ASSESSMENT REPORT:
The Health Situation at EU Southern Borders - Migrant Health, Occupational Health, and Public Health

MALTA

Field work 11–15 November 2013

This document is based on the Assessment undertaken by the International organization for Migration (IOM) within the framework of the project "Fostering health provision for migrants, the Roma, and other vulnerable groups" (Equi-Health). 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 DG for Health and Consumers (DG SANTE), through the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA).

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ACRONYMS

AIDA	Asylum Information Database
ASU	Asylum-Seekers Unit
AFM	Armed Force of Malta
AWAS	Agency for the Welfare of Asylum-Seekers
CPT	Committee for the Prevention of Torture
CSO	Civil Society Organizations
EASO	European Asylum Support Office
ECHR	European Convention on Human Rights
EMN	European Migration Network
ERF	European Refugee Fund
EUREMA	EU Relocation from Malta
EURODAC	European Dactyloscopy
HIV	Human Immunodeficiency Virus
HP	Health Personnel
HRW	Human Rights Watch
ICJ	International Commission of Jurists
IOM	International Organization for Migration
JRS	Jesuit Refugee Service
MJHA	Ministry for Justice and Home Affairs (now MHAS)
MFSS	Ministry of Family and Social Solidarity
MHAS	Ministry of Home Affairs and National Security (previously MJHA)
MoH	Ministry of Health
NGO	Non-Governmental Organization
NSO	National Statistics Office
ORC	Office of Refugee Commissioner
PFC	People for Change Foundation
PQ	Preliminary Questionnaire
PTSD	Post-Traumatic Stress Disorder
SOP	Standard Operating Procedures
TB	Tuberculosis
UAM	Unaccompanied Minors
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

EXECUTIVE SUMMARY

Malta has seen an increase in arrivals of irregular migrants into its territory during the last decade, with surging numbers in 2014, much like in Italy, Spain, and Greece. The main nationalities of new arrivals include Malians, Eritreans, Somalis and other sub-Saharan Africans, as well as Syrian nationals (Frontex, 2014), and they arrive in Malta by boats from Libya; newer routes are from Egypt (Syrians) and sometimes from Greece. According to the latest report from UNHCR (2014), Malta has the highest number of asylum-seekers per 100 inhabitants among the major destination countries for asylum-seekers – 20.2 asylum-seekers/1,000 inhabitants. Considering Malta's proximity to the African continent, its relatively smaller size and population, tackling irregular migration has become one of the top policy priorities for Malta. In addition to the continuing influx of migrants from Africa, Malta has to manage a number of asylum-seekers who are returned to Malta by other EU member states in compliance with the Dublin regulation.

Migrants arriving in Malta without valid documents are detained and this practice has attracted severe criticism from local non-governmental organizations (NGOs) and international organizations, although the asylum reception process in Malta has in fact shown signs of improvement over the past decade (UNHCR, 2013a). The Office of the Refugee Commissioner has been operative since 2002, an Agency for the Welfare of Asylum-Seekers (AWAS) was setup in 2009, and providing better accommodation for migrants in open centres has generally been attempted, however facilities are continuously and increasingly overstretched.

Policy and legal framework

The two main legislative acts forming the basis of the asylum system in Malta are the Immigration Act, Chapter 217 (Ministry of Home Affairs, 1970) and the Refugees Act (Ministry of Home Affairs, 2000). Both of these laws were amended several times and subsidiary legislations were introduced to transpose EU directives pertaining to the asylum reception process. A policy document released by the Government in 2005 serves as the basis for indicating various entitlements and services provided to migrants (MJHA and MFSS, 2005a). However, since this is a policy document and not a legal regulation, the implementing officers have discretionary powers. This non-binding nature of the policy document has invited criticisms from local and international organisations working with migrants.

In 2011, Malta adopted the Common Standards and Procedures for Returning Illegally Staying Third-Country Nationals Regulations (Return Regulations, Legal Notice 81), which transposed the EU Returns Directive into Maltese law. Malta took advantage of the option offered in the Directive to limit the scope of some of its provisions, namely that it excludes persons refused entry or those who are apprehended "in connection with the irregular border crossing" and who have not subsequently obtained an authorization to stay in the country (Return Regulations, Regulation 11(1)).

The Office of the Refugee Commissioner receives and processes asylum applications. The Refugee Commissioner can reject an asylum claim, as well as grant international protection, temporary humanitarian protection, or subsidiary protection. AWAS is the main agency responsible for

implementing the national legislation and policies concerning the welfare of migrants in both open and detention centres, whilst migrants in the community are mainly supported through mainstream services. The agency manages accommodation facilities (open centres) and provides information to the migrants during various stages of the reception and asylum application process. AWAS is the agency responsible for identifying and assessing the vulnerability of migrants, although its limited capacity as to available staff affects structured assessment.

Article 13(2) of the Refugees Act (Ministry of Home Affairs, 2000) grants refugees and asylum-seekers access to state provided health care services. However, they are required to contribute or cover the cost of health care if found to have sufficient resources and/or if they have been working a paying job (a right refugees do have), for a reasonable time (Article 11(4), Ministry for Justice, 2005). Although irregular migrants have access to state public health care services through the aforementioned Refugees Act, their entitlements mainly depend on the non-legally binding 2005 policy document.

Partnerships, networks, and multi-country frameworks

The reception process usually starts when a boat carrying migrants is intercepted and rescued in the Mediterranean Sea by the maritime squadron of the Armed Forces of Malta (AFM), which falls under the Ministry for Home Affairs and National Security. In case of emergencies, AFM personnel on board the rescue vessel can request medical assistance via satellite/cellular connection with the hospital. Rescued migrants are then brought to the Maltese military port at Hay Wharf. Ministry of Health (MoH) health personnel at the port perform medical screening to treat emergencies and assist in transfers to the hospital for care if necessary. Maltese Immigration police collect (for European Dactyloscopy (EURODAC) registry) fingerprints and basic information from the migrants at the police headquarters close to the port. Medical personnel then conduct an initial screening at the police headquarters mainly to identify any possible infectious diseases such as tuberculosis and to identify vulnerable individuals. At any point during the reception process, identified emergencies are transferred to the hospital. From the police headquarters, migrants are transferred to detention centres, which are run by the AFM. In these centres, migrants can apply for asylum. Until this stage in the process, there are no formal cultural mediators or interpreters employed or utilized to facilitate communication and cultural sensitivity.

Migrants are then detained until they are granted protection or up to a maximum period **of eighteen months** in case of irregular migrants or rejected asylum-seekers, in line with the subsidiary legislation 217.12. Government representatives pointed out that asylum application processing times have improved significantly over the past year (from 12 to around 6–8 months), although migrants indicated the maximum duration of detention as the rule, except for vulnerable cases. Identified vulnerable individuals such as unaccompanied minors, persons with disability, elderly persons, or pregnant women are recommended for an early release to the Office of the Refugee Commissioner. In addition to AWAS, detention staff, medical personnel, and NGO volunteers visiting the centres remain vigilant in the identification of vulnerable individuals. The migrants are however mainly dependent on NGOs visiting the detention centres for assistance. NGOs provide legal assistance and organize limited activities in detention – for

example, English lessons. Since 2007, medical services within the detention centre have been outsourced by the Ministry for Home Affairs and National Security with two separate tenders (one for doctors and one for nurses). A doctor and a nurse are available at the detention centres during weekdays. If during the doctor's consultation times migrants are diagnosed with medical emergencies or health concerns, they are transferred to the main hospital, Mater Dei or to Floriana Health Centre, though reports confirmed that sometimes access to antibiotics and other important treatment is problematic. Detainees are also screened for tuberculosis while in detention.

Once migrants are released from detention centres, they are accommodated in open centres, which are managed or supervised by AWAS. In line with a contract migrants sign with AWAS, the migrants are allowed to stay in open centres for a year. This period can be extended for a few more months in selected cases. Open centres mainly provide basic accommodation. These are temporary accommodation facilities provided for the migrants until they find their own accommodations. A fixed quota of meals is provided at the open centres, although this supply roughly meets about half of the residents' one time meal requirement and the cash provided to migrants does not fill the gap. Some NGOs conduct information sessions and educational sessions at open centres, however these are not held regularly as they are highly dependent on external funds and/or volunteers. Migrants receive a subsistence allowance based on their protection status. This is withheld once they find work, and in addition, they are required to contribute to the running costs of the open centre.

Once released from open centres, migrants encounter further difficulties to find housing and jobs due to language barriers, skill mismatching, and overall insufficient integration mechanisms. Some of them will participate in relocation programmes; IOM Malta participates in EUREMA (relocation to other EU Member States, Norway and Switzerland from Malta), and also assisted in the operational and medical side of the relocation of 21 migrants to Australia in 2011.

Monitoring Migrant Health

The main health concerns for migrants arriving in boats were severe dehydration, general fatigue, post-traumatic stress disorder (PTSD), heat stroke, salt/petrol burns and other injuries sustained while in Libya or on the boat journey over. Scabies was a common diagnosis among migrants from closed and open centres. Despite this, the majority of migrants in Malta seem to be in good overall health (Padovese et al., 2013). However, due to adverse reception conditions in detention centres, the mental and physical health of migrants may deteriorate over time.

In detention, migrants with mental health issues are referred to Mater Dei first, and if need be to the Asylum-Seeker Unit of the Mount Carmel hospital – the mental health hospital in Malta. Mental health concerns arising from open centres are managed by social workers from AWAS, who if required will refer the migrants so diagnosed to hospitals. An evaluation by the AWAS staff members might take time since the open centres in Malta depend on only on a very limited number of social workers to assess migrants' psychological issues. Moreover, mental health concerns might not be readily visible, because of language and cultural barriers that impede proper communication. These barriers may indeed cause serious delay in providing assistance in

the absence of regular support. Similarly, other vulnerabilities which may not be easily visible, for example chronic diseases or torture victims, are also often not easily identified.

Migrants released from detention centres have access to the state run health-care services, however accessibility remains an issue as those are often far from the centres, and because languages and cultural barriers persist. Open centres provide very limited health care services; in one case health assistance is provided regularly but on voluntary basis. There are no health screenings or disease prevention mechanisms present in the open centres. AWAS is also responsible for assessing mental health concerns arising at open centres.

