ASSESSMENT REPORT:
Health Situation at EU Southern borders:
Migrant Health, Occupational Health, and Public Health

SPAIN

Field work 18–27 November 2013

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This document is based on desk review and field work undertaken by the International Organization for Migration (IOM), the Andalusian School of Public Health (EASP), and the Coalition for the Study of Health, Power, and Diversity (CESPYD), the Centre of Community Research and Action at the University of Seville, within the framework of the project "Equi-Health: Fostering health provision for migrants, the Roma, and other vulnerable groups." The Equi-Health project is co-financed under the 2012 work plan, within the second programme of Community action in the field of health (2008–2013), by a direct grant awarded to IOM from the European Commission's Directorate Generale (DG) for Health and Consumers (DG SANTE), through the Consumers, Health, and Food Executive Agency (CHAFEA).

The Equi-Health project is designed and managed by the IOM Regional Office Brussels, Migration Health Division (MHD). The methodology for the field work and analysis, based on the prior "*Increasing Public Health Safety Alongside the New Eastern European Border Line*" (PHBLM) EC co-funded IOM project experience, was developed by IOM with support from CESPYD and the EASP.

This Assessment Report was completed under IOM Migration Health Department (MHD), Regional Office (RO) Brussels guidance by Manuel García-Ramirez, Rocío Garrido, Violeta Luque-Ribelles and Marta Escobar-Ballesta, based on the initial draft report produced by EASP (Amets Suess, Olga Leralta Pinan, Ainhoa Ruiz Azarola, José Ignazio Oleaga Usategui). Due acknowledgment and thanks go to Belén Aguilera, Mª Jesús Albar, Mª Dolores López, Zaira Morales, Lucas Olmedo, Virginia Paloma and Noelia Pelícano. Giuliana Urso, Mariya Samuilova, Marina Rota, Roumyana Petrova-Benedict and Isabelle Beauclercq (IOM MHD) also peer-reviewed and edited the report. We thank Isabel de la Mata, Principal Advisor with Special Interest on Health, Health and Food Safety European Commission for her valuable input and DJ Krastev for his copy-editing, proofreading, and general editing assistance.

IOM is grateful to project and local implementing partners involved during the field visit, as well as to the National Consultative Committee (NCC) – comprised by representatives of various stakeholders, including CSO – for their personal and technical support. In particular, we thank the staff and representatives of: (a) *Tarifa/Algeciras:* Red Cross, Algeciras Acoge, Fundación Cruz Blanca, Colectivo Lacalle; Junta de Andalucía, University of Cadiz, University of Seville, Nursing School, Guardia Civil, Hospital Punta Europa, CIE Isla de las Palomas, Ports of Tarifa and Algeciras, Centre managed by Red Cross, Shelter Parroquia de Pescadores; (b) *Madrid:* CEAR, SJM, Comillas, Pueblos Unidos, ACCEM, ACOGE Madrid, Salud entreculturas NGO, Hospital Ramón y Cajal, CIE Aluche-Carabanchel, Médicos sin Fronteras, Médicos del Mundo, CAR Vallecas, Centro de Acogida Red Cross; and (c) *Melilla:* Red Cross, SJM, Melilla Acoge, CEAR, Guardia Civil, El Telégrafo de Melilla, PRODEIN, Hospital Comarcal de Melilla, CETI Melilla, Port of Melilla.

IOM would also like to convey its appreciation to the Spanish Ministry of Internal Affairs for providing access to the different centres mentioned in this document.

A particular vote of thanks is due to national and international team members who carried out the field visits with great enthusiasm and professionalism, and who provided valuable insights in the process: Alberto Rodríguez García – Spanish Ministry of Interior (MoI); Carmen Cosentino – Italian MoI; María Ochoa Llido and Markus Jaeger from the Council of Europe, Ileana Andrea

Niculiu from Frontex, the researchers Amets Suess, Olga Leralta Pinan, Ainhoa Ruiz Azarola and Bibiana Navarro from EASP, the researcher Soorej Jose Puthoopparambil, and Magdalena Bjerneld from Uppsala University, and the IOM team Roumyana Petrova-Benedict, Giuliana Urso and Marjolein Devos (MHD, RO Brussels), Teresa Botella and Olivia Rodríguez (IOM Spain).

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ACRONYMS

CAR	Refugee Assistance Centres (*Centro de Ayuda al Refugiado*)
CETI	Centres for Temporary Stay of Migrants (*Centros de Estancia Temporal de Inmigrantes)*
CIE	Migrant Detention Centres (*Centros de Internamiento de Extranjeros)*
CEAR	Spanish Refugee Assistance Commission (*Comisión Española de Ayuda al Refugiado)*
COS	Operation Centre of the GC Headquarter in Melilla (*Central de Operaciones de la Comandancia de la Guardia Civil de Melilla)*
CSOs	Civil Society Organizations
DG	Directorate General
DG SANCO	European Commission's Directorate General for Health and Consumers
EC	European Commission
EDATI	Immigrant Support Team (*Equipo de Atención al Inmigrante de la Guardia Civil)*
EU	European Union
EWG	Expert Working Group
GC	*Guardia Civil*
GEAS	Special Group of Underwater Operations of the GC (*Grupo Especial de Actividades Subacuáticas de la Guardia Civil)*
HIV	Human Immunodeficiency Virus
HR	Human Rights
HSP	Health/Social-care Providers
IHR	International Health Regulations
IOM	International Organization for Migration
IS	Information Service of the GC (*Servicio de Información de la Guardia Civil)*
LO	Ley Orgánica
LEO	Law Enforcement Officers
MH SEUB	Equi-Health project Southern EU Border component
MRS	Maritime Rescue Service
NCC	National Consultative Committee
NGOs	Non-Governmental Organizations
PHS	Public Health System
PRL	Occupational Risk Prevention Office of the GC (*Servicio de Prevención de Riesgos Laborales)*
RC	Red Cross (*Cruz Roja)*
SAS	Andalusian Health-care System (*Servicio Andaluz de Salud)*
RDL	Royal Decree-Law (*Real Decreto Ley)*
SIRIA	Integrated and Collection Capacity Information System (*Sistema Integrado y Recolección de Información de Aforos)*
SIVE	Integrated Exterior Surveillance System
TB	Tuberculosis
UNHCR	United Nations High Commissioner for Refugees
USC	Citizen Safety Unit (*Unidad de Seguridad Ciudadana)*
WHO	World Health Organization

EXECUTIVE SUMMARY

Spain has been transformed from being traditionally an emigration country to becoming one of the most important European centres for immigration in the last few decades.[1] In 2013, out of a total population of 46,609,652, the foreign nationals (4,870,487) represented 10.45 per cent. However, due to the economic crisis of the last few years, Spain registered a negative migratory balance (–256,849 from 1 January 2013 to 1 January 2014).

There are two groups of migrants that deserve special attention due to their legal status: asylum-seekers and irregular migrants.

- Spain has a relatively high asylum application rejection rate compared to other European countries. However, the total number of asylum applications diminished from 7,664 in 2007 to 2,588 in 2012 (INE, 2014e). The confirmed nationalities of origin with the highest number of asylum applications in 2012 were Syrian Arab Republic (254), Nigeria (203) and Algeria (202), followed by Cameroon (121) and Côte d'Ivoire (109) (INE, 2014e).
- Data on arrivals of irregular migrants to Peninsula and Balearic Islands show a decrease in the last years. However, Ceuta and Melilla registered in 2013 a growth of 49 per cent of irregular migrants' arrivals (4,235) from 2012 (2,841).

Migrants enter Spain in different ways: (a) by air – arriving at the two main Spanish international airports, Madrid (Barajas) and Barcelona (El Prat); (b) by boat – coming ashore primarily in Andalusia and Canarias; and (c) by land – crossing the French–Spanish border or the borders between Morocco and Spain (either Ceuta or Melilla) (FRA, 2013; Frontex, 2013; ICMC-EUROPE, 2011).

The desk review findings and the results of the November 2013 assessment undertaken within the Equi-Health project are structured according to the four pillars proposed by IOM, based on the WHA Resolution on the Health of Migrants (2008) and resulting from the IOM-WHO-Spanish Presidency of the EU *Global Consultation on the Health of Migrants (2010*) Framework for Action:[2]

I. **Policy and Legal Framework**
II. **Partnerships, Networks, and Multi-Country Frameworks**
III. **Monitoring Migrant Health**
IV. **Migrant-Sensitive Health System**

[1] Reher, D. and Requena, M. *The National Immigrant Survey of Spain: A new data source for migration studies in Europe*. *Demographic Reasearch, 2.* (2009). Available from www.demographic-research.org/volumes/vol20/12/20-12.pdf

[2] Please see Annex II.

Policy and Legal Framework

At EU level, there is a broad legal and strategic framework addressing migration, cross-border mobility, return, expulsion, deportation, asylum, and public health surveillance, applicable to Spain as an EU Member State.

At national level, *"legislation has been modified many times in order to keep pace with the increase of migrant population and the new challenges derived from it. From the beginning, the focus has been on controlling the flow of migrants and combating illegal migration, which represents a central problem for Spain. Although questions concerning the social integration of Ceuta migrants were not initially addressed, they are increasingly gaining importance. While immigration has become a key political and social issue in public debate, discussion over what it will mean for Spain and the Spanish self-image in the future is only starting to get off the ground".*[3]

The *residence* entitlements and deportation norms for migrants are regulated by *Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social* (LO 4/2000), which has been modified several times over the last decade. Regular foreigners are entitled to move freely across Spanish territory and to choose their residence. Besides, Spain is committed to guaranteeing the protection of Human Rights and to cover the needs of all asylum-seekers, in accordance with the EU law known as "Dublin Regulation."[4] Regarding irregular foreigners, LO 4/2000 states that foreigners who are denied entry at the borders must return to their place of origin. If their return is delayed longer than 72 hours, the examining judge must determine the detention centre where they must remain until they leave the country. Irregular migrants' expulsion and denial of entry is regulated by LO 4/2000 (modified by LO 2/2009 and Royal Decree-Law 16/2012). LO 4/2000 also contains specific regulations concerning pregnant women and minors.

Foreigners who do not comply with the established requirements for entry into Spain and/or those who enter the country illegally can be transferred to different *centres*, according to the judicial decision (LO 4/2000, 11 January): (a) Migrants who are to be removed from Spain are sent to Migrant Detention Centres (CIEs) while their expulsion is processed; (b) Migrants granted the asylum-seeker or refugee status who can prove that they have no resources are sent to Refugee Assistance Centres (CARs); (c) migrants about whom a judicial decision has not been made are sent to reception centres in the interim (CETIs – Centres for Temporary Stay of Migrants, and centres managed by CSOs). Current legislation establishes that legally constituted organisations for the protection of migrants and other relevant international organisations may visit migrant detention centres. Nevertheless, some CSOs have denounced the secrecy, lack of transparency and restrictions to their access to these centres.[5]

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[3] Focus Migration (2008). http://focus-migration.hwwi.de/Country-Profiles.1349.0.html?&L

[4] See Council Regulation (EC) No. 343/2003 (Dublin II Regulation) and Regulation (EU) No. 604/2013 (Dublin III Regulation).

[5] Centros de Internamiento en España (APDHA, 2008). www.apdha.org/media/CIESoctubre.pdf

Regarding migrants' *entitlement to health-care services,* until recently health care was free in Spain.[6] However, on 20 April 2012, Royal Decree (RDL) 16/2012 limited access to the Public Health-care System (PHS) to those insured and certain other beneficiaries officially labelled as "beneficiaries." Legally residing migrants are covered by the same system as nationals. If they are neither insured by, nor beneficiaries of the Social Security System, they can only access health services if they pay for them (RDL 16/2012).

The following people in vulnerable situations are also entitled to health care: (a) Foreign women during pregnancy, childbirth, and postpartum, subject to the same requirements as Spanish women; (b) Foreign minors under 18 are treated similarly with all Spanish citizens; (c) Victims of human trafficking. Emergency cases are also covered by the PHS. Also, according to LO 4/2000, modified by LO 2/2009, undocumented migrants who are at the centres while their deportation is being processed are entitled to health care and social assistance.

As the PHS of every autonomous region is independent from central authority, the implementation of the RDL 16/2012 differs from one region to another, resulting in a variety of contradictory health entitlement models in Spain. On the whole, because of the RDL 16/2012, migrants in Spain have practically lost their health care coverage.

Partnerships, Networks, and Multi-Country Frameworks

Irregular migrants attempting to reach Spain by land enter the border city of Melilla through one of these three entry points: (a) The pedestrian border crossing known as Barrio Chino, which also serves as a border checkpoint for freight traffic; (b) The Beni Enzar border point – where there were cases of women and children presenting fake passports or hiding in the false bottoms of vehicles to enter Spain; and (c) the fenced border that separates Melilla from Morocco, which young men try to jump to get into Spanish territory. Entry by sea takes place in Melilla and Algeciras-Tarifa, where there is a clearly defined reception process for migrants who are intercepted, and all those actors (e.g. Red Cross, Moroccan Law Enforcement Officers (LEOs), Maritime Rescue Service, Guardia Civil, etc.) involved in the process are coordinated by an intervention protocol. And third, undocumented migrants also reach Spain through main airports; Madrid's Barajas airport is one of the biggest travel hubs in the country with direct connections to many other EU countries.

Migrants without urgent medical needs who are intercepted on land, at sea, on the coast, or at airports are transferred directly to the nearest Policía Nacional station, where registration and nationality assessment are carried out. The transfer process reassigns migrants to different centres depending on their own circumstances (ICMC-Europe, 2011): Either Reception Centres (i.e. CETIs, Centres managed by CSOs) and CARs or CIEs for those whose deportation is pending. In Melilla and Ceuta, migrants are taken to CETIs, where they wait for a judge's decision. In Algeciras-Tarifa, they are transferred to the Red Cross centre, a CAR, or a CIE, depending on their administrative status.

[6] Health system in Spain was based on social security rights and extension of coverage. Health provision was financed via the tax system although people in freelance professions were not covered. Extension of coverage was provided to additional groups entitled to health care, such as migrants and asylum-seekers.

When the deportation process cannot be completed, migrants are "freed" and abandoned to their fate, living in social and legal limbo. The same applies to asylum-seekers who are not granted asylum and are forced to leave the CAR. In this situation, migrants are released in the community and so they become part of the large migrant and undocumented population living in Spain. There is no regulation for migrants in this situation, as they cannot legally work, and have no access to health-care services, or social protection. In many cases, and in order to survive, they look for shelter in migrant settlements characterized by deplorable living conditions and the total lack of health care and social services. Nevertheless, regional laws are also responsible for the differences in the health-care services offered in different regions. In *Andalusia,* access to health care is guaranteed for everyone including irregular migrants, even individuals without health cards and those who refuse to identify themselves. In Madrid, RDL 16/2012 limits adult migrants' access to emergency and perinatal medical services. In Ceuta and Melilla, health care is ensured for migrants only if they are residing legally with a working visa, as well as if they fulfill the requirements imposed by RDL 16/2012. Migrants who are living at CETIs and other open centres are entitled to health care and social assistance according to LO 4/2000 modified by LO 2/2009. Undocumented migrants who are not living at these centres are only entitled to receive health-care assistance if they are minors, pregnant women and in cases of medical emergencies. Additionally, hospitals in Melilla assist Moroccan people who live in adjacent areas to Melilla free of charge. This situation causes a critical public debate since the resources are not designed to cover all this population or Spain to assume health-care assistance of Moroccan people.[7]

Two main issues threaten *public health in external EU border cities* (i.e., Melilla and Ceuta). First, thousands of people legally cross the border daily without any health control, either to go to work or to shop on Spanish territory. Second, deteriorating living conditions in the centres and settlements, together with migrants' fewer financial resources to buy medicines are causing some diseases long since eradicated to re-emerge. In order to prevent this, when migrants arrive at the centres, they first have to undergo a medical examination known as "Africa profile", as well as other tests and examinations. However, first-line staff – in particular the Guardia Civil - has not been sufficiently trained to protect themselves from infectious diseases and to detect basic symptoms in order to inform health authorities.

Monitoring Migrant Health

Out of the migrants[8] arriving in Spain, those with the most health problems are the ones who scale the border fences and the ones arriving by boat. The latter often suffer from hypothermia, muscle strains, skin burns (caused by fuel, sea salt, or sun exposure), dehydration, and anaemia. Migrants often spend long periods of time hiding in camps on Gourougou Mountain, waiting for the right moment to cross the border. Health care and social-care providers (HSPs)

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[7] El Gobierno sigue sin contestar sobre el gasto sanitario a marroquíes. El Faro. See more at: http://elfarodigital.es/melilla/politica/26882-el-gobierno-sigue-sin-contestar-sobre-el-gasto-sanitario-a-marroquies.html#sthash.J5J0Ow7V.dpuf

[8] To reflect the current mixed migration flows, the term "migrant" in this report refers to asylum-seekers, and migrants in irregular situation. As mixed migration flows IOM define the "complex migratory population movements that include refugees, asylum-seekers, economic migrants and other migrants, as opposed to migratory population movements that consist entirely of one category of migrants". IOM Glossary of Terms, 2nd Edition (2011).

report diseases linked to their stay there, including respiratory diseases, parasitism, and skin diseases such as scabies.

After having overcome the perilous journey to Spain and the health problems that it entails, migrants face further health challenges due to poor living conditions such as overcrowding, lack of health care, poor diet, and cold weather in the settlements and in the centres where they are housed.

Provision of health care in reception and detention centres

Migrants receive emergency medical assistance on an as needed basis. Although some centres do have primary care units, the services available and the immediacy of the assistance depend on the type of centre.

In Andalusia, respondents indicate that migrants are generally in good physical condition. Among female migrants, frequent cases of gender-based violence are reported by first line staff. Furthermore, staff interviewed during our field visits indicated anxiety disorder, alcoholism, and adaption problems in migrants who had been living in Spain for some time.

In Madrid, respondents identify Chagas as the most common health problem in migrants. In CARs, anxiety, depression, as well as consequences from the migration journey, torture, and gender-based violence were identified as the most common problems.

In Melilla, interviewed experts highlight that migrants arriving at the CETI present specific injuries as a consequence of climbing over the fence and/or from physical altercations with Spanish and Moroccan LEOs. Most of the reported (by the Melilla hospital) cases of migrants (from both sides of the border) seeking hospital care stem from traffic accidents, multiple injuries, hip fractures, cancer, as well as high risk pregnancies. In Melilla, interviewed experts highlight the specific situation of health-care services and difficulties in calculating their respective cost in a region with a high number of trans-border commuters who may or may not have insurance. Furthermore, as per recent changes in Spanish legislation (i.e. RDL 16/2012), irregular migrants do not have access to health care.

Provision of health-care services (PHS) and social assistance

Primary health care at CIEs and CETIs is subcontracted out to private health-care services providers. If hospital care is needed, migrants are escorted by LEOs to the nearest public hospital. In CETIs, there is a standard procedure for migrants to follow in the first days after their arrival, including a compulsory medical screening before being transferred to the Spanish mainland. Asylum-seekers living in CARs have access to the PHS through primary health-care centre and/or the reference hospital.

Health-care services available in CIEs are considered insufficient by the expert team who visited the facilities. Gaps and irregularities in the health-care services provided were noted, as well as in the hospital referral process.

Regarding access to HIV testing and treatment, respondents indicate that testing and treatment are free of charge to all in Spain, as an exception to the restrictive measures established by RDL 16/2012. According to respondents, HIV testing in CIEs is conducted on a voluntary basis.

Interviewed experts indicate that in CETIs, upon arrival migrants undergo a compulsory testing procedure called "African Profile", which includes a haemogram test and also screens for Hepatitis B/C, HIV, and Tuberculosis (TB).

Data collection systems differ by region

Interviewees highlight that medical records from CIEs are not available, making health monitoring of released migrants challenging.

Migrant-sensitive Health System

The infrastructure and the living conditions in reception, refugee, and detention centres vary from one facility to another. The most frequent problem is budget deficit, which affects living conditions (i.e. poor diet, overcrowding, excessive cold or heat, inadequate sanitation, lack of social activities). These are self-evident obstacles to the establishment of a migrant-sensitive health system.

In evaluating *infrastructure and physical conditions* in centres, we can summarize:

- CETIs are conceived as first reception centres located in Ceuta and Melilla that offer services and basic social benefits. Although they have been designed for short-term stays, these stays can be extended.
- CETIs can accommodate around 400 people, including single males and females, and families. The main problem of CETIs is the overcrowding. Centres provide three meals a day and have ample supplies of personal hygiene kits, clothing, bedsheets, etc.
- Regarding centres managed by CSOs, the RC centre in Algeciras is subsidised by the Government of Spain**,** and also provides pocket money for the residents' minor expenses (EUR 25 a month). The centre has 35 beds for stays ranging from three to six months. Men are separated from women and children, even if they are members of the same family.
- CARs are managed by the Ministry of Employment and Social Security together with different CSOs (e.g. RC, ACCEM, CEAR). There are four CARs in Spain with a total of almost 400 available spaces – that is insufficient relative to demand for places. Stays in CARs are generally for six months, but can be extended to 12–18 months maximum. Centres provide three meals a day and a personal hygiene kit, towels, blankets, and laundry products for each individual. Families and single people reside on different floors.
- CIEs are usually located in former prisons and military buildings, and are inadequately equipped to accommodate migrants. NGO and International Organisations' reports highlight a variety of problems, including: overcrowding, deteriorated building infrastructure, physically enclosed architecture, virtually locked-down cells at night, segregated modules for men and women, use of isolation cells and use of handcuffs, lack of external communication, absence of essential items, shortage of toilets, lack of dedicated medical services rooms or even physical space, lack of privacy, etc. These deficient living conditions create physical and mental health risks for detainees.

Concerning *occupational health of staff*, HSPs and LEOs acknowledge the shortage of staff in centres. Also, they state that there is a lack of training in cultural competences, which is a prerequisite in order to work with diverse people. HSPs report being highly motivated with respect to their work and aware of basic protection measures, and generally do not believe

there is a need for specific prophylaxis. LEOs indicate that they suffer from high staff turnover. Both LEOs and HSPs acknowledge that working with irregular migrants is psychologically challenging, so they often suffer from anxiety and stress. Also, some LEOs report having ambivalent feelings about dealing with the paradox of following institutional orders, which are in conflict with their humanitarian feelings. Finally, providers' health knowledge, attitudes, and practices vary according to their professional background. In general, the training they have received is limited to first aid. Nevertheless, they claim having specific training in health, migration issues (e.g. human trafficking), and competences to work with vulnerable populations.

Conclusions

Key challenges identified during the assessment are: (a) the limited access to health services for undocumented migrants and potential public health risks in consequence of the health-care reform introduced by the RDL 16/2012; (b) the lack of coordination between CIEs/CETIs and the public health-care system; (c) the lack of resources in reception centres and poor living conditions in detention centres; (d) the limited number of staff at the centres; (e) the unavailability of psychological care for migrants; (f) the lack of information about legal rights to migrants, while detained; and (g) the absence of adequate recordkeeping of medical information.

In order to respond to these challenges, we make the following core recommendations:

- Fostering strategies at EU level that strengthen the efficient management of migration flows, in order to prevent sea tragedies during the migration processes and to guarantee fundamental rights of migrant people;
- Ensuring compliance with national, European, and international legislation which regulate the reception process and the health-care system, and which create regulations for loophole situations;
- Increasing cooperation between the EU and countries of origin in order to foster regular migration. Spain would be a strategic country in this task, due to the physical borders it shares with Africa;
- Providing universal and equitable access to health-care services for all migrants, with particular attention being paid to vulnerable groups like undocumented migrants, women, and minors;
- Guaranteeing decent living conditions, health care, and social assistance, including intercultural mediation, in centres;
- Training LEOs and HSPs in cultural competencies, and including topics such as (a) critical awareness which would enable providers to reflect upon their own cultural backgrounds and to empathize with migrants; (b) finding positive meaning in their work; (c) gaining capacity to take action in contexts of cultural diversity – based on intercultural skills, social justice values, and organizational support which empower them; and (d) embedding community based sustainability in cooperation with other professionals and institutions.

Finally, we want to point out: (a) the provision of universal access to health-care services in several autonomous regions despite the changes brought on by RDL 16/2012 (b) the

establishment of a "Monitoring Courts" in CIEs; (c) the inclusion of CSOs in provision of legal services, (d) the European project "Migrant-Friendly Hospitals";[9] (e) the cultural sensitivity in perinatal care in Andalusia;[10] and (f) the availability of simultaneous interpretation services by phone in Andalusia and Madrid.

[9] For more information about the Migrant Friendly Hospital project, see at: http://ec.europa.eu/health/ph_projects/2002/promotion/fp_promotion_2002_frep_14_en.pdf

[10] García-Ramírez, M., Hernández-Plaza, S., Albar, M.J., Luque-Ribelles, V. and Suárez-Balcázar, Y. Building healthcare stakeholder coalitions: a community psychology approach to user involvement for migrant populations. In D. Ingleby, A. Chiarenza, W. Devillé, and I. Kotsioni (Eds.). *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity* (pp. 207-22), Volume II. Antwerp/Apeldoorn: Garant (2012).

INTRODUCTION

This document has been developed within the framework of the Equi-Health project co-funded by EC/DG SANTE, Southern EU Border component (MH SEUB), to present the findings of the International Organization for Migrants (IOM) desk review[11] and field work held in Spain (Algeciras, Huelva, Madrid, Melilla, and Tarifa) from 18 to 27 November 2013.[12]

The Equi-Health desk review and field work assessment aims to address: (1) migrant health; (2) occupational health; and (3) public health under the overall lens of equitable migration management during different stages of the **reception process of complex migration flows[13] –** from rescue at sea onward, including detention and reception centres.

Health is an essential element for effective migration management. The concept of health goes beyond diseases – it includes physical, psychological, and social wellbeing. Migration health addresses both the needs of individual migrants and the public health of the receiving communities through policies and practices that face the challenges concerning migration.

Therefore, the approach used in this assessment aims to be as comprehensive as possible, covering communicable and non-communicable diseases, emergency interventions, chronic diseases, mental health, understanding of culture and health beliefs, Human Rights (HR) protection, migration health management, and other factors that impact the health of migrants, staff, and the communities which interact with them.

The desk review and field work findings are presented within the IOM/WHO/Spanish Presidency of the EU "Global Consultation on Migrant Health" conceptual framework (Madrid, 2010), following its four pillars:

I. **Policy and Legal Framework;**
II. **Partnerships, Networks and Multi-country Frameworks;**
III. **Monitoring Migrant Health;**
IV. **Migrant-Sensitive Health Systems.**

[11] The objective of the desk review was to collect all the relevant information on migrant health, occupational health of health professionals/law enforcement officers and public health in order to assess the gaps on the topics to be covered in the assessment phase. It reviewed available literature on national and regional level.

[12] This report presents a snapshot assessment conducted at a given moment in time, so additional developments and policy actions may have taken place in the meanwhile.

[13] IOM identifies complex flows as comprising: asylum-seekers, victims of trafficking, smuggled and stranded migrants, unaccompanied (and separated) migrant children, those with specific health needs or subject to sexual, physical, and psychological violence (including gender-based) during the migration process and family members seeking to re-unite with their families. In addition, these flows may include migrant workers and migrants moving for environmental reasons (IOM, *Addressing complex migration flows and upholding the rights of migrants along the central Mediterranean route*, Discussion paper, 21 October 2013, Brussels).

BACKGROUND INFORMATION

Spain has been transformed from traditionally being an emigration country to becoming one of the most important immigration destinations in Europe in the last few decades.[14] The rapid economic growth, the needs of an increasingly fragmented labour market, and aging of the population have turned Spain into an attractive destination for migrants from all over the world – especially from North Africa, Latin America, and Eastern Europe.[15]

In 2013, Spain's foreign population (defined as residents not possessing Spanish nationality) **was 10.45 per cent (4,870,487) of the total (46,609,652)** (Table 1), representing a net migration of 599,997 for the 2010–2014 period. The main autonomous communities of destination are Cataluña, Madrid, and Andalusia.

Table 1: Evolution of population resident in Spain during the first six months of 2013

	Población residente a 1 de julio 2013(*)	Crecimiento absoluto en el semestre(*)	Crecimiento relativo (%)(*)
Total	46.609.652	-118.238	-0,3
Españoles	41.739.166	83.956	0,2
Nacidos en España	40.102.277	-21.962	-0,1
Nacidos en el extranjero	1.636.889	105.918	6,9
Extranjeros	4.870.487	-202.193	-4,0
Nacidos en España	437.780	8.869	2,1
Nacidos en el extranjero	4.432.707	-211.062	-4,5

Source: INE, 2014.

