 December 2007. Romania aims to join by 2011.
38. According to IOM Glossary on Migration (2004), regular migration is the migration that occurs through recognized, legal channels.
39. A short-term detention facility refers to the arrest facilities at the border.
40. Migrants from Kosovo were registered as Serbians.
41. See Pribytkova, I. and J. Gromovs. 2007. *Migration trends 2004-2006 Söderköping Process countries*.
42. WHO. 2009. Global burden of disease: 2004 update. Geneva. Switzerland.
43. WHO. 2008. World Health Statistics 2008. Geneva. Switzerland.
44. Additional 47 BGHSS surveys have been filled from BGs during the Second Field visits to Poland in 4 sites where a very low number of successful face-to-face interviews have been conducted.
45. The presented data is not representative, thus subsequent findings should be read with respective limitations.
46. As outlined in the methodology section, there were 204 surveys conducted in border region hospitals in Hungary; however, the interviewed persons were filtered and only medical staff, who had stated that they worked with migrants, were considered for the analysis.
47. Answers "fairly high risk" and "very high risk" are combined.
48. Answers "fairly high risk" and "very high risk" are combined.
49. Potential categories of measures listed included: programs of compulsory screening for the most common infectious diseases in the region, compulsory/optional vaccination programs, awareness-raising campaigns via local media focusing on a heightened risk of infectious disease or rising cross-border crime, school health promotion programs, special health education workshops for shop and restaurant owners, special prevention and health promotion programs for BGs, and support programs for migrants.
50. Answers "moderately important" and "very important" are combined
51. Refer to the sampling for the checklists in the methodology section.
52. Refer to the limitations for the checklists in the methodology section.
53. BCPs in most of the sites visited are a few kilometres away from the branch offices. On-site detention facilities at BCPs are generally a waiting room where migrants are kept for a few hours before being transferred to the branch office's on-site detention facility.
54. Refer to the field visits section of the methodology.
55. Other staff suggested to the JPT#1 that the librarian would not stay for long as she knows foreign languages and would find a better job.

- 56. From the checklist assessment of physical conditions and procedures, it should be noted that the health and social care provisions in reception centres are better, although not sufficient, than in detention centres – more medical staff, social workers and psychologists work with asylum seekers in RCs in comparison to DCs. Please refer to section V6.2.
- 57. Regarding the information on communicable and non-communicable diseases in RCs, such information was not collected by RCs or collected but not shared with the border police as RCs fall under different structure within the Ministry of Interior. In fact, health information is not exchanged between different institutions or within the system of the Mol.
- 58. Information was provided only about irregular migrants in DCs. It is not collected for BCPs and short-term detention facilities.
- 59. Extrapolated on the basis of answers to the question how long the staff have worked on present site and age, as well as findings from the retrospective data collection.
- 60. IOM glossary of terms has been used for the interpretation of BGs knowledge on key concepts on international migration.
- 61. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).
- 62. Council Conclusions on Health and Migration in the EU of 5-6 December 2007, 15609/07.