Limited amount of data are collected on migrants' health. There is a need to collect more stratified data on their health status and needs. The first screening is done at disembarkation, where all migrants are screened for emergency cases to be referred to the hospital, and a second screening is done within the police HQ for any dermatological or infectious disease. At the detention centre migrants are all screened for active tuberculosis. Vaccinations for Diptheria, Tetanus and Polio are provided, according to local health authorities, to all at arrival, while children are given vaccination per the Maltese immunisations schedule.

Migrant sensitive health system

Suboptimal living conditions, staff numbers and skill mix in detention centres and open centres are major concerns. Unhygienic surroundings, and in particular toilets, pose further health risks for migrants.

The IOM assessment team also found the Asylum-Seekers Unit facilities at the Mount Carmel hospital to be non-conducive for asylum-seekers. There were no arrangements for physical or social activities for the patients. Migrants, patients with substance abuse problems, and female prisoners were all accommodated in the same unit.

While in general migrants do have access to public health care services, accessibility and entitlements vary depending on the migrants' protection status. Limitations on 'free' access to services depend on the protection status. In practice, most of the primary health care services are available to all migrants. However, there seems to be a lack of clarity on the accessibility of services such as medicines among the services providers and migrants. This often leads to migrants not accessing the free services they are entitled to.

There is furthermore an acute shortage of interpreters and of cultural mediators in Malta, including at the hospitals and at the open or closed centres. Migrants are often requested to bring their acquaintances for translation, which is not a good practice considering the sensitivity of the issues discussed. By using fellow migrants and/or family members as interpreters, sensitive translated information could be leaked to the migrant communities or to the general public, which can result in further marginalization or other undesirable effects for the migrants. Language barriers prevent health care providers from providing proper services to migrants. This also affects the migrants' uptake of information and service utilization due to lack of understanding.

Lack of funding and human resources have been partially mitigated by the services provided by NGOs, which play a significant role in assisting migrants in Malta. They are the main stakeholders conducting social activities and trainings at both detention and open centres. Some of them also provide legal assistance. Additionally, three open centres are run by NGOs in agreement with AWAS. The assessment team noted that infrastructure facilities at open centres are often financially (75–80%) supported by the European Refugee Fund. This creates a scenario where projects are highly dependent on EU funds and sustainability of the projects is at stake.

There is a lack of clarity among the service providers and migrants on various provisions and assistance available to migrants. Most of the entitlements, in particular social and health entitlements are based on the non-legally binding policy document released by the Government of Malta in 2005. Lack of clarity in regulations creates discrepancies in services provided, thereby resulting in further marginalization of migrants.

Along with ensuring the health and wellbeing of migrants, it is also important that the health and wellbeing of the personnel working with migrants is safeguarded. Indeed, there is lack of proper training and support structures for staff from different sectors who are working with migrants, thereby preventing them from providing optimal service delivery to migrants. Most of the state employees reported receiving psychological support. However, there are institutions, in which there is no regular support. All staff working with migrants expressed the need for increased cultural awareness and competence, while at the same time reporting the lack of training in migrant-related topics.

1. INTRODUCTION

This draft document has been developed within the framework of the Equi-Health project EC/DG SANTE co-funded, Southern EU Border component (MH SEUB) to present the summary of findings of the IOM, MHD desk review[1] and field work done in Malta from 11 to 15 November 2013.[2]

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

Health is an essential element of effective migration management. Moreover, the concept of health goes beyond physical diseases, and comprises the psychological and social wellbeing of mobile populations and communities affected by migration. Migration health addresses the needs of individual migrants as well as the public health needs of receiving communities through policies and practices corresponding to the emerging challenges facing mobile populations today.

Therefore, the approach used in the assessment attempts to be as comprehensive as possible, covering communicable and non-communicable diseases, emergency interventions, chronic diseases, mental health, the understanding of culture and health beliefs, human rights protection, migration health management and other factors that impact on the health of migrants and the communities along.

The desk review and field work findings are presented following the IOM/WHO/Spanish Presidency of the EU "Global Consultation on Migrant Health" conceptual framework (Madrid, 2010),[4] according to the following four pillars:

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

[1] 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 at national and regional level.

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

[3] IOM identifies complex flows as comprising, in addition to 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).

[4] Please see Annex I.

2. BACKGROUND INFORMATION

Malta is a southern European country in the Mediterranean Sea with a population of 417,432 (NSO, 2011). According to the 2011 census (NSO), there were 20,289 (4.9%) non-Maltese nationals residing in Malta, of which 2,279 were living in institutional households such as open centres for migrants. Malta joined the European Union (EU) in 2004 and the Schengen area in 2007. Due to Malta's geographical location and EU membership, it has seen an increased arrival of irregular migrants during the last decade and furthermore in 2014.

The majority of the irregular migrants arriving in Malta apply for asylum.[5] Malta has relatively high recognition rates with the majority of the asylum-seekers obtaining some form of protection, mainly subsidiary protection (UNHCR, 2013a). According to the latest UNHCR report (2014), **Malta has the highest number of asylum-seekers per 1000 inhabitants** (20.2/1,000) among the 44 industrialized countries covered in the report, which include the 28 member states of the EU and other major asylum claims-recipient countries.

Some migration statistics for the year 2013[6] are reported below, and in Table 1 and Table 2:[7]

- 2008 migrants arrived in Malta on 24 boats;
- Somalis, Eritreans and Syrians were the largest groups of migrants arriving on boats;
- In 2013 there has been an increase of minors (especially in the age class of 14–17 years old);
- Over 1,900 migrants were detained in 2013;
- Towards, the end of the year, around 1,500 migrants were living in open centres;
- 71 per cent of all asylum-seekers were granted international protection. A further 11 per cent was granted complementary forms of protection such as subsidiary protection or temporary humanitarian protection;
- Somali, Eritrean and Syrian nationals were the major recipients of international protection;
- 412 refugees were relocated/resettled and 73 migrants returned to their home countries through voluntary return programmes.

[5] In 2012, out of the 1890 individuals arrived by boat, only 52 did not apply for asylum. www.unhcr.org.mt/statistics/652

[6] For an update on the recent data, please notice that UNHCR has published some new data for 2014: 308 individuals arrived by boat; protection rate (January–March 2014): 61 per cent granted international protection, 6 per cent granted other forms of protection, 26 per cent rejected and 7 per cent closed; resettlement (as 7 May 2014): 226 resettled from Malta to the US. Access on 01 SEPT 2014. According to the last FRONTEX data (2014), already in March 2014 the number of arrivals in Italy and Malta seemed to reach the exceptionally high levels of the summer of 2013 (equals to 5,000 individuals).

[7] Available at: www.unhcr.org.mt/statistics (accessed 9 March 2014).

2.1. Political debate

Considering Malta's proximity to the African continent, its comparatively smaller size and population, tackling irregular migration has become one of the top policy priorities for Malta. **In addition to the continuing influx of migrants from Africa, Malta has to manage a number of asylum-seekers who are returned to Malta by other EU member states in compliance with Dublin regulation.**

Malta has long been demanding burden sharing and support from fellow EU Member States (Lutterbeck, 2009; MJHA and MFSS, 2005b:6). A project for intra-EU relocation from Malta (EUREMA) was a result of this plea (EASO, 2012).[8] Through this project, beneficiaries of international protection are relocated to other EU Member States. IOM,[9] along with other international organisations such as UNHCR, facilitate other relocation programmes, for example the United States Refugee Programme (USRP).[10] However, because of these efforts for relocation, Maltese authorities have been criticised for their more **limited focus on integration** (ICJ, 2012; UNHCR, 2013a; Durick, 2012; Lutterbeck, 2009; Falzon, 2012). In addition to the relocation activities funded by European funds, Malta receives assistance from the EU through solidarity funds, namely the European Return Fund and the European Refugee Fund, so as to better manage and respond to the migration flow.[11]

Another point of discussion as policy response from the Government of Malta is **to detain irregular migrants on arrival** (DeBono, 2013:67; MJHA and MFSS, 2005b:6). This practice has faced strong criticism from international organisations and NGOs (Jesuit Refugee Services, 2010; UNHCR, 2013b).

Malta ratified the European Convention on Human Rights (ECHR) in 1967. There have been cases pertaining to immigration detention brought to the European Court of Human Rights. In 2013, there were three cases where the court found Malta to be in violation of the ECHR.[12] The case of Aden Ahmed v. Malta[13] is of particular interest since this was the first time where the Court found

[8] More information on EUREMA project. Available from http://mhas.gov.mt/en/MHAS-Information/EUREMA/Pages/EUREMA-II.aspx (accessed 26 December 2013).

[9] IOM Malta participates in EUREMA (relocation to other EU Member States, Norway and Switzerland from Malta) and also assisted the operational and medical side of the relocation of 21 persons to Australia in 2011.

[10] More information available from www.iom.int/cms/en/sites/iom/home/where-we-work/europa/european-economic-area/malta.html (accessed 19 March 2014).

[11] More details about the funds awarded to Malta under 2008–2013 can be found here: https://secure2.gov.mt/fpd/migration_funds?l=1 , http://mhas.gov.mt/en/MHAS-Information/EU%20Funds/Pages/EU-Funds-Programmes.aspx (accessed 19 Mars 2014).

[12] European Court of Human Rights, Country Profile: Malta. Available from www.echr.coe.int/Documents/CP_Malta_ENG.pdf (accessed 20 March 2014).