Morocco, Romania, and Great Britain are the foreign countries with the most nationals in Spain (Table 2). Romania and Morocco also lead the list of countries whose citizens are emigrating from Spain and thus returning to their countries of origin or going somewhere else (Figure 1).

Table 2: Fluctuation in foreign population resident in Spain

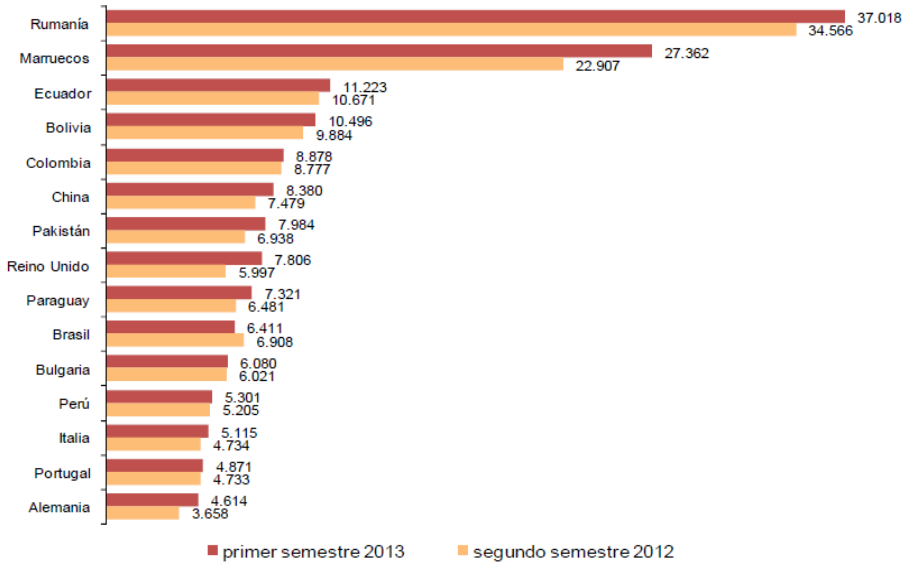
Principales nacionalidades	Población residente		Crecimiento absoluto en el semestre	Crecimiento relativo (%)
	a 1 de enero 2013	a 1 de julio 2013(*)		
Total	5.072.680	4.870.487	-202.193	-4,0
Rumanía	769.608	746.604	-23.004	-3,0
Marruecos	759.273	736.121	-23.152	-3,0
Reino Unido	316.362	314.585	-1.777	-0,6
Ecuador	269.436	240.735	-28.701	-10,7
Colombia	223.140	194.812	-28.328	-12,7
Italia	181.046	181.673	627	0,3
China	169.645	167.067	-2.579	-1,5
Alemania	153.432	151.891	-1.541	-1,0
Bolivia	162.538	144.665	-17.873	-11,0
Bulgaria	147.310	143.931	-3.379	-2,3
Portugal	116.431	113.269	-3.162	-2,7
Francia	101.466	101.255	-211	-0,2
Perú	109.639	96.220	-13.419	-12,2
Argentina	95.415	88.502	-6.913	-7,2
Ucrania	84.081	83.288	-792	-0,9

Source: INE, 2014.

[14] Focus Migration (2008). Available from http://focus-migration.hwwi.de/Country-Profiles.1349.0.html?&L

[15] The National Immigrant Survey of Spain: A new data source for migration studies in Europe. Available from www.demographic-research.org/volumes/vol20/12/20-12.pdf

Figure 1. Emigration of foreigners according to nationality (first semester 2013 – second semester 2012)



Source: INE, 2014.

More than 55 per cent of foreigners living in Spain are between 25 and 44 years old, which is the working-age population.[16] The economic crisis – that has affected productive sectors such as services and construction which employ migrants – has resulted in a high unemployment rate among them. In the last trimester of 2012, there were 4.7 million unemployed Spaniards and 1.2 million foreign unemployed – an **increase of over 200 per cent in the number of unemployed in Spain**, compared to 2007.[17]

And so, due to the economic crisis of the last few years and the acquisition of Spanish nationality by a number of foreign-born persons, **Spain registered** from 1 January 2013 to 1 January 2014, **a negative net migratory balance** of 256,849 people (Table 3). For Spanish nationals, 79,306 people emigrated while 33,393 people immigrated in 2013, confirming the overall negative net migration trend.

Table 3: Migratory flows in 2013 by nationality

	Immigration	Emigration	Migratory balance
Total	291,041	547,890	-256,849
Spaniards	33,393	79,306	-45,913
Born in Spain	16,172	52,160	-35,988
Born abroad	17,221	27,146	-9,925
Foreign nationals	257,648	468,584	-210,936
Born in Spain	6,968	24,189	-17,221
Born abroad	250,680	444,395	-193,716

Source: INE.[18]

[16] See at: www.iom.int/cms/en/sites/iom/home/where-we-work/europa/european-economic-area/spain.html
[17] Junta de Andalucía. *Informe Anual Andalucía Inmigración*. (2012) Available from www.juntadeandalucia.es/justiciaeinterior/opam/?q=informe_anual
[18] INE (2014). *Press Releases*. Available from www.ine.es/en/prensa/np854_en.pdf

Migrants enter Spain in different ways. The main ways of reaching Spain are: (a) by air – arriving at the two main Spanish international airports, Madrid (Barajas) and Barcelona (El Prat); (b) by boat – landing primarily at the Andalusian and Canarian coasts; and (c) by land – crossing the French–Spanish border or the borders between Morocco and Spain (either Ceuta or Melilla) (FRA, 2013; Frontex, 2013; ICMC-EUROPE, 2011).[19] Although the boat and Ceuta/Melilla arrivals are a small percentage of the all arrivals, their social relevance is impressive for various reasons. On the one hand, they represent an important door for irregular migration from Africa. On the other hand, they reflect the harsh conditions of the journey and the extreme risk for migrants. **The deaths, disappearances, and health risks stemming from attempted entry into Spain by sea or by means of jumping the fence** (i.e. recent re-installation of blades in the fence in Melilla) have been widely reported by the press[20] and denounced by CSOs (APDHA, 2014;[21] FRA, 2013).

Attempted breaches of the Spanish enclave borders of Ceuta and Melilla point to a general shift from sea to land borders on the Western Mediterranean route; one of the reasons for this trend may be the strengthened surveillance by the Guardia Civil (GCs) at sea (Frontex 2014). According to the most recent Frontex data (Q1 2014), however, "*the land border with the strongest increase of illegal border-crossings, compared to both the last quarter and the situation one year ago, was around the Spanish enclaves of Ceuta and Melilla. As a result of a number of attempts to cross these borders, three times as many people as in Q1 2013 were able to enter the protected enclaves. While those with sufficient funds used the services of facilitators to reach Spain as clandestine migrants hidden in motor vehicles* (see Figure 3), *the majority of individuals eager to reach Spanish territory simply climbed the fences* (see Figure 4), *frequently in large groups."* (Frontex, 2014:6). The long-term upward trend in land border crossings to Spain continued in Q1 2014, when the country reported more irregular migrant detections than ever, mainly at Madrid Barajas airport, and in Ceuta and Melilla.[22]

The data on arrivals of irregular migrants to Peninsula and Balearic Islands show a decrease (Figure 2) in the last years. However, in 2013 **Ceuta and Melilla registered a 49 per cent increase in irregular migrant arrivals** (4,235) relative to 2012 (2,841). This demonstrates how the routes of irregular migration have changed.

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[19] INE (2007). *National Immigrant Survey*. Available from www.ine.es/jaxi/menu.do?L=1&type=pcaxis&path=%2Ft20%2Fp319&file=inebase

[20] *Regarding the fence in Melilla*, El País. http://elpais.com/tag/melilla/a/ and Ceuta: http://elpais.com/tag/ceuta/a/. In relation to embarkations. http://elpais.com/tag/pateras/a/ and www.wanafrica.com/la-ue-recomienda-alternativas-a-las-cuchillas-en-la-valla-de-melilla/

[21] According to data contributed by APDHA, the number of disappearances or deaths of migrants arriving on the Spanish coasts diminished from 2009 (206) to 2013 (130) (APDHA, 2014:14). In 2013, the highest number of death or disappeared migrants were observed in Morocco (42), followed by Algeria (25), Andalusia (24 and Ceuta (24) (APDHA, 2014:15).

[22] In Q1 2014, of the Member States that are faced with illegal border–crossings, reported the highest increase in detections compared to the same period in 2013. The biggest increase was reported by Italy, where detections rose by over 600 per cent, followed by Spain with an increase of nearly 130 per cent.

Figure 2. Arrivals of irregular migrants to Peninsula

Source: Spanish Ministry of Internal Affairs.

Figure 3. Arrivals of irregular migrants to Melilla and Ceuta

Source: Spanish Ministry of Internal Affairs.

The Spanish Ministry of Internal Affairs[23] **repatriated 23,889 migrants in 2013**, 10 per cent less than the previous year. The main reasons for these repatriations were the following: (a) entry denial at official border posts, such as ports and airports; (b) deportation of readmitted people who have crossed from Spain into France or Portugal, and who were later intercepted and sent back to Spain; (c) returns of people who tried to reach Spain through non-official border posts; and (d) expulsions of people who were apprehended with no legal documents within Spain (Table 4).

Table 4: Repatriation data

	2012	2013	Balance
Denegation	8,647	8,704	+0.7%
Rep. of readmitted people	1,409	1,199	-15%
Returns	6,271	5,002	-21.2%
Expulsions	10,130	8,984	-11.3%

Source: Spanish Ministry of Internal Affairs.

[23] Spanish Ministry of Internal Affairs (2014). See at: www.interior.gob.es/web/interior/prensa/noticias/-/asset_publisher/GHU8Ap6ztgsg/content/id/1915582

Compared to other European countries, **Spain has a relatively high asylum application rejection rate**. The 2013 CEAR report ranks Spain 13th in the EU based on the number of asylum applications received. The total number of asylum applications diminished from 7,664 in 2007 to 2,588 in 2012 (INE, 2014e). According to latest UNHCR report (2014), the number of new asylum applications received in the first two quarters of 2014 was 2,174. The confirmed nationalities of origin with the highest number of asylum applications in 2012 were Syrian Arab Republic (254), Nigeria (203) and Algeria (202), followed by Cameroon (121) and the Ivory Coast (109) (INE, 2014e). The majority of asylum applications are presented inside the Spanish mainland, and only a residual part at border check points, CIEs, or Spanish embassies abroad (CEAR, 2013).

The current political debate over Europe's southern borders revolves around whether to back EU policies focused on border control and the fight against irregular migration, or to give priority to the CSO driven focus of how such policies affect HR. According to Migreurop (2014), European policies are intended to prevent people from leaving their countries of origin; when migrants do manage to leave, European policies are intended to prevent them from reaching European borders; and finally, if they do succeed in crossing into Europe, policies are intended to speed up the repatriation process. Cooperation and repatriation agreements, such as "Planes África" and "Morocco-EU Advanced Status," are examples of this approach (Migreurop, 2014).

The measures adopted by the government to control migration, e.g. "hot returns" in Melilla,[24] the blades on the border fence, and the disproportionate use of riot control weapons at Spanish borders have become a regular issue in political speeches and the media. These measures contravene Spanish laws on foreigners and asylum-seekers, EU legislation, and international agreements to which Spain is a signatory (Migreurop, 2014). The Government of Spain has proposed a reform of the immigration legislation to legalize the abovementioned police practices. Nevertheless, some CSOs and researchers have pointed out that that would contravene EU regulations and international Human Rights laws.[25]

[24] For instance, "Hot returns" is the term coined popularly to the action carried out by the law enforcement authorities and consists of handing the foreign citizens who have been intercepted by those authorities in the area under Spanish sovereignty over to the Moroccan authorities on a de facto basis without carrying out the legally established procedures or meeting the internationally acknowledged guarantees. See more at: www.statewatch.org/news/2014/oct/eu-hot-returns-legal-report.pdf

[25] Martínez et al. *Hot returns: When the State acts outside the law*. (2014). Available from http://oppenheimer.mGCill.ca/Hot-returns-When-the-State-acts?lang=en

METHODOLOGY

The Equi-Health project is designed and managed by the IOM Brussels Regional Office (Migration Health Division). The field work methodology and analysis was based on the prior PHBLM EC co-funded IOM project experience. It was developed by IOM with support from EASP and CESPYD.[26] The work carried out by CESPYD was part of the "Community Cultural Competence: Competent Providers for Diverse Communities" project (PSI2011-25554) funded by the Ministry of Economy and Competitiveness. Some of the information used in this report has been taken from this project.

The methodology also benefited from the discussions and recommendations of an Expert Working Group (EWG) meeting held in Granada, Spain in June 2013 to review the priorities for assessment and the methodology for field work. Moreover, a meeting of a National Consultative Committee (NCC) was held in Spain after the assessment in order to validate the findings and recommendations for finalization of the situational assessment report.

3.1. Overview of data collection

The places and centres visited in Spain were selected according to data and information collected during the desk review prior to field work, and after consultation with national stakeholders, partners, and IOM Spain. The selection was based on the following criteria:

- ***Migration flows***: to cover the route of different migration flows and nationalities to the country of destination. Ceuta and Melilla were the areas with the largest migrant influx in 2013 (4,354) – the only Spanish regions with an increase (1,493) over 2012. In 2012, Andalusia had the biggest migrant influx (3,415), not counting migrants arriving at Madrid Barajas airport (APDHA, 2013).

- ***Management type****:* to cover different types of management of facilities (i.e. police, CSOs, etc.) and types of facilities (i.e. reception centres, refugees assistant centres, detention centres).

The visited locations are shown in the Picture 1 (red points) and the visited sites are presented in Table 5 (divided into Reception centres, Detention centres, and security and law enforcement institutions). These facilities are further described in the infrastructure and physical condition section.

[26] See at: www.cespyd.es

Picture 1: Visited locations

Source: CESPYD.

Table 5: Sites visited

Type	Name	Region
Reception Centres	• CETI, Centres for the Temporary Stay of Migrants, Melilla	Melilla
	• Centre managed by Red Cross, Algeciras	Andalusia
	• Centre managed by Red Cross, Canillas	Madrid
Refugees Assistant Centres	• CAR, Refugees Assistant Centres, Vallecas	Madrid
	• CAR, Refugees Assistant Centres, Sevilla	Andalusia
	• CAR, Refugees Assistant Centres, Valencia	Valencia
Detention Centres	• CIE, Migrant Detention Centre, Algeciras – with an additional facility in Tarifa	Andalusia
	• CIE, Migrant Detention Centre, Aluche	Madrid
Health-care Centres	• Hospital of Melilla	Melilla
	• Punta Europa Hospital, Algeciras	Andalusia
	• Ramón y Cajal Hospital, Madrid	Madrid
Security and Law Enforcement	• Guardia Civil Headquarter, Huelva	Andalusia
	• Guardia Civil Headquarter, Algeciras	Andalusia
	• Guardia Civil Headquarter, Melilla	Melilla
	• Guardia Civil Headquarter, Ceuta	Ceuta
	• Port of Tarifa	Andalusia
	• Port of Algeciras	Andalusia
	• Port of Melilla	Melilla
	• Border crossing points in Melilla – including the fence	Melilla

The international assessment team[27] gathered information from key actors involved in the reception process. They included: health/social-care providers (HSPs – including doctors, nurses, psychologists, mediators, social workers); law enforcement officers (LEOs – including Guardias Civiles, Policías Nacionales, private security officers); civil society organisations (CSOs – including representatives of churches, local entities, NGOs and media); and migrants. Table 6 shows the number of interviews carried out per profile.

Table 6: Number of interviews per profile

Profile	Number of interviews
Law Enforcement Officers	37
Health/Social-care providers	19
Civil Society Organizations	25
Migrants	20
Total	101

The field work done by EASP started with an NCC meeting that covered the four profiles addressed in the analysis. The Algeciras stakeholder meeting was attended by: (a) representatives of the Andalusian RC, (b) Platform for International Cooperation on Undocumented Migrants (PICUM), (c) Algeciras Acoge, (d) Cruz Blanca, (e) regional government representatives (Andalusia), (f) HSPs, and (g) representatives of the Universities of Cadiz and Seville. In Madrid, the NCC meeting was attended by: (a) Comisión Española de Ayuda al Refugiado (CEAR), (b) Salud entre Culturas, (c) Pueblos Unidos and (d) Red Acoge. Finally, in Melilla the meeting was attended by: (a) the RC, (b) Comisión Española de Ayuda al Refugiado (CEAR), (c) Servicio Jesuita de Migraciones, (d) Melilla Acoge, and (e) HSPs. CESPYD also conducted 22 interviewees of GCs of the Commanderies of Algeciras, Melilla, Ceuta, and Huelva. The interviews were done by four researchers at GC Headquarters. The profiles of the GCs interviewed were: (a) the Commander of the GC Headquarters in Melilla, (b) GC responsible for the Occupational Risk Prevention Office (PRL), (c) Sergeant and guards from the Group of Underwater Operations of the GC (GEAS), responsible for monitoring activities at sea, (d) Lieutenant and guards of the USC, in charge of monitoring the land and fence border, and (e) people in charge of the GC Information Service in Melilla (SI), who work to gather information from the CETI.

After the stakeholder meeting, the assessment team continued with visits and data collection at various sites. A mixed research method was used during the assessment, including semi-structured interviews, focus-group[28]/stakeholder meetings, and observational analysis.

[27] The team was composed of: Alberto Rodríguez García – Spanish MoI; Carmen Cosentino – Italian MoI; María Ochoa Llido and Markus Jaeger from the Council of Europe, Ileana Andrea Niculiu from Frontex, the researchers Amets Suess, Olga Leralta Pinan, Ainhoa Ruiz Azarola and Bibiana Navarro from the Andalusian School of Public Health (EASP), the researcher Soorej Jose Puthoopparambil and Magdalena Bjerneld from Uppsala University, and the IOM team Roumyana Petrova-Benedict, Giuliana Urso and Marjolein Devos (MHD, RO Brussels), Teresa Botella and Olivia Rodríguez (IOM Spain), and the researchers Manuel García-Ramirez, Mª Jesús Albar, Virginia Paloma, Violeta Luque, Rocío Garrido and Zaira Morales (CESPYD).

[28] The focus group format was used in some occasions with migrants, law enforcement officers and health professionals.

The scripts for face-to-face semi-structured interviews and focus group meetings with key respondents were developed in English by the IOM with methodological support from the Andalusian School of Public Health, and adapted according to the different profiles. For the field visit in Spain, IOM Madrid contributed with a first draft of the script translations, reviewed and completed by the EASP. Additionally, for the 22 in-depth GC interviews, CESPYD used the interview guide and scripts provided by the Equi-Health project *Interview guide for law enforcement officers serving at border crossing points, ports or in maritime rescue and multipurpose shelters.*

The individual interviews and focus groups were audio recorded, unless the interview partner preferred not to be recorded. In each interview, a research team member different than the interviewer himself took the role of rapporteur.

Ethical review clearance was obtained by EASP and CESPYD and the fieldwork activities were compiled according to Spanish, European, and international standards regarding access to information, voluntary character of participation, informed consent process, confidentiality, anonymity, and data protection. Before individual interviews or focus group meetings, participants were also informed about the objectives and methodology of the project.

3.2. Limitations

- During the first stage of field work in November 2013 (by the international assessment team), interviews with law enforcement officers were mostly done in groups, without the possibility of semi-structured interviews. With the addition of the second round of interviews (done by CESPYD), the total number of interviews collected for the assessment was 101;[29]

- The overall number of LEO interviews is higher than the number of interviews done with other profiles. For example, HSPs – both at senior and first line level, CSOs – including church representatives, local authorities, NGOs, media representatives and migrants;

- Most of the interviews were conducted in Spanish. Migrant interviews were sometimes held in English or French – on one occasion, the focus group meeting with migrants was held in French, with an informal interpretation provided by one of the migrants into languages spoken by migrants. When difficulties arose during interviews due to the lack of interpreters, some of the participants took the role of informal interpreters. This situation happened at the Tarifa's CIE and at the Centre managed by RC in Algeciras;

- Migrant interviews at the CIEs in Tarifa and Madrid were held in the presence of LEOs. In some cases, LEOs also attended our interviews with HSPs.

[29] Interviews performed in Spain: 79 (international expert team in November 2013) and 22 (CESPYD).

FIELD WORK

I. POLICY AND LEGAL FRAMEWORK

I.I EU, national, and regional legal framework: interception, sea rescue, and "green border"

In the EU, there is a broad legal and strategic framework addressing migration, cross-border mobility, return, expulsion, deportation, asylum, and public health surveillance. An overview of the European legal framework is available on the European Commission website, as well as on the websites of the Spanish Ministry of Employment and Social Security and the Andalusian Ministry of Equality, Health and Social Policies.

At a national level, LO 4/2000 (11 January) on the rights and liberties of foreigners in Spain and their social integration defines **"foreigners" as those who do not hold Spanish citizenship**. However, this law has been modified several times over the last decade. The last major changes were introduced by LO 2/2009 (11 December) and two RDL (2393/2004 and 557/2011), which establish the rights and obligations of foreigners depending on their country of origin. In this way, Spanish legislation distinguishes between **EU nationals** – foreigners from countries within the EU — and **non-EU nationals** – foreigners from countries outside the EU. Citizens from EU countries have the right to freedom of movement, according to Directive 2004/38/EC. Concrete proceedings regarding freedom of movement, residence, and work entitlement for citizens from EU and EEA member states are established by RDL 240/2007. LO 4/2000 also distinguishes between "regular" and "irregular" foreigners. Also, within the group of regular foreigners, it distinguishes between foreigners with stay permits, residency permits, and residency and work permits, depending on their type of visa.

Chapter I, Article 3 of Organic Law 4/2000 on the **rights and liberties of foreigners in Spain** and their social integration establishes that:

"Foreigners in Spain are entitled to the rights and liberties acknowledged in Title I of the Spanish Constitution in the terms established by international treaties, in the present law and the laws that regulate the exercise of such rights. The general interpretive criterion is that all foreigners exercise the rights acknowledged by this law under the same circumstances as Spanish citizens."

At the same time, LO 4/2000 states that:

"Policies regarding the fundamental rights of foreigners will be interpreted according to the Universal Declaration of HR and to the international agreements and treaties in force in Spain. In this regard, the person's religious, ideological or cultural beliefs may not be used to justify actions taken against such rights."

Also, Article 4 of LO 4/2000 describes the regular foreigner **requirements for entry**:

"Foreigners who are in Spain in the circumstances described in Title II of the present law are entitled to move freely across Spanish territory and to choose their residence, always under the general conditions established by laws and treaties; or by judicial decision on a precautionary

basis, or due to a criminal or extradition process where the foreigner is a suspect, a victim or a witness, or due to unappealable judgement."

Regarding irregular foreigners, LO 4/2000 states that **foreigners who are denied entry at the borders must be deported to their place of origin**. If their return is delayed by longer than 72 hours, the examining judge has to determine the detention centre where they must remain until they leave the country. However, Article 58.6 establishes that an expulsion order is not needed for foreigners who attempt to enter the country illegally. It also states that:

"Foreigners who do not comply with entry requirements must be denied entry by means of a reasoned decision, and must be given information about how to lodge an appeal, the deadline to do it and to which authority it must be addressed. Also, foreigners must be informed that they are entitled to a lawyer, who can be a public defender, and to an interpreter. This right will be in operation at the border checkpoint."

Irregular migrants' expulsion and denial of entry is regulated by LO 4/2000 – modified by LO 2/2009 and RDL 16/2012. **Deportation policies depend on the readmission agreements that Spain has signed with the countries of origin and transit.** According to the Ministry of Employment and Social Security, Spain currently has readmission agreements with 16 other countries (Ministry of Employment and Social Security 2014). There are also readmission agreements at the EU level: in chronological order, by 2011, Europe had signed such treaties with Hong Kong, China; Macao, China; Sri Lanka, Albania, Russian Federation, Ukraine, the former Yugoslav Republic of Macedonia, Bosnia and Herzegovina, Montenegro, Serbia, Republic of Moldova, Pakistan and Georgia (FRA, 2013: 98).

LO 4/2000 also contains **specific regulations concerning women and minors**. Pregnant women are not deported if this implies a risk for the mother or the foetus (Articles 57.6 and 58.4). Unaccompanied minors (underage foreigners who are not accompanied by adult relatives) must be transferred to Minor Protection Centres of the respective autonomous region. The legal framework for unaccompanied minors is established by Article 35 and its application is regulated by RDL 2393/2004, RDL 557/2011, and the Protocol for Unaccompanied Minors (Ministry of Employment and Social Services 2005). **Under no circumstances is it possible to take minors to CIEs (Article 62.4), unless their parents are being kept there (Article 62 bis 1.i).** Notwithstanding, and in their best interest, minors may be repatriated to their country of origin for family reunification, or delivered to the Minor Protection Centre of the country where their family is – if not in the country of origin. When repatriation is not carried out, minors under the protection of the Spanish public administration (i.e. in Minor Protection Centres) are to be considered by the Minors' Prosecuting Office as **regular migrants for all intents and purposes** (Article 35).

The procedures of age assessment of minors are regulated by Article 35.3 of LO 4/2000, and Article 190 of RDL 557/2011 (Ombudsman 2011). Article 35.3 of LO 4/2000 establishes that when the legal age of a migrant is not clear, LEOs must inform the Department of Public Prosecution, which then proceeds to determine the age of the migrant in collaboration with the corresponding health institutions, such as hospitals. Article 190 of RDL 557/2011 specifies that the Department of Public Prosecution must consider the migrant a minor if at least one of the age indicators establishes that the person is under 18 years old.

Spain recognizes the right to asylum and subsidiary protection by virtue of LO 12/2009 (30 October) and Article 13 of the Spanish Constitution.[30] Article 2 of the Constitution defines the right to asylum as the protection afforded to non-EU and stateless foreigners recognised as refugees in the terms defined in Article 3, and in the Convention relating to the Status of Refugees (Geneva, 28 July 1951) and its Protocol (New York, 31 January 1967). Asylum applicants are entitled to: (a) be documented as applicants for international protection; (b) receive free legal assistance and an interpreter; (c) have ACNUR (Alto Comisionado de Naciones Unidas para los Refugiados) informed about their application; (d) the cancellation of any process of return, expulsion or extradition that may affect them; (e) have access to their administrative records at any time; (f) health-care assistance; and (g) receive social benefits under the terms specified by law.

Besides, Spain is committed to guaranteeing the protection of HR and to covering the needs of all asylum-seekers, in accordance with the EU law known as "Dublin Regulation".[31] This Regulation establishes that people in need of protection have to formally request it in the first EU member state they physically enter, or in the state responsible for their entry into EU territory or non-EU Schengen Area countries including Norway, Iceland, Liechtenstein or Switzerland.

Currently, most asylum applicants are Syrian, Palestinian, Jordanian, and Libyan nationals. The majority of asylum-seekers arrive by plane, some of them stopping in several neighbouring countries during their journey to the country of destination. Some of the migrants interviewed in Spain stated their intention to go to Sweden, while others said they preferred to remain in Spain, where family members had arrived several years ago. **The asylum application process can take over a year, which is one of the main complaints made by those seeking asylum.** Only 23.96 per cent of those who submit an application in Spain are actually granted asylum. Final decisions are made by the Comisión Interministerial de Asilo y Refugio (CIAR – composed of representatives of ACNUR and the Ministries of Foreign Affairs, Justice, Labour and Immigration, Internal Affairs and Equality. If asylum is denied, the applicant may appeal to the Supreme Court of Justice.

Finally, **there are no clear protocols on how to deal with victims of human trafficking.**

I.II Legal and financial frameworks of open and closed centres

According to LO 4/2000 (11 January), **foreigners who do not comply with the established requirements for entry into Spain and/or those who enter the country illegally can be transferred to different centres**, according to a judicial decision: (a) if a judicial decision has not been made, migrants are sent to **reception centres** (**CETIs and Centres managed by CSOs**), (b) if migrants are granted the status of asylum-seekers or refugees, and can also certify that they have no resources, they are sent to **CARs**; (c) if migrants are ordered removed from Spain, they

[30] Regarding the asylum application, a report published by CEAR (2013) provides an overview of the procedure followed in Spain, which includes the following stages: application; decision regarding acceptance or denial; review; and second decision regarding acceptance.