# References

- > Bashford Alison (ed). 2006. *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present* Palgrave. Basingstoke.
- > Caritas Polska. 2007. "Actions in Support of Civil Society in the EU Member States which acceded to the European Union on May 1 2004: Creating and strengthening a sustainable network of civil society concerning administrative detention of asylum seekers and illegally staying third-country nationals across the ten new EU Member States." *Report on Detention of Asylum Seekers and Illegally Staying Third Country Nationals in Poland*.
- > Council of Europe. 1987. Recommendation No. R (87) 3 of the Committee of Ministers to Member States on the European Prison Rules. R (87) 3. Strasbourg, France.
- > Council of Europe. 1996. The European Social Charter. Strasbourg, France.
- > Council of Europe. 2001. Recommendation 1503: Health Conditions of Migrants and Refugees in Europe. Parliamentary Assembly (PACE). Strasbourg, France.
- > Council of Europe. 2005. "Explanatory Report on to Council of Europe Convention on the Prevention of Terrorism." 925th meeting of the Committee of Ministers. Strasbourg, France.
- > Council of Europe. 2006. "Report to the Polish Government on the visit to Poland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) of 4-15 October 2004." CPT/Inf (2006) 11. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Strasbourg, France.
- > Council of Europe. 2008. Convention on Action Against Trafficking in Human Beings. CETS No.: 197. Strasbourg, France.
- > Council of the European Union. 2006. 2767th Council Meeting: Employment, Social Policy, Health and Consumer Affairs (30 November-1 December 2006). 15487/06 (Presse 330). Brussels, Belgium.
- > Council of the European Union. 2007. Employment, Social Policy, Health and Consumer Affairs Council Meeting on 5 and 6 December. Health and Migration in the EU - Policy Debate / Adoption of Council Conclusions. 15609/07. Brussels, Belgium.
- > Davies, A., A. Basten, and C. Frattini. 2009. *Migration: A Social Determinant of the Health of Migrants*. IOM. Unpublished manuscript.
- > Divinský, B., 2008. "Data and Trends across Europe." *Undocumented Migration: Counting the Uncountable*. Country Report: The Slovak Republic ed.
- > Dodge JS. 1969. The Fieldworker in Immigrant Health. Staples Press.
- > *Dougoz C. Grèce*. 40907/98 (European Court of Human Rights, 2001).
- > Duckett, M., 2001. *Migrants' Right to Health*. UNAIDS/01.16E. Geneva, Switzerland: UNAIDS, IOM.
- > EC. 2003. Council Directive on Laying Down the Minimum Standards for the Reception of Asylum Seekers. Official Journal of the European Union 2003/9/EC[L 031 ].
- > EC. 2004. Council Directive on Minimum Standards for the Qualification and Status of Third Country Nationals or Stateless Persons As Refugees or As Persons Who Otherwise Need International Protection and the Content of the Protection Granted. Official Journal of the European Union 2004/83/EC[L 304/12].
- > EC. 2004. Council Directive on the Residence Permit Issued to Third-Country Nationals Who Are Victims of Trafficking in Human Beings or Who Have Been the Subject of an Action to Facilitate Illegal Immigration, Who Cooperate With the Competent Authorities. Official Journal of the European Union 2004/81/EC[L 261/19].
- > EC. 2006. Commission Recommendation Establishing a Common "Practical Handbook for Border Guards (Schengen Handbook)" to Be Used by Member States' Competent Authorities When Carrying Out the Border Control of Persons. C (2006) 5186.

- > EC. 2006. Regulation (EC) of the European Parliament and of the Council Establishing a Community Code on the Rules Governing the Movement of Persons Across Borders. Official Journal of the European Union 562/2006[L 105/1].
- > EC. 2008. "External borders control, Removal and readmission: Recommendations and best practices." *EU Schengen Catalogue*. 15250/2/08. Brussels, Belgium.
- > ECRI. 1995. Report summarising the replies received to the questionnaire drawn up by ECRI European Commission against Racism & Intolerance (ECRI), Strasbourg: Council of Europe (Document CRI (95)3).
- > EP. 2008. "Draft Report from the Committee on civil liberties, justice and home affairs on the delegation to Poland." European Parliament Committee on civil liberties, justice and home affairs.
- > European Commission of Human Rights. 1999. "Report of the Commission on Applications 6780/74 and 6950/75."
- > European Refugee Fund. 2007. "Country Report: Poland."
- > European Refugee Fund. 2007. "Country Report: Slovakia."
- > European Refugee Fund. 2007. "Country Report: Hungary."
- > Futo P. 2008. "Data and Trends across Europe." *Undocumented Migration: Counting the Uncountable*. Country Report: Hungary ed.
- > German Aids Federation. 2009. *Global Database on HIV related Travel Restrictions*. European AIDS Treatment Group (EATG), German AIDS Federation (Deutsche IDS-Hilfe, DAH), International AIDS Society (IAS).
- > Gmaj, K., 2008. "Data and Trends across Europe." *Undocumented Migration: Counting the Uncountable*. Country Report: Poland ed.
- > Hungarian Border Guards, 2007. *Statistics 2006*.
- > Hungarian Helsinki Committee. (HHC). 2006. "Alternative Report Regarding the Fourth Periodic Report of Hungary Under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment." Budapest, Hungary.
- > Hungarian Helsinki Committee (HHC). 2008. "Asylum Seekers' Access to Territory and to the Asylum Procedure in the Republic of Hungary" *Report on the Border Monitoring Program's First Year in 2007*. Budapest, Hungary.
- > International Helsinki Federation for Human Rights and Coll. 2006. "Places of Detention in Hungary" *Report from the visit of the delegation of human rights NGOs to places of detention in Hungary on 11 and 12 May 2005*. Vienna, Austria.
- > International Helsinki Federation for Human Rights and Coll. 2006. "Places of Detention in Poland." (Report from the visit of the delegation of human rights NGOs to places of detention Poland on 24 - 26 October 2005.) Vienna, Austria.
- > IOM. 2003. *Budapest Declaration on Public Health and Trafficking in Human Beings*. Regional Conference on Public Health & Trafficking in Human Beings in Central, Eastern and Southeast Europe. 2003. Budapest, Hungary.
- > IOM. 2004. "Glossary on Migration." *International Migration Law No 1*. Geneva, Switzerland.
- > IOM. 2004. *A Set of Minimum Standards: The Mental Health Aspects of Trafficking in Human Beings*. Budapest, Hungary.
- > IOM. 2004. *Migrant Health for the Benefit of All*. MC/INF/275. Geneva, Switzerland.
- > IOM. 2005. "Costs and Benefits of International Migration." *World Migration 2005*. Geneva, Switzerland.
- > IOM. 2008. *Exchange of information and best practices on first reception, protection and treatment of unaccompanied minors: Manual of Best Practices and Recommendations*. Brussels, Belgium.
- > IOM. 2007. *Migration and Health Factsheet*. Cairo, Egypt.
- > IOM. 2008. "Managing Labour Mobility in the Evolving Global Economy." *World Migration 2008*. Geneva, Switzerland.
- > Jesuit Refugee Service Europe (JRS). 2007. "Civil Society Report on Administrative Detention of Asylum Seekers and Illegally Staying Third Country Nationals in the 10 New Member States of the European Union."
- > Kindler, M. and E. Matejko, 2008. "Gateways to Europe: Checkpoints on the EU External Land Border." *Monitoring Report*. Warsaw, Poland: Stefan Batory Foundation.