[13] Aden Ahmed v. Malta. Available from http://hudoc.echr.coe.int/sites/eng-press/pages/search.aspx?i=003-4443108-5346240#{"itemid":["003-4443108-5346240"]} (accessed 20 March 2014)

a violation of Article 3 of ECHR[14] against Malta concerning immigration detention conditions. The Court found that the conditions in detention constituted a degrading treatment breaking Ms Aden Ahmed's moral and physical resistance. Along with Italy, Malta lies on the central Mediterranean migratory route, along which irregular migrants try to reach Europe on boats mostly from Libya.[15] Malta's search and rescue zone is large – extending up to 250,000 km[16]. In another incident,[17] migrants rescued by a commercial vessel had to remain on board the vessel for two days, during which time Malta and Italy were negotiating on where and in which country the migrants would be allowed to disembark. This incident also prompted heavy criticism[18] from the European Commission. Migrants were finally allowed to disembark in Syracuse, Italy.[19] A third case occurred during summer 2013, when a group of 102 Somali migrants were intercepted at sea and brought to Malta by AFM. The Government of Malta's primary intention was to deport the migrants back to Libya. An action was taken urgently by ECHR and the Government of Malta was handed a Rule 39 interim order blocking the return of around 45 Somali migrants from Malta to Libya.[20, 21]

However, recently there have been some positive developments. **In March 2014, the Prime Minister of Malta committed himself to end child detention,** a decision that was welcomed by international and national stakeholders. The President of Malta, Ms Marie Louise Coleiro Preca, reaffirmed that she will be pushing the policy further and will make sure that **children are adequately protected.**[22]

[14] Article 3 of ECHR, Prohibition of torture: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

[15] The other form of irregular migration is by air which is comparatively low. In 2013, for example, there were only 347 non-boat asylum applications out of the 2240 lodged with the Office of the Refugee Commissioner. www.unhcr.org.mt/statistics/722

[16] Search and Rescue Training Centre in Malta. www.sarmalta.gov.mt/sar_in_Malta.htm

[17] Newspaper article on the incident. www.maltatoday.com.mt/news/national/28888/malta-italy-bide-their-time-as-conditions-on-the-salamis-worsen-20130805#.U5w4bpSSzTo www.maltatoday.com.mt/news/national/28888/malta-italy-bide-their-time-as-conditions-on-the-salamis-worsen-20130805#.U5w4bpSSzTo (accessed 28 May 2014).

[18] Newspaper article on the incident. www.timesofmalta.com/articles/view/20130806/local/tanker-with-rescued-migrants-still-outside-maltese-waters.481002 (accessed 28 May 2014).

[19] Please refer to (Attard, Cassar, and Gauci,2014:12–14) for further details.

[20] News articles on the incident. www.timesofmalta.com/articles/view/20130709/local/ngos-holding-protest-outside-police-headquarters.477305#.Udw32D7J09w.twitter] www.maltatoday.com.mt/news/national/28246/pushbacks-suspended-as-european-court-demands-explanation-from-malta-20130709#.U5wy_5SSzTo (accessed 28 May 2014).

[21] Please refer to (Attard, Cassar, and Gauci,2014:11–12) for further details.

[22] News article: www.maltastar.com/dart/20140401-malta-committed-to-ending-detention-of-child-migrants (accessed 28 May 2014)

Table 1: Number of boat arrivals in Malta, 2003–2013

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total
Number of people	520	1,388	1,822	1,780	1,702	2,775	1,475	47	1,579	1,890	2,008	16,986

Source: UNHCR Malta.[23]

Table 2: Asylum applicants by age and sex Annual aggregated data, 2008-2013 (rounded)

Period	2008			2009			2010			2011			2012			2013		
Age	M	F	Unk	M	F	Unk	M	F	Unk	M	F	Unk	M	F	Unk	M	F	Unk
<14 years	60	40	0	30	30	0	10	10	0	50	50	0	40	35	0	70	45	0
14–17 years	250	25	0	95	55	0	10	0	0	55	15	0	150	20	0	380	50	0
18–34 years	1,840	230	0	1,700	335	0	95	15	0	1,200	275	0	1,285	375	0	1,270	240	0
35–64 years	130	20	0	120	20	0	20	5	0	195	30	0	145	25	0	140	35	0
≥ 65 years	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0
Unknown	0	0	0	5	0	0	5	0	0	5	0	15	0	0	5	5	0	0
Total	**2,285**	**315**	**0**	**1,950**	**440**	**0**	**140**	**30**	**0**	**1,505**	**370**	**15**	**1,620**	**455**	**5**	**1,870**	**370**	**0**

Source: Eurostat.[24]

[23] Available from UNHCR Malta: https://drive.google.com/folderview?id=0B6aJpCO6sQYhSjdrS1VkNkhublE&usp=sharing&tid=0B6aJpCO6sQYhTDJIb0NPdWNHakU and www.unhcr.org.mt/statistics (accessed 9 March 2014).

[24] Eurostat: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=migr_asyappctza&lang=en (accessed 22 March 2014).

3. METHODOLOGY

3.1. Overview of data collection

The selection of sites and centres visited in Malta was driven by data and information collected during the desk review prior to field work and after consultation with Equi-Health focal points at the Ministry of Health and AWAS, partners, and IOM Malta based on the following criteria:

- Migration flows/Reception process: to cover the route of different migration flows and nationalities in the country of destination and cover all the different steps of the reception process in the country.
- Management type: to cover different types of management and types of facilities for migrants' reception.

The range of target groups involved during the assessment[25] was meant to gather information and perceptions from respondents involved during the whole reception process, being health professionals (HPs) (both at senior and first line level); law enforcement officers – LEOs (both at senior and first line level); civil society organizations (CSOs) (including Church representatives, local authorities, NGOs, media); and migrants (Table 3).[26]

Table 3: List of interviews conducted and sites visited

Profile	Total number of interviews	Sites Visited
Law Enforcement Officers	6	➢ Marsa open centre, Marsa ➢ Hangar open Centre, Hal-Far ➢ Tent village open centre, Hal-Far ➢ Dar il-Liedna open centre (unaccompanied minors and families), Fgura ➢ Good Shepherd convent – Balzan ➢ Lyster Barracks (detention centre), Hal-Far ➢ Mater Dei Hospital, Msida ➢ Mount Carmel hospital, Attard ➢ Floriana Health Centre, Floriana ➢ Hay Wharf port, Floriana ➢ Police Headquarters, Floriana
Health-care Professionals	16	
Migrants	23	
Civil Society Organizations	15	

Source: IOM Equi-Health project.

[25] Ethical review clearance was obtained and the fieldwork activities complied with international, European and national standards regarding access to information, voluntary character of participation, informed consent process, confidentiality, anonymity and data protection.

[26] Unless otherwise specified, the term migrant will be used to refer to an individual(s) who belong to one of the following groups: asylum-seeker; migrant with a protection status (temporary, subsidiary, and refugee); migrant with no protection status (irregular status).

The field visit began with a stakeholders meeting hosted by IOM Malta. The meeting was attended by representatives of the Immigration Police, Armed Forces of Malta (AFM), medical personnel at the hospital and the detention centres, NGOs, Agency for Welfare of Asylum-Seekers (AWAS), Ministry of Health, UNHCR Malta, IOM Malta, and the assessment team.

After the stakeholders meeting, the assessment team continued with visits to various sites and data collection. Prior to each interview/focus group, information regarding the Equi-Health project was provided to the participants. Informed consents were used and whenever allowed, the interviews were also audio-recorded.

A national Consultative Committee (NCC) was held in Malta on 18 September 2014 after the assessment in order to validate findings and recommendations for finalizations of the SAR.

3.2. Limitations

- Due to a necessary selection for the assessment, the team was not able to visit all the open centres, in particular the Hal Far Reception centre, which accommodates only female migrants. However, the three open centres visited by the team – namely Marsa Open Centre, Hal Far Hangar Open Centre, and Hal Far Tent Village Open Centre – were among the biggest open centres in Malta. Moreover, Hangar Open Centre and Tent Village Open Centre accommodated families and single women, some of whom took part in interviews.

- Among the migrants interviewed, there were only a few females. This reflects the gender distribution of the migrant population in Malta, as most of the migrants are single males between 18–34 years of age.

- It was not possible to interview minors due to locally stated ethical considerations and lengthy clearance procedure. However, some minors (17 years old) in open centre Hal Far were interviewed.

- The assessment team was not able to conduct individual interviews with the law enforcement officers at Hay Wharf port, Lyster Barracks, and Immigration Police Headquarters. This was mainly due to officers' unavailability, as well as their preference of a more informal discussion, especially at the operational level. This holds true also for officers working at AWAS.

- Unexpected assignments of the staff working at Dar il-Liedna open centre for minors prevented the team from conducting individual interviews with the staff and limited the allotted time to observation during the site visit.

- Out of the two immigration detention centres in Malta, IOM team visited Lyster Barracks. The other detention centre, Safi Barracks, is often described as having poor living conditions (CPT, 2013; ICJ, 2012). However, some of the migrants from the open centres and communities who took part in the study were previously detained in Safi Barracks and were therefore able to provide some information regarding the conditions at Safi barracks.

- The assessment team was not allowed to take photos of the sites visited**.**

- Finally, the presence of Government officials as part of the visiting team during site visits could have kept some of the interviewees from fully sharing their honest opinions and information during visit and interviews.

4. FIELDWORK

I. POLICY AND LEGAL FRAMEWORK

I.I EU and national/local legislative framework on interception/reception/rescue at sea/green border

All procedures pertaining to **migration management** in Malta, such as border control, detention and issuance of residence permits are regulated by the Immigration Act, Chapter 217 (Ministry of Home Affairs, 1970). The **asylum system** in Malta is regulated by the Refugees Act (Ministry of Home Affairs, 2000). The Immigration Act and the Refugee Act were amended over recent years and subsidiary legislation was introduced with the aim of transposing EU directives relevant to asylum-seekers such as those relating to asylum procedures, reception conditions,[27] and return of illegally staying third country nationals[28] (EMN, 2013; Global Detention Project, 2014).

The Refugees Act defines duties and rights of asylum-seekers and refugees and established the Office of the Refugee Commissioner (ORC) and the Refugee Appeals Board. The ORC is responsible for receiving and processing the asylum applications. **There is no time limit set in law for the ORC to make a final decision on an asylum application; however most of the decisions are taken within 6 months**. The ORC is also the head of the Dublin Unit and the Immigration Police Department is entrusted with implementing Dublin transfers. The asylum application procedure is regulated by Subsidiary Legislation 420.02.[29] If the asylum application is rejected, asylum-seekers have the right to appeal against the decision to the Refugee Appeals Board within two weeks of the rejection of the application. **A recently published report on the Maltese asylum-system (AIDA, 2014:15,26) highlighted difficulties faced by the asylum-seekers in appealing against application decisions due to the limited legal assistance and language barriers present in detention centres.**

In 2005, a policy document (hereafter referred to as the **2005 policy document**) was published by the Ministry for Justice and Home Affairs and Ministry for the Family and Social Solidarity (MJHA and MFSS, 2005a). The objectives of the policy document are to set out parameters to ensure: "*a fair, just and humane treatment of irregular immigrants; standard procedures and practices when dealing with asylum-seekers; the social inclusion of asylum-seekers; and the orderly removal of irregular immigrants who are ineligible for refugee or humanitarian protection status*" (p.8). However, since this is a policy document and not a legal regulation, the implementing officers have discretionary powers. **The non-binding nature of the policy document has invited criticisms from local and international organisations working with migrants.**

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[27] EC, Reception of Asylum Seekers (Minimum Standards) Regulations, 2005. Available from www.globaldetentionproject.org/fileadmin/DIVERSE/Malta_Reception_Regulations.pdf (accessed 20 March 2014).

[28] Subsidiary legislation 217.12. Common standards and procedures for returning illegally staying third-country nationals regulations. Available from www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=11637&l=1 (accessed 22 December 2013).

[29] Subsidiary legislation 420.02 asylum procedures (application for a declaration) regulations. Available from www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=10658&l=1 (accessed 20 March 2014).

The **Agency for the Welfare of Asylum-Seekers[30] (AWAS)** was established in 2009 under the Ministry of Home Affairs and National Security[31] through the Subsidiary legislation 217.11.[32, 33] Article 6 of the legislation lists the functions of the agency in detail, including "*the implementation of national legislation and policy concerning the welfare of refugees, persons enjoying international protection and asylum-seekers",* **oversee the daily management of accommodation facilities, provide information** in the areas of employment, housing, education and **health and welfare services** offered under national scheme, provide information to migrants and management of the open centres, **act as facilitator with all public entities responsible for providing services to ensure that national obligations to refugees and asylum-seekers are accessible**; advise the Minister on developments in the field of migration, and propose policy or legislation to improve the services to fulfil legal obligations to its service users.[34] During the assessment it was reported that only three social workers and four community workers are available at AWAS.[35]

An assessment mission done by WHO Regional Office in Rome back in 2011 (Rockenschaub, 2012) recommended international cooperation of preparedness efforts, namely the need for international human, financial and technical support in the eventuality of a mass migrant influx. In the same vein of reasoning with regard to European co-operation, there is as yet no documentation on how the European cross-border health care directive may affect migrants.

I.II Legislative and financial framework of open/closed centres

Closed/Detention centres

The Constitution of Malta allows the detention of a person for the following reasons:

> *'for the purpose of preventing the unlawful entry of that person into Malta, or for the purpose of effecting the expulsion, extradition or other lawful removal of that person from Malta or the taking of proceedings relating thereto or for the purpose of restraining that person while he is being conveyed through Malta in the course of his extradition or removal as a convicted prisoner from one country to another' [Article 34.1 (j)]*

All migrants entering the country without necessary documentation are detained under the Immigration Act.[36] Migrants arriving in Malta by boat or intercepted and rescued by AFM in the

[30] It is worth noticing that former name of the Agency was OIWAS - Organisation for the Integration and Welfare of Asylum-Seekers – thus then including as well an explicit integration mandate. It was created in 2007.

[31] According to art. 7 (2) the Agency shall be paid by Government out of the Consolidated Fund.

[32] The Agency for the Welfare of Asylum Seekers (AWAS). Available from www.gov.mt/en/Services-And-Information/Business-Areas/Law%20Enforcement/Pages/Refugee-Services-in-Malta.aspx

[33] AWAS was established under Subsidiary Legislation 217.11 Agency for the Welfare of Asylum Seekers Regulations. Available from www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=9566&l=1

[34] For more information, please refer to: International Commission of Jurists, 2012*; Not here to stay*; p. 35–36.

[35] During the 2NCC held in Malta (18 September 2014), AWAS representative informed that they are in process of recruiting 25 support workers, 2 social workers and 2 community workers plus a number of administrative positions. A team of 'maintenance' persons increasing the number of the team from one to four people.

[36] In October 2013, a vast majority of Syrian asylum-seekers rescued from the sea were accommodated in the open centres instead of closed centres (UNHCR, 2013a:9; AIDA, 2014:29).

Mediterranean Sea are detained. They usually express their interest to apply for asylum while being detained. Migrants such as visa over stayers or students, who manage to apply for asylum before being detected by the police, are not detained. As outlined as well in the 2005 policy document:

> *"Although **by landing** in Malta without the necessary documentation and authorisation irregular immigrants **are not considered to have committed a criminal offence**, in the interest of national security and public order **they are still kept in detention** until their claim to their country of origin and other submissions are examined and verified."* [p. 11]

In 2011, Malta adopted the Common Standards and Procedures for Returning Illegally Staying Third-Country Nationals Regulations (**Return Regulations**, Legal Notice 81), which transposed the EU Returns Directive into Maltese law. The Returns Directive provides basic safeguards against mandatory detention. Malta took advantage of the option offered in the Directive to limit the scope of some of its provisions, namely that it excludes persons refused entry or those who are apprehended "in connection with the irregular border crossing" and who have not subsequently obtained an authorization to stay in the country (Return Regulations, Regulation 11(1)). As a result of this option, the Directive's provisions are not applied to most detention cases because the majority of migrant detainees in Malta are people who have entered the country without authorization or have been refused entry.

Several international and non-governmental organizations (the UN Committee on the Rights of the Child, 2013; UN Working Group on Arbitrary Detention, 2010; Commissioner for Human Rights of the Council of Europe, 2011; Human Rights Watch, 2012) have criticized Malta's detention policies. In particular, the UN Working Group on Arbitrary Detention recommended that Malta should change its laws and policies related to administrative detention of migrants to one of an irregular situation and asylum-seekers, thereby allowing detention to be decided by a court of law, and on a case-by-case basis (WGAD, 2010). Similarly, the International Commission of Jurists (ICJ) reported that Malta's administrative detention of asylum-seekers and migrants was *"automatic, excessive, and disproportionate in length and duration"* (UN Press Release, 2009). Furthermore, Malta failed to transpose the Directive's due diligence standard regarding extension of detention, notably that the 18-month detention is permissible if the removal operation lasts longer than the initial six-month period, regardless of all reasonable efforts of the authorities. Maltese legislation also provides a mechanism for extending detention to 18 months that is not provided in the Returns Directive, namely that detention can be extended whenever "the Principal Immigration Officer" deems it necessary (Return Regulations, Regulation 11(15)(c)).

AWAS is responsible for conducting **vulnerability assessment** through two specific procedures – the age assessment procedure, which is applied in cases involving persons claiming to be unaccompanied minors; and the vulnerable adult's assessment procedure, which is used to determine vulnerability on grounds of pregnancy, old age, serious, acute or chronic illness, disability, and physical or mental health problems (Jesuits' Refugee Services Europe Report, 2010).

Vulnerable individuals can also be referred to AWAS by organisations or individuals who come in contact with the migrants. These could be the immigration police officers identifying someone as vulnerable during the initial phase of the reception process, or UNHCR or NGOs, which provide various services to the migrants in the detention or personnel working in the detention. In such instances, vulnerable individuals are transferred to a hospital if needed or released to open centres based on AWAS's vulnerability assessment.

AWAS also conducts an elaborated **age assessment for minors,** a three-stage process (AIDA, 2014: 32–33). An AWAS staff member performs an initial interview, which if found inconclusive will proceed to the next stage of the assessment, when a psychosocial assessment team of three members[37] will conduct a second interview with the migrant, who claims to be a minor. If this interview is also inconclusive, during the third stage, the migrant is referred to a further age verification test with X-ray of the wrist. As soon as their age/vulnerability is assessed and established by AWAS, recommendations are made to their release and transferred to the open centres or specialized centres for unaccompanied minors (UAMs). The legal responsibility of UAMs is vested in the Minister for Family and Solidarity, while a legal guardian is appointed to represent the minor.[38] With the issue of a care order, however, the welfare of the child is passed onto AWAS. As indicated by the European Migration Network (EMN, 2012:35) "*The application of the Care Order Act and the provision of guardianship under its auspices similarly signify that, while mainly transferred to OIWAS under the Ministry for Justice and Home Affairs, the welfare of UMs in many particular areas still enjoys the input and support of the mainstream children and family services under the Ministry for Social Policy".*

Subsidiary legislation 420.06, Reception of asylum-seekers (minimum standards) regulations, *t*ransposing the EU Directive 2003/9/EC, sets the basic living condition standards and provisions in the closed centres.[39] The 2005 policy document also describes the various provisions, which the Ministry of Home Affairs and National Security (MHAS) *in conjunction with other ministries and NGOs* needs to be made available at the closed centres, as indicated under page 12:

- ***Basic Conditions:*** *Closed centres shall adhere to international standards in terms of physical environment. A degree of privacy, adequate sanitation facilities and basic material necessities shall be made available.*
- ***Health Services: People in detention shall be entitled to free State medical care and services.***
- ***Sanctions:*** *Disobedience or criminal behaviour on the part of detainees is to be addressed according to established norms. However, when pressing charges, due weight shall be given to such mitigating circumstances as trauma, disorientation or inability to communicate. No sanctions shall prevent the detainee's claim for refugee status or his/ her right to basic necessities.*
- ***Religion and Customs****: Detainees have the right to freedom of thought, conscience and religion. Customs and religion are to be respected as far as these do not entail disrespect for the customs of other ethnic groups and do not hinder the safety and proper running of the centre.*

[37] The assessment team is made by a social worker, psychologist, and a coordinator (HRW, 2012).
[38] The legal guardian is often an AWAS staff member (AIDA, 2014).
[39] Please refer to footnote no. 26.

- ***Communications:*** *Detainees shall not be prevented from seeking professional assistance or from communicating with relatives and UNHCR and NGO representatives.*
- ***Regulations and conditions:*** *The competent authorities shall ensure that all detainees are made aware of their detention rights and obligations.*

AFM and detentions services (DS) are the authorities responsible for managing closed centres. DS was set up under the MHAS,[40] and the majority of DS personnel have previously worked with the police or AFM (DeBono, 2013).

In line with the EU Return Directive (Directive 2008/115/EC), the subsidiary legislation 217.12,[41] defines the initial duration of detention for irregular migrants as 6 months (Regulation 11(14)) which could be extended further by twelve months if there is a lack of cooperation from the migrants or delays in obtaining documents from the country of origin or if the Principal Immigration Officer deems it necessary to extend detention (Article 11(15)) (Ministry of Home Affairs, 2011). **There is no time limit specified for the detention of asylum-seekers in law, however, in practice, they are released after maximum 12 months and the rest, irregular migrants, are released after 18 months.**[42]

Open Centres

Once released from the detention centres, migrants are accommodated in open centres. The living conditions and other provisions at the open centres should follow the regulations present in the subsidiary legislation 420.06. The scope of the legislation is applicable to asylum-seekers; however, in practice migrants living in open centres include asylum-seekers, migrants who are granted protection status and irregular migrants. The 2005 policy document states that irregular migrants could be accommodated in open centres against the presentation of documents issued by the Principal Immigration Officer and certificate from the Ministry of Health showing that the migrant is free from infectious disease (MJHA and MFSS, 2005a:23). The document sets out as well the conditions under which the open centres should operate, indicating that '*prior to transfer from closed centres, prospective open centre residents are to be informed of their rights and obligations in their new residential setting,* ***possibly in a language that they can understand;*** *that a copy of the open centre's regulations shall be given to each immigrant at point of first admission into the open centre; that registered residents of an open centre will be provided with food, shelter and* ***social welfare support'*** while on the other side '*the open centre shall take cognisance of any immigrant's disability and* ***address it accordingly; residents' culture, ethnic origin, and personal religious beliefs shall be respected'*** (p. 23).

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[40] The Ministry of Home Affairs, http://mhas.gov.mt/en/MHAS-Departments/Detention-Services/Pages/DS.aspx (accessed 5 December 2013).

[41] Common Standards and Procedures for returning Illegally Staying Third-Country Nationals (Amendment) Regulations, 2014. Available from www.justiceservices.gov.mt/DownloadDocument.aspx?app=lp&itemid=25883&l=1 (accessed 20 March2014).

[42] In 2010, European Court of Human Rights found Malta in violation of Article 5 §§ 1 and 4 of ECHR in Louled Massoud v. Malta where the migrant was detained for more than 18 months. Louled Massoud v. Malta. Available from http://hudoc.echr.coe.int/sites/eng/Pages/search.aspx#{"languageisocode":["ENG"],"respondent":["MLT"],"documentcollectionid2":["GRANDCHAMBER","CHAMBER"],"itemid":["001-100143"]} (accessed 21 March 2014).

Some indications are particularly related to health, as the Centre is requested to adapt a code of conduct for residents so as to maintain an orderly, safe and *healthy environment,* and to maintain regular contact with the respective public authorities regarding health issues, or liaise so as to promote and safeguard the health and social welfare of the residents. During the field visit, the assessment team was informed about the support of the infectious disease department of the MoH requested by the manager of the centre in case of fear of possible infectious disease(s) among the residents.

Subsidiary legislation 217.17 (Article 6 (2.a)) entrusts AWAS with the task of overseeing the daily management of accommodation facilities either directly or through subcontracting agreements. There are mainly three types of **management models** for the open centres:

I. Managed directly by AWAS
II. Subcontracted to a Non-Governmental Organization(NGO) by AWAS
III. Managed by NGOs

Table 4: List of Open centres in Malta

Location/Name[43]	Targeted population	Management model
Hangar open Centre, Hal-Far	All	I
Tent village open centre, Hal-Far	Single males and families	I
Dar il-Liedna	Unaccompanied minors and families	I
Dar is-Sliem	Unaccompanied minors	I
Dar il-Qawsalla	Families	I
Hal Far Reception centre	Single females	I
Marsa Open centre, Marsa[44]	Single males	II
Good Shepherd Home, Balzan	Mainly vulnerable individuals	III
Peace lab open centre[45]	Single males and families	III

Source: IOM Equi-Health project.

Malta has nine open centres with Marsa, Hal-Far Hangar and Hal-Far Tent village open centres being the bigger ones (with capacity of up to 550 migrants). Notwithstanding, a higher number are often accommodated in the centres depending on the number of boat arrivals and subsequent release from detention centres. This essentially leads to overcrowding conditions.

[43] Some of the open centres are currently undergoing renovation works.
[44] More information available from www.fsmmalta.org/projects-fsmm/moc-home (accessed 26 December 2013).
[45] More information available from www.peacelab.org/services.htm (accessed 26 December 2013).

According to the interviewees, in case of "health incidents" at the centre, Standard Operating Procedures are indicated in AWAS manual of procedures namely Health Section on pages 8, 9, 10 in Interventions w/adult service users residing in AWAS open centres standard operating procedures (SOP), Procedures for Issues of Self Harm SOP and Incident Report SOP.

Open centres are temporary accommodation facilities: migrants sign a contract known as the **integration contract** with AWAS, which enables them to live in the open centres for up to one year provided that they fulfil certain conditions such as signing a register three times a week,[46] keeping the premises clean, and contributing to the running cost of the centre (if they are working). Migrant can request an extension of the contract from AWAS, which is then evaluated on a case-by-case basis.

If migrants fail to sign the register three weeks in a row, they lose their place at the centre and the related subsistence allowance (Table 5). All migrants living in the open centres receive a subsistence allowance from the government depending on their protection status. **The allowance is supposed to provide for migrants' daily needs other than accommodation.**

Table 5: Subsistence allowance based on migrant category

Category	Subsistence allowance (in EUR/day)
Children (under 17yrs)	2.33
Rejected asylum-seekers	3.49
Refugees*	4.08
Asylum-seeker	4.66
Migrant under temporary humanitarian protection/subsidiary protection	4.66
Single parent	4.66

*Entitlement until the social security payments come into force.
Sources: IOM Equi-Health project based on Anecdotal evidence and The People for Change Foundation (PCF). "Housing asylum-seekers"; p. 34–35.
www.pfcmalta.org/uploads/1/2/1/7/12174934/housasyseekers.pdf

Food and other basic needs such as cooking gas (Hal-Far tent Tent Village) have to be covered by the migrants themselves. Some open centres (Marsa and Hal Far Hanger Centre) offer free wireless internet connectivity for the residents. Most of the centres provide one meal per day which meets the meal requirement for half of the residents. The justification provided by the open centre management is that the migrants receive subsistence allowance which should be used to buy food. The one time meal served at the open centres is served on a first come first serve basis and there are no preferences for women, children or vulnerable individuals.

[46] If a migrant is working, it is assumed that he/she will miss the opportunity to sign the report which usually happens during noon time.

I.III Entitlements to health care; health service provisions

Asylum-seekers are granted access to free State medical services under the Refugees Act article 13(2).[47] However if they have sufficient resources, they are required to cover or contribute to the health care costs.[48] Asylum-seekers in detention are exempted from the latter and are to receive free health care service in detention.[49] **There are no legal regulations or law granting access to health care** for **irregular migrants** (Cuadra, 2010; HUMA, 2011). However, the non-legally binding 2005 policy document establishes free access to state health care services for all foreigners in detention (MJHA and MFSS, 2005a:12). Pregnant women and minors also enjoy free access to health care services. Minors are additionally fully vaccinated as stipulated by Maltese law.

The absence of a legal framework that clearly differentiates the groups of migrants and/or that specifies access to health care for undocumented migrants in practice creates room for arbitrary interpretation of this entitlement, which eventually affects asylum-seekers and refugees population. Moreover, pharmacies do not have clear indications as to what kind of medicines should be made freely available to migrants. Normally, medicines are free as long as they are procured in a government pharmacy within the health organization.[50] This created situations where migrants paid for medicines to which they had free access. For example, similar to the Maltese, migrants have to pay for some medicines such as antibiotics. However, during the assessment it has been noticed that migrants believe that they are being discriminated against, as they are unaware that Maltese citizens also have to pay for this kind of medicines. AWAS has reportedly held a meeting with the pharmacies and clarified the various entitlements for migrant groups.

I.IV Discussion Section - I

Vulnerability Assessment

The 2005 policy document (MJHA and MFSS) states that vulnerable individuals such as unaccompanied minors, persons with disabilities, families and pregnant women are not to be detained. However, **almost every migrant, including vulnerable individuals, pass through detention since vulnerable individuals are mainly identified in detention**. Visible vulnerabilities such as physical disabilities, serious injuries, pregnancy, age (minors and elderly) get identified faster. Psychological problems, traumas and torture victims might not be readily identified which results in these vulnerable individuals being detained in conditions which are detrimental for their health. **Moreover, there is no time limit set for the vulnerability assessment**: this on the one hand keeps open the possibility to detect a vulnerability that occurs after detention, and on the other hand it often takes longer periods while the migrant is detained. The assessment team noticed that there is **no systematic assessment of victims of torture or trauma**; however

[47] Refugees Act, Article 13(2): An applicant for asylum shall have access to state education and training in Malta and to receive state medical care and services.

[48] See Article 11(4) Subsidiary Legislation 420.06. Reception of Asylum Seekers (Minimum Standards) Regulations. Available from http://justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=10662 (accessed 2 March 2014).

[49] Ibid: See Article 12(6.d).

[50] In Malta there exists a positive discrimination as migrants are entitled to free medicines even if they are working (not valid for Maltese).

interviewed physicians noted the large numbers of those coming via Libya had suffered serious abuse.

After the first screening upon arrival, which usually focuses on cases of visible vulnerabilities, the responsibility to identify vulnerable migrants is left to a number of actors who are in contact with migrants during the detention: DS, NGOs, health professionals. However, none of them has a/the referral of potential vulnerable cases to AWAS as a specific role; b/ enough competences to monitor and assess possible vulnerabilities. A second bottleneck, indirectly related to the first one, is adequate and impartial staff available to perform the (vulnerability) assessment which also impinges the assessment process.[51] Considering the number of activities under the responsibility of AWAS relative to the number of staff, **the assessment team found AWAS staff, in particular social workers, to be overstretched**, this putting under pressure the entire reception process.

While AWAS representatives indicated the risk of counting all migrants as vulnerable and to label them as vulnerable if a systematic assessment is conducted, CSOs instead underlined the importance of such a vulnerability assessment.

"There should be a proper screening for vulnerability, not trusting that people will deteriorate so badly and someone will notice and then they will be referred… When somebody is at the point of breaking down, then someone come and say that you can go out or after they have already entered the Mount Carmel (mental hospital). I always feel that as the major shortcoming in detention… there should proper screening by professional and not trusting the soldiers or DS to somehow realize who is vulnerable and even with NGOs, because it is not systematic ...they won't go through everyone and see that they are not vulnerable people …it is like if you come to complain to me, I will help you. But who will be concerned about the people who will not come? Who just stay in their bed all day long and nobody will notice."

(CSO)

Unaccompanied Minors

The assessment is of particular importance especially whenever it applies to a minor, as illustrated below:

"I spent 4 months in detention. They came after 2 weeks [since detention] and they needed to do a few tests to make sure that I am a minor. It was not just me, there were a group of people who declared themselves as minors."

(Migrant)

The age assessment procedure applied in Malta is to be considered as **one of the most advanced in Europe, as it is based on a psycho-social approach and uses the x-ray test as last resort.** However, for age assessment, the procedures can take several months especially when a high number of minors arriving to the island. According to the Asylum Information Database (AIDA,

[51] A recent agreement between the Department of Counselling at the university of Malta and AWAS will allow having a final year student on the team.

2014), other improvements may include adequate procedural guarantees, including information about the procedure and the possibility of appeal.[52]

An unaccompanied minor detained with non-relative adults poses a huge threat to his/her safety, health and wellbeing. This has been a particularly acute issue especially in 2013,[53] when a large influx of minors arrived in Malta, a trend continuing in 2014. Indeed, even if allocated in open centres, there were no possible solutions to keep these children other than in reception centres with adults, this being not an ideal scenario. It should be stated however that the Reception Regulations concedes that "an unaccompanied minor aged sixteen years or over may be placed in accommodation centres for adult asylum-seekers" (L.N. 320 of 2005, art. 15). This provision is a **de facto lowering of the threshold for the age of a minor** and poses 16-17 years old under a higher risk of exploitation and abuse, by depriving him/her to the protection assured to a minor.

After the recognition of their minor age, AaM are released from detention and transferred to open facilities. In Malta, there are only two of such facilities dedicated to unaccompanied minors (Dar is-Sliem and Dar il-Liedna), with an overall capacity of around 50 children. **The places available are not sufficient to accommodate the number of unaccompanied minors in Malta.**[54]

Information on Health entitlements

For the migrants and the service providers, there is a lack of clarity in various entitlements and provisions available for migrants. This creates confusion among both the groups. It is important that migrants are made aware of their entitlements so that they could avail those services and prevent arbitrary or misinformed actions from the service providers.

[52] During the 2NCC has been reported (AWAS) that as of March potential minors are immediately transferred to tailored facilities.

[53] In March 2014, the Prime Minister and the President have made public statements on the situation of unaccompanied migrant children indicating that should not be kept in detention, not even for one day. Positive developments were registered in the following months which lead at the end of April, to a joint mission IOM-UNHCR hosted by the Prime Minister to address the situation of UAMs in Malta after which both made public statements committing themselves to a higher level of support. In May 2014, a joint IOM-UNHCR report: "*Unaccompanied Migrant and Refugee Children: Alternatives to Detention in Malta*" was launched summarising the findings and recommendations from the joint IOM and UNHCR technical mission. Available from www.iom.int/files/live/sites/iom/files/pbn/docs/Unaccompanied-Migrant-and-Refugee-Children-Alternatives-to-Detention-in-Malta.pdf

[54] Recently, spaces for UAM increased from 50 to 150.

II. PARTNERHSIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

II.I Description of the reception process and coordination

The issue of migration management is so complex and multifaceted that it requires a holistic approach and strong coordination between the different government ministries. Indeed, presently, several government ministries are dealing with different dimensions of immigration in Malta. The **Ministry of Home Affairs and National Security** is the lead policy department for all issues to do with irregular immigration. The Commissioner of Police is the Principal Immigration Officer. This Ministry is also responsible for and therefore finances the open and closed centres where the migrants are being housed. Some of the open centres are run by NGOs in partnership with the government. The **Ministry of Foreign Affairs** also has a central role to play since it deals with all repatriation and foreign policy issues affecting immigration. The **Ministries for Energy and Health, Ministry for the Family and Social Solidarity**, and the **Ministry for Social Dialogue, Consumer Affairs and Civil Liberties** are responsible for the provision of medical and social benefits, and housing of immigrants. Finally, the **Ministry for Education and Employment** is in charge of providing educational programmes for migrants, as well as for regulating employment of immigrants in Malta.

The assessment covered all the phases of the reception process, identified as the following: rescue at sea, disembarkation, transfer, permanence in a centre, release/integration (Figure 1).[55]

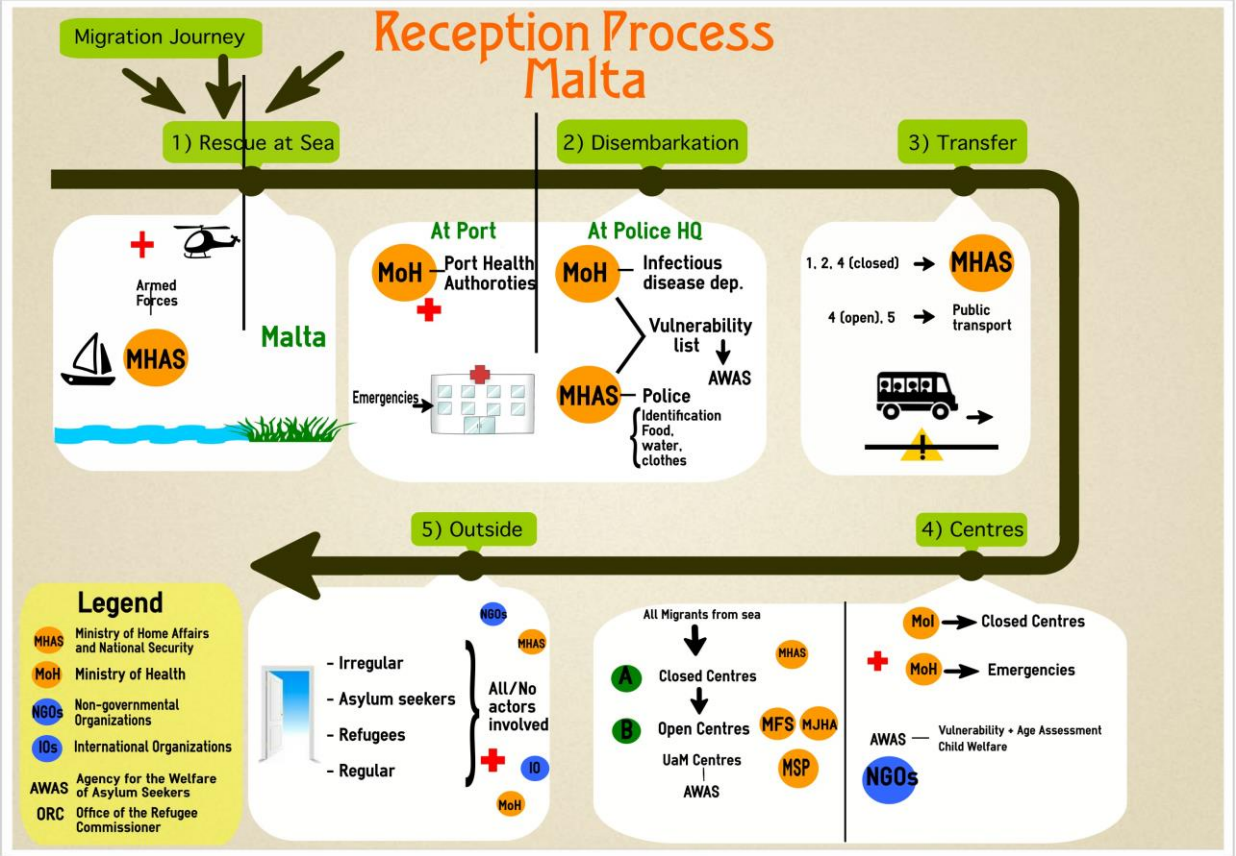
Search and Rescue

Since the majority of irregular migrants arrive in Malta on boats, a typical reception process starts when irregular migrants are intercepted and rescued in the Mediterranean Sea by the maritime squadron of the Armed Forces of Malta (AFM). AFM, along with other authorities such as the Italian Navy and Coastguard plays a major role in responding to search and rescue (SAR) requests in the region.[56] This is the first phase of the reception process. AFM intercepts the migrant boats as part of their normal patrolling operation or a search and rescue operation based on requests from private ships, migrants or other relevant authorities. Migrants are usually rescued due to unseaworthy boats or bad weather conditions. An initial health screening is done by the AFM on board the rescue vessel and in case of medical emergencies, the crew is in contact with the hospital via telephone and for particular cases, a helicopter will be requested to accompany the person to the closest safe port, according to the principle of non-refoulement. Once on board of the rescue vessel, they are provided with the basic needs: food, water, blankets. Migrants are then handed over to the Immigration police of Malta at the Hay Wharf port.

[55] The last phase will be covered in details in another component of the Equi-Health project dealing with access to health care.

[56] Search and rescue in Malta: www.sarmalta.gov.mt/sar_in_Malta.htm (accessed 10 March 2014).

Figure 1: Reception Process, Malta



Source: IOM Equi-Health project.

Migrants arriving on boats from North Africa often intend to go to Italy (mainland Europe). However, when caught in bad weather conditions or due to unseaworthy boats, they often require rescue by the maritime squadron of the Armed Forces of Malta (AFM) and therefore unintentionally arrive in Malta.

"I prefer Italy or any other European country much more than Malta...I was in Libya when I heard Malta existed. I never knew where Malta was. So I never thought of coming to Malta."
(Migrant)

Some of the migrants interviewed reported not receiving anything except water while on board the rescue vessel. Some of the migrants also said that the rescue operations might take a while to start even when the rescue vessel (AFM's rescue vessel or a private vessel requested by the authorities to assist in the rescue operation) is on site. This delay was reported to have caused losses of life as explained below:

"We asked them (a private cargo ship) to rescue us. They said they can't rescue us. We pleaded and pleaded and pleaded … we said we needed water…. We waited there for almost 30 minutes before they even started to make any attempts and for that 30 minutes people were dying there. They threw their ladder to take some people. Some [migrants] trying to take the ladder fell into the water. We lost so many lives there. We spent a night on their ship before the Maltese authorities came and took us to Malta."
(Migrant)

Disembarkation

During this phase of the reception process, the Immigration Police are responsible for the migrants. A doctor from the MoH public health department will be present at the port to perform the initial medical screening, performing an initial triage. Any acute health conditions identified during the screening are transferred to Mater Dei hospital. Depending on the condition of the migrants on the boat, crew on board the rescue may send request[57] in advance to the emergency support team at Mater Dei hospital. In such an instance, the emergency team would be already present at the port and at the hospital a major disaster protocol will be activated for large influx of patients. After the initial medical screening, the migrants are transferred to the police headquarters for the identification process.

At the police headquarter, basic information such as name, country of origin, and fingerprints for EURODAC[58] database are collected. During the interview there is a glass window separating the migrant and the police officer, as a precautionary medical measure. The migrants are given a booklet titled "**Your entitlements, responsibilities, and obligations while in detention**" (hereafter named "booklet").[59] It also contains information about the asylum process in Malta, such as the meaning of the Dublin regulation, the fact that the asylum-seeker must apply for asylum *within two months* of the applicant's arrival in Malta.

Once the police have collected all the required information, another round of medical screening is done by a team of personnel from infectious disease prevention and control unit. Any medical condition which requires immediate medical care is transferred to the hospital upon doctor's recommendation. The migrants are provided with food (usually a sandwich) and water. A limited number of toilets and showers are available for the migrants to use and there is also a playroom available for children.

The police send a list containing the number and type of migrants (including the details of identified vulnerable individuals) to the ORC, AWAS, and UNHCR. Before being transferred to the detention centres, migrants have to submit all their documents and other valuables including mobile phones and passport to the police and are in turn provided with a receipt. They are allowed to borrow their passport while applying for asylum at the ORC. During the assessment this has been indicated as a problem by the migrants, as it might take some time before they can access their documents in order to apply for asylum.

The entire process, data collection, medical screening and provision of food, is organised similar to a **factory assembly line** with a high level of coordination and inter-sectorial cooperation among health professionals and law enforcement officers. The process takes around 2 hours. Migrants are then transferred from the police headquarter to the detention centres.

There are no interpreters, mediators or NGOs present during this phase. Police personnel reported that migrants spoke basic English, Arabic or Italian and this helped them to overcome the language barrier at this stage.

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[57] In any case the crew inform the competent health authorities about the composition of the rescued boat.

[58] For more information on EURODAC, please see at: https://secure.edps.europa.eu/EDPSWEB/edps/lang/en/EDPS/Dataprotection/Glossary/pid/75

[59] Available in English, French and Arabic.

Detention/Open Centres

At the detention centres

Malta has two detention centres, namely Lyster and Safi barracks.[60] Together, they have a 950 bed capacity.

Personnel from the ORC visit (usually within 2 weeks of the arrival) the centre and provide information about asylum process and help the migrants, who wish to apply for asylum, to fill a preliminary questionnaire (PQ) through which they express their wish to apply for asylum. Migrants who have filled the PQ are called for an interview by the Refugee Commissioner where they can apply for asylum. If the migrant falls under the Dublin regulation the case is managed by the immigration police and the migrant is sent to the responsible member state under the regulation. Detainees usually get their first decision within 6 months. They are released from detention as soon they are granted a protection status (refugee/subsidiary/temporary). If they have not received an answer to their application, they will be released from detention after 12 months.[61] In case of rejected applicants, release from detention occurs after 18 months, as it is the case for irregular migrants. As described earlier, AWAS assess vulnerability and identified vulnerable migrants will be released to open centres after ORC's approval. Since 2007, medical services within the detention centres have been outsourced by the Ministry for Home Affairs and National Security with two tenders (one for doctors and one for nurses) (CPT, 2013:28; UNHCR, 2013a:7).

The booklet indicates that migrants are entitled "*to a safe and well-managed admission and discharge process at the closed accommodation centre, which will treat you with respect and regard for your immediate well-being and will record essential information about you'* (art. 15). Migrants are also entitled to '*varied and nutritious food, taking account, in-so-far as local food availability allows, of religious, cultural and medical needs, while also complying with relevant food, health and safety legislation"* (art. 17). The assessment team has indeed noticed the practice of the black board at the entrance of the structure, where particular diet where indicated for specific cases, including for health-related aspects.

In relation to hygiene and health care, the booklet describes a combination of rights and duties of the hosted migrants (Table 6).

Table 6: Hygiene and Health Care at Detention

	Rights	Duties
Hygiene	*You are entitled to living conditions that are hygienic and are provided with basic toiletry requirements. You are entitled to regular bath or shower facilities* (art. 24)	*You are obliged at all times to have proper regard for personal hygiene in your own interests and that of others. You are to ensure that you keep your accommodation clean and tidy*

[60] Previously, there were three detention centres of which one has been closed recently.

[61] The average period has been indicated as around 10 months from CSOs, around 6 months from government representatives, while still 12 months from migrants.

		and in a proper condition and to avoid committing any damage to it. You are obliged to contribute your part in the up-keep, tidiness and cleanliness of the closed accommodation centres (art. 32)
Health Care	*You are entitled to the same range of medical services as the Maltese citizens receive from the Public Health Service. You are entitled to have access to qualified medical and nursing personnel. You are entitled to expect that matters relating to your health care will be treated in confidence and in a sensitive manner* (art. 25)	*You are obliged to follow the advice and take any treatment recommended to you by the medical staff who assist you if you are unwell, and to ensure that you do not indulge in any self-harm or do anything that may require unnecessary medical attention* (art. 33)

Source: IOM Equi-Health project on booklet "Your entitlements, responsibilities and obligations while in detention".

It is at this phase of reception that NGOs and other International organizations meet the migrants for the first time during the reception process. UNHCR offers its assistance in terms of information on their rights and asylum seeking process. Jesuit Refugee Service (JRS) has a regular presence at the detention centre, providing legal assistance to the migrants mainly by referring their case to the concerned authorities. Other NGOs such as Integra are also active in the detention centres. They provide English lessons to the migrants in detention and have developed a library for the detainees at Lyster barracks.

A degrading practice noted by the assessment team was the use of handcuffs while the detainees are taken to the hospital from the detention centres. Since there are no formally established channels for interpretation, a fellow detainee, who will also be handcuffed, could be requested to accompany the DS personnel to the hospital. One migrant described the experience as follows:

"Whenever you want come out [from detention], they are going to tie [handcuff] your hands… I used to be an interpreter [while detained], to help people who are taken to the hospital from detention centre. So whenever I was taken to the hospital for translation, my hand was handcuffed to the hand of the patient. So it was like... I was feeling like I was in prison."
(Migrant)

Another degrading practice highlighted by the detainees and the health professionals at the hospitals was the use of ID numbers instead of names to identify migrants. Migrants in detention considered it to be humiliating and expressed their desire to be called upon by their names.[62]

[62] The Committee for the Prevention of Torture (CPT, 2013) already reported this to the Government of Malta.

At the open centres

After the permanence in the detention centre, which varies in relation to the specific case,[63] AWAS is responsible for the transportation of migrants to the open centres from the detention centre. When released to open centres, migrants receive an ID card for administrative purpose, as no rights are attached to it but it is used for registration purpose and requested to access health-care services. AWAS allocates migrants to open centres depending on the availability of space and the condition of the particular migrant. For example, a limited number of vulnerable individuals (due to limited capacity) are allocated to the Good Shepherd convent in Balzan whereas a majority of the single women are accommodated at the Hal Far reception centre.

As soon as the migrants are transferred from detention centres to open centres, AWAS conducts information sessions about basic hygiene, their rights and entitlements and basic information about the centre. The interviews with migrants, however, highlighted that migrants find it difficult to understand this presentation mainly because of language barriers, and that they find the session not very informative as most of what was being communicated was perceived as inconsequential (formalities like the name of the centre's manager, the centre's organization, etc.) UNHCR and other NGOs also conduct information sessions on various educational and other services available for the migrants in Malta.

The open centres mainly provide accommodation only, with the exception of open centres for unaccompanied minors, where food and opportunities for schooling are provided. The approach applied in all the open centres is based to the intent to instil a sense of responsibility among the guests, to foster their contribution to the well management of the centre and, especially in the case of UAM, to promote their autonomy. They are therefore expected to contribute through cleaning (if not they have to pay a penalty of EUR 5) and cooking, and by behaving in a respectful way towards others (violence can lead to expulsion from the facility).

NGOs provide information sessions and occasionally conducts educational sessions for migrants. However, the majority of services are offered outside open centres. These services are not always easily accessible since migrants need to use public transport to reach them. A CSO representative commented as follows:

"I think there are lot of issues in the open centres in terms of the location of where the centres are, it is very difficult for people that live in Hal Far to access English lessons which might be in the evening in Floriana. Transportation is an issue. It more difficulty for the single women to do that journey ...or families with children. Actually lot of people have difficulties in physically leaving the centre and access all the services that are available."

(CSO)

Usually migrants move out of the open centres to the community after living in the open centres for a year.

[63] See first pillar.

Outside in the community

The reception process up to the open centres is quite clear. However, once the migrants leave the open centre and start living in the community the rules and various entitlements for the migrants are not clearly known to the migrants and the personnel working with migrants. One CSO representative explained it as follows:

"…. What is unclear is what happens after [the open centre? ...let us say there is a particular incident ...somebody might have a tooth problem or somebody might have chest pain, finding the correct person to speak about the entitlement, whether they should be provided free medicine or not, that is sometimes a lot of phone calls and checking with a lot officers and hoping you find the right person and hoping that the person you speak to is bit sympathetic to refugees because that also sometimes decides whether the person gets help or not."
(CSO)

Some migrants choose to move to other member states and some others get relocated to other member states, Norway, Switzerland, or the United States of America through the relocation programmes carried out by UNHCR and IOM. Migrants in irregular situation continue to live in the community without any protection status or documents which would enable them to travel. Some of them will eventually be deported forcefully or through assisted voluntary return programmes.[64]

Migrants living in the community often face difficulty in finding accommodation and jobs, which is also one of the reasons why they apply for relocation. They attributed this to language barriers and some discriminatory practices. One migrant explained this as follows:

"I moved from the open Centre and started to live with my friend. But that place was bit far and I wanted to find a new accommodation. There were advertisements in the newspapers and I contacted them. Most of them...when they ask me 'where are you from? and I tell them that I am from Somalia, they refuse to rent me their place."
(Migrant)

In recent publications (UNHCR 2013; PFC, n.d.) it is similarly observed that **migrants face discriminatory practices while seeking employment and accommodation.** Migrants with some form of protection status receive social security benefits from the Government. According to AWAS data, since March 2012, 2940 persons have made social security applications. During the assessment it was reported that migrants are often not able to make full use of the benefits due to the eligibility requirements, especially a valid address.[65] One CSO representative explained it as follows:

"… to get the social security benefits, it was a very big hassle…because normally to get social security, you already need to live in an address where you are living by yourself, but how are you going to get that address when you don't have the benefit?" **(CSO)**

[64] A list of return programmes operated in collaboration with the Government of Malta. Available from https://secure2.gov.mt/fpd/file.aspx?f=9059 (accessed 10 March 2014).

[65] For more information on housing for migrants in the community, please refer to "Housing asylum-seekers". The People for Change Foundation. Available from www.pfcmalta.org/uploads/1/2/1/7/12174934/housasyseekers.pdf (accessed 15 March 2104).

During this phase, there is a lack of policies and programmes focused on the integration and support of migrants living in the community which eventually means migrants with or without a protection status. A CSO representative illustrated the issue as follows:

"We have examples of rejected migrants who open business in Malta, marry Maltese people, sometimes speak Maltese and English at a much faster rate than those with protection…but with this constant fear that they might be returned any time...without any integration any programme available there is no distinction between individuals with different protection status or an irregular migrant."
(CSO)

II.II Public health in border communities

The Maltese health care system offers universal coverage and is based on the Beveridge model of health financing, as it is primarily funded through taxation. The health system operates through integrated health services that are organised at a national level. In 2010, Maltese women had the highest healthy life years,[66] and mortality among Maltese men is among the lowest in Europe (OECD, 2012:16, 20). However, mortality rates arising from Ischemic heart diseases are high in Malta. Mortality rates arising from other non-communicable diseases and suicides are low in Malta when compared to other European countries (OECD, 2012). Human Immunodeficiency Virus (HIV) incidence is below EU27 average, whereas Acquired Immunodeficiency Syndrome (AIDS) incidence rates are slightly above EU27 average. Furthermore, the prevalence of diabetes and obesity among adults in Malta were above the EU27's average in 2010. There were 3.1 practising doctors and 6.5 practising nurses per 1,000 population. Sixty five per cent of the health financing for the Maltese came from the Government and the rest through out of pocket and private insurance payments (OECD, 2012). The latter is a voluntary system, which provides supplementary financing and does not replace any mandatory statutory contributions.

All Maltese nationals receive vaccination against diseases such as tuberculosis, hepatitis B, measles, mumps, rubella, human papillomavirus infection.[67]

The Disease Surveillance Unit, which falls under the Public Health Directorate at the Ministry of Health, is responsible for the surveillance and control of infectious diseases.

As also confirmed in a recent study (Padovese et al., 2013), the IOM assessment team did not observe or was not made aware of any major epidemiological threats related to the various groups of migrants in Malta. However, some among the general public still believe that the

[66] Healthy life years HLY is a measure of disability-free life expectancy which indicates how long people can expect to live without disability.

[67] For more details please refer to http://vaccine-schedule.ecdc.europa.eu and https://ehealth.gov.mt/HealthPortal/health_institutions/primary_healthcare/the_primary_child_health_and_immunisation_unit/the_schedule.aspx

migrants are a threat to the public health.[68] The health authorities partially attributed this to the media expressing the concern that the **media tend to over emphasize** migrant health issues, which may cause fear among the locals.

The Maltese President's message for Christmas 2013 published in newspapers was that "***Irregular migrants are a resource, not a threat"***.[69] Newspapers articles about migrants usually receive both positive and negative comments from the readers. However, the majority of the comments consider migrants as a burden to the Maltese economy. According to CSOs, however, it has to be noticed that there is not a specific policy on what people can and cannot comment, nor the comments can be flagged by other readers saying this is inappropriate or request the moderator to look at the comment. People who choose to comment are often the people with strongest ideas, not necessarily the most informed, while the people with moderate opinion don't usually comment and write on comment boards.

Although in Malta there continues to exist some resistance of migrants, the assessment team generally found a widespread sense of welcoming acceptance by the health professionals interviewed.

"Migration is a social problem, not for us but for them. The fact that they go through the all process with the possibility of danger, dying, etc. and still do it, I believe they are doing it because they can't do otherwise. So we are obliged in a human way to help."
(HP)

II.III Discussion Section - II

Medical Assistance

All AFM crew members engaged in the **rescue operations** are trained in first aid techniques. However, there are no dedicated medical personnel on board the rescue vessel. There have been situations where the AFM personnel had to deliver a baby on board the rescue vessel based on telephone instructions from a doctor.[70, 71] This creates a situation where the migrant's health and

[68] Maltese newspaper articles reporting events related to migrants. Please refer to the readers comment's section of the articles to get an idea about the public discourse on immigration in Malta. See at: www.independent.com.mt/articles/2013-06-27/news/700000-investment-in-public-health-1931739137/ www.timesofmalta.com/articles/view/20130627/local/new-facilities-to-screen-migrants-for-tb.475657 www.independent.com.mt/articles/2013-07-05/news/pm-will-definitely-consider-using-veto-to-obtain-eu-help-1995964420/ www.timesofmalta.com/articles/view/20130709/local/government-considering-sending-migrants-back-to-libya.477273 www.maltatoday.com.mt/news/world/37090/italy_rescues_over_2000_migrants_in_48_hours#.UyrE-j9dXTo www.independent.com.mt/articles/2013-07-23/news/malta-fines-33000-after-detention-facilities-complaint-2145026048/ (accessed 20 December 2013).

[69] See at: www.independent.com.mt/articles/2013-12-24/news/irregular-migrants-are-a-resource-not-a-threat-president-abela-in-message-for-christmas-3536715776/

[70] See at: www.timesofmalta.com/articles/view/20120115/local/68-migrants-being-brought-to-malta-after-rescue.402307#.UrwYNtJDvTo (accessed 26 December 2013).

[71] Baby born on migrants' boat airlifted to Malta, *Times of Malta*. Available from www.timesofmalta.com/articles/view/20090812/local/afm-airlifts-baby-mother-to-hospital.269180#.UrwYQNJDvTo

life might be in danger and where there is increased pressure and stress on staff. This is highly important considering the reports of delayed rescue operations[72] whereby the medical condition of a migrant could worsen before the arrival of the rescue team.

Some issues related to provision of medical services/facilities continue in the next phase in the reception process, namely **disembarkation**. Though basic medical services are to be made available for the migrants at the port, one of the main difficulties indicated by the medical personnel was that there was lack of privacy to perform the initial medical examination onsite at the port. This was further corroborated by migrants. However the emergency team at the Mater Dei hospital, who provides emergency services at the port, reported the availability of a room at the port to set up the equipment for emergency services.

At **detention centres**, medical assistance is outsourced to private entities, while being financed and supervised by MHAS. This creates discontinuity of care assistance[73] and of responsibility from the health sector to the security / immigration sector and might pose risks to the independency of the health professionals contracted within the detention centres. Coordination among a number of actors involved in the reception of migrants (DS, private entities, public health system, AWAS) is subject to improvement, especially in relation to specific competences to be performed by each actor.

No medical services are provided at **the open centres**; migrants have to access health services at the primary health centres or Accident & Emergency Department. This is often mentioned as being problematic mainly due to **the lack of transport,** especially for open centres located far away from the city (Hal-Far).[74] The **concept of space** therefore seems to be differently perceived by Maltese and migrants: for the former, Malta is a small country and this allows a rather smooth coordination and relatively fast transportation, while migrants – who can rely neither on the network nor on their own transportation – find Malta extremely expensive and difficult to get around in.

Unclear information

One of the outcomes of the focus group discussion with NGO representatives was the importance for Malta to draft legislative references regarding the various services available for migrants. The 2005 policy document only provides guidelines which are leading to confusion or differential treatment for migrants from the authorities since this remains a generic document without more specific information on the application. Also health professionals reported a lack of coordination[75] between various authorities which results in unclear information and confusion among the staff working with migrants. Unclear information affects three levels:

- Those who should provide a service do not know the entitlements of different categories of migrants;
- Staff of the centres or NGOs do not know to whom refer for the service they would like to have;

[72] Please refer to footnote no. 16.

[73] Please see as well data collection info.

[74] This was similarly highlighted in an International Catholic Migration Commission (ICMC) report on the condition of migrants in Malta (2011:124).

[75] This was also highlighted in ICMC report (2011) and recent report from the NGO Aditus and UNHCR (2013).

- Unclear information are indicated to migrants/migrants do not understand the procedure.

To further explain this trilogy, one of the health professionals said that it is common that staff members from open centres call different offices in order to obtain information or to avail of a service. Imprecise information also affects the services offered to migrants. The following quote highlights such an issue:

"We do have a major problem of people not understanding asylum in Malta...This also comes out to the frontline offices. If somebody [a migrant] is in front of them, they don't know what service they should provide to that person. They don't understand their status. They don't know what kind of distinctions they should be making…for example…the umbrella organization that takes care of (a specific service) these operations made a decision to offer it to all migrants; everybody would be treated the same. [However]One of the managers at a centre who provide this service recently admitted that she had been turning away a lot of people and only accepting people with refugee status, because she thought the service was only for the refugees not for temporary or subsidiary protection."

(CSO)

Role of NGOs

NGOs play a major role in providing various types of services and assistance to the migrants (ICMC Europe, 2011; Durick, 2012). As highlighted in a recent report (Aditus, 2013), cooperation between NGOs and government mainly remain ad-hoc. In some cases, NGOs are not supplementing the exist services, rather they are providing essential services, such as legal assistance in detention or organising activities at the open centres.

However, this raises questions about the **sustainability and regular availability of the services**. According to the NGOs, they were forced to provide services for the migrants since the responsible authorities were not doing so.

"…it shouldn't be us; we are doing it [to provide services to migrants] because no one else will do it…but it is not our responsibility. We would like to see it to be done by the state as structured system to ensure that there is continuity because even the system which is existing now goes through the NGO staff and then through AWAS….There have been huge gaps between one project and the other during which no one was (providing the service)."

(CSO)

Most of the NGOs in Malta are local NGOs and lack human and financial resources. NGOs find it difficult to acquire funding from bigger funding agencies such as the European Refugee Fund (ERF). They find the application process too complicated and hindered by 'red tape'. They often reported the need to employ a financial administrator, who they cannot afford, to prepare an application and run the project according to the donor's financial constraints. They found the initial financing, which needs to be taken from their own budget till they get the first instalment from ERF, to be too heavy for them to afford.

There needs to be more coordination between the NGOs and the Government. This would be beneficial for both the parties and would result in better services for migrants. For example,

programmes/activities organised by the NGOs could be adopted by the Government or the Government could create an agreement with the NGOs to continue these activities.

III. MONITORING MIGRANT HEALTH

III.I Migrant health

The main health concerns for recently arrived migrants were severe dehydration, salt/petrol burns which happened during the boat journey, heat stroke and other injuries, and trauma incurred in Libya or on the boat. The health professionals