[31] See Council Regulation (EC) No. 343/2003 (Dublin II Regulation) and Regulation (EU) No. 604/2013 (Dublin III Regulation).

are sent to **CIEs** while their deportation is being processed. A description of legal framework that regulates these centres follows.

Reception Centres

***CETIs*, or Centres for Temporary Stay of Migrants**, are reception centres located near the Spanish–Morocco borders, specifically in **Ceuta and Melilla**. **They are managed by the Spanish Ministry of Employment and Social Services**. CETIS are **open centres,** with freedom of movement for residents within the respective city where these facilities are located. From a legal perspective, migrants in these centres are not "detained", but rather temporarily "sheltered". These migrants are gradually transferred to CIEs on mainland Spain where their court files are then processed. The CETI in Melilla can lodge up to 480 people in dormitories and 100 in tents, while the one in Ceuta can lodge up to 450 people in similar conditions (APDHA, 2008).

When CETIs are overcrowded, migrants are taken to CSOs, where they remain until they are transferred to mainland Spain. In some cases, *ad hoc* centres are set up in tents outside CETIs or in sports centres. CSO representatives refer to cases of individuals who, having lived in a CETI for three years, were then transferred to a CIE and finally deported to their country. They also mention cases of illegal deportations to Morocco that led to the migrants getting abused or abandoned in the desert by Moroccan LEOs

Refugee Assistance Centres

***CARs*, or Refugee Assistance Centres**, are **centres where refugees are provided board, lodging, urgent and primary medical care, and psychosocial support**. **The aim of these centres is to provide social support to asylum-seekers and refugees who have no economic resources to cover their basic needs**.

Article 264.2 of LO 4/2000 refers to specific programmes for foreigners who are officially recognized as asylum-seekers or refugees. At the same time, the Ministerial Order of 13 January 1989 regulates these centres; and the Decision of 6 July 1998 approves the basic statute of CARs, and develops the Order of 13 January 1989, which regulates them. The asylum system is managed by two different ministries: The Ministry of Internal Affairs, in charge of granting or denying asylum; and the Ministry of Employment, in charge of social aid. The final decision is made by the Ministry of Internal Affairs, based on the recommendations of the *Comisión Interministerial de Asilo y Refugio* (CIAR – composed of representatives of ACNUR and the Ministry of Foreign Affairs and Cooperation, Ministry of Justice, Ministry of Employment and Social Security, Ministry of Internal Affairs and Ministry of Health, Social Services and Equality).[32]

The services provided in CARs are: temporary lodging and board; information and advice about the asylum application process; counselling regarding integration in the education, health and social system; psychological assistance; social assistance and advice regarding applications for supplementary economic aid; language courses and basic social skills courses; counselling and mediation to facilitate access to professional training and placement programmes;

[32] See at: http://acnur.es/quienes-somos/acnur-espana/la-proteccion-internacional-de-los-refugiados

occupational, leisure, and free-time activities; and sensitisation activities for the receiving community. **The maximum stay in these centres is six months**. In case of a negative decision of their asylum application, beneficiaries must leave the centre within 15 days. Exceptionally, and in case of need, the centre's manager may decide an extension, which must be sufficiently justified by the needs of the person in question.

In order to benefit from the services of CARs, foreigners must comply with either one of the following **requirements**: (1) to be recognized as an official applicant or beneficiary of international protection in Spain; (2) to have been denied international protection while another EU member state has accepted the responsibility to assess the application by virtue of Council Regulation (EC) 343/2003 (18 February 2003).[33] Additionally, refugees and asylum-seekers must also: (1) be unemployed or have no economic resources to cover their and their families' basic needs; (2) not have infectious/contagious diseases or physical/psychological disabilities that may affect life in the CAR; and (3) expressly accept the centre's norms and regulations.

Migrant Detention Centres

***The CIEs,* or Migrant Detention Centres, are eight non-penitentiary centres managed by the Ministry of Internal Affairs devoted to the protective and precautionary custody of foreigners, in order to guarantee their deportation or voluntary return under the terms and conditions established by the Spanish immigration legislation** (RDL 162/2014 of 14 March). Internment takes place while disciplinary proceedings are carried out, and **cannot last for longer than 60 days.** In CIEs, foreigners are entitled to access legal, social, cultural, and health services. Article 16 of RDL 162/2014 (14 March), establishes the rights of interned foreigners: the right to be informed about their legal situation; the right to physical integrity; the right to receive adequate medical assistance; the right to be assisted by the centre's social services; and the right to receive legal assistance. At the same time, they are entitled to communicate with the outside world.

However, **according to several reports, these rights are frequently not respected by CIE management** (see APDHA, 2008; APDHE, 2013; Consolider Ingenio HURI AGE, 2010). In this case, CIEs become *de facto* penitentiaries, yet without the basic guarantees and resources of the latter. In this sense, the Observatory for HR of Universidad de Barcelona has described CIEs as "unconstitutional" because "people are detained for what they are, rather than for what they have done" (Viejoblues, 2005). According to the Order of 22 February 1999 on the standards of practice and internal regulations of migrant detention centres, the **Ministry of Internal Affairs is in charge of managing, inspecting, coordinating, and monitoring CIEs**. This is done through the General Police Directorate, which is also in charge of the safety and security of the centres.

The provision of medical assistance and social services is also the responsibility of the Ministry of Internal Affairs, although it may also be shared with other ministries and/or other public or private institutions. In any case, the public administration must ensure that health, safety and social conditions are similar in all CIEs. Current legislation establishes that legally constituted organisations for the protection of migrants and other relevant international

[33] See at: http://extranjeros.empleo.gob.es/es/ProteccionAsilo/car/

organisations may visit migrant detention centres. Furthermore, their work in centres must be facilitated by the administration. Nevertheless, Asociación Pro Derechos Humanos de Andalucía (APDHA) denounced the secrecy and lack of transparency in the access of CSOs to these centres (APDHA, 2008):[34]

> *"Only rarely are NGOs allowed to enter and interview foreign detainees, in spite of what Article 6.2 of the Order of 22 February 1999 states: 'The administration will facilitate collaboration with institutions and associations devoted to assisting foreigners, provided that the internal regulations of the centre are complied with.'"*

I.III Entitlement to health care and provision of services

In Spain, Article 43 of the Spanish Constitution recognises the right to health protection and establishes that the public administration is in charge of organising and protecting public health through the necessary preventive measures and services. Accordingly, until recently, access to and provision of health care was free and universal. However, on 20 April 2012, **RDL 16/2012 limited access to public health-care services to those officially considered as "insured" and "beneficiaries." Also, the Public Health Care System (PHS) is decentralised,** so the responsibility for public health care is shared by the central and the regional governments of the 17 autonomous regions**. In practice, this means that the application of the law differs from one autonomous region to the next**. The following are some of the most notable exceptions in the application of the RDL 16/2012 (Olías 2012):

- *Andalusia* does not implement the RDL 16/2012 restrictions, and provides those excluded from the PHS with temporary entitlement to health-care assistance for a renewable one year period;
- *Catalonia*: Regional Regulation 10/2012 extends medical coverage provided by the PHS to those without a residency permit and without economic resources, if they have been registered as residents with the city council for at least three months. According to this regulation, patients with diseases such as HIV and sexually transmitted diseases are always treated regardless of residency status;
- *Basque Country*: Migrants need to be registered as residents with the city council for at least one year, and their income must be below the region's minimum income in order to get a health card. The health card, in turn, guarantees access to medical assistance and health-care services subject to the same conditions as those who are covered by the PHS. Those with pre-RDL 16/2012 cards are entitled to continued health-care coverage;
- In the *Autonomous region of Madrid*, the following groups are entitled to health-care services covered by the PHS: asylum-seekers and victims of human trafficking who have been provided with temporary residency permits; patients with infectious and contagious diseases; and people with chronic diseases whose treatments began prior to 31 August 2012.[35]

[34] APDHA. "*Centros de Internamiento en España".* (2008). Available from www.apdha.org/media/CIESoctubre.pdf
[35] This last group is, nevertheless, not entitled to prescription medicines.

Legally residing migrants

Initially, **legally residing migrants are covered by the same system as nationals**. That means that **citizens who are insured by the Social Security System** must satisfy at least one of the following requirements: (a) being employed or self-employed and affiliated with the Social Security System, paying all necessary contributions; (b) being a pensioner within the Social Security System; (c) being the recipient of any other periodic benefit from the Social Security System, including unemployment benefits and subsidies; (d) having used up all unemployment benefits and subsidies; (e) being registered with an employment office. Besides, their partners may also have the beneficiary status if they reside in Spain, provided that both partnership and residence can be proved. The same applies to spouses/partners, descendants, and dependent relatives who are either under 26 or have a degree of disability equal to or greater than 65 per cent, on the condition that they live in Spain and are able to prove their residence.

If none of these criteria is met, Spanish citizens and people from EU member states, EEA countries and Switzerland, and foreigners authorised to live in Spain are covered by the Social Security System if they can prove that their income is below EUR 100,000 per year (LO 22/2013 of the Spanish General Budget).

Finally, **people who are neither insured nor beneficiaries of the Social Security System are entitled to receive medical assistance subject to payment** by signing a special agreement, as specified in RDL 576/2013).

Irregular migrants and asylum-seekers

According to LO 4/2000, modified by LO 2/2009, **undocumented migrants who are in centres while their deportation is processed are entitled to health care and social assistance:**

- In **CETIs,** primary care is provided by private companies. Emergencies and cases requiring specialized assistance are referred to a public hospital. CETIs provide psychological assistance if mediators or psychologists detect a mental health problem, or if psychological assistance is requested by the patient. Psychiatric cases are referred to the mental health team of the corresponding public hospital;
- Asylum-seekers that are in **CARs** have full access to the health system. Given their status as a vulnerable group, they receive a "health certificate" which enables them to access health-care services without being insured by the Social Security System;
- To describe health-care service at **CIEs,** Article 16 of RDL 162/2014 (14 March) states:

"In each centre there will be a health-care service managed by a doctor of the PHS, assisted by at least one medical assistant or a nurse. The Police General Directorate will be endowed with all means necessary to guarantee the adaptation of the service to the needs of the centre, according to occupancy levels."

On the other hand, according to RDL 16/2012, **undocumented migrants** not living in centres, **can access the health-care system only by paying the corresponding fees**, which is often difficult due to their precarious economic situation. Consequently, this makes them a vulnerable group, which implies also a public health risk. Nevertheless, there are **special entitlements for the following vulnerable groups**: (a) Foreign women who are not registered as residents in Spain are entitled to free medical assistance from the PHS during pregnancy,

childbirth, and postpartum subject to the same conditions as Spanish women; (b) Foreigners under 18 who are not registered as residents in Spain are entitled to free health care from the PHS with the same rights as any Spanish citizen; (c) Victims of human trafficking whose temporary reflection and recovery stay in Spain has been approved receive health care and are offered the basic services of the PHS regulated in Article 8 bis of LO 16/2003 (28 May).

I.IV Discussion Section - I

This section describes the legal framework which regulates irregular migrants' reception and detention system and the health-care assistance they receive. **Formally, the reception/detention procedures and the public health-care system comply with European and international agreements on borders and migration**. Nevertheless, as some CSOs have recently pointed out, some laws that Government has imposed in order to stiffen CIE regulations and process of deportation are conflicting with European and Spanish legislation. In fact, in January 2015 The Spanish Supreme Court struck down part of the rules of CIEs for this very same reason.[36]

Another important aspect to consider in the analysis is **Morocco's role as a "border country."** Many of those who manage to get to Morocco encounter even more difficulties in reaching European borders. In fact, most of those who attempt to enter Spain find themselves in a sort of legal limbo on top of the precarious living conditions they face while in Morocco. This worsens their overall mental and physical conditions before they reach Europe:

"You cannot separate the two sides of the border when it comes to health care and provisions."
(CSO)

Also, it must be highlighted that **Spain, in compliance with the Dublin III Regulation, is contributing to situations of irregularity**.[37] This regulation establishes that asylum applications will only be processed by the member state through which the applicant enters the EU. Because of this, foreigners who reach Melilla or Ceuta from countries like the Syrian Arab Republic avoid applying for asylum for fear of being "trapped" in Spain. This would prevent them from the possibility to apply for asylum in another EU country, where they would prefer to settle down. The main consequence of this is that many potential asylum applicants, including vulnerable groups, prefer to remain irregular migrants in Spain and even to be temporarily detained in CIEs or to live in reception centres rather than applying for asylum status.

CIEs' main objective is to guarantee compliance with the order of expulsion from Spanish territory. However, rarely does this happen within the required period of 60 days. In fact, **only 50 per cent of detained migrants are eventually expelled from the country**; the other half is released at the end of the maximum detention period. This is due to the fact that in many cases

[36] See "*El Supremo suspende parte del reglamento de los CIE por incumplir la normativa europea y española",* El Diario. www.eldiario.es/desalambre/Supremo-reglamento-CIE-Ley-Extranjeria_0_350316044.html

[37] See at: http://europa.eu/legislation_summaries/justice_freedom_security/free_movement_of_persons_asylum_immigration/l33153_es.htm

it is not possible to expel detained migrants, either because they come from countries with which Spain has not signed readmission agreements – and therefore they cannot be deported, because the country of origin is unwilling to provide them with travel documents or because they can prove that they have family ties to Spain. The "*Centro de Internamiento de Extranjeros en España*" report, drafted by the Asociación Pro Derechos Humanos España in 2013, pointed to a series of weaknesses in the Order of 22 February 1999 on the standards of practice and internal regulations of migrant detention centres – namely, that it: (a) does not explicitly state that detention must be an exceptional measure; (b) reproduces the same monitoring measures as those used by police; (c) gives the Police General Directorate too much control in the management of CIEs; (d) does not provide legal counselling and interpreting services; (e) offers worse infrastructure and services than those specified in the General Penitentiary Law.

Regarding migrants' right and access to health-care services in Spain, the implementation of RDL 16/2012 has resulted in a variety of contradictory health entitlement models in Spain, depending on the different autonomous regions. Thus, in some regions such as Andalusia – an area with a large migrant population, undocumented migrants are entitled to free and universal health care. This contrasts with the case of Ceuta and Melilla, where, in spite of their high migration rates, RDL 16/2012 has been applied with no exceptions. In sum, **the results of RDL 16/2012 show that migrants in Spain are no longer covered by the PHS, thereby affecting their health and that of the receiving community as a whole.** This situation is made worse for those who are unemployed or have precarious jobs – most of the foreigners who do not have a residency permit – for they cannot afford private health care.

Also, **although undocumented migrants who are in CIEs and reception centres are entitled to health care and social assistance, they often have problems when they are transferred from the centres to hospitals, as they do not have health-care cards**. These administrative barriers jeopardize access to diagnostic procedures and specialized care in hospitals and other centres, even when migrants suffer from communicable diseases. Because RDL 16/2012 has restricted irregular migrants' access to health care to emergencies only, institutions and experts alike draw attention to the complexity of defining what constitutes a medical emergency – for example, some stages of chronic diseases can be seen as emergencies. However, emergency services offer no treatments or follow-ups. This violates the principle of prevention and poses a serious threat for both the patient and public health.

In spite of all this, it is possible to identify **good practices that may lead to better health care for migrants,** if they're used more often:

- CSO platforms and campaigns to protect and inform migrants about their rights – such as the "Somos Migrantes" platform;
- Hospital projects that try to promote migrant-friendly services – such as the European project "Migrant-Friendly Hospitals" in Punta Europa Hospital (Algeciras). The aim of this project (now discontinued due to staff cutbacks) was to improve health-care services for migrants;
- Reproductive health clinics in Andalusia and Catalonia have shown to be culturally sensitive, i.e. by working with health professionals on how to address patients with female genital mutilation. A maternal care guide was drafted and translated into several languages, including Chinese and Arabic. Other basic documents, such as a list of

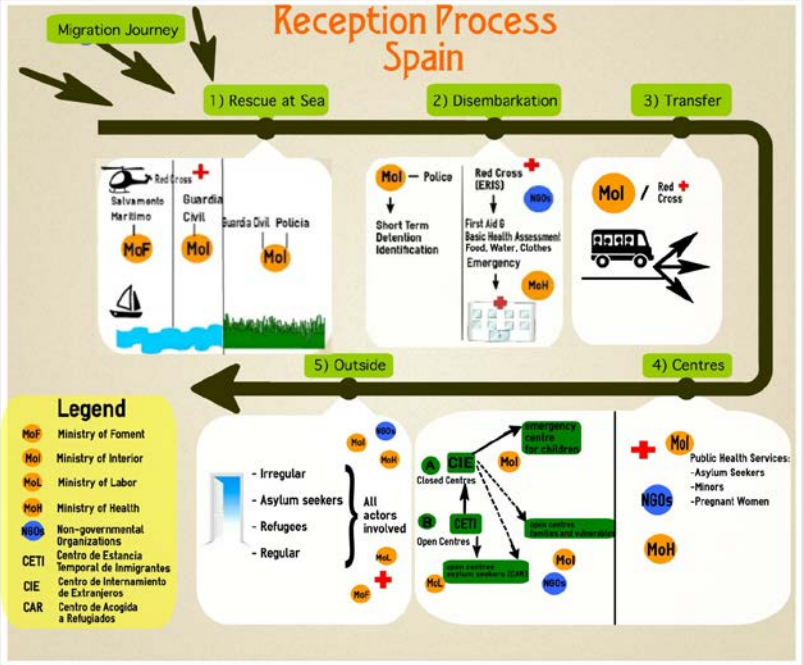
patients' rights and obligations, have also been translated and provided to HSPs to use in their daily practice.

II. PARTNERSHIPS, NETWORKS, AND MULTI-COUNTRY FRAMEWORKS

II.I Description of the reception process and coordination

Irregular migrants reach Spain by land and sea, as well as through airports. **Migrants are usually intercepted by the Guardia Civil (GC) except at airports where they are stopped by the Policía Nacional.** These LEOs are responsible for the identification of migrants after their apprehension. Various reports published by CSOs, European institutions, and individual authors provide detailed descriptions of the reception process on the Spanish Southern borders.[38] This section describes the process of reception of irregular migrants who enter Spain through Melilla, Tarifa-Algeciras, and at Madrid.[39]

Picture 2: Reception process in Spain



Source: IOM Equi-Health project.

By land

Entry by land occurs through the Spanish–Moroccan border cities of Ceuta and Melilla. The characteristics of both cities, located on the North African coast, are rather similar. The following section focuses on the process of reception in Melilla, as it is the point through which most migrants reach Spain.

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[38] Please see CEAR, 2013; FRA, 2013; ICMC-EUROPE, 2011; Jarrín Morán, Rodríguez García, De Lucas, 2012; Migreurop, 2011, 2012a, 2012b, Ministerio de Fomento, Salvamento Marítimo, 2013; Ministerio del Interior, GC, 2014a, 2014b, 2014c.

[39] There are other entry points for irregular migrants in Spain, mainly Ceuta and the Canary Islands. Although these are not included in this study, their characteristics are similar to those in Melilla and Tarifa-Algeciras respectively.

There are three main areas through which irregular migrants attempting to reach Spain by land enter Melilla: (1) the pedestrian border crossing known as *Barrio Chino*; (2) the Beni Enzar border point; and (3) the fenced border that separates Melilla from Morocco.
Barrio Chino is the Chinese district in the Moroccan city of Nador where the pedestrian border crossing also known as *Barrio Chino* is located. **The pedestrian border crossing is for Melilla and Nador residents only** and also **serves as a border point for freight traffic.** The same crossing is also sometimes used for Illegal trade or smuggling of goods from Melilla into Morocco without paying custom duties. Moroccan law considers all goods that people can carry by themselves as personal baggage are duty-free, a situation that is taken advantage of by Spanish traders intending to sell their goods in Morocco. **There is a complex network that involves Spanish traders in contact with Moroccan mafia groups who employ "carriers"** (mostly Moroccan women) to go to Melilla, pick up heavy bales of goods of about 50kgs each which Spanish traders have previously left in the vicinity of checkpoints, and transport them into Morocco for EUR 5 or 10. Women carriers make this journey several times a day to provide for their families even though 'working conditions' are in complete and direct violation of HR. There is ample photographic documentation of the inhumane conditions in which these women — many of them old and disabled women — work (see Picture 3). The Spanish state does not seem to object to these illegal activities and even facilitates access and exit through this border point, mainly to favour Spanish traders in Melilla. Moreover, this border point do not have the facilities of other border crossings – such as rest areas, public toilets, food, health-care services or shelters.

The GC is the only Spanish authority and the only representative of the Spanish state in this border area. In order to assist the sort of trade described above, GCs work in collaboration with so-called "gorillas" — Moroccan citizens who act as mediators between the GC and carriers and are paid by Spanish traders to organize the transport of goods through the border. Officially, the GC's role is to prevent injuries and fights between carriers. Since the carriers' goal is to enter and exit as many times as possible, crowding often occurs, with sometimes fatal consequences. For instance, in 2009, a woman carrier was killed in a stampede on the Moroccan side of the border.[40] Since then, the GC's presence has been intensified at this border. Nevertheless, some GCs question their role there:

"Regarding Barrio Chino... it's disgraceful that we are there, because that's not our job. It's disgraceful that the GC has to do this job so that some business people in Melilla can benefit from it." **(LEO)**

[40] See *"La muerte de Safia, la porteadora"*, El País. http://elpais.com/diario/2009/01/04/domingo/1231044754_850215.html

Picture 3: Carriers with heavy bales of good

Source: Interviu.[41]

At **Beni Enzar border point**, **migrants – mostly women and children – often enter Spain by presenting fake passports or by hiding in the false bottoms of various vehicles** (Picture 4). In recent months, the number of Syrians trying to get to Melilla through this border point has increased significantly. If they get caught, migrants who enter this way are considered victims of human smuggling and are referred to the CETI in Melilla, while the drivers of the vehicles caught by the GCs may be arrested for human smuggling:

"Sub-Saharan migrants, most of them, or all of them, hidden inside false bottoms, in dashboards, in tanker trucks, under car seats, anywhere inside vehicles, 4x4 SUVs, lorries, buses (...). Migrants also cross this way, and a large number of them (...) a large number, 6 or 7 people every week on average. (...) Bear in mind that even if we arrest the driver, the migrant enters."
(LEO)

Although GCs are doing their best in order to control the borders, hundreds of vehicles pass through the border post every day, making it a particularly complex task for the GC to organize the checking of documents and to control traffic.

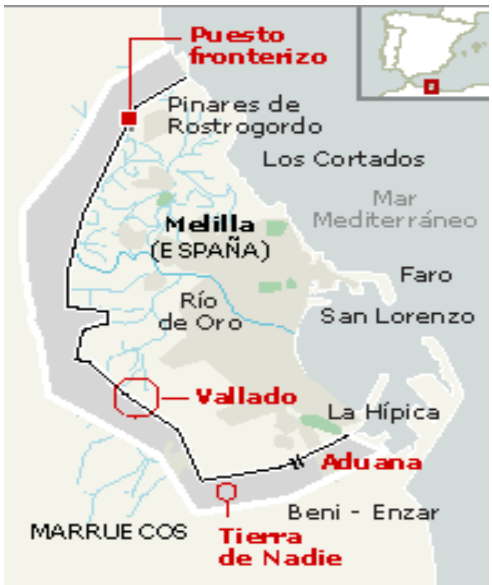
[41] See "*Porteadoras en Melilla: España lo consiente*", Interviú. www.interviu.es/reportajes/articulos/porteadoras-en-melilla-espana-lo-consiente

Picture 4: Migrants hidden inside cars and luggage

Source: Guardia Civil.[42]

Melilla's perimeter is protected by a 10.2 kilometre-long, GC guarded, fence to prevent illegal entries (Picture 5). This **fenced border** is composed of three fences, built in 1973, 2000, and 2005 respectively (Pictures 6–9). The procedure involved migrants' crossing by climbing the fence is multifaceted and explained further in Box 1.

Picture 5: Melilla fenced border

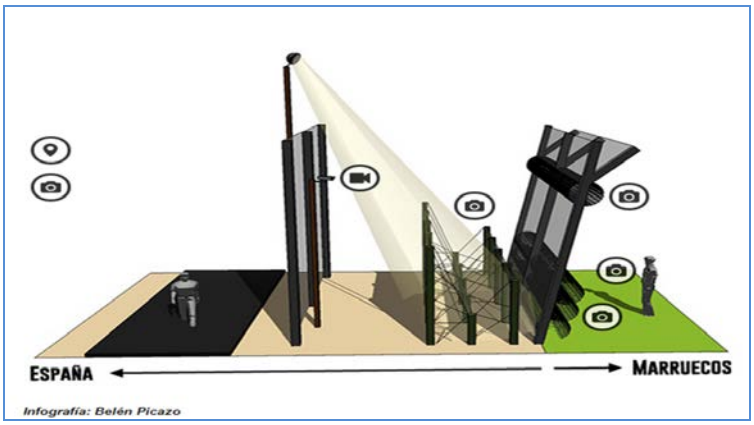


Source: El Mundo.[43]

Picture 6: Melilla fenced border

[42] See *"Cuánto paga un inmigrante para llegar a España".* Huffington Post. www.huffingtonpost.es/2013/07/12/cuanto-paga-inmigrante-llegar-espana_n_3585409.html

[43] See *"Otros 500 inmigrantes protagonizan un nuevo asalto a la valla de Melilla"*. El mundo. www.elmundo.es/elmundo/2005/09/27/sociedad/1127854612.html



Sources: eldiario.es[44]

Picture 7: Melilla fenced border

Source: eldiario.es – Photograph: J. Blasco de Avellaneda.

Picture 8–9: Migrants and LEO on the fences

Sources: Libertad Digital[45] and La Vanguardia.[46]

[44] See *"Frontera en Melilla: Drama Humanitario".* El Diario. www.eldiario.es/desalambre/valla_de_melilla/

[45] See *"La UE dice a España que las devoluciones en frontera podrían ser ilegales según cómo legisle".* Libertad Digital. www.libertaddigital.com/espana/2014-11-25/la-ue-dice-a-espana-que-la-devoluciones-en-frontera-podrian-ser-ilegales-segun-como-legisle-1276534466/

[46] See *"El PP propone legalizar las devoluciones 'en caliente' de inmigrantes".* La Vanguardia. www.lavanguardia.com/politica/20141022/54417396619/pp-legalizar-devoluciones-caliente.html

The most difficult and tragic situations at this fenced border are those which are inherently the riskiest, such as massive fence jumps (up to 500 people at once), when GCs are frequently overwhelmed. The seriousness of fence-related injuries has increased recently as a result of the newly installed razor wire and blades,[47] while another threat to fence-climbing migrants' health is the frequent beatings by Moroccan LEOs.[48]

There is an ongoing debate as to where the Spanish territory starts. According to influential Spanish judges' professional association, *Jueces para la Democracia*, the first fence on the side of Morocco is already on Spanish territory.[49] However, **according to the GC, it is only when the person jumps the last fence that the migrant is considered to be on Spanish territory**. That is why GCs put a lot of emphasis on preventing migrants from passing over the third fence. To do so, GCs enter the space between the fences and use physical force against migrants, trying to stop them and hand them over to Moroccan LEOs. The use of rubber bullets and batons is being criticized by CSOs' and general society because it is understood as police abuse.

The absence of a clear and fair protocol in this regard causes uncertainty among GCs as to what actions to take while patrolling at the fence. For example, they might follow conflicted orders (e.g. "do not let anyone pass" or "do not use violence"):

"The GCs are always uncertain: it's wrong if I do this and it's wrong if I do that too. We don't know (...). I handcuff someone and yet I might be doing something wrong. What am I doing wrong?" **(LEO)**

In the same vein, the GC receives harsh criticism from the media and CSOs for being the "bad guys" and the "puppets" in the hands of political parties. Thus, **they work under significant public and institutional pressure,** especially in cases of excessive force being used against people trying to jump the fence or when they (LEOs) have to "return" migrants back to Morocco:

"They [Moroccan police officers] have more freedom of action; there are neither NGOs nor immigration laws there." **(LEO)**

At the same time, GCs consider their work as balancing the interests of Spanish citizens in Melilla and the lives of migrants who try to climb over the fence.

Smugglers and organized crime networks also play an important role in the irregular crossing of the border. Migrants who manage to cross are usually well prepared and informed on how to act in case they are arrested by the GC:

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[47] See *"El Ministerio del Interior reintroduce las cuchillas en la verja de Melilla"*. El País. http://politica.elpais.com/politica/2013/10/31/actualidad/1383248597_158835.html

[48] Agentes marroquíes "golpean con palos" a los inmigrantes que entraron en Melilla. El País. http://politica.elpais.com/politica/2014/06/20/actualidad/1403249154_546020.html

[49] See Jueces para la Democracia. www.juecesdemocracia.es/txtComunicados/2005/14Octubre05.html

"The migrants who come here are very well coordinated by the mafia. It's true that the real immigration problem is not the migrants themselves (...), but the mafia that uses them. The mafia knows the system, how to set up services, they know everything. And we are restless all night, back and forth, from one side to another, until they finally jump." **(LEO)**

The Melilla fenced border is one of the main challenges that Syrians encounter when trying to reach European territory. According to the UNHCR, there is **currently no legal way asylum-seekers may access Europe through these points.** This situation forces many of them to turn to smugglers, which increases their risk of becoming victims of human trafficking. In January 2014, the UNHCR confirmed 32 cases where migrants – including families with minors – were expelled to Morocco at the entry points. In February 2014, the Beni-Enzar border point was closed for a few hours due to Spanish LEOs were informed by Moroccan authorities that a group of 200 Syrians was determined to cross to Melilla (UNHCR, 2014: 8).[50]

Box 1: Actors involved in the reception process at the fence of Melilla

The actors involved in the migrants' reception and administrative process in Melilla are:

- *The Guardia Civil* (GC): Their main function is to prevent migrants from approaching the fence and scaling it. If migrants manage to cross all the fences, they have to assist them since migrants already are in Spanish territory.
- *The Policía Nacional*: They provide support to the GC when requested, usually in the case of massive jumps over the fence. Subsequently, they identify migrants who have entered Spanish territory and process this information.
- *The Policía Local*: They support the GC, mainly by stopping vehicle traffic in the area where fence jumps occur.
- *Civil Society Organizations (CSO)*: At best, the GC views CSOs as non-cooperative; at worst – as an obstacle to its law enforcement tasks. GCs often perceive CSOs as being on the "other side" of the conflict:
  "In all the jumps we have witnessed, CSOs haven't helped us at all, they have always been against us and used verbal violence. They are always trying to intimidate us and they praise the people attempting to enter." **(LEO)**
  In fact, CSOs are generally present while fence jumps occur, thus acting as HR monitors and reporting possible irregularities and law violations.
- *Journalists*: They play an important role as observers and speakers against HR abuses in Melilla. They often have helpers on the Moroccan side who inform them about violations and abuses on that side of the border. The GC complains that journalists do not usually share this information with them:
  "Yesterday (...) I found out that people were going to jump in Barrio Chino and, what is worse, there was a journalist hidden there, waiting for the jump to occur. What does this mean? It means that we don't know [when this will happen] and they do. I find this very shocking. What is this turning into, a war against whom? Against our interests, against migrants, against Spain?" **(LEO)**
- *Health services* (e.g., ambulances, the RC): The COS (*Central de Operaciones de la Comandancia de la Guardia Civil de Melilla*) contacts them in cases of people needing

[50] See "*Unos 200 sirios intentan entrar a la fuerza por la frontera de Melilla*". El Mundo. www.elmundo.es/espana/2014/02/13/52fd3692ca474184318b4583.html

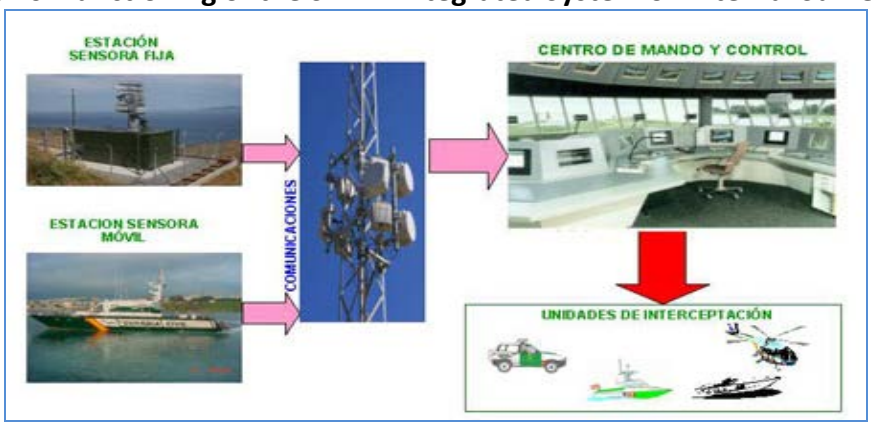
medical assistance.

- *Firefighters*: when they are needed, they help the GC at the fence, for example by placing inflatable mattresses at the foot of the fence to prevent injuries in case of a fall,[51] or by providing extension ladders to help migrants down the fence.[52]

By sea

There is a clearly defined reception process for migrants intercepted at sea, and all those involved in the process are coordinated by an intervention protocol (see Box 2 for more details). The GC is responsible for customs and ports of entry control, including security of border areas and anti-smuggling operations, and of the Integrated System of External Surveillance (*Sistema Integrado de Vigilancia Exterior*, SIVE) (Pictures 10–11). When migrants —mainly women and youngsters—travelling irregularly are detected on a boat, hidden in a ship or cargo container, or in the false bottoms of vehicles transported on ferries (Picture 12), the GC is in charge of their arrest. Once on the coast, the GC together with the Red Cross (RC) are in charge of the reception process, offering first aid and doing a basic health assessment. If any of the migrants need health assistance, an ambulance is called. After being treated by the HSPs, migrants are referred to a Policía Nacional station for positive identification.

Picture 10: Functioning of the SIVE – Integrated System of External Surveillance



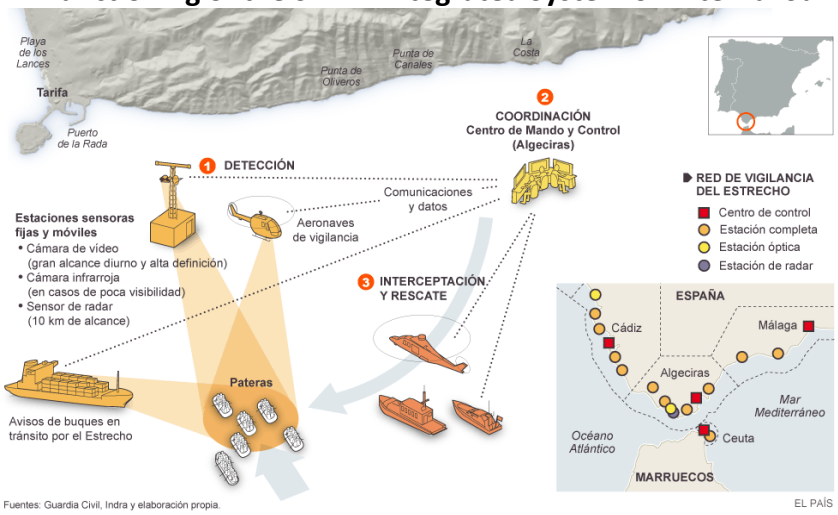
Source: Guardia Civil.[53]

[51] See *"Trece horas encaramados a la vall"*. El Mundo. www.elmundo.es/espana/2014/10/22/5447a62ee2704ed26f8b4581.html

[52] See *"Quince inmigrantes logran acceder a Melilla saltando la valla fronteriza"*. El Ideal. www.ideal.es/nacional/201408/30/grupo-inmigrantes-protagoniza-nuevo-20140830083318-rc.html

[53] See Guardia Civil. www.guardiacivil.es/es/prensa/especiales/sive/funciones.html

Picture 11: Functioning of the SIVE – Integrated System of External Surveillance



Source: El País.

Picture 12: Migrants crossing by boat on the Strait of Gibraltar

Source: Huffington Post.[54]

In Melilla, maritime jurisdiction belongs to Morocco. Consequently, this country is in charge of all sea rescue operations. Nevertheless, **the GC assists Moroccan authorities with a Special Team for Underwater Operations (GEAS) whose mission is to prevent migrants' boats from entering Spanish waters and reaching the coast of Melilla** (Picture 13), blocking their path and waiting for the Moroccan sea rescue units so they can return the boats to Morocco. However, sometimes Moroccan patrols either do not turn up or take too long to arrive, thus creating life-threatening situations for the people on the boat.

"Basically, we make sure that there is no risk for the life of those people or on the boat. Then we wait for the corresponding authority, which is Morocco." **(LEO)**

[54] See *"Cuánto paga un inmigrante para llegar a España".* Huffington Post.www.huffingtonpost.es/2013/07/12/cuanto-paga-inmigrante-llegar-espana_n_3585409.html

Picture 13: GEAS blocking migrant boat

Source: El Imparcial.[55]

According to the GC in Melilla, **five percent of the irregular migrants who arrived in Melilla by boat in 2013 required health assistance upon arrival or during the reception process**. At the same time, the GC reports that 15–20 per cent of migrants who tried to enter Melilla by sea exhibited hostile behaviour, including throwing stones, plunging into the sea, trying to crack the boat or setting it on fire, etc. In these cases, GCs try to reassure migrants and neutralize any dangerous behaviour by calming them down and promising them a bigger and more stable boat to bring them to the coast of Melilla, when in fact they are just waiting for the Moroccan LEOs to take them back to Morocco. This makes some GCs feel uneasy, as they consider it being dishonest and hypocritical:

"When a boat is attacking us, what we do is basically protect ourselves [...] because, after all, the Moroccan authorities are on their way." **(LEO)**

Situations involving children are the most delicate ones. Sometimes migrants threaten to throw little children overboard or to set fire to a boat full of children and pregnant women, in order to dramatize their situation and gain sympathies. **Other difficult situations include accidental drowning and people arriving in very poor health. This puts GCs in further difficulties, as they have to find a way to handle the situation so as to save the lives of people on board**:

"There were, I think, four women, two of them pregnant; three children of about five, six and seven years; and a new-born. And the captain and another with a bottle of petrol threatened to burn the children." **(LEO)**

In ***Tarifa-Algeciras*, maritime jurisdiction belongs to Spain. When a boat is detected, it is the Maritime Rescue Service** (MRS, *Salvamento Marítimo*) **that is in charge of the rescue, assisted by the GC**. According to the GC, if they detect the boat first and it is not at risk of sinking,

[55] See *"Heridos cuatro guardias civiles tras interceptar una patera".* El Imparcial. www.elimparcial.es/noticia/141847/sociedad/Heridos-cuatro-guardias-civiles-tras-interceptar-una-patera.html

regulations require the GC to wait for the MRS. However, frequently migrants themselves call the RC if their boat is in trouble.

The main tasks of the GC when intercepting a migrant boat include: reception; initial assessment of migrants' health condition; search for minors on board; registration of the self-declared identities of the people on board; provision of food and clothes; and transfer of migrants to the Policía Nacional station or the hospital if needed.

The GC in Algeciras states that **the transfer of migrants from their boat to the GC ship is the most critical moment in the reception process,** due to the many nervous breakdowns of migrants who cannot swim.

At the border point, there are no specific health-care facilities or HSPs from the PHS to assist migrants on the spot upon arrival. There is no psychological assistance either: If a person is crying or appears to be sad or showing signs of anxiety resulting from the perilous journey, they are offered tranquilizers, but no other significant measures are taken.

The RC has signed an agreement with the Spanish Ministry of Employment and Social Security to provide health care to migrants upon arrival and so the GC calls the RC at the time of initial interception. Migrants are mostly assisted by RC volunteers who provide basic health care, clothes, food, blankets, etc. A system of coloured bracelets is used to classify migrants according to their health condition: a green bracelet is put around the wrist of those with no urgent health problems, while a red one is used for those that require immediate transfer to the hospital. The Algeciras RC team, which assists migrants on their boats and on the beach, is composed of five staff members and around 200 volunteers. If needed, an ambulance or a specialized doctor from the PHS may be called.

The RC and the GC in Algeciras state that coordination between them is good, and that they also work well with other institutions involved in the assistance of migrants (e.g., MRS, health-care centres). However, some of the CSOs interviewed also claim that **institutions involved in the reception process have not held a coordination meeting in the last decade and therefore they do not have clear and agreed-upon procedures to follow, something that hinders coordination.** For example, if a migrant arrives by sea and needs to be hospitalised, there is a gap in the protocol regarding who is in charge of keeping track of this person's physical presence.

"Ten years ago or so, we developed a protocol with the RC and it was implemented. A referral protocol, a protocol for treatments and everything else. It has to be somewhere… (…) Among the causes… Well, before health-care attention was a priority, the SAS was the first one interested on it. By then the primary health-care centre of Tarifa, RC, Civil Protection and us, were involved. (…) Now, it is not a priority, so the public forces are managing these issues. And we haven´t have any contact never again, none." **(HSP)**

Box 2: Actors involved in the reception process in Algeciras

The actors involved in this reception process are:

- *USC (Citizen Safety Unit)*: It is a GC unit responsible for informing the corresponding authority when a boat is spotted from land. Also, if the boat reaches the coast, the USC may do initial processing, check if there are any minors on board, and register people's self-declared identities. However, in many cases, the USC also provides food and clothes, check migrants' physical and health condition and assess if a transfer to a health-care facility is needed.
- *GEAS (Special Group of Underwater Operations)*: this GC unit provides boats equipped with basic first-aid kits (e.g., seasickness medication and other first-aid drugs) and other resources (e.g., blankets, water and biscuits) to go to the interception location and assist migrants' most pressing needs.
- *COS (Operation Centre of the GC Headquarter in Melilla)*: This is the authority that coordinates all the activities of the Moroccan sea patrol and of the GEAS.
- *The 112 Emergency Dispatch Centre:* In Andalusia, it is the unit coordinating all the actions of the 112 Emergency Centre and the 061 Health Emergency Centre. These two centres, together with the COS, contact the RC to assist migrants' medical needs if required. The main objectives of the Emergency Dispatch Centre are: to support the MRS; and to provide humanitarian aid (e.g., water, food, blankets, clothing, etc), primary care, medication, social mediation, problem solving (e.g., accommodation, transfers to other places, etc), and counselling.
- *Red Cross* (RC)*:* They come to the rescue if the COS, the 112 or the 061 call centres request it, and deal with medical emergencies once migrants reach land. The RC, which has an emergency plan to assist migrants reaching the shore, typically waits on land and provides assistance when required (e.g. hypothermia, dehydration, and psychological assistance).
- *Ambulance services* of the PHS are responsible for transferring migrants to hospitals when needed.

Through airports

Undocumented migrants also reach Spain through the main airports in Madrid and Barcelona. Madrid's Barajas airport is one of the biggest travel hubs in the country, with direct connections to many other EU countries. At Barajas, LEOs from the Policía Nacional intercept migrants and also provide information to those who state their intention to apply for asylum:

"The Policía Nacional does offer migrants [information on asylum process] and those migrants who are smarter require a public lawyer who goes and assist him. And if he is a good lawyer he starts the process, and if he is not, the process doesn´t start until the migrant is in a centre. There exists a dysfunction so the system cannot take care of these people's rights." **(CSO)**

Transfer

Migrants intercepted by land, at sea, on the coast, or at airports, and who are without urgent medical needs, are transferred directly to the nearest Policía Nacional station, where registration and nationality assessment are carried out. After this assessment, the transfer process reassigns migrants to different centres (ICMC-Europe, 2011): (a) Reception Centres (i.e. CETIs, centres managed by CSOs); (b) Refugee Assistance Centres (CARs); and (c) Detentions Centres (CIEs), where migrants are detained and await deportation. In Melilla and Ceuta,

migrants are generally taken to CETIs, where they wait for a judge to rule on their cases. In Algeciras-Tarifa, migrants are transferred to the RC centre, a CAR, or a CIE, depending on their administrative status. Unaccompanied minors are transferred directly to Minor Protection Centres. These centres should not be considered as reception centres, as they are also used by social care services for local minors in need of protection. In Box 3, we describe the protocol used in the case of unaccompanied minor newcomers.

According to the ICMC-Europe report (2011), there are three possibilities regarding further referrals of migrants:

- When migrants come from countries with which Spain has a signed readmission agreement, the Ministry of Internal Affairs begins the removal process and migrants are sent to a CIE;
- If a migrant's asylum application has been formally accepted, he/she leaves the CIE and settles in a CAR, where they may stay for a maximum period of six months while their asylum application is processed. In case of denial, the migrant has fifteen days to leave the CAR or may remain in the CIE until his/her deportation;[56]
- If migrants in CIEs cannot be deported after the maximum period of 60 days and are found to be in vulnerable situation (e.g., single mothers, disabled or elderly people, etc.), they are transferred to an Emergency Reception Centre or a Temporary Reception Centre – both managed by CSOs, where they can live for a maximum period of 15 days (ICMC-Europe, 2011).

Reception Centres

- **CETIs**

In Ceuta and Melilla, irregular migrants are sent to CETIs. Once there, migrants are taken — usually by mediators — to the Policía Nacional station to get an identification card. This **card grants them freedom of movement throughout Melilla and entitles them to medical assistance** – at the CETI, in health-care centres, and in hospitals. Those who do not undergo an initial medical check-up at the CETI forfeit their right to receive a card. Initial medical assistance is provided at the CETI; in case of emergency, migrants are taken to a public hospital.

Length of stay in CETIs is currently not limited by law:

"The stay of residents in the CETIs can vary from a few months to up to a few years due to political issues…" **(HSP)**

One critical issue is the transfer from the CETIs in Melilla and Ceuta to mainland Spain, a process which is usually protracted and arbitrary (UNHCR, 2014). Sometimes these transfers are due to overcrowding in the CETIs. Usually by means of agreements between the government and CSOs, migrants are transferred by the government to the peninsula where they are housed in centres managed by CSOs, until they find their own accommodation through their personal contacts and networks (APDHA, 2008). However, due to financial cuts, often

[56] See at: http://extranjeros.empleo.gob.es/es/ProteccionAsilo/car/

these centres discontinue assistance to migrants before they find accommodation for the own resources. **Long waits in CETIs before migrants can continue their journey onwards to mainland Spain often lead people to despair**.

The manager of the CETI and some GCs state that, as a general rule, few migrants apply for asylum in Melilla. This is due to the Dublin III Regulation and to the fact that the CETI provides scant information about the asylum application process, as well as the release of migrants before they apply.

- **CSO- managed Centres**

The Red Cross centre in Algeciras is very similar to a CETI, but it is managed by the RC instead of the Government of Spain. Migrants in this centre generally come from either the CIE in Algeciras or the CETIs. **Most of the residents in this centre are minors, women and pregnant women** in order to protect the most vulnerable groups. **Men are only accepted as a member of** whole families, since one of their objectives is to keep the families together.

The centre offers emergency shelter and humanitarian aid in two of situations: Firstly, it takes care of homeless, helpless migrants expelled from CIEs. In the RC centre, they are provided with lodging, food, and other basic resources for a period of up to 15 days. The centre also helps them get in touch with and their families or their Spanish contacts. Secondly, the centre also helps migrants in need of protection, such as families or women with children coming from CETIs. They generally stay there between three and six months, although they can apply for an extension of up to eight months from the Ministry of Health, Social Services, and Equality.[57]

Refugee Assistance Centres (CARs)

CARs are managed by the Ministry of Employment and Social Security in cooperation with different CSOs (e.g. RC, ACCEM, CEAR). Generally, migrants apply for asylum either at the border after crossing over or in Policía Nacional stations, although the application can theoretically also be filed afterwards.

To be admitted to the centre, migrants must have asked for international protection and must have no economic resources. **Stays in CARs are generally for six months, but can be extended to 12–18 months maximum** if it is adequately justified by the manager of the CAR and the person in question.

In case of refusal, a legal document is given to the applicant who must return to his/her country within 15 days. Nevertheless, asylum applicants may lodge an official appeal by judicial means.

Migrant Detention Centres (CIEs)

According to current legislation, **once migrants have been identified and the decision to deport them has been made, they must be sent to a CIE to wait for the expulsion order to be processed. In the CIE they can stay for up to 60 days while their deportation order is**

[57] See *"El centro de acogida de la Cruz Roja atiende a 150 inmigrantes"*, Europasur. www.europasur.es/article/algeciras/116398/centro/acogida/la/cruz/roja/atiende/inmigrantes.html

processed. **After the maximum period of 60 days is over, such migrants are released and continue to live in Spain with an irregular status**.

In the CIE of Algeciras-Tarifa, newcomers are sent from the Policía Nacional station to the centre, where they may remain for a maximum period of 72 hours. The Algeciras CIE manager states that 80 per cent of migrants who pass through the Algeciras CIE are eventually removed from the country. However, there are some "non-removable" undocumented migrants who cannot be deported either because their nationality is unknown or because there is no bilateral agreement with their country of origin.

Box 3: Protocol for unaccompanied Minors

In Andalusia, unaccompanied minors are immediately taken to a Minor Protection Centre and, in case of suspicion regarding their age, they have to go through an age assessment process (Consejería de Igualdad, Salud y Políticas Sociales, 2014; OIA et al., 2012). In Madrid, unaccompanied minors are taken to the section of the Judicial Police (GRUME) that is in charge of minors for the age determination process (Gallego Obieta et al., 2006). Afterwards, they are referred to a residence for minors run by the Autonomous Region of Madrid (Comunidad de Madrid 2014). In Melilla, unaccompanied minors are sheltered in the Centro Educativo Residencial de Menores "Fuerte Purísima", an institution managed by the Autonomous City of Melilla (Ciudad Autónoma de Melilla, 2014).

The age assessment tests are conducted to unaccompanied minors either because they have no identification documents or because these are false. However, according to CSOs, these procedures are not very effective. In their opinion, there are errors in the protocols of medical examinations, and bone tests are not reliable in some cases, as they have a two-year margin of error. Consequently, minors may be mistakenly not identified as such in the several examinations they go through (e.g., in forensic and medical examinations, in court proceedings, and at the police station). CSOs have reported cases of minors whose age is uncertain, but who had no right to a second examination, despite the recommendations of the Spanish Ombudsperson. Reference was made to the case of a minor who, following the corresponding medical examination, he remained in the CETI for several months before being referred to a minor protection centre. Moreover, CSOs claim that these controls are used by those responsible for deciding who stays and who is ejected from the centres. In July 2014, the Supreme Court of Justice ruled that these tests cannot be made for minors who prove their age by official documents.[58]

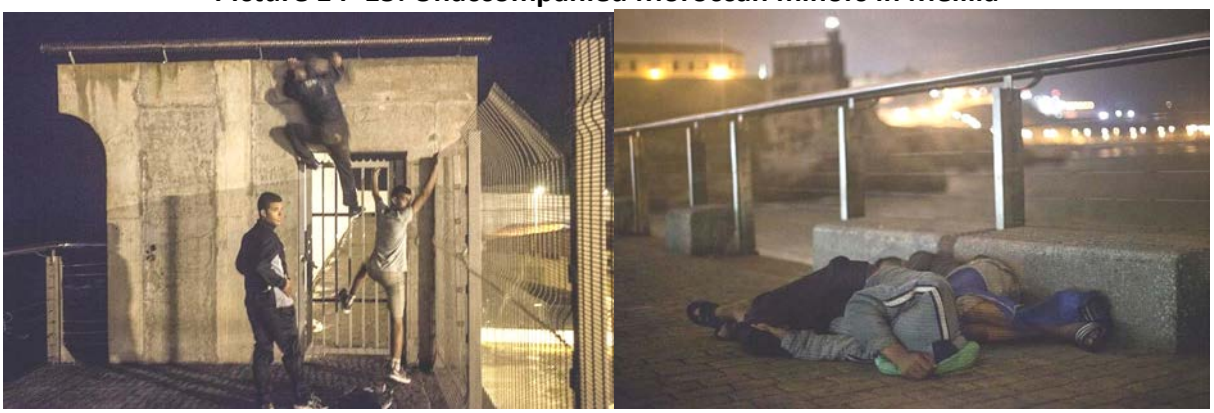
"referring to bone tests] those are not determinant. Andalucía ACOGE has denounced it and we have also worked on this issue. Besides, if a male minor arrive the test is run, but if sub-Saharan women came alone by boat, test are not run. Even if you see they have no breasts and look very young. Why aren´t the tests done unless they require it? (…) In the CIE, we told the director that we thought a girl was a minor and they tested her. (…) The Ombudsperson has also questioned this procedure." **(CSO)**

[58] See "*El Supremo prohíbe someter a todos los menores inmigrantes a pruebas de edad",* El País. http://politica.elpais.com/politica/2014/07/18/actualidad/1405709552_799676.html

CSOs are also concerned about the legal status of minors —particularly Moroccan— who turn 18. It is of special interest, the case of minors in Melilla,[59] which run away from the minor protection centre "Fuerte Purísima" due to several reasons: (a) physical and psychological abuse; (b) the withdrawal of the residence permit when reaching adulthood; and (c) the non-enrolment of children in the public education system. These minors leave the protection centre without valid identification documents. Consequently, they are still considered as irregular migrants and they cannot continue their studies or work legally. They survive in the streets near by the CETI, waiting for the opportunity to arrive to mainland Spain hiding in boats. They hope to arrive in the Peninsula in order to access to a less hostile protection system, or even trying to apply for roots for a residence permit together with a labour contract.

Minors who turn 18 and are expelled of the centre, are sent on their own to mainland Spain if they have no family to live with. Sometimes they are simply given a bus ticket to Madrid, where they often find themselves living on the street if they do not have a personal social support network.

Picture 14–15: Unaccompanied Moroccan minors in Melilla



Source: eldiario.es (photographer: Robert Bonet).[54]

In the Community

If the deportation process cannot be completed, migrants fall into a social and legal limbo, and are left loose without documents and without any provision. The same applies to asylum-seekers who are not granted asylum and are forced to leave the CAR. In this case, **migrants are released in the community and join the large undocumented migrant community in Spain.**

"When migrants leave the centres, they go to the street. And if they are in the Street and have nowhere to go, many of them go to the settlements. (…) People in these settlements have no information. They have no Access to the PHS unless we tell them so, because normally, they consider that they are illegal and if they go to the primary health-care centre, they will be detainee again. So, in this case, there is a great work of health prevention and promotion. (…) The most frequent problems in the settlements are due two causes. First, because of where they live. Because they live in subhuman conditions, they sleep on the ground, they are in the open, it rains, it is hot, so they have problems related to these situations. Secondly, they have health problems related to their migration journey (…) Consequently, problems are normally physical,

[59] See "*Los niños de la calle de Melilla: huir del centro de menores para evitar la expulsión",* El Diario. www.eldiario.es/desalambre/FOTOS-Ninos-Melilla-maltrato-institucional_12_339236074.html

psychological, infectious diseases, Hepatitis, TB, HIC, fungus, and many of them have parasites, slices, bedbugs and fleas due to unhealthy conditions." **(CSO)**

There are no rules and regulations addressing such situations, and as a result migrants cannot work legally, access health-care services, or social protection services. Nevertheless, **in order to survive, these migrants look for shelter in migrant settlements**, such as the ones on Gourougou Mountain in Nador (Picture 16), or the ones in the forest near the strawberry fields in Huelva (Picture 17). These settlements have deplorable living conditions, and a total lack of health care and social services. However, there are some CSOs and LEOs who offer some basic assistance in these settlements, as described in Box 4.

Box 4: Guaranteeing basic health care in migrants' settlements of Morocco and Spain

Picture 16: Settlements in Nador

Source: El País.[60]

In **Nador**, there is a health-care service for migrants who are waiting on **Gourougou Mountain's settlements** to cross the border. This project is currently managed by the CSO Jesuit Migration Service, and it has four objectives:
(1) The migrant health-care assistance programme within the Moroccan health system in Nador for those who are injured after trying to cross into Melilla through the fence and those waiting on Gourougou Mountain. This programme includes transfers to health-care centres, translation services and payment of medications;
(2) 24-h emergency service to assist women in labour, people injured in confrontations with the police and between migrants themselves;
(3) Distribution of materials, hygiene and winter kits (e.g., materials to build shacks, sheets and blankets);
(4) HIV and STD prevention educational activities.

According to CSOs, on the Moroccan side of the border, emergency health services are provided in the hospital in Nador. According to statistics, around 500 migrants were treated during the summer; most of them after being injured by the police (e.g., head wounds, broken legs, arms, and jaws).

[60] "*A las puertas de Europa*". El País. http://elpais.com/especiales/2014/europa-frontera-sur/el-relato.html

Picture 17: Settlements in the forest near the strawberry fields in Huelva

Source: CESPYD.

The settlements in the forest near the strawberry fields in Huelva (Andalusia) began in 2000, when destitute migrants looking for work in the strawberry fields started to camp out in the surrounding area. At present, the GC in Huelva has identified up to 25 different settlements in the area, populated mainly by undocumented migrants.

A number of CSOs work in the Huelva settlements:

- *CEPAIM* provides social services, shelter and legal counselling, as well as assistance in obtaining asylum and work.
- *Huelva Acoge* offers legal assistance in relation to work.
- *RC* distributes food and basic goods in the settlements.
- *Caritas* distributes food and blankets.
- *ACCEM* processes documentation and mediates with embassies and consulates in cases of missing documents. They also provide food, clothes and hygiene products to migrants. Additionally, they have a job board for migrants, and sometimes offer repatriation assistance.
- *Mujeres en Zonas de Conflicto* advises women on sexual and reproductive issues, including sexual exploitation and violence against women.
- *Social Services of Moguer* coordinates the work of different actors involved in providing support to the settlements.

"Moguer City Council has been struggling to find the ways to coordinate the different services. Social Services are in charge of this task (...) they coordinate the different institutions and organisations. They focus on shack areas, and try to avoid the creation of new settlements. Several meetings have taken place (...) with no results so far." **(LEO)**

However, one of the most important actors working for the assistance of migrants in these settlements is a special group within the GC, the EDATI (*Equipo de Atención al Inmigrante*). This group was created in 2000 with the aim of protecting the rights of migrants living in improvised settlements in rural areas. Teams are composed of at least three members of the GC who constitute a task force. The number of teams in each province depends on the migrant rates in the area. There are EDATI teams in the GC in Granada, Almería, Huelva, Valencia, Alicante, Barcelona, Tarragona, Murcia, Baleares, Algeciras, Málaga, Cádiz, and Castellón.[61]

[61] See EDATI. Guardia Civil. www.guardiacivil.es/es/prensa/noticias/4313_01.html

In Huelva, EDATI begins work in October/November, when the migrant population increases in the area during the strawberry season, and then ceases its activity in June when farming is over and officers return to the regular GC activities. EDATI deals with two main migration-related problems: (1) risks resulting from the shack settlements (e.g. garbage, fires, floods, collapse of shacks, etc.); and (2) labour exploitation of migrants, especially in the agricultural sector.

Among EDATI's main tasks, the following are included:
(a) To carry out labour inspections to prevent the violation of workers' rights (such as exploitation and non-payment of wages) and to act as mediators, providing information and help with paperwork, job search, etc.:

"This is 21st-century slavery, total servitude. We go deep in all those recruiting issues, the exploitation, the conditions they are working in (...). Then, the problems they face with social integration, documentation (...) how to pay their social security contributions." **(LEO)**

(b) To collect information of migrants living in the settlements (country of origin, legal status, vulnerable groups, details of the journey, etc.). One of the main goals is to check if there are minors living in the settlements. Weekly or bi-weekly, EDATI officers send reports to the GC headquarters, where the information, which is strictly confidential, is recorded in the SIGO programme (*Sistema Integral de Gestión Operativa)* used by the GC to register and track offenders and suspects.

(c) To guarantee public safety, by preventing conflicts by means of regular patrols and monitoring. Conflicts in the settlements arise because of the presence of many different nationalities (e.g. Algerians, Moroccans, Lithuanians, Romanians, and Ecuadorians) and disagreements during food distribution:

"When the RC distributes food, sometimes there are fights, as they think there won't be enough food for everyone, and we must intervene." **(LEO)**

(d) To inform migrants about their rights: generally, EDATI agents try to be close to the migrants living in the settlements and build trust among them. With time, migrants look for their help and assistance in solving daily problems.

According to the GC, EDATI agents share information with the other actors involved (e.g., CSOs and social services), although their work is not so closely coordinated, due to EDATI's specific mandate to deal with more individual cases than CSOs.

In spite of these good practices, as a general rule, the provision of health-care services to irregular migrants differs by region and according to regional laws. In ***Andalusia,*** **access to health care is guaranteed for everyone including irregular migrants**, even individuals without health cards and those who refuse to identify themselves (i.e., refuse to provide their personal information – such as name, last name, country of origin, and ID number - to administrative staff in hospitals and health centres). CSOs highlight that although the limited access to health care for undocumented migrants established by the RDL 16/2012 is not applied in Andalusia, it is important to train HSPs and administrative staff, as many of them do not have information about migrants' entitlement to health care and, therefore, the assistance provided locally varies

greatly from one centre to another. Lack of information about legally guaranteed health-care rights can cause confusion: for example, in some cases, administrative staff requests that migrants identify themselves as a *sine qua non* to access health care; in other cases, irregular migrants, not knowing that they are entitled to health-care services, make use of another's identification details. This has caused different patients to be registered and treated under the same name. This situation obstructs health-care services, since the same medical record may contain information about different people, which makes it even more difficult to monitor patients.

In ***Madrid,* the RDL 16/2012** limits adult migrants' health-care access to emergency services, prenatal care, and perinatal services. According to the RDL 16/2012, minors are entitled to health care under the same conditions as Spanish children. Migrants suffering from communicable diseases such as HIV, and victims of human trafficking are also entitled to subject to the same conditions as Spanish citizens. In this context, different CSOs offer support to people excluded from the Spanish public health-care system. Additionally, CSOs offer intercultural mediation services to facilitate communication and to overcome cultural barriers interfering with health care.

"The rapid HIV test is done with many facilities, in theory. Health card is not required, is free, confidential, anonymous. Even if a positive is detected, our mediators or team accompanies the migrant throughout that process, as far as possible and to the extent that the patient demands it (...) Treatments are covered by the Community of Madrid. In theory, because there are cases where it is not doing." **(HSP)**

There are around 3,000 Moroccan migrants residing legally (with a working visa) in Melilla. They are commonly called "*fronterizos*" and, as affiliates of the Spanish Social Security System, have the same PHS coverage as with Spanish nationals (RDL 16/2012). Nevertheless, HSPs highlight that if these migrant workers stop working, they can no longer access the PHS, as **Melilla applies the health-care access limitation established by the RDL 16/2012**: when migrants lose their working visa or retire, they remain in the country with no documentation and no medical assistance. There are also undocumented Moroccan workers without access to health care who work on industrial ships and who may not report a situation of illness for fear of losing their jobs. Finally, there are also a significant number of people who do not apply for asylum for fear of being turned down and deported. While their asylum applications are being processed, which can take up to two years, they cannot leave Melilla or Ceuta, a situation that forces them to live in camps and work illegally and without medical coverage.

II.II Public Health in Border Communities

In **Melilla and Ceuta**, two main issues threaten public health. **First, thousands of people who legally cross the border daily without any health control,** either to go to work or to shop on Spanish territory (e.g., Barrio Chino), may seek health care at the Spanish PHS:

"In Nador, there is a public hospital, but as in any public hospital in Morocco (…) you have to pay for the gauzes, syringes, drugs, doctor, ambulance, nurse, so… I think that even these are not expensive, if they charge you for everything—and taking into account the economic level of Morocco—it is expensive. Consequently, they come in here and indiscriminately use the Spanish

PHS. They access through the emergency services. We have the highest number of emergencies in the whole country… the 92 per cent of admissions are through emergency services." **(HSP)**

Second, deteriorating living conditions in detention centres, together with migrants' fewer financial resources to buy medicines are causing some diseases (e.g. skin disorders) long since eradicated to re-emerge.

In order to prevent this, when migrants arrive at the centres (i.e. the CETI in Melilla; the CIE and CAR in Madrid; or the RC centre in Algeciras), **they first have to undergo a medical examination known as "the Africa profile,"** which includes tests for Hepatitis B and C and HIV; a Mantoux test for TB; and blood tests for Malaria and other diseases. Migrants also undergo a mouth and throat exam and eye examination. If any disease is detected, they are taken to the hospital to be treated. With regard to TB, HSPs explain that in case of detection, it is necessary to inform the Spanish Ministry of Health, Social Services and Equality. TB treatment takes six months and is fully covered by the public health-care system. Residents in CETIs are not allowed to leave until all test results are received – this typically takes around three months.

However, **first-line staff** (especially the GC) **have not been trained sufficiently to protect themselves from infectious diseases and to detect basic symptoms** in order to inform health authorities. In Huelva, the GC's Occupational Risk Prevention Office (Servicio de Prevención de Riesgos Laborales PRL) stated that there are protocols for emergency cases involving health risks that are activated and work properly. The biggest risk for public health in Huelva is not due to newly arrived migrants but to unsanitary living conditions in the settlements (e.g., the lack of drinking water, poor sanitation, no garbage collection service, etc.). There are cases of scabies, as well as TB, mumps, and other diseases that had been previously eradicated in the area. No cause-effect relation between these medical cases and the flow of migrants has been factually established to date, however there might be a connection, due to the rare nature of these diseases. Also, the number of cases of sexually transmitted diseases has increased:

"Some people needed health assistance due to intense itching, but no outbreak was observed. Now there is concern about sexually transmitted diseases (...). This all started last year and has spread since due to prostitution." **(LEO)**

II.III Discussion Section - II

Reception process and coordination

- The Government of Spain should take more steps to counter the situation over the pedestrian border of Barrio Chino, including the illegal activity of the freight traffic itself, but also subhuman and unhealthy labour conditions of the carriers entering in Spain;
- The work of the LEOs in Barrio Chino should be acknowledged for going beyond their regular activities and playing an important humanitarian role in ensuring the safety of these carriers in this point;
- The Government of Spain should increase the number of LEOs at the Beni Enzar border point in order to improve their capacity to perform border controls over the great number of vehicles that pass through this border daily;
- Following the recommendations of the ombudsman, as well as relevant international social organizations (e.g., Amnesty International, Human Rights Watch, CEAR), wires and

blades throughout the Melilla fenced border should be removed, as they are an inhuman measure that threatens people's physical integrity and HR;

- It is necessary to develop a fair and clear protocol on the actions that LEOs should take actions in the fenced border of Melilla, including where Spanish territory begins and when the use of rubber bullets and batons are appropriate. When these issues are resolved, LEOs may cease receive less criticism from the media and pressure from their institution;
- It is necessary to build networks and partnerships with the countries of origin in order to develop actions to further eradicate smuggling activities and organize crime;
- Legal frameworks and protocols should be established to facilitate the Syrian population that reaches the fenced border of Melilla to seek refuge and asylum on Spanish territory. This would reduce the risk of migrants resorting to smugglers and thus becoming victims of human trafficking;
- The PHS should be included in the reception process of migrants on the Spanish coast in order to improve the health-care assistance provided. This is currently a task performed by LEOs and RC mainly. In this phase of the reception process, it would be desirable to incorporate the provision of psychological assistance as well;
- The Spanish Maritime Rescue Service (MRS) should be incorporated in the rescue efforts on the coast of Melilla-Morocco since it possesses more resources than the GC to effectively assist migrants at sea:

"The problem here is that the service we provide should be provided by the Spanish Maritime Rescue Service (MRS) because they have better resources and more experience dealing with immigration." **(LEO)**

- It is necessary to increase the coordination of all stakeholders involved in the reception progress of migrants, especially by sea. To this purpose, it may help to organize regular coordination meetings, establishing common procedures to follow, share resources, etc;
- It is necessary to improve the transfer protocols from CETIs to the peninsula. Likewise, to improve agreements between government and CSOs to welcome migrants leaving the CETIs;
- Living spaces that guarantee basic rights and livelihood should be made available to migrants leaving the centres.

Public health in border communities

Regarding Public health in border communities, it is important to:

- Strengthen and expand the initial medical check-ups protocols for the arrival of migrants at the various centres;
- Increase and improve coordination with the public health system upon detection of outbreaks, diseases, etc. in the centres, as well as to develop specific protocols for each of the cases;
- Increase initial assessment and infection detection training for first-line staff, as well as preventive measures against any staff exposure to diseases;
- Pay special attention to migrant settlements. They involve a great risk to public health due to diseases that are spawned by the unhealthy living conditions of the settlement and the consequences of the migratory journey.

III. MONITORING MIGRANT HEALTH

III.I Migrant Health

LEOs, CSOs, and HSPs indicate that, **as a general rule, migrants are in good physical condition, despite unjust stigmatization by the media as disease carriers.** In fact, migrants are generally young adults –the healthiest and strongest members of their respective communities, the ones able to endure the journey. Recent studies conducted in Spain conclude that migrants' health is relatively good when compared to the rest of the population (Hernandez Quevedo, Jimenez Rubio, 2008; Rivera, Casal, Currais, 2013). This is mainly due to their relative young age and health demands of the migration procedure, something described in the literature as "the healthy migrant effect" (Rivera, Casal, Currais, 2013:339).

Out of the migrants arriving in Spain, **those with the most health problems are the ones who scale the border fences and the ones arriving by boat**. The latter often suffer from hypothermia, muscle strains, skin burns (caused by fuel, sea salt, or the sun), dehydration, and anaemia. These are all conditions whose recovery time is relatively short. Pregnant women arriving on illegal boats are immediately referred to a hospital for a check-up and so they can receive medical attention. If necessary, people with medical conditions, such as TB or skin and eye diseases, are also referred to a hospital. Those who get to Melilla after scaling the fence sometimes suffer serious injuries (e.g., broken wrists or elbows, etc.) and deep cuts caused by the razor blades on the fence:

"Many are injured after the fall, with open and apparently serious wounds. Sometimes they are under the effects of alcohol or glue huffing, so that the injuries caused by the fall don't affect them." **(LEO)**

Migrants often spend long periods of time hiding in settlements on Gourougou Mountain, waiting for the right moment to cross the border. **HSPs report diseases linked to their stay there, including respiratory diseases, parasitism, and skin diseases such as scabies**. CSO representatives also refer to physical abuse at the hands of the Moroccan LEOs.[62, 63]

"On 24 July 2013, 300 members of the Moroccan Armed Forces are committed to cleaning the area. Expanding bullets, iron bars for truncheons, flying stones and quick matches. Destroyed camps, five deaths, seven children torn from their mothers, and an eight-month baby with a burned arm. Four hundred people thrown into the desert – 40 of them severely injured-, at least eight dead people and a raped girl, six poked-out eyeballs, bleeding hernia, smashed jaws, broken legs, dislocated arms, scattered teeth, two forest fires, and documents – including refugee cards and asylum applications – reduced to ashes." **(APDH, 2014)**[64]

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[62] See *"El monte Gurugú se ha terminado"*, El Mundo. www.elmundo.es/espana/2014/08/21/53f51a0822601df24a8b4584.html

[63] See *"Marruecos: abuso de migrantes del África subsahariana"*, Human Rights Watch. www.hrw.org/es/news/2014/02/10/marruecos-abuso-de-migrantes-del-africa-subsahariana

[64] APDHA. *Derechos Humanos en la Frontera Sur.* (2014). Available from www.apdha.org/media/frontera_sur_2014_web.pdf

Having overcome the perilous journey to Spain and the health problems that it entails, migrants face further health challenges from poor living conditions such as overcrowding, lack of health care, poor diet, and cold weather in the settlements and in the centres where they are housed. In this regard, HSPs refer to TB (due to the journey and to overcrowded living spaces and unsanitary living conditions) and to Hepatitis B (because of the relative ease of transmission) as the most frequent communicable diseases among migrants. With regard to other health problems, CSOs believe that it is necessary to work towards preventing sexually transmitted diseases. Moreover, from a cultural and psychological perspective, they point out that **migrants often develop fear of contracting diseases due to new and unfamiliar climate, diet and hygiene.**

The GC acknowledges that in the past few years mental health problems have increased in migrant people. For example, GC interviewees explain that there are cases of **depression among young men caused by the pressure from their families back home**:

"Recently, we've seen people with mental health problems (...). They sacrifice everything to come here, especially those from Mali, Senegal (...). They risk everything when they cross the border. When they finally make it, they are excited. This is like Promised Land for them, but then they come here and it's an altogether different reality that they have to face. Living in a shack is not easy. We had a guy from Ghana who, after ten years, is still undocumented. He also had drinking problems." **(LEO)**

Different studies published by Spanish and European CSOs and individual authors include analyses of the health situation of migrants and asylum-seekers in reception and detention centres.[65] The following section is devoted to the results of these analyses and the provision of health care in these centres.

III.II Provision of Health-care Services and Social Assistance

As described in Pillar I, "Policy and Legal Framework," migrants housed in reception centres, refugee assistance centres, and detention centres are entitled to health care and social assistance. As a general rule, emergency medical assistance is the only health-care service that they receive. Although some centres do have primary care units, the services available and the immediacy of the assistance depend on the type of centre. The main functions of these health-care units are: (a) to perform medical examinations upon arrival, (b) to detect health problems, and (c) to refer patients to hospitals or primary health-care centres for further treatment. Although applicable to other centres, this information mainly refers to the CAR and CIE in Madrid, the CETI in Melilla, and the centre managed by RC in Algeciras.

Reception Centres

- **CETIs**

[65] See APDHA, 2008; APDHA, 2012; APDHE, 2013; Campaña por el cierre de los centros de internamiento, 2013; CEAR, 2013; Centro Pueblos Unidos, 2013; Ferrocarril Clandestino, Médicos del Mundo Madrid, SOS Racismo Madrid, 2009; Jarrín Morán, Rodríguez García, De Lucas, 2012; JRS-Europe, 2010; 2011; SMJ-España, JRS-Europe, 2014; WLW, 2012.

In CETIs, primary care is provided by the private company called CLECE. The health-care team at the Melilla CETI consists of a doctor and several nurses. For emergencies and specialized assistance, as well as paediatric and pregnancy cases, patients are referred to public hospitals and/or the nearest primary health-care centre.

Together with the "African Profile" tests for all new CETI arrivals, some additional health-care services are provided – for example, such as HIV treatment, which is voluntary and free of charge for anyone at the CETI who exhibits HIV symptoms. If residents do not wish to receive it, they may sign a treatment refusal form. However, HPs and NGO representatives consider that access to follow-ups and treatment for TB and HIV becomes difficult for migrants once they arrive on mainland Spain, as RDL 16/2012 states that undocumented migrants must pay for treatments out of their own pockets.

CETIs offer additional tests and services for vulnerable groups (e.g., families, minors, and women). Many of the women living in CETIs suffer from urinary infections and anaemia, and have no access to family planning, so that many of them take free of charge oral contraceptives. Interviewees indicate that many migrant women who come to Spain are pregnant because it is known among migrants that women who give birth in Spain are entitled to remain in the country. Sometimes, women arrive at the centre with dependent children, and later disappear leaving the children (known as "anchor children") behind. When this happens, **CETIs have to perform additional blood tests to verify who the parents are and to protect the abandoned children from potential human trafficking**. Also, DNA tests must be run in case of doubts about the paternity of minors who stay with their families in the CETI family units. These tests are developed by the Ministry of Social Welfare and Health and the University of Granada, which signed a collaboration agreement with the "DNA-Prokids Melilla" programme.[66] Children also receive medication free of charge and are visited by a paediatrician of the Public Health System. **Mothers are given diapers and basic baby care equipment for free**.

HSPs in Melilla CETI point out that **no informed consent procedures for medical treatment are available.** However, there are interpreters available and some official documents (i.e., flyers and leaflets) written in different languages with information about the symptoms, treatment, and prevention of TB, Hepatitis, and HIV. Nevertheless, there is no information about other diseases such as syphilis. Where there is no printed material available in the migrants' language, the health-care provider must explain the situation to the patient as well as possible.

HSPs also highlight that when migrants leave the CETI, they are given an envelope containing their medical records. At the same time, interviewees observe **difficulties in the transfer of medical information**. As an example, they refer to the death of Samba Martine,[67] a 34-year-old Congolese woman who died in the CIE of Madrid on 19 December 2011. Medical staff there was unaware that Samba was HIV positive, despite the fact that the Melilla CETI medical staff, where she had been housed before her transfer to Madrid, had tested her for HIV. She was

[66] See "*La Consejería de Bienestar Social hará las pruebas de paternidad a los menores acogidos en el CETI*", Melilla Media. www.melillamedia.es/n/3192/la-consejeria-de-bienestar-social-hara-pruebas-de-paternidad-a-los-menores-acogidos-en-el-ceti

[67] See "*Family of immigrant who died with undiagnosed AIDS fights for justice*", El Pais. http://elpais.com/elpais/2013/04/10/inenglish/1365618958_460207.html

transferred to Madrid before the Melilla CETI found out that the test for HIV was positive and that her condition was serious. Her death, which could have been avoided, was a direct result of lack of coordination between centres.

CETIs also provide psychological assistance if HSPs detect mental health problems, or if assistance is requested by the migrants. Psychiatric cases are referred to the mental health department of the local public hospital. Psychological care is fundamental, considering that migrants experience high levels of stress as a consequence of crossing the border between Morocco and Spain after a harsh journey and a long wait in Morocco, for example, on Gourougou Mountain.[68] The RC also provides psychological assistance to migrants who are referred by other HSPs in the CETI, or request it themselves.

Finally, it is worth mentioning that **the reception process in the Melilla and Ceuta CETIs guarantees that migrants receive a series of services and perform activities that are considered essential for their later transfer to mainland Spain**. **There is a mediation service run by CSOs,** composed of an intercultural mediator, a social worker, a psychologist, and volunteers who can speak Arabic, English, and French. Their role is to accompany migrants to medical appointments, and to provide information and legal support regarding the laws and legal procedures that may affect undocumented migrants in Spain (i.e. access to health care, asylum, etc.). Also, the CSO Melilla Acoge organises different workshops at their own facilities and the CETI of Melilla on disease prevention (e.g., mental and emotional health) and even others based on photography, theatre, and arts). Furthermore, in CETIs there are other activities run by several CSOs: social and leisure activities, language lessons and health and social workshops. **Schooling is mandatory for children, so they are sent to different public schools near the CETI.** The CETI provides children with educational materials (e.g. textbooks, notebooks, pencils) and there is a day-care centre for children aged one to three. Interviewees point out that, although residents do request it, they are not allowed to cook for themselves. Also, CETIs adapt their mealtimes accordingly during Ramadan, yet residents are only permitted to assist in preparing traditional dishes when a "multicultural week" is organised.

Centres managed by CSOs

AT the RC centre in Algeciras, the most common health problems are fatigue, muscle pain, and mental health issues. Alcohol and drug abuse have also increased recently. **Centre residents are informed about their right to receive health care, about the rules and requirements for doing so, and about the health ID card application process.** Additionally, residents receive health education through workshops aimed at preventing sexually transmitted diseases.

"There is need of an explanation of the (Spanish) sanitary system... migrants attach a great value to the health services but they actually don't know them... they should be aware about their functioning." **(CSO)**

Upon arrival, migrants are tested for transmissible diseases and Hepatitis B and C, and they receive a Tetanus vaccination. Staff also checks if migrants have their medical records. HSPs

[68] For more information on the critical health and security situation on Gourougou Mountain in Nador. See at: www.trappedinmorocco.org/#/atrapados

point out that **migrants are referred to a public hospital when warranted**. Although health mediators are often not available, HSPs manage to communicate with migrants in French.

"We are lucky because a couple of doctors can speak French (…) Nevertheless it is important that in the front desk, the staff who take the analysis, take the samples, over there, more sensitization it is needed." **(CSO)**

There are no mental health services available at the Reception Centre in Algeciras, although on occasion support may be provided from an NGO or the PHS, e.g. in some regions, like Andalusia, residents are referred to the mental health service of the nearest public hospital. Some of the migrants interviewed claim that there should be greater attention paid to female residents, considering that they are frequently the victims of human trafficking.

According to staff's observation and experience, the ongoing economic crisis makes it significantly harder for residents to find employment. To remedy that, centres managed by **CSOs organise courses and activities** (e.g. Spanish classes, computer training, and employment counselling). Schooling is not compulsory for children because their situation is considered to be temporary.

Refugee Assistance Centres (CARs)

In **CARs, asylum-seekers receive a "health certificate" instead of a health card, which entitles them to access the PHS with the same rights as Spanish citizens**. Some centres have their own doctors (e.g. Seville), although this is rare. Centres usually cover pharmaceutical co-payments and CSOs provide additional or specialized medical services (e.g. dental prosthesis).

Asylum-seekers housed in CARs are referred to public health centres or hospitals, **for which they may use an interpreter free of charge if required.** Although there used to be medical staff in CARs, financial cutbacks have made it impossible to continue offering this service. It is a member of the technical team who is in charge of the follow-ups. **Residents in CARs do receive psychological and social assistance in the centre**, and each resident goes through an interview process upon arrival with providers of both services. This process forces them to repeat their story several times which is usually traumatic for them. When psychological follow-ups are required, residents generally prefer to go to a different centre, to avoid the stigma associated with mental illness.

HSPs state that the most common mental health problems among migrants are anxiety, depression, psychosis, psychological trauma, alcoholism, and adaptation problems, including some isolated cases of suicide attempts. **Women are the most vulnerable group**, suffering from mental problems triggered by rape and gender violence during the journey. Victims of human trafficking are referred to specialized services:

"Sometimes there are groups of women who are bought in Africa to be prostituted in Europe, and most women do not tell the truth. Sometimes when they tell you the truth in a confidential interview… These people are victims of trafficking or many other types of situations. There is an NGO called Proyecto Esperanza that helps women who are in this case..." **(HSP)**

In CARs, mental health problems are frequently caused by the **migrants' feelings of uselessness and their uncertainty about the future.**

There is no data available regarding other types of health problems in CARs, as migrants are referred to health centres and hospitals in order to receive care. However, HSPs in CARs see the lack of prevention of Chagas disease among residents as a problem, since it is stigmatised as a poverty-related medical condition.[69] Therefore, they demand that Chagas tests be done, especially to pregnant women, because of the risk of transmission to the foetus:

"This disease needs to be dealt in another way because if you talk directly about Chagas they may tell you 'I´m not poor, I wasn't poor back home, neither I am here…' (…) It is necessary to use other cultural tools to explain Chagas and convince them about the importance of doing this test (…) The risk is that later the mother may transmit it to her child, specially a pregnant woman." **(HSP)**

CAR residents acknowledge that there **is a good follow-up mechanism for the asylum application process**, and that they generally are able to have meetings with the same lawyer and interpreter, in addition to being given all the legal information required (i.e. copies of rules and regulations, information on how to apply).

To help migrants prepare for independence and self-reliance, **CARs offer vocational and language classes**. **Children go to day-care or school**, and sometimes participate in children activities organised by the CARs. Every Saturday, they children visit parks and participate in neighbourhood activities. Family education workshops are also provided. However migrants in the Madrid CAR point out that they would also like to have better access to computers and more activities, such as intercultural cooking classes, and more outdoor and cultural activities.

Detention Centres (CIEs)

CIEs have a health-care unit run by a private company (Clínica Madrid), whose contract is being granted on a competitive basis for up to two years. This fact prevents CIEs from building on the health providers' years of accrued experience in this type of centres:

"As long as the contract only lasts two years, not much can be done." **(HSP)**

Recruitment is done by the private health-care company and staff is often composed of foreign physicians with significant work experience and adequate training.

Although **the number of HSPs working at CIEs varies according to the number of migrants in the centre**, HSPs staff must be comprised of at least a general practitioner and a nurse. Health-care services at CIES include: (a) medical examinations for migrants entering and leaving the centre; (b) medical assistance and provision of medicines; (c) referrals to hospitals when needed; (d) organisation and inspection of health and safety measures (e.g. food preparation

[69] Ministerio de Sanidad y Política Social. "*Enfermedad de Chagas en personas procedentes de latinoamérica residentes en España".* (2009). Available from www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/migracion/docs/enfermedadChagas.pdf

and distribution, migrants' personal care and hygiene, sanitation, heating, lighting, and ventilation of premises, epidemic prevention, and isolation precautions).

According to the HSPs interviewed, **each resident undergoes an initial medical examination and a blood test upon arrival**. Subsequent care is substantively equivalent to primary care, complete with medical reports and records. Gynaecological exams are also conducted when requested. However, systematic vaccinations are not carried out. Migrants transferred from CETIs bring with them their medical records, including the test results for TB, HIV and Hepatitis. HSPs state that these medical records are given back to migrants when they leave the centre, but only on request. In case of an emergency, HSPs must call 061 and an ambulance is sent within 15 minutes. In these cases, the hospital where the patient is sent may carry out specific examinations if the test results are not available. If HSPs suspect an infection, Mantoux and HIV tests, and a chest X-ray are performed.

The CSOs interviewed point to **shortcomings in the provision of health care, especially regarding continuity of treatments and follow-ups appointments.** For instance, after migrants leave the CIE, treatments are provided for a maximum of 15 days, which is insufficient with regard to continuity of care. Additionally, there are cases of migrants in CIEs who have been charged for emergency services in hospitals, migrants who do not receive the prescribed medication, and migrants who do not receive their medical records unless they specifically request them.

"When there is a TB case the patient is taken to an insurance health-care centre. Over there, there are a doctor and a nurse who gets in contact with the epidemiologist, and the person receives treatment…. However, if this person goes to another place as there is no identification… if there is not following nor continuity of the treatment, we do not have any guarantee if they move to another place." **(HSP)**

HSPs complain that health care provided at CIEs is insufficient and that there are **no chances of monitoring migrants' health once they leave**. **They say that they do not have any information about these patients or access to their medical records in CIEs.** Attempts to schedule specific care, especially ophthalmology appointments, are made through the Citizens Advice Service (*Atención a la Ciudadanía*) or through primary care. HSPs also refer to cases of migrants in CIEs who were admitted to hospital and, after being discharged and having concluded their 60-day period of maximum stay at the CIE, have nowhere to go. HSPs add that CIEs may take no responsibility for this situation, and so the HSPs themselves send migrants to centres managed by CSOs so they can be medically cared for.

"They leave with everything that we have done here and with the suggestions to where they should go, what they should do… But if they then go to France you lose them…" **(CSO)**

In CIEs, mental health problems are not diagnosed and no referrals to mental health departments have been registered because migrants may not stay in CIEs long enough, which interferes with medium-term treatments. **Nevertheless, HSPs and CSOs admit that it is necessary to offer these services:**

"Psychological support is essential when you deal with victims of human trafficking." **(CSO)**

HSPs have also reported cases of self-inflicted wounds, which migrants use to temporarily suspend deportation proceedings. The report of the injuries is sent to the governmental administration, which then sends it to the competent administrative law judge.

Interviewees indicate that **some CIEs do offer social assistance services regulated by agreements between the government and specific CSOs**. These agreements are intended to support social activities, which, with the exception of religious rituals and customs, are scant in this type of centres. In Madrid, the RC conducts social assistance and mediation activities. Interviewees indicate that, in response to migrants' requests, they have made an office available to facilitate appointments. Also**, intercultural mediators** provided by CSOs have detected situations that require action on their part: looking for material necessities, contacting lawyers, mediating in emotionally charged situations, etc. For instance, they may play an important role in conflicts, mediating between migrants, as well as between them and the police.

"Proliberta is in charge of giving Spanish lessons and they are also in charge of the wardrobe. (…) Proyecto Alma also collaborates in the CIE with women victims of trafficking." **(CSO)**

"In court I am given the name of the lawyer, so I go to the CIE, talk and inform them about their lawyer and his contact details." **(CSO)**

"The person who gets in here play games, ping-pong, or any other kind of game, but suddenly, he stops playing (...) in two months this place becomes very stressing (…) That is why we try to talk to them, we bring games and play with them… We bring books and try to make them less stressed; we call the family, friends, some people text… Anything that helps them to not be stressed." **(CSO)**

However, **migrants complain from lack of legal support**; for instance, an interpreter is not always available to help them understand their court appointed lawyer or the documents they have to sign. Some migrants who had already applied for asylum requested more frequent contact with their attorneys, in addition to additional information regarding their legal status. All migrants interviewed in the CIEs were aware of how to lodge official complaint addressed to either the centre's manager or the judge.

"The RC provided me a lawyer (…) I met him in person and ask asylum, but it was denied (…) and I have not contacted to my lawyer any more. Now I haven´t got any information." **(Migrant)**

In sum, these details about the Madrid CIE match several reports that criticize the **insufficient access to health care and the inadequate health-care services**.[70] Additionally, these reports draw attention to the private subcontracting of health-care services; the short hours of health-care service; the limited number of medical staff; and the lack of adequate spaces for medical

[70] APDHA, 2008; APDHE, 2013; Campaña por el cierre de los centros de internamiento, 2013; CEAR, 2013; Centro Pueblos Unidos, 2010; Centro Pueblos Unidos, 2013; Ferrocarril Clandestino, Médicos del Mundo Madrid, SOS Racismo Madrid, 2009; Jarrín Morán, Rodríguez García and De Lucas, 2012; JRS-Europe, 2010; Migreurop, 2011, 2012a, 2012b; WLW, 2012.

services. Other shortcomings highlighted are the lack of systematic medical examinations on arrival and prior to departure; and difficulties in accessing emergency, specialized and mental health care. Frequently, migrants' requests for medical appointments are rejected, which obviously delays health care and negatively affects their overall health status. CSOs have also reported lack of access to medical attention in cases of physical aggression against migrants in CIEs (in most cases, police aggression occurs during escape or rebellion attempts[71] and suicide attempts).[72] As a consequence, **some CSOs have campaigned for the closing of CIEs**.[73]

With respect to women, **there is insufficient attention paid to** their specific health needs, especially in relation to **sexual and reproductive health**. Furthermore, the above referenced reports identify medication availability issues, especially when it comes to chronic diseases and HIV treatment. Finally, they indicate the absence of medical records or, in case they do exist, migrants' difficulties in accessing them and their test results.

Additionally, other barriers to health-care access include the **lack of social and legal support services, and the lack of interpreters and intercultural mediators**.[74] The report of the Committee on Civil Liberties, Justice and Internal Affairs (2007:193) points to the "lack of medical services"; to "medical staff openly reluctant to respond to the needs of migrants"; and to "difficulties in obtaining information concerning migrants' rights; absence of legal assistance and translation services; and limited presence of CSOs due to difficulties in gaining authorized entry." The Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia, and related intolerance of the UN Human Rights Council confirms this observation, reporting challenges "with regard to inadequate access to health care, including the lack of medical personnel and of adequate psychological and psychiatric care," also identifying the need to improve "the provision of social assistance services" (Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia, and related intolerance, 2013a:11).

III.III Data Collection

The Ministry of Internal Affairs is the institution in charge of issuing work and residence permits, confirming nationality, and approving asylum applications The National Statistics Institute (INE, *Instituto Nacional de Estadística*) periodically publishes data regarding the number of migrants, asylum applications, and the decisions over these applications (INE, 2014a, 2014b, 2014c, 2014e, 2014f).

Health information is treated differently in each region in Spain. At a national level, there is not a unified system that regional services and institutions may use to compile, share and

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[71] See "*Denuncian 'agresiones policiales' en el centro de extranjeros de Madrid*", El Mundo. www.elmundo.es/elmundo/2011/12/20/espana/1324393045.html and Campaña por el Cierre de los Centros de Internamiento de Extranjeros. https://ciesno.wordpress.com/tag/agresion-policial/

[72] See "*La Policía impulsará una instrucción para evitar suicidios en los CIE*", Diario Público. www.publico.es/actualidad/policia-impulsara-instruccion-evitar-suicidios.html

[73] CIES NO Campaign. https://ciesno.wordpress.com/

[74] APDHA, 2008; APDHE, 2013; Campaña por el cierre de los centros de internamiento, 2013; CEAR, 2013; Centro Pueblos Unidos, 2010; European Parliament, 2007; Ferrocarril Clandestino, Médicos del Mundo Madrid, SOS Racismo Madrid, 2009; Jarrín Morán, Rodríguez García and De Lucas, 2012; Migreurop, 2011, 2012a, 2012b.

assess the information about migrants' health in Spain. Thus, each region, and even each centre, uses different methods for data collection. As suggested by HPs:

"It would be good to digitalize [data]… We don't have a programme to record clinical histories." **(HSP)**

The Andalusian Health Service (*Servicio Andaluz de Salud, SAS)* has an electronic health record (BDU, *Base de Datos de Usuarios*) where all health-care processes are registered, regardless of the nationality or administrative status of users. Health and personal data are subject to special data protection requirements. In SAS, patients have full access to their medical records, although they are often not requested at all simply because patients are not generally aware of their rights. **In Melilla, there is no unified electronic health record, but rather a specific system for primary care and a different one for hospitals.** Besides the lack of connection between databases of different regions – and even within the same region, there is yet another problem pointed out by HPs: since the approval of the RDL 16/2012, it is **compulsory to have a health card to receive medical assistance.** This implies that **one single card is likely to be used by different people (the card holder and other undocumented migrants), so medical records end up containing information about several people.** Also, there is confusion among staff as to who is entitled to what services and, as result, medical assistance has sometimes been denied to irregular migrants who were in fact entitled to it.

Regarding migrants reaching the Andalusian coast, the Red Cross registers the name and overall health condition of each person. Nevertheless, it is the Policía Nacional who is responsible for the registration and identification of migrants upon arrival (ICMC-Europe, 2011). The identification process collects very basic information (e.g. name, date and place of birth) and fingerprints; all the information is collected and electronically filed.

The CETI in Melilla uses the SIRIA software of the Ministry of Employment and Social Security (*Sistema Integrado y Recolección de Información de Aforos*). According to the staff, SIRIA is a data collection system containing protected information (i.e. social, legal, and health-related data). Only authorized providers have access to this information, and their access is limited according to their professional profile (i.e., doctors, nurses, social workers, psychologists, etc.). These interviewees point out that **SIRIA is not connected with any of the health-care systems of the other Spanish autonomous regions,** and that not all the information is systemically recorded due to the high number of migrants. However, **statistical data on the cases of illness treated at the centre are registered monthly and reported to the corresponding local and regional health authority** (e.g. information collected in the African profile tests).

Systematic monitoring is only done in cases of contagious diseases, **which are systematically reported to the Ministry of Health, Social Services, and Equality.** The Spanish Network for Epidemiological Surveillance of the Health Institute Carlos III is in charge of the surveillance and epidemiological analysis of diseases of compulsory declaration (Centro Nacional de Epidemiología, 2014). Information on communicable diseases is sent monthly to the corresponding regional institutional bodies and to the Spanish Ministry of Health, Social Services and Equality. However, there is no systematic communication with the Ministry of Internal Affairs. This means that the information does not go back to the centres, thus making it very difficult to complete contact tracing.

CIEs are not coordinated with the Public Health System either. When medical services at CIEs register any incident regarding migrants, the information is kept in files under lock and key. According to the personal data protection legislation (LO 15/1999), this type of data is considered to be personal and non-transferable, and is therefore not shared with anyone, not even with lawyers. However, LEOs are always present during the medical examination. **Migrants' medical records and personal identification information are available upon request, but not systematically delivered unless it is a matter of communicable disease**. However, the reviewed reports state that frequently there are no health records, or that these are not provided to migrants (CEAR, 2013; Jarrín Morán, Rodríguez García and de Lucas, 2012).

In CARs, HSPs share a database ensuring confidentiality in cases of communicable diseases. Migrants referred from CETIs bring with them their medical records, but those referred from CIEs do not.

Finally, **in centres managed by CSOs, the system is much more informal and there is neither health information nor communication protocol.** They use their own software to register medical data. Thus, except for cases of referrals to the PHS due to communicable diseases, the information collected is for internal use only. When migrants are released from any of these centres managed by CSOs, they are given a file containing all their health and legal documents.

III.IV Discussion Section - III

Migrants' Health

In order to improve migrants´ health, it is necessary to know and monitor their living conditions and health status in their countries of origin, during the migration process, and during their stay in Morocco while they wait to cross the Spanish border. When migrants manage to enter Spain, it is important to provide them with **quality health assistance and services, especially in receiving zones**, such as Melilla and Algeciras. Migrants found in these areas have had to climb over razor wire and bladed border fences or endure long and perilous sea journeys, thus presenting dire health and physical conditions in need of specialized care.

Migrants' health can be negatively affected in centres, especially in CIEs. This report and others[75] have found that the conditions in these centres (i.e. overcrowding, long periods spent in these facilities, poor living conditions, limited health service, and lack of providers for an increasing population) not only lessen the quality of the health care offered, but clearly worsen migrants' health (e.g. psychosocial consequences of internment, diminished self-esteem, suicide attempts, and even deaths).

"Any place where one is locked up is stressful, even your own house; if one is locked up in a room for two months, it is stressful." **(Migrant)**

[75] APDHA, 2008; APDHA, 2012; APDHE, 2013; Campaña por el cierre de los centros de internamiento, 2013; CEAR, 2013; Centro Pueblos Unidos, 2013; Ferrocarril Clandestino, Médicos del Mundo Madrid, SOS Racismo Madrid, 2009; Jarrín Morán, Rodríguez García and De Lucas, 2012; JRS-Europe, 2010; Migreurop, 2011, 2012a, 2012b; WLW, 2012.

During the deportation process, lack of certainty about the future and no control over one's own life, the ill-treatment received in transfers, and the deficient travel and arrival conditions **may have harmful** and life-changing effects on the health and wellbeing of migrants.

In relation to the health situation of migrants in CETIs, a HR Commission composed of several Spanish CSOs on a 3–6 July 2014 Melilla visit, detected health risks stemming from insufficient access to hospital care, and to paediatric care in the case of underage migrants. Furthermore, frequent **overcrowding** is reported in the Melilla CETI (APDHA, 2008), with clear risks for migrants' health and wellbeing. **Psychological stress** due to prolonged stays in CETIs and to LEO's control has also been reported (Manrique, 2009).

Migrants' mental health is an area still requiring more attention, as it is not adequately dealt with from the moment of reception and throughout their stay in these centres. It is necessary to reinforce further these services, especially for women, who are more likely to suffer traumatic experiences (e.g. gender violence) during the migration process.

In order to avoid negative consequences and improve migrants´ health in centres, living conditions need to be improved (e.g. by installing adequate heating systems, providing nutritious meals, and reallocating residents to alleviate overcrowding). Another way **to improve migrants' health is through diverse activities**, such as training courses, internet access, and educational, outdoor and leisure activities. All this can help to better their physical condition as well as their mental health.

One last way to improve the provision of health services to migrants is to **reinforce health-care programmes in Nador, as well as to develop bilateral agreements with health-care centres and hospitals in other parts of Morocco**, especially in areas with large migrant populations waiting to enter Spain.

Data Collection

The absence of standardised protocols and streamlined statistics to assess migrants' health makes it more difficult to evaluate their health status and to adapt health services to their needs. The mechanisms for data collection and information transfer between centres, non-profit organizations and institutions are neither systematised nor always fluid. A clear example of this is that medical records are given to migrants, instead of being systematically transferred from CETIs to CIEs. An example of good practice is the use of the SIRIA system in Melilla. This system allows health-care providers to enter, manage and transfer all the information related to migrants (e.g. health information, administrative situation, etc.). Regrettably, the system is only used in the city of Melilla and not connected with any other data collection system in Spain.

Finally, **it is also important to develop protocols adapted to the general mobility of migrants**. **This would facilitate the continuity and tracking of treatments, as well as HSPs' access to medical records in case of transfers.**

IV. MIGRANT-SENSITIVE HEALTH SYSTEM

IV.I Infrastructure and Physical Conditions

The infrastructure and the living conditions in reception, asylum-seekers centres, and detention centres vary from one facility to another. A frequent complaint is **the insufficient financing**. According to the CETI staff in Melilla, they receive money to cover basic needs, such as clothes and food, but in the last year there was a 40 per cent increase in food needs that is never foreseen because of the amount of new residents. The impact of staff shortages and budget cuts is further intensified during peak periods (e.g. in massive fence jumps or the arrival of several migrant boats at once). **Other frequent complaints stem from the inadequate living conditions such as poor diet, overcrowding, excessive cold or heat, inadequate sanitation, and lack of social activities.** These are self-evident obstacles to the establishment of a migrant-sensitive public health-care system.

Reception Centres

- **CETIs**

Migrants residing at CETIs have freedom of movement only within the autonomous cities of Ceuta and Melilla. However, the geographic isolation of Ceuta and Melilla, located on the African continent, makes them prison-cities for migrants who are trying to get to mainland Europe.

According to the CSOs and CETI residents, the centres in Ceuta and Melilla are conceived as **first reception centres that offer services and basic social benefits to migrants to Ceuta and Melilla**. Although they have been designed for short-term stays, these stays can be extended for a variety of reasons, including that some do not wish to leave.

The Melilla CETI can accommodate up to 400 people, including single males and females and families. However, maximum occupancy has been pushed to its limits for several years now (APDHA, 2008; SMJ-España, JRS-Europe, 2014; Ministerio de Empleo y Seguridad Social, 2014). According to its manager, since 2010 the number of migrants housed there has increased exponentially well beyond the established capacity. Interviewees have reported that this centre has accommodated more than 1,900 people at once throughout 2014. This overcrowding situation has been described and censured in several previous reports and media[76, 77] (Pictures 18–19). Even, the Spanish army has had to provide tents with bunk beds and military rations to the CETI of Melilla to feed and house everyone (Picture 20).[78]

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[76] See *"El CETI de Melilla se desborda tras el salto de la valla de otros 200 inmigrantes",* El País. http://politica.elpais.com/politica/2014/02/28/actualidad/1393568776_354129.html

[77] See *"El ejército instala en el CETI de Melilla otras cuatro tiendas"*, abc. www.abc.es/espana/20150105/abci-ejercito-instala-ceti-melilla-201501041811.html

[78] See *"Unos diez inmigrantes llegan al CETI de Melilla ras saltar la valla",* El Comercio. www.elcomercio.es/politica/201501/09/unos-diez-inmigrantes-llegan-20150109134936-rc.html

Picture 18: CETI of Melilla

Source: info Melilla.[79]

Picture 19: Courtyard of the CETI of Melilla

Source: abc.[80]

Picture 20: Installation of tents by the Spanish army in the Melilla CETI

Source: teinteresa.es[81]

It is stated that the situation in CETIs is "noticeably better than in CIEs" (APDHA, 2008:14). Modules for families are available, so that children can live together with their parents (APDHA 2008). Workers at the CETI of Melilla see the classification for assigning migrants to different dormitories as arbitrary and baseless. **Often, overcrowding makes it impossible to adequately**

[79] See "*El Gobierno prevé ampliar el CETI de Melilla que actualmente alberga a 500 inmigrantes",* Info Melilla. www.infomelilla.com/noticias/index.php?accion=1&id=12982

[80] See "*El CETI al límite de sus recursos con casi 1300 inmigrantes"*, abc. www.abc.es/espana/20140301/abci-ceti-limite-recuross-201402282024.html

[81] See "*El ejército facilita más tiendas de campaña y raciones militares al CETI de Melilla al superar los 1.300 acogidos"*, teinteresa.es. www.teinteresa.es/melilla/Ejercito-militares-CETI-Melilla-acogidos_0_1093092029.html

physically separate families from the other residents at the centre. Consequently, women and their children are sometimes separated from their husbands and fathers, who must share a room with other unmarried men. Interviewees consider single mothers to be the most vulnerable group.

"The main problem is overcrowding. We are many people sleeping in each room, coming from all countries. We spend the day outside because inside there is not enough space, children do not sleep well and have no good hygiene. You get sick a lot". **(Hamed, a Syrian migrant from Homs, El País, 5 June)**

"In the CETI [of Melilla] many rights under the Convention on the Rights of the Child signed by Spain are violated. For instance, the right to live in family: many children living with mothers in the CETI and parents sleep in separated dormitories; or the right to have a decent life. They live in unsanitary conditions; living with adults who are not their family, which is the breeding ground for abuse and violence against children." **(Elizabeth Lazarus, El País, June 2014)**

According to data provided by the Melilla CETI, the annual budget must cover maintenance costs as well as the purchase of clothing and bedding for residents (1,300,000€) as well as the subcontracting of companies and CSOs (e.g. CEAR, ACCEM, Melilla Acoge) that provide services such as security, laundry, health and social care, and meals (EUR 3,000,000).

The centre provides three meals a day (breakfast, lunch, and dinner), along with snacks for children and pregnant women. **CETIs have an ample supply of personal hygiene kits, clothing, sheets, etc.,** which are periodically renewed. Housecleaning at the centre is not the responsibility of residents; **they are only responsible for cleaning their own rooms**. Despite that there are no individual telephone booths at the CETI in Melilla, **the use of mobile phones is permitted,** and there is also one public payphone. There are residents with computers who are allowed to rent their own internet access.

The CETI of Melilla closes at 23:30h and no one is again allowed in before 7:00h the next morning. **Entrances and exits are controlled, and if a person leaves and does not return within three days, they are crossed off the resident roster.**

Current CETI regulations or house rules contain a set of sanctions for irregular behaviour, up to and including expulsion from the facilities. Only one person is said to have ever been expelled, and that case involved an individual with mental health problems who continued to receive mental health assistance outside the CETI. Sanctions for minor rule violations (e.g., stashing canteen food or selling CETI issued items such as diapers) include tasks such as cleaning or maintenance work.

Complaints can be referred directly to the CETI manager. Some of them are related to poor sanitation and the fact that there is no hot water in the showers. Other residents said it is difficult to sleep due to the noise level in shared rooms.

Centres managed by CSOs

According to the RC staff, in 2012 the **RC centre in Algeciras** assisted 380 people. The centre **is subsidised by the Government of Spain,** and includes expense of pocket money for the residents (i.e. EUR 25 a month).

There are rules regulating resident-HP relationship in the centre, yet some residents claim they were never told about their rights, only about their obligations. **The centre has 35 beds for stays ranging from three to six months**; stays can be extended for up to 18 months for the most vulnerable migrants. There are seven rooms furnished with four to seven beds, but **men are separated from women, who are also with children, even if they are members of the same family.**

Residents in centres managed by CSOs say that they can call their families even when they do not have any money for calls because the centre facilitates a telephone. On the other hand, residents complain that computers are in short supply, and that they cannot participate in sports activities because they do not have adequate clothing or shoes. They are required to take their meals at the centre, although they indicate that they would prefer to cook their own food and to have their dietary suggestions or preferences taken into account. However, according to employees, religious diets and special schedules are observed during Ramadan.

Picture 21: Living room of RC centre

Source: Andalucía Información.[82]

Refugee Assistance Centres (CARs)

There are four CARs in Spain – two in Madrid, one in Seville, and one in Valencia – **with a total of almost 400 available spaces**. According to the interviewees, **this number is vastly insufficient relative to demand for places**. Half of the spaces in CARs are financed by the Ministry of Employment and Social Security. The centres of Seville and Madrid are managed directly by public staff, while the centre in Valencia is managed by CSOs (e.g. Movimiento por la Paz and CEAR).

[82] See "*Cruz roja reparte esperanza e ilusión a inmigrantes",* Andalucía información. http://andaluciainformacion.es/campo-de-gibraltar/97121/cruz-roja-reparte-ilusin-y-esperanza-a-inmigrantes/

Stays are initially for six months, but can be renewed for an additional period of six months. However, normally stays do not extend past a year and a half. Exceptions are made when families are involved and periods can be extended as longer as needed.

Residents are given a written set of house rules, available in several different languages (i.e. English) which they must sign once they have read and understood them. Also, residents are given a EUR 180 allowance per family member when they first arrive. Afterwards, they receive EUR 260 monthly for the whole family, which is far from sufficient to cover their needs.

Upon arrival, each family is issued a basic personal hygiene kit, towels, blankets, and laundry products for each individual. Once a week, each family is assigned six hours to use the laundry facilities wash their clothes. CAR's residents can come and go as they please, although they are expected to comply with facility schedules, particularly at meal times.

Families and single people reside on different floors. All rooms have three closets, a sink, and separated bathroom facilities. Some of those interviewed complained that family rooms were small. They said five family members had to sleep in three single beds. Others complained that the CAR centre had no chapel, that sometimes it is a very place, and that it was not centrally located. **There is a committee of resident representatives that meets to discuss what works well or what needs to be improved.** These meetings are highly valued by the migrants who were interviewed.

Residents appreciated the general cleanliness and the quality of the meals at the Madrid CAR. Special medical and religious based diets are available. However, some residents complain that food is lacking in variety (e.g. too much fried food and not enough fresh vegetables) and quantity (e.g. not sufficing for the entire family), which is forcing them into additional expenditures to supplement their diet.

Picture 22: Facilities of the CAR of Seville

Source: Integra Local.[83]

Migrant Detention Centres (CIEs)

The CIEs in Algeciras, Tarifa and Madrid are located in former prisons and military buildings, and are inadequate and/or poorly equipped to accommodate migrants (Picture 23–24). The CIE's additional facility in Tarifa can house up to 160 male adults in dormitory style lodging. There are neither minors (they are referred to minor protection centres), nor women (they are held at the Algeciras CIE). When there are no more available spaces, migrants are sent to another CIE. Staff highlights that currently only sub-Saharan males reside there, and that there are six to eight people in each room.

[83] See Integralocal. www.integralocal.es/index.php?accion=detalleGeneral&id=1034&seccion=3&tipo=2

Picture 23: CIE of Algeciras

Source: Le Migrant.[84]

Picture 24: CIE of Madrid

Source: El País.[85]

The reviewed reports[86] denounce the **penitentiary character of the Algeciras and Madrid CIEs and its deplorable conditions and management** (Picture 25–26). Various reports point out:

[84] See Le Migrant. www.lemigrant.net/w0/?p=6586

[85] See *"Los análisis descartan el caso de ébola en el CIE de Madrid",* El país. http://politica.elpais.com/politica/2014/10/01/actualidad/1412166965_562611.html

[86] APDHA, 2008; APDHE, 2013; Campaña por el cierre de los centros de internamiento, 2013; CEAR, 2013; Centro Pueblos Unidos, 2010; Centro Pueblos Unidos, 2013; Committee on Civil Liberties, Justice and Internal Affairs,

overcrowding, deteriorated building infrastructure, the physically enclosed architecture, virtually locked-down cells at night, segregated modules for men and women, use of isolation cells and the use of handcuffs, lack of external communication, ban on mobile phones, lack of proper heating and ventilation, lights that never go off at night, absence of essential items (e.g., sheets, clothing, and personal hygiene kits), shortage of toilets, inconsistent warm water supply, lack of dedicated medical services rooms or even physical space.

Picture 25: Living room of Madrid's CIE

Source: El País.[87]

Picture 26: Toilets in the CIE of Algeciras

Source: periodismohumano.com[88]

CSO **providers also refer the lack of privacy — even in dormitories or bathroom facilities — and lack of sensibility towards family needs** (absence of private rooms, frequent separation of families in different modules or centres, and no telephones for family members to communicate with each other (or prohibitively high cost for phone use). Married couples are also housed in different buildings; even though they are allowed to see each other in the women's area during the day. Unlike prisons, conjugal visits are not permitted. Previous reports also note inadequate conditions in the visitors' room, including lack of intimacy and impossibility for physical contact, criticizing the presence of a glass partition. Consequently, in January 2015, **the Spanish Supreme Court of Justice struck down as invalidated four articles of CIEs' rules and regulations** due to the breach of the Spanish Migration Law and European

2007:193; Ferrocarril Clandestino, Médicos del Mundo Madrid, SOS Racismo Madrid, 2009; Jarrín Morán, Rodríguez García and De Lucas, 2012; JRS-Europe, 2010; Migreurop, 2011, 2012a, 2012b.

[87] See "*4.500 inmigrantes fueron internados en los CIE de Madrid y Barcelona en 2013*", El País. http://politica.elpais.com/politica/2014/03/26/actualidad/1395857889_539689.html

[88] See "*Mujeres en los CIE peor que en la cárcel, según una jueza*", Periodismo Humano. http://periodismohumano.com/mujer/mujeres-en-los-cie-peor-que-en-la-carcel-segun-una-jueza.html

Directives. **Two of the annulled articles refer to the privacy of detainee families.** Articles 7.3 and 16.2 of the regulation did not ensure the separation of families in different modules as is required by European legislation in order to ensure, as far as possible, family unity and privacy when a family with young children is detained and waiting for deportation.[89]

The deficient living conditions at the Algeciras and Madrid CIEs create physical and mental health risks for detainees; some of the migrants interviewed said they felt afraid, lonely, and hopeless:

"Circumstances at the centre are a lot worse than in jail." **(Migrant)**

During the visit field, **migrants released from the Madrid and Algeciras CIEs complained of the poor living conditions there**. They stated buildings were not adequately insulated and windows were made of thin metal sheets that block the sun. They also complained that there are no en-suite bathrooms, meaning that LEOs control toilet access behind locked doors. They stated that the cells have had sinks installed recently, and that they receive a weekly allowance of shampoo and shower gel. They also said they do not have a change of clothes and that the only clothes they had were those provided to them by a CSO. Another complaint from CIE detainees was about the food, which they consider repetitive and lacking of fruit, vegetables, and protein sources such as fish and meat. Besides, interviewed migrants refer to poor sanitation and having sleeping problems both due to the cold and the noise in the overcrowded dormitories, and to their own personal problems (e.g. future, legal status).

Migrants complained of being treated like animals by LEOs. Some CSOs condemn the arbitrary use of force and lack of response to complaints made by the migrants themselves and NGOs. The "Special Rapporteur of the United Nations on Contemporary Forms of Racism, Racial Discrimination, Xenophobia, and Related Intolerance" indicated that the situation of women detained in CIEs is also alarming, as there have been cases of women being sexually abused by police officers at the Malaga CIE (which has since closed). Other related challenges were reported, including shortcomings and limitations in video surveillance systems, the absence of effective mechanisms to ensure ethical police behaviour in CIEs, and LEOs sometimes failing to wear their identity badge, making their identification difficult (2013a:11).

The space and resources available for free time, sports, and leisure activities are scarce. For instance, the only spaces available for this at the CIE in Madrid are a small room for entertainment and the courtyard. Residents organise activities to do during their own free time at the courtyard; men have access to the courtyard four pre-set hours per day while women can go out any time as long as it is during the time they are allowed outside their rooms. During the month of Ramadan, the centre's schedule is restructured and adapted to meet the needs of its Muslim residents (e.g. mealtimes).

[89] See "*El Supremo suspende parte del reglamento de los CIE por incumplir la normativa europea y española*", El diario. www.eldiario.es/desalambre/Supremo-reglamento-CIE-Ley-Extranjeria_0_350316044.html

IV.II Occupational Health of Staff

HSPs and LEOs acknowledge staff shortages, meaning they cannot giver enough time to each migrant. They also state that, as a general rule, **they are not trained to deal with culturally diverse people and that they lack the competences to do it.** Regarding occupational health, both **LEOs and HSPs acknowledge that working with irregular migrants is psychologically challenging; so they suffer from anxiety and stress very often.** Some LEOs working at the Melilla CETI report having ambivalent feelings as a result of dealing with the extreme situations of migrants while following orders from above.

"It is complicated to come here to work. We come here to work and face two sides of a same coin. I mean, on one hand, we have to protect the resident, the migrant. On the other hand, if they make a sanction, we have to go and enforce it. Then we try not to be overwhelmed by any of these two sides. We try to keep a balance, although it is very difficult sometimes. (…) at the time the imbalance wins… (…) we go back home with our heads messed up." **(LEO)**

Specific issues regarding the occupational health of several providers are addressed below.

Law Enforcement Officers at the border and communities (Guardias Civiles)

There is a medical unit in the Guardia Civil's Headquarter of Melilla which performs basic health-care interventions for the staff (e.g. immunizations and superficial sutures). All GCs are vaccinated against Hepatitis. In the case of exposure to sick people or elevated risk of infection, they are vaccinated accordingly. Of note is that some of the GCs who are temporarily working as backup officers have not been vaccinated for Hepatitis A or B, typhus, or tetanus.

There are no planned annual medical or psychological check-ups neither required nor offered for GCs, as they are voluntary —except for the Special Group of Underwater Operations of the GC (Grupo Especial de Actividades Subacuáticas de la Guardia Civil, GEAS) officers, who undergo physical and psychological check-ups annually. Hence, the GC **does not seem to track possible infectious diseases officers may have contracted.** However, GCs usually pay for additional private medical insurance, which they prefer to use instead of the GC's. In fact, many GCs undergo medical check-ups at least twice a year, given the increased health risk exposure in the course of their daily work. However, this self-directed medical exam schedule practically means that what **medical follow-ups might occur would be ad hoc.**

Another reason for GCs preferring private health care is their fear of their superiors and colleagues finding out a about their health problems, and this leading to possibly being transferred to a different location and post. As a matter of fact, when officers are on sick leave, their payroll is reduced, which makes many of them go back to work earlier than advisable:

"It's wrong for people to lose money, but it's even worse if they come to work when they are sick. For example, with the flu: before, they stayed at home for six or seven days; now, they start losing money after the third day, so you know they are going to be back in three days. I go back to work after the third day even if I have a cold, a backache or a complex psychological problem. So, our health has worsened. There are no studies, no reports, but we can see it." **(LEO)**

Regarding GCs' motivation at work, we can distinguish five sources: (a) private family life (e.g., getting home safely, seeing their children grow, economic stability, etc.); (b) good work performance (e.g., saving lives at sea, helping to make things better, defending the border); (c) moving up the career ladder; (d) salary and days off; and (e) job specific advantages: freedom to act and to establish their own work schedules, opportunity to build collegiate and professional relationships at work. **Nevertheless, there are some GCs for whom it is more difficult to feel motivated, either because of the characteristics of the migration phenomenon, or because of the lack of professional recognition:**

"Every so many years, we ask for a voluntary leave, because we are burned-out and tired." **(LEO)**

GCs also admit that the negative view the media offers about their work at the Melilla fence (e.g. use of force against migrants, hot returns) dampen their motivation and desire for work:

"We don't feel recognized, not at all – we're the bad guys, neither recognized nor respected." **(LEO)**

GCs' health and perception of safety depend on their post and their assigned area. For instance, **GCs in Melilla perceive their physical and mental health as very vulnerable** when migrants try to jump the fence, or when they are at sea. Not surprisingly, GCs have experienced fractures, injuries, etc.:

"We are at the fence, at two or three in the morning, it is cold, we are tired, and suddenly, they jump! 300 men jumping, there are not many of us, they jump over us, our legs are aching with cold, they throw stones at us (...). Because when you have to carry out an action of public security, you can first assess how they are going to approach you, but with these people, some of them, you don't know how it's going to happen, most of them approach us like horses, in a brutal way." **(LEO)**

GCs working at the surveillance post indicate that the thermal cameras they use to detect migrants at night are tiring and harmful to the eyes. They must take turns using the equipment in order to avoid physical and mental exhaustion. GCs on the GEAS complain about the lack of adequate resources for sea rescues (e.g., lack of personnel, boats that are not well equipped, and lack of training). LEOs working in the PRL in Melilla suffer different incidents such as traffic accidents or physical aggressions while trying to control the migrants.

In Huelva, GC and Immigrant Support Team (Equipo de Atención al Inmigrante de la Guardia Civil, EDATI) officers are mainly concerned about contagious diseases, to which they are exposed when they visit the settlements; and about backache and chronic fatigue due to tiring work schedules and the long time spent in vans. Others, although they are aware of the risk of outbreaks, do not seem to be overly concerned:

"It is in Mali where Ebola is emerging now, but any day you can have an outbreak here. Any type of pandemic, for example, TB (...). You do worry a little bit (...) but every week there is a nurse from the RC that goes to the settlements. I don't think there is a problem, in spite of the

fact that they generally don't boil the water that they take from strawberry farms. We tell them to buy it, that it's cheap, but they drink the same water that is used for strawberries." **(LEO)**

However, **GCs involved in the very first stages of the reception process state are worried about the diseases that migrants may carry,** and which they can pass on to their families. The contagions officers are afraid they might be exposed to, suffer together with the **lack of sufficient training in occupational health may increase their fear:**

"We are exposed to all kinds of diseases that migrants bring with them, as we don't know which ones they have and we are the first ones to receive them. When they enter, we are the people they first encounter (...) and many times they are covered in blood from jumping the fence (...). Of course, I always use gloves and we use our equipment, but the risk is always there, because if the guy has a respiratory disease or something, it's going to happen. You are always feeling paranoid and saying to yourself, have they passed something on to me?" **(LEO)**

GCs' stated perceptions about their own mental health range from complete denial to a clear recognition of the existence of problems in this area. This may be due to the image of strength and endurance which the GC is in the habit of projecting, and which would be significantly threatened by any overt admission of psychological weakness or hesitation. Despite that stress and other mental health risks have long been linked to GCs' position, recognition or acceptance of this fact is generally frowned upon in the GC culture and tradition.

Some GCs in Melilla suffer from constant stress, anxiety problems, and emotional fatigue. They additionally reported feelings of abandonment and loneliness in their work – sometimes because contradictory orders from different superiors or because of the lack of professional recognition; habituation or lack of sensitivity towards human pain; feelings of guilt; fear of the possibility of appearing on television while working at the fence – as a consequence of the pressure from NGOs and the media to show a negative image of the GC that might affect what friends and relatives think of them; fear of dying – because of the violence between migrants and LEOs; fear that disciplinary action may be taken against them for not obeying orders from their superiors – which sometimes contradict current immigration law; or uncertainty as to the use of materials such as rubber balls and batons:

"A little bit of support (...) from authorities, it is what I miss. Because the officers are essential tools in this, and sometimes… I mean, fortunately or unfortunately, we belong to the GC and we have to obey orders quietly (…) So, a little bit more of communication with the officers and trying to understand them is what I would like. A boss that would tell you 'hey, it is ok'. That is what I would love, because we are not in the military, we are all professionals here, and among all codes and subordinations, I think that with a little bit more of communication, everything would go much better." **(LEO)**

"The situations that you experience at sea, where you are all alone and you have all the responsibility for what is happening, are not the same as the ones you experience at the fence. At the fence, at any given time, (...) you can ask for reinforcements and, in 5 minutes, you have 1, 3, 5, 6, 8 cars there (…). At sea, if there is a disaster as you say, and a boat sinks, it can take 5 minutes or 10 hours for another boat to arrive. You live with that kind of stress." **(LEO)**

"If you have 40 migrants on a boat screaming and crying and there are only two guards there, try to imagine how much this messes up with you. And this experience, you take it home and you pass it on to your wife. You think about work all the time and you can never get a rest from it, not even when you are on holidays." **(LEO)**

In addition, **GCs experience sleep problems caused by work shifts and by recurrent nightmares** about the extreme situations lived through at sea and at the border fence. There is one issue that is particularly controversial – suicides within the GC. The topic is taboo among rank and file officers, who refuse to acknowledge that a problem might exist. However, the high command admitted that seven GCs had committed suicide in the past three years in Melilla. When we researched this issue, we determined that the GC identified these suicides as isolated cases invariably related to personal and family causes, and not to work conditions or stressful situations:

"It is the brigade with the most suicides. It appears in the press. I think that, in this job, the physical and mental conditions of guards should be monitored, because maybe 12 years ago you were a very sane person but, sadly, because of changes in your personal situation, a divorce, a bad relationship, an addiction to gambling, etc." **(LEO)**

If GCs decide to seek psychological assistance, it is provided on the telephone from the national GC headquarters, as local and regional GC departments do not have in-person mental health services. There are courses organised through the distance training platform on the GC intranet, but GCs acknowledge that this is not adapted to their working conditions and schedules:

"Those who work on the street do not have time to sit at the computer. It's difficult." **(LEO)**

If a GC officer is diagnosed with mental health issues, the consequences are even direr – typically, their firearm is confiscated, he or she is given a leave of absence, and in the end transferred to a different post with different responsibilities. Sometimes this also means a pay cut, complicating things even further both professionally and personally.

GCs believe that there is not much they can do to prevent mental health problems, although in fact they use different strategies to deal with daily stress: (a) emotional distancing from the problems; (b) minimizing professional problems and acknowledging one's own limitations; (c) searching for personal spaces to get away, such as playing sports, although there are no sports facilities at the local GC headquarters – GCs believe they should be allowed to sport during working hours in order to maintain their level of fitness; (d) looking for support within family, professional, and social support networks; (e) separating time spent at work from time devoted to family; and (f) personal enrichment through religion. Families are the main source of support and emotional balance helping GCs to cope with the demanding nature of their work. Notwithstanding, officers also acknowledge that they do not share everything which happens at work with their families.

Reception Centres

- **CETIs**

Eight people from the Red Cross work at the Melilla CETI – including social workers, a psychologist, nurses, and a monitor for leisure activities. They mention that staff is stable and work full time. Currently, the doctor and the rest of health and social care services are hired through the external company CLECE. Furthermore, since 2012, the CETI's manager position is announced publicly by the Government of Spain through the DG of Migration. The GC is called as adequate LEOs for security issues in CETI. Although the staff belongs to different institutions (i.e., public servants, CSOs, service agencies, interviewed workers state that they all work well as a team and that their coordination is good, constant, and ongoing. The interviewees of CETI also consider collaboration with public hospitals as adequate. However, **HSPs complain that there is not enough staff to meet migrants' needs, and that tasks seem to be done in a hurry because there is simply no other option.**

Melilla CETI working hours are from 8:00h to 14:30h Monday to Friday, except for nursing staff who work on shifts to ensure daytime coverage, and security personnel who also work eight-hours shifts overnight.

HSPs in CETIs report being highly motivated. They consider their job satisfying because it covers a wide range of work areas (e.g. assistance and management of resources) with all residents.

The main occupational health risks are, according to respondents, **stress and overwork.** All HSPs agree that work has changed a lot over the last four or five years, becoming more demanding, more stressful, and more bureaucratic. **Providers have an annual medical check-up and do not perceive significant health related risks at work**.

"When a resident fights another, we deal with it. The problem is when a whole group fights another whole group. That has happened several times, for example, the Sub-Saharans against the Algerians. Sometimes they have thrown stones to each other. In this case, our forces are not enough and we have to call the GC." **(LEO)**

"The centre does not take a stance on vaccinations… We are not vaccinated." **(LEO)**

"Sometimes I wonder that these people might be sick, they might pass on diseases (…) When intervening in a fight, a provider, or a resident, we protect ourselves with gloves because we don´t know. We are aware that, well, Africa is the first exporter of AIDS. So we know that there is AIDS and Hepatitis around here. We don´t know who has what. In a 90 per cent of the cases I feel comfortable wearing gloves, protected; but I can´t assure you in a 100 per cent." **(LEO)**

Refugee Assistance Centres (CARs)

CAR staff consists of HSPs, LEOs, a technical team, cleaning staff, kitchen help, and maintenance personnel. An **Arabic interpreter can be made available when requested.** Residents say they generally appreciate the staff, who help them deal with the paperwork needed to apply for a health-care card, get their foreign degrees recognised, or be registered in the municipality census.

According to HSPs, **CARs have highly personally and professionally engaged staff,** who value building positive interpersonal relationships with asylum-seekers. Regardless, **CARs' providers go through stressful work situations for which they lack of training** (e.g. torture, psychological and physical trauma, and human trafficking). They indicate there is **no psychological support assistance for staff**, and that the demanding nature of the work, together with reduced salaries and benefits due to the economic crisis, lead to loss of motivation and increased stress levels.

"It is very stressing… We have not need it yet, but it is true that there are times of a lot of pressure and maybe that [mental health] support would have been very useful. However, it seems that right now we still don´t need it." **(CSO)**

CAR's security is provided by a private company and LEOs work 12 hour shifts on a rotation system with six agents, 40 hours a week – three days on, three days off — day and night. They are the only staff present at night, thus they are in charge of contacting ambulances and resolving whatever other emergency or conflict may arise during those times.

Migrant Detention Centres (CIEs)

According to respondents, **the ongoing economic crisis has created higher staff turnover at CIEs, especially among LEOs, who consider difficult to keep their staff trained.** The CIE in Algeciras offers no occupational health services for its staff.

HSPs at the Algeciras CIE are genuinely concerned about the migrants' well-being. The whole team derives personal satisfaction out of helping residents achieve self-sufficiency and independence in the long run. Staff base their motivation on lifelong learning, opportunities to be in contact with migrant population, and the fact that migrants appreciate the work done to improve their future. In addition, they stress that shifts are long and hard (35 hours a week, four days on rotating shifts) and that the harsh realities of what they see every day add a lot of pressure, thus generating individual conflicts and psychological distress among the staff.

In the **Madrid CIE**, HSPs work on rotating shifts to enable the follow-up of patients, and every forth night they switch morning to evening shifts. Respondents claim that the **two-year labour contract hinders the achievement of objectives at work since the accumulated professional experience of staff is not capitalized and built upon.** When performing clinical interviews, HSPs are always guarded by LEOs for security reasons. HSPs also believe they use all essential and necessary protection measures so they see no need for specific prophylaxis, other than their tetanus vaccinations.

IV.III Health Knowledge, Attitudes and Practices

Law Enforcement Officers in the borders and communities (Guardias Civiles)

Some GCs do not think that handling health issues is part of their responsibilities. Others consider it important to receive training on such topics (e.g. on diseases migrants are sometimes carriers of, on mechanisms of infection transmission, and on prevention measures).

"We have a one-week training in protecting people and the odd day when the second lieutenant, doctor or nurse comes and gives us a talk about cardiopulmonary resuscitation, injuries, trauma and other things that we could come up against." **(LEO)**

*"I don't even remember anything about first aid, it was so many years ago."***(LEO)**

Generally, **GCs possess only basic knowledge regarding first-aid courses and protection measures** such as use of masks and gloves. However, they do not always wear them so migrants do not feel 'rejected,' or because events sometimes unfold simply too fast:

"I don't know what to take with me at that moment. We've got masks, we've got gloves, but you don't have time to put them on. When you're in the middle of a struggle, you can't stop and think." **(LEO)**

The GC High Command organises a number of voluntary online courses for and as such, there are very few who actually take them outside working hours. Some GCs mention a voluntary professional risk course recommended by the EU:

"They tell you that there is a new regulation and you have to go and read it and sign, just in case. But this [course] is there but nobody has ever seen it." **(LEO)**

They also do receive some training and refresher courses updates regarding current issues, such as gender-based violence, pat-down searches, etc. The topics of these classes are selected by their superiors, sessions are usually one full day, and attendance is mandatory.

Nevertheless, **there is no specific training on migrant health**. **GCs do not receive information regarding migration and employment laws**, something they deem necessary:

"We need to know about immigration law. It changes every now and then, and I don't know it. And not only immigration issues, but professional issues (...), unions (...). And every time there is something new, we look it up ourselves, and we do the internet searches ourselves." **(LEO)**

They would also like to receive more information about different stress coping strategies, foreign language courses – especially French, Arabic and, to a lesser extent, English, in order to better communicate with migrants — as well as classes in sociology, immigration, **and multiculturalism to better understand migrants**, their cultures, and their sociocultural backgrounds:

"To know their culture and how they are, in order to be able to approach them." **(LEO)**

Reception Centres

- **CETIs**

CETIs have crisis protocols, mainly on occupational safety and health; fire drills are also occasionally practiced. They also have contingency plans for riots and major disturbances. Incidences of diseases among staff are monitored, and analyses are carried out, and there have been no cases of contagion in 13 years.

CETI staff receive first-aid training and courses on personal protection measures. With regards to communicable diseases, CETI employees receive periodic information and training from the medical staff there. There are ongoing training sessions for public sector employees, health controls for all staff, and Hepatitis B and C vaccination programmes for all those interested. LEOs from private security companies are also required to have first aid training, although a security officer indicates that they do not receive any specific training on migrant health or how to work with migrants.

Interviewees described how HSPs are not aware of the available or updated health-care resources on new legal or health-care procedures. For instance, only a few are familiar with International Health Regulations (IHR), the European Early Alert System, or the FRONTEX code of behaviour.

"When you go to the emergency services the first person you see is not a nurse, not a doctor but an administrative… It is never highlighted how the administrative staff never attend the meetings. I have never seen any representative (…). Consequently, if they don´t know which is their post, their mission or the general idea related to the management of migrant's health care…" **(HSP)**

CETI employees, despite being fully aware of health risks (e.g. being infected with TB), do not always use masks because it hinders patient–doctor communication and hence, medical practice (i.e. sometimes health workers avoid the use of sanitary masks so that patients are able at least to read their lips, or avoid the use of gloves in order to generate a mutual trust atmosphere).

The training undergone by staff is supposedly adequate for them, however they claim that they receive only basic training on first aid, risks associated with working with vulnerable populations, nutrition, and specific training in health. In order to meet some of the demands of their job, the RC has organized training on human trafficking issues.

Regarding communication, HSPs do not encounter problems, except for cases of migrants coming from rural areas, who speak minor dialects that sociocultural mediators or interpreters are not able to translate. In such cases, another immigrant from the same place is often available to help. Most HSPs working for private companies or CSOs indicate that they often learn the most commonly used languages of their users on their own – mainly English and French.

"We haven´t had any training in foreign languages. We are learning little by little, and so do they [migrants]." **(LEO)**

"There is a translation service called SETI and it depends on the CONRADE NGO. (…) We use it for the entrance interviews, for medical or school appointments. We have a data base to know when the translator comes to the centre, so we can use it that day. Or we can ask for the translator the day we need it. We always use a translator of this NGO. Sometimes we pay for it directly if the NGO hasn´t got money. The cases are very few, for example, for Mongolian and Tibetan translations, when there is a person from a rare place… (…) I can speak English, a little bit of French, and I am learning a little bit of Arabic." **(HSP)**

On the other hand, some migrant interviewees reported cases of disrespectful behaviour or inappropriate behaviour on the part of staff employed by private companies that provide services at CETIs.

- **CSO managed centres**

HSPs from the Algeciras RC centre indicate that they receive very little training regarding migrants' health issues and the risks associated with their work. The RC centre in Algeciras offers an online course in occupational health but it is rather general with no specific references to the actual situations guards are likely to face. Thus, HSPs ask for better specific training dealing with AIDS, nutrition, how to read medical results, etc.

Additionally, according to the RC's providers, **there are action protocols in the centre**, but they are scattered since there is no unified regulation regarding the management of these facilities (e.g. there is no protocol of action in case of crisis).

Refugee Assistance Centres (CARs)

According to CAR HSPs, there is a need for specialized training on torture, traumas related to difficulties on migrant process (i.e. shipwreck, fear to cross the border, violence episodes), and human trafficking. Moreover, they point out that LEOs don't receive specific training on migration, health, or asylum legislation, but only on first aid. They do not receive any information on possible diseases or infections they may have to deal with, and there is no employer provided/paid psychological assistance in case of need.

"In order to get the diploma of security officer I had to take a course on first aids. (…) When a person is feeling sick, we call the emergency services and that´s it." **(LEO)**

LEOs indicate they do not receive training on detection of diseases. In addition, they say they are not aware either of the legal and political framework or of the migrants' legal rights. **They highlight that the learning of languages is being encouraged by their work, but this need is not encouraged** by their organization or the government. LEOs sometimes pursue language courses (mainly English and/or French) on their own outside of work.

"[He is asked about the law and rights for the migrants] No, I don´t know. We have the data protection law. You cannot say anything about who is in here, or where they come from, or if they have kids or not (…) I guess that the HR includes all these aspects, right?" **(LEO)**

Nevertheless, CAR's HSPs see helping residents become self-sufficient as their most important task, although they also readily admit that in the current situation of economic crisis, it is generally challenging, if not impossible, for migrants to find steady work.

Migrant Detention Centres (CIEs)

LEOs highlight not having any meetings or workshops on health, besides occasional training on first aid, communicable diseases, or preventive measures. **Although, they do not believe that it is necessary for their work.**

According to HSPs, the **Algeciras CIE does not offer many training opportunities for them, so they take classes on their own outside of work** (e.g., inexpensive or free first aid or emergency cardiograph courses offered by the SAS). **At least once a year, LEOs receive refresher training on relevant law, use of force, migration issues, etc.** – frequently taught by judges, police specialists, doctors, and UNHCR.

On the other hand, at **the CIE in Madrid LEOs report not having a specific vaccination protocol and do not receive specific health measures or specific training.** Because of the high officer turnover and the difficulty in recruiting enough CIE security staff, it is difficult for them to receive appropriate and timely training.

Some CIEs' HSPs have received training on treating drug addictions, minor trauma injuries, and on dealing with gender violence and human trafficking issues – courses which are usually taken on their own since the government does not offer them. **They additionally note the need for intercultural competences training**. HSPs feel primarily motivated by building a positive relationship with patients.

"Certainly, it would be interesting. As a matter of fact, last week I have taken a course in the Police Station of Algeciras about centres like this. In this course participated, well, the chief of the brigades (…) there have been conferences of doctors… But there are also updated on security issues, legislation for both public servants and other citizens… They take place usually once a year… I think it would be a good idea to organize conference on first aid, for example, or epidemics or anything related." **(HSP)**

IV.IV. Discussion Section - IV

Physical and living conditions

Infrastructure and living conditions vary from one centre to another. Also, **multiple factors contribute to overcrowding and prolonged stays in the centres**, which in turn worsen living conditions and quality of medical care. Some of these factors are:

- Constant and complex flux of migrants;
- Reduced availability of spaces in reception centres;
- Low budget for reception and detention centres;
- Staff shortage in reception and detention centres;
- Long waiting periods in CETI centres and long deportation processes;
- Protracted asylum application processing.

Long stays at CIEs have a negative effect on migrants' physical and mental health, consequently increasing the demand for health-care services. In this context, **coordination and collaboration between reception centres/CARs/CIEs and health-care institutions become even more imperative.**

Although it is theoretically guaranteed by law, **migrant access to health care and other social services inside detention centres is, in fact, severely curtailed**. This is mainly due to a shortage of HSPs. At the same time, migrants have little information about their health-care rights and about how the public health-care system in Spain functions.

Staff Occupational Health

HSPSs and LEOs' scant knowledge of migrants' native languages may give rise to misunderstandings and conflicts. It may also have a negative effect on the quality of the services provided. **It is therefore necessary to increase the number of intercultural mediators and improve the translation services available**.

HSPs and LEOs need to be trained in issues related to health protection, intercultural competencies, and international migration laws.

It is necessary to offer mental health services for providers, especially GCs. GCs experience sleep disorders, anxiety, and insecurity due to the extreme situations they encounter at work, the pressures to which they are subjected professionally, and the general difficulties they face when dealing with migrants. The conditions in which GCs work often lead to mental and physical health problems.

Many LEOs present characteristic signs of burnout syndrome, which has negative consequences for them and for centre residents. First, emotional exhaustion entails costly health treatments, depression, and poor work performance. It involves a process of depersonalization that leads providers to infra-humanize residents. This may explain why humiliation and racist treatment towards internees are so common in CIEs. Second, the very atmosphere and physical layout inside centres – some of which are located in old, decommissioned and frequently run-down prisons — contribute to the process of dehumanization and allow some LEOs to see residents as criminals who deserve punishment.

LEOs work under constant pressure and scrutiny. Besides, they sometimes have to obey orders that go against their personal principles, leading to deep internal conflicts. It is necessary to offer the LEOs more control in the decision-making process on their work-related issues, as well as skills and protocols that allow them to denounce possible abuses and defending from injustice situations.

Nevertheless, despite the risks that LEO's face in their work with migrants (especially CGs at borders), they can overcome adverse conditions. The main strengths that they possess for that are (a) their feeling of contributing to the common good when performing their work (e.g., saving lives, defending borders, helping the vulnerable migrants), (b) coping strategies to manage stress and negative emotions (i.e. spiritual, physical and leisure activities) and (c) social

support, especially from the family. These strategies allow them to be resilient[90] to cope with fundamental risk situations in their workplace.

In this way, work spaces and training are also needed to improve their resilience, which means their ability to work in extreme conditions and increase their personal and team competences.

Health Knowledge, Attitudes, and Practices

HSPs' cultural competencies on migrants, asylum-seekers, and detainees´ health vary according to their individual professional background.

Many providers are CSOs providers or volunteers, so they are sensitive to cultural differences, and able to empathize with the difficult circumstances faced by the migrants they treat.

In general, **LEOs at border posts are sensitive to the difficulties lived by migrants.** Their cultural competencies are not exceptional, but in general they are able to empathize with newcomers due to the often poor physical conditions in which migrants often arrive. In addition, many LEOs are familiar with migrant populations due to their coexistence in officers' own communities (e.g. schools, public spaces, health centres, etc.), especially in Ceuta and Melilla. As previously reported, it is striking to see how migrants and GCs amicably share the broadcast of a football game in bars while previously struggling against each other on the border fence. Such normal, mundane interactions positively influence LEOs' level of intercultural awareness and their ability to empathize. Also, the contact between LEOs with women and children who have overcome dramatic and often life-threatening situations to reach Spanish territory, together with the dramatic rescues at border posts and at sea, lead towards increased tolerance and understanding. Paradoxically, at the same time LEOs have to develop psychological defence mechanisms to guard the cognitive dissonances inherent in some aspects of their jobs (i.e. their mandate and obligation to prevent illegal entry into the country).

LEOs at CIEs lack this aspect of understanding based on experience, and as a result dehumanize and devalue residents more easily. **Training on the values and principles of social justice, as well as the on coexistence with undocumented migrants in terms of humanitarian aid should be part of CETI LEOs' in-service training**.

[90] Cacioppo, Reis and Zautra. Social resilience: The value of social fitness with an application to the military. *American Psychologist, 66*(1), 43–51 (2011).

CONCLUSION AND RECOMMENDATIONS

V.I Conclusions

This report assesses the Migrant Health, Occupational Health, and Public Health at Europe's Southern borders in Spain, describing contextual, institutional, and professional aspects related to the situation of migrants in the following three key locations: Melilla, Tarifa-Algeciras, Madrid, and Huelva. The report's ultimate aim is to provide basic knowledge about the challenges to health equity at the Spanish Southern border. The field work included visits to different detention and reception centres, and interviews with migrants, different stakeholders, HSPs, volunteers, LEOs, and rescue teams among others.

In the second half of the last century, Spain emerged as one of the most important immigration countries in Europe due to its economic growth and the needs of an increasingly fragmented labour market.[91] In consequence, policies and practices of Spanish public services have been modified many times in order to keep pace with the increasing migrant population and the challenges derived from it. From the beginning, the focus has always been on controlling the flow of migrants and combatting irregular migration. Also, wellbeing and social integration of migrants are increasingly gaining importance.

The health of people who reach Spanish borders is one of these challenges. It is determined by multiple factors related to the physical and mental conditions in which they arrive, and how they are treated in our country. Surveillance and reception protocols and the services in reception and detention centres are defined by national laws in compliance with international treaties and the FRONTEX code. These protocols – which go into effect when an irregular migrant person is detained within Spanish territory or while attempting to cross the border irregularly – dictate how, when, and where rescue, medical assistance, processing, detention, and deportation or granting of protected status take place. Theoretically, the rules and regulations are defined to protect the free movement of people and to prevent crimes. In fact, however, money is mainly invested in preventing entry and in deporting migrants.

Hundreds, if not thousands of people wishing for a better future live in dilapidated, unsanitary, and overcrowded settlements on the outskirts of Ceuta, Melilla, and other coastal areas in the North of Morocco, waiting for a chance to reach Spain. Moroccan authorities do not recognize their existence, so they take no measures to ensure their health. Migrants in these settlements live bereft of resources, food, clean water, or medical assistance, and at a daily risk of violence, life threatening infections, and racist discrimination. Many of them, having fled persecution in their war-torn homelands, fall prey to cruel and inhuman exploitation at the hands of human traffickers and organized criminal gangs. Many die while making the journey to Europe. Families are torn apart. For others, just getting to Europe is the first small step in their long, in some cases lifelong, struggle for acceptance and some basic human dignity. In Box 5 we describe our theoretical approach to view these circumstances for what they actually are – sources of outrageous inequality and suffering.

[91] See Focus Migration (2008). http://focus-migration.hwwi.de/Country-Profiles.1349.0.html?&L

Because of all this, the protection of migrants and their social acceptance must be promoted as a shared social, economic, and political responsibility.

Although changes in border policy are beyond the responsibility of service providers, they all play an important role in tackling situations of inequality and discrimination. All human beings who live in conditions of oppression have the capacity to resist them and to contribute to reduce or transform those conditions, the oppressors, or both at once (García-Ramírez et al., 2011; Prilleltensky, 2012).

This is a common goal for all stakeholders at Europe's Southern borders as the constant armed conflicts in many other regions already point to further deterioration of the living conditions of millions of displaced people, many of whom see reaching Europe as their only salvation and way out. Being an underpinning theme of this assessment, the issue of health equity is only possible in social systems whose ethical principles are social justice and the protection of HR (Marmot et al., 2012; Suarez-Balcazar, 2014).

Due to the extreme situations that many service providers working with migrants experience daily, it is vital to pay close attention to their occupational health. Many professionals, especially LEOs, endure tense and tiring working conditions that seriously affect their health. In this context, these LEOs – mainly from the GC and Policía Nacional — are exposed to the most severe cases of occupational vulnerability and stress. LEOs are subject to unclear *legal liability*, because they do not know exactly which procedures they have to follow in every case, or whether policies comply with the law. For example, sometimes they fear that obeying senior officers may require committing illegal actions. Some other times, they fear that their mistakes may be considered a criminal offence against migrants (e.g. physical aggressions, "hot returns"). There is also the issue of *working liability*, since disobedience to follow orders may result in disciplinary actions, transfers, or dismissal. Constant scrutiny and criticism on the part of the media contribute to their *social liability*. For example, some LEOs feel ashamed to appear on television, and they fear losing face in front of their communities and families, on account of the work they do. They do not feel protected by their superiors or respected by citizens while they are being watched and criticised by CSOs and worldwide media. They are also exposed to *physical liability*, because they do not know the diseases and injuries to which they are exposed in their physical contacts or confrontations with migrants. Moreover, there is *psychological liability*, as their job often leads to sleeping problems, guilt, recurrent nightmares about the extreme situations they have been through. Last but not least is the *health-care liability*, as a result of the LEOs' general reluctance to consult HSPs about their ailments, for fear of being transferred, mocked, or mistrusted by their colleagues and superiors.

Box 5: Theoretical approach on inequity sources

The migrant dilemma is part and parcel of a dehumanised social context that affects all members of society. Broadly speaking, there are three sources of inequity: the construction of oppressive narratives, the polarisation of the parties involved, and the normalisation of violence (Andersson, 2014; Martín Baró, 1982; Prilleltensky, 2012).

The construction of oppressive narratives. The legal artifices of political discourse to justify the inhuman treatment of migrants, displaced, and newly-arrived people are undermining the role of institutions. It also makes institutions appear as a source of insecurity and service providers

as allies of those who support these injustices. This inevitably erodes the prestige of the institutions that exist to ensure safety and the protection of HR. Finally, some members of society also dehumanise LEOs involved in border protection or immigration control, ignoring the often challenging, complex, multifaceted, and at times contradictory and ungrateful nature of the work these officers perform on a daily basis.

The polarisation of the parties involved. One of the most immediate consequences of what is already a difficult immigration reality is social polarisation –the segregation of social groups towards extreme opposites. The dramatic and often tragic situations that take place at the borders are leading LEOs on the one hand, and CSOs on the other, to adopt opposite and irreconcilable positions. They both look at each other as if in an ethical mirror where the faults of "the other" are "our" virtues (Martín Baró, 1982). This may lead to the disappearance of the common ground for daily interaction at the borders in Southern Spain, and there is also the risk that HR may cease being the shared reference framework, that democratic values may stop having collective validity, and that violence may be then justified.

The normalisation of violence. Respect and solidarity towards those who arrive are being replaced by justification and excuses for more razorblade wires, more security cameras, more frequent calls to the Moroccan LEO, all of which serve to discourage, threaten, and ignore the basic HR and the safety of migrants willing to risk all on their journey.

V.II. Recommendations

What follows is a series of recommendations that may contribute to building collaborative capacity to transform health policies at the borders in southern Spain. The following policy recommendations are the results of the assessment done in Spain and integrated with the outcomes of the National Consultative Committee (October 2014).

I. Legal and policy framework

- At EU level, what is needed are **strategies that strengthen the efficient management of migration flows in order to prevent sea tragedies in the Mediterranean.** Also, these strategies should be based on fundamental rights. In this way, The Asylum, Migration and Integration Fund (AMIF), proposed four key aims: (1) *Asylum,* strengthening and developing the Common European Asylum System by ensuring that EU legislation in this field is efficiently and uniformly applied; (b) *Legal migration and integration*, supporting legal migration to EU States in line with the labour market needs and promoting the effective integration of non-EU nationals; (c) *Return,* enhancing fair and effective return strategies, which contribute to combating irregular migration, with an emphasis on sustainability and effectiveness of the return process; and (d) *Solidarity*: making sure that EU States which are most affected by migration and asylum flows can count on solidarity and assistance from other EU States.[92]

[92] See at: http://ec.europa.eu/dgs/home-affairs/financing/fundings/migration-asylum-borders/asylum-migration-integration-fund/index_en.htm

- **At national level, the reception system needs to guarantee respect of Human Rights**; it also must be responsive and adaptable to migration flux/numbers based on the recognition of migration as an ongoing phenomenon. Responses characterized by urgency/emergency mode should be avoided and used only for limited periods of time.

- Some CSOs have recently denounced laws that Government of Spain has imposed in order to stiffen CIE regulations. In fact, in January 2015, the Spanish Supreme Court struck down some of the CIE rules for being in violation of European and Spanish legislation.[93] **Ensuring compliance with National, European and International legislation** is therefore of primordial importance.

- While **alternatives to detention should be sought out as a win-win solution for the well-being of migrants and for the smooth operation of reception facilities**; it is of further importance to establish CIE admittance **protocols which distinguish** between migrants who, for administrative reasons, are to be deported, and those with criminal records. The dynamic between both groups is to the disadvantage of the former, forcing them to live in unfair and restrictive conditions. This represents the basic paradox of detention centres – they impose liberty restrictions even harsher than those in penitentiaries. CIEs should only house irregular migrants whose deportation can be guaranteed, and therefore a strict analysis of those who must be sent to CIE's should be done before they are detained there.

- **Positive personal identification for the purposes of deportation of migrants with criminal histories should be done while they are still serving out their sentences in prison**. In case of judicial decisions on deportation/forced returns, it is necessary to make sure that health issues, such as chronic diseases, are taken into consideration.

- When the deportation process cannot be completed in the required period of 60 days, migrants are released from CIEs and they are "free" in a social and legal limbo – they cannot legally work or receive health-care services and social protection services. The same applies to asylum-seekers who are not granted asylum and are forced to leave CARs. They are released in the community and become part of the substantial community of undocumented migrants in Spain. **The state needs to provide migrants in this "limbo's situation" with some kind of legal coverage and entitlement to health care and social assistance.**

- Until recently, access to and provision of health care was free and universal in Spain. However, RDL 16/2012 limited access to the public health-care system (PHS) only to those officially considered as "insured" and "beneficiaries." **The result has been dramatic for migrants, especially for those who are forced to travel in very vulnerable conditions. Considered as "irregular**" migrants, they are barred from the PHS and penalised for their precarious status. This is leading many of them to abandon their medical treatments, while at the same time the diagnosis of communicable diseases is

[93] See "*El Supremo suspende parte del reglamento de los CIE por incumplir la normativa europea y española*", El Diario. www.eldiario.es/desalambre/Supremo-reglamento-CIE-Ley-Extranjeria_0_350316044.html

becoming more expensive. Returning to earlier legislation (LO 4/2000) would be a crucial improvement, as it was considered exemplary and a Good Practice at European level. As also proposed by the Fundamental Rights Agency (2011b), access to health care should be ensured for all people regardless of their legal status, and independently from immigration policies or considerations.

- **Formal obstacles to health-care access should be removed**. One clear example would be the development of simple and clear procedures for obtaining health cards and making sure any procedural requirements are explained to all migrants during the initial reception process.

- **Accelerate the administrative procedures** required for asylum-seekers to be recognized as refugees and procedures that affect migrants living in centres of reception and detention.

II. Partnerships, Networks, and Multi-Country Frameworks

- **Recalling the development suggested by the Council of European Union[94] related to the Common Basic Principles**, a holistic approach to integration presupposes effective reception policies and measures responding to both the needs of individuals and different groups of migrants more likely to be exposed to social exclusion.

- **Seeking and intensifying interagency and intergovernmental dialogues**, exchanges of best practices, effective cooperation and solidarity on regional, European, and international levels. That would be especially important between Spain and Morocco, in order to prevent irregularities that happen in their border (e.g. the complex network that involves Spanish traders in contact with Moroccan mafia groups who employ "carriers" exposed in Pillar II).

- **Spain must strengthen monitoring and enforcement to prevent human trafficking**, and to protect actual and potential victims of sexual exploitation. GCs that they lack the necessary resources to prevent it.

- **A structured response, involving multiple sectors and levels**, during the entire reception process needs to be established by developing shared/horizontal protocols outlining specific roles and responsibilities.

- **Explicit protocols for guaranteeing the health and safety of all migrants should cover all stages of the reception and deportation processes**. These protocols must comply with EU rules and regulations on HR and international migrant laws. Any current Spanish immigration and/or border protection protocols which are in violation of HR need to be annulled and rewritten. Melilla's fence is not only designed to dissuade migrants from

[94] Council conclusions of the Council and the Representatives of the Governments of the Member States on the integration of third-country nationals legally residing in the EU Justice and Internal Affairs Council meeting Luxembourg, 5 and 6 June 2014.

entering irregularly, but it is also a de facto physical attack on them, as it causes serious bodily harm to those who attempt to climb over it. Spain must also rethink its policy of "hot returns" or returns without legal guarantees for humane treatment of migrants. There are at least two types of actions by the Spanish state that clearly threaten the health of those who arrive. On the one hand, LEOs' actions at Melilla's fence; on the other, LEOs' response at sea, where Spain must define and take responsibility for an area of search and rescue instead of hindering or preventing boats from reaching Spanish soil, as it is currently happening.

- **Spain and the EU must increase cooperation with countries of origin in order to foster regular migration**. For instance, through information campaigns and programmes of Assisted Voluntary Return and Resettlement from Morocco to countries of migrant origin.

- Authorities need to **review information protocols regarding the identification of minors, asylum requests, and human trafficking victims**, and to ensure their proper implementation. Particularly for the most vulnerable groups and for persons lacking resources or support networks, it is crucial to increase the number of free shelters available.

- Spain could lead the process of development and implementation of **collaboration protocols with local and international organisations**, as well as with the Moroccan government in order to ensure decent living conditions for the hundreds of displaced people who gather at its borders. Migrants in settlements live in squalor and abject misery; they suffer from hunger, and lack clothing, shelter, medical care, and other basic necessities.

- Efforts need to be collectively taken to promote policies that do not impinge upon the health of migrant populations. Also, **strengthening migrants' social networks** will guarantee that migrants may reach their destination while minimizing the journey's negative effect on their resources and health. **Promoting people's socioeconomic networks will stimulate socioeconomic development in their countries of origin**. People are the links between societies – indeed they are the single most valuable social asset in today's global world.

- During the last phase of reception – inclusion into the community – **awareness campaigns aimed at encouraging people to know more about migration and migrants' health can support the bilateral process of integration**. In this aspect, the "*Stop Rumores*"[95] campaign can be taken as a model for combatting negative stereotypes about migrants.

- **Promoting an overall constructive discourse and reporting on migration and public health in the media** are also important in fostering social integration, while at the same time addressing misperceptions in the community. Malpractices and miscommunication combine to fuel unfounded fears of infection epidemics both among local authorities

[95] For more information of Stop Rumores campaign, see at: http://stoprumores.com

and the public. To counteract them, the socially responsible cooperation of the media is crucial, as are information campaigns on the positive contribution that migrants make to the community as a whole.

III. Monitoring Migrant Health

- **Further efforts must be made to study and analyse the health conditions of migrants, displaced and newly arrived people**. It is necessary to draw attention to the different types of health risk to which they are exposed due to the places where they come from or the countries they have to go through. Also, when migrants manage to enter Spain, it is important to provide them with **quality health assistance and services, especially in reception zones** such as Melilla and Algeciras. Migrants found in these areas have had to climb over razor wire and bladed border fences or endure long and perilous sea journeys, thus presenting dire health and physical conditions in need of specialized care.

- **Implement basic guidelines and protocols to securing public health**, especially for LEOs that work in border.

- **Specific vulnerability identification protocols should be created in order to identify two particularly vulnerable groups** – elderly people who arrive alone and people with mental disorders. The PHS must be adapted to the special needs of these categories, and particular attention should be paid to chronicity and not only to pathology of their condition.

- It is especially relevant to continue **monitoring communicable diseases**. At the same time, it is important to implement mechanisms for early detection of psychological distress in victims of rape, assaults, war, the mafia, etc.; as well as to improve the sexual and reproductive health of women who have been victims of human trafficking.

- **Standardized health assessments for health related data collection** – for communicable and non-communicable diseases — is to be considered a priority. Relevant as well would be vaccination campaigns, especially for women and children.

- One of the best ways to improve health-care services for migrants is to **reinforce health-care programmes in Nador, Morocco** – where migrants congregate prior to crossing into Melilla, Spain — as well as to develop bilateral agreements with health-care centres on both sides of the border. It might be beneficial to research the health conditions of displaced people in Morocco. Many of them are seriously injured when attempting to cross the border. There are also many people who suffer abuse and torture; many women are the victims of sexual assaults and human trafficking in very complex conditions which are difficult to detect and identify, since corruption has become endemic in the border areas. Collaboration with the Moroccan health-care system and other international organisations which offer humanitarian assistance to displaced people may contribute to finding out more about the health condition of migrants. It is also advisable to have international observers placed in charge of these monitoring tasks (e.g. specialists from IOM or WHO), to ensure the validity and reliability of the collected data.

- **In detention/migrant centres, reliable psychological assistance is urgently needed yet lacking**. The absence of mental health services is one of the most serious limitations, as it is a missed opportunity to empower migrants psychologically, to help them strengthen their social support networks, develop strategies of psychological resilience, manage stress, and move closer to self-sufficiency.

- **An information system has to be set-up to encourage an appropriate sharing of health-related data locally, nationally, and at EU level which would ensure a better continuity of migrant health care.** Especially important in that regard would be to improve collaboration between CIEs, CETIs, and hospital managers.

- **Comprehensive data on migrants' health should be collected and monitored regularly** in PHS, reception and detention centres, and through Migrants Observatories, e.g. OPAM, reports and the National Migration Survey – which was done by the Spanish Institute of Statistics in 2007 but not repeated. Disaggregated data based on migrants' status could be harnessed to anticipate needs and analyse service utilization.

- Finally, **it is necessary to systematize data collection and to implement fully compatible and interconnected databases**. Clearly, relevant policies must be developed so that health, administrative, and social information is collected responsibly and lawfully. Referral mechanisms have to be monitored and migrants leaving the centres must always – and automatically — be given copies of their health-care records to ensure compliance and continuity of care.

IV. Migrant-Sensitive Health-care Systems

- **Reception centres must be assigned sufficient resources** in order to adequately assist a high number of migrant arrivals and to offer adequate care. Improving the facilities in reception centres in order to respond the needs of families. Currently families are split apart – women and minors stay together, while fathers are housed in men's modules.

- **It is necessary to improve CIE living conditions**, especially with respect to dormitories, bathrooms and toilets, day rooms, and leisure and sports spaces. More has to be done to address families' privacy needs. Minimum standards of living conditions must be ensured and continuous monitoring to assess compliance has to be implemented. Some of the professionals interviewed for this assessment have suggested that residents help with general upkeep of the centre, the premises, gardening, and cooking, and perhaps receive some type of financial compensation for doing so – an idea worth exploring.

- **CIEs have to improve and expand the health services they provide, especially mental health evaluations and psychological assistance**. Social and legal assistance also need to be strengthened through various activities such as exercise and sports-related activities, social activities, gardening, or vocational training classes.

- It would also be helpful to establish **participation mechanisms to allow centres' residents to participate in the decision making process of organization** and operation aspects of the centres which affect them most directly.

- **Promoting information activities in centres** such as informative tables, delivering of flyers, to improve migrants' access to health care and their knowledge of how the system functions – especially in CIEs. HSPs also have a role to play in reducing social inequalities in the quality and availability of medical care, and so an important step in the right direction would be an educational and awareness campaign aimed squarely at those very same doctors and nurses.

- Of particular importance is the presence of **more intercultural mediators and HSPs in centres where migrants live as well as in health centres to which residents are generally transferred, so that communication is more effective**. Mediators must play an essential role in assessing the needs of detained migrants, working actively with them and building trustworthy interactions in an informal context. At the same time, mediators are ideally positioned to train and inform service providers on improving sensitivity towards the needs and characteristics of migrants. Also, they can play a central role in improving health literacy of those living in settlements in Morocco, in the centres, and around the border area. The role of mediators is far beyond that of mere support professionals, and their practice must include strategies based on community power, religious and spiritual beliefs and traditions – whenever and if they are relevant.

- **Particularly difficult working conditions seriously affect the work of HSPs and LEOs, who usually show clear signs of stress or occupational burnout**. These professionals require organisational support on the part of institutions as much as on the part of their superiors. For instance, it is through their superiors that GCs access to the information and resources needed to do their job properly. Supervisors are also responsible for providing most of the formal professional appreciation and acknowledgment that GCs receive within the police force – key to their motivation in challenging situations (Albar, 2009). On the other hand, citizen collaboration, seeing their work's impact and gratitude gives greater meaning to their work.

- **To create training programmes aimed at overcoming existing cultural barriers by educating staff, as well as by encouraging the development of competencies in cultural diversity, based on social justice principles**. A broad range of potential training topics for HSPs, LEOs, and CSOs have been collected along the fieldwork of this research, including intercultural competencies, project management and fundraising, health-related courses on first aid, infection diseases, safety and security at the work place. Also, HSPs and LEOs demand **training on the specific subject** of human trafficking and gender violence, violence towards children, as well as culturally specific health-related issues (e.g., female genital mutilation). Ultimately, it is necessary to train them in professional competences to enhance their resilience and capacity[96] for providing

[96] Cacioppo, Reis and Zautra. Social resilience: The value of social fitness with an application to the military. *American Psychologist, 66*(1), 43–51 (2011).

equitable services and assuring their occupational health. These competences refer to the development of critical thinking, as well as the capacity to act in the community in which they must be involved.

- **To facilitate regular updates on developments related to health-care services** (e.g., the availability of new services or changes in legislation) directed to all HSP staff – including administrative personnel. Updated and periodic first aid training could also be beneficial for all professionals.

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ANNEXES

Annex I. Laws, Decrees and Regulations

EUROPEAN HUMAN RIGHTS FRAMEWORK

Council of Europe	– Convention for the Protection of Human Rights and Fundamental Freedoms (1950) – European Social Charter (1996 [1961]) – Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum-seekers (2003) – Bratislava Declaration on Health, Human Rights and Migration (2007) – Resolution 1637. Europe's boat people: mixed migration flows by sea into southern Europe (2008)
European Commission	Action Plan on Unaccompanied Minors 2010–2014
European Parliament	European Parliament Resolution of 8 March 2011 on Reducing Health Inequalities in the EU (2011)
EP, CoE	Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the European Union and their family members to move and reside freely within the territory of the Member States (2004)
EP, CoE, EC	Charter of Fundamental Rights of the European Union (2000)

INTERNATIONAL HUMAN RIGHTS FRAMEWORK

United Nations

- Convention relating to the Status of Refugees (1951)
- International Covenant on Economic, Social and Cultural Rights (1966 [1976])
- International Covenant on Civil and Political Rights (1966)
- Convention on the Elimination of All Forms of Racial Discrimination (1969)
- Convention on the Law of the Sea (1982)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
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- Committee on Economic, Social and Cultural Rights (2007). No. 19 The Right to Social Security
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Residence Entitlements and Deportation Norms related to

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- Instrumento de ratificación del Acuerdo de Adhesión del Reino de España al Convenio de aplicación del Acuerdo de Schengen de 14 de junio de 1985 entre los Gobiernos de los Estados de la Unión Económica Benelux, de la República Federal de Alemania y de la República Francesa, relativo a la supresión gradual de los controles en las fronteras comunes, firmado en Schengen el 19 de Junio de 1990, al cual se adhirió la República Italiana por el Acuerdo firmado en París el 27 de noviembre de 1990, hecho el 25 de Junio de 1991
- Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social
- Ley Orgánica 8/2000, de 22 de diciembre, de reforma de la Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social
- Ley Orgánica 11/2003, de 29 de septiembre, de medidas concretas en materia de seguridad ciudadana, violencia doméstica e integración social de los extranjeros
- Ley Orgánica 14/2003, de 20 de noviembre, de Reforma de la Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social, modificada por la Ley Orgánica 8/2000, de 22 de diciembre; de la Ley 7/1985, de 2 de abril, Reguladora de las Bases del Régimen Local; de la Ley 3/1992, de 26 de noviembre, de Régimen Jurídico de las Administraciones Públicas y del Procedimiento Administrativo Común, y de la Ley 3/1991, de 10 de enero, de Competencia Desleal
- Ley Orgánica 2/2009, de diciembre de 2009, de reforma de la Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social
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Other Autonomous Regions	– Decreto 114/2012, de 26 de junio, sobre régimen de las prestaciones sanitarias del Sistema Nacional de Salud en el ámbito de la Comunidad Autónoma de Euskadi – Recurso de inconstitucionalidad n.º 414-2013, contra los artículos 1.Uno, Dos y Tres; 4.Uno, Cuatro, Cinco y Catorce; 6, apartados 2 y 3; 8. Dos; 10.Cuatro y disposición final sexta. Uno del Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones

Legal Regulation of Access to Health care

in CIE / CETI	– Orden de 22 de febrero de 1999 sobre normas de funcionamiento y régimen interior de los centros de internamiento de extranjero – Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social. Texto consolidado (Última modificación: 26 de diciembre de 2013)
for Asylum-Seekers	– Real Decreto 557/2011, de 20 de abril, por el que se aprueba el Reglamento de la Ley Orgánica 4/2000, sobre derechos y libertades de los extranjeros en España y su integración social, tras su reforma por Ley Orgánica 2/2009
for Unaccompanied Minors	– Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones
Legal Regulations related with the Reception Process	– Ministerio de Fomento, Salvamento Marítimo. Informe Anual 2013 – Ministerio del Interior, Guardia Civil (2014a). Servicio Marítimo – Ministerio del Interior, Guardia Civil (2014b) Unidad de Actividades Subacuáticas – Ministerio del Interior, Guardia Civil (2014c) Sistema Integrado de Vigilancia Exterior (SIVE)

ANNEX II. Equi-Health topics covered under the assessment, out of Conceptual Framework IOM/WHO/Spanish EU Presidency, 2010

Monitoring Migrant Health	Policy and Legal Frameworks
Assess with multi-stakeholder perspective how health of migrants is determined from the borders onwards; the accessibility to health and support services; the quality of care and of data collection analysis, storage and dissemination; health status perception and knowledge of the epidemiological situation. The IOM assessment focuses as well on routine information gathered from the borders on data collection, processing, analysis, dissemination, storage.	Information collected under this section is related to policies, laws and legal frameworks concerning health rights of migrants, taking into consideration how they are implemented, monitored and evaluated. A special focus is also devoted to division of responsibilities and roles as well as financing aspects. Assess the adoption and implementation of relevant international standards and policies on the protection of migrants and the right to health in national law and practice, the development and implementation of national health policies that incorporate a public health approach to the health of migrants and promote equal access to health services for migrants, regardless of their status.
Migrant-sensitive health systems	**Partnerships, networks and multi-country frameworks**
Assess existing health and support services preparedness for diversity, human resources, infrastructures including physical and living conditions, hygiene and safety, referral institutions; and occupational health of staff working at the borders and in open/closed centres, including health concerns, work conditions, perceived health risks, health knowledge, attitude and practices. Also, the information collected under this section aims at understanding the quality of health services provided to migrants and collect information inter alia, in the migrant sensitive health system component (routinely available medicines, equipment, vaccines, PEP kits, etc., as well as PPE). Workforce issues are included in several components of the IOM assessment (types and numbers, preparedness of staff). The IOM focus is on personnel working from the borders on and in related communities/settings with specific focus on cultural competency and also on their occupational health.	Information collected under this section looks at partnership in the area of migration and health among various stakeholders. The IOM assessment focuses on institutional cooperation between actors involved in the migration management process in the country, with special focus on the referral mechanisms in place, personnel management, partnerships, network and multi-country framework, exchange of good practices. Links to EWR, IHR as well as information of critical events, incl. emergency situations and issues of public health concern, public health promotion and prevention campaigns are also included.

Source: IOM Equi-Health.

ANNEX III. List of participants to the NCC Spain, Seville 23 October 2014

Governmental Actors

- Generalitat de Catalunya
- Junta de Andalucía
- Ministry of Interior
- Ministry of Labour and Social Security

HP, CSO, IO and others

- Acoge
- Asociación Claver, Servicio Jesuita a Migrantes (SJM) que tienen en Sevilla
- Centro de Acogida a Refugiados (CAR), Seville
- Centro de Estancia Temporal de Inmigrantes (CETI), Melilla
- Comisión Española de Ayuda al Refugiado (CEAR)
- Escuela Andaluza de Salud Pública
- IOM RO Brussels
- IOM Spain
- Platform "Somos Migrantes de Sevilla"
- Spanish Red Cross in Andalusia
- CESPYD (University of Seville)