- > Mink, J., 2007. *Detention of Asylum-Seekers in Hungary. Legal Framework and Practice*. Budapest, Hungary: Hungarian Helsinki Committee.
- > Ministry of the Interior, Bureau of Border and Alien Police. 2007. *Yearbook: Slovakia*. Bratislava, Slovakia.
- > Odysseus - Academic Network for Legal Studies on Immigration. 2007. *Comparative Overview of the Implementation of the Directive 2003/9 of 27 January 2003 Laying Down Minimum Standards for the Reception of Asylum Seekers in the EU Member States*.
- > OECD. 2006. *International Migration Outlook*.
- > OHCHR. 2008. *The Right to Health, Fact Sheet No. 31*. Geneva, Switzerland.
- > Pace, P. 2007. "Migration and the Right to Health." *International Migration Law* No 12. IOM.
- > Pribytkova, I. and J. Gromovs. 2007. *Migration trends 2004-2006 SÖDERKÖPING Process countries*.
- > STEPS Consulting Social. 2007. *The Conditions in Centres for Third Country National (Detention Camps, Open Centres as well as Transit Centres and Transit Zones) with a Particular Focus on Provisions and Facilities for Persons with Special Needs in the 25 EU Member States*. IP/C/LIBE/IC/2006-181. European Parliament Committee on Civil Liberties, Justice and Home Affairs.
- > Szigo, T. 2007. *Reception Conditions and the Impact of the EU Directive in Hungary*. Budapest, Hungary: Hungarian Helsinki Committee.
- > UN. 1988. Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment. 7th Plenary Meeting. A/RES/43/173. General Assembly of the United Nations.
- > UN. 1955. Standard Minimum Rules for the Treatment of Prisoners, Article 19. General Assembly of the United Nations.
- > UNHCR. 2006. *The Monitoring of Access of Refugees and Other Persons of Concern to UNHCR to Refugee Status Determination Procedure in Poland*.
- > University of Athens Medical School, IOM. 2005. *Integrated Methodological Framework of the Monitoring and Assessment Tool and Questionnaires*. Athens, Greece.
- > University of Primorska. 2007. "The Risk Group of Unaccompanied Minors: Protection Measures in an Enlarged European Union." (Report about the Final Conference of the Minors Project), Science and Research Centre of Koper, Slovenia.
- > UNODC. 2006. "Chapter 8: Victim Assistance." *Toolkit to Combat Trafficking in Persons*. Vienna, Austria.
- > U.S. Department of Health and Human Services. 2007. *Rescue & Restore Campaign Tool Kits*.
- > Vselkova, M. 2007. *Reception Conditions and the Impact of the EU Directive in Slovak Republic*. Bratislava, Slovakia: Slovak Humanitarian Council.
- > WHO. 2003. *International Migration, Health and Human Rights*. Issue no 4. Geneva, Switzerland.
- > WHO. 2005. *International Health Regulations*.
- > WHO. 2005. "Mental Health Policy and Service Guidance Package." *Mental Health Policies and Programmes in the Workplace*. Geneva, Switzerland.
- > WHO. 2005. Revision of the International Health Regulations. WHA58.3 [Fifty-Eighth World Health Assembly]. Geneva, Switzerland.
- > WHO. 2008. World Health Statistics 2008. Geneva, Switzerland.
- > WHO. 2009. Global burden of disease: 2004 update. Geneva, Switzerland.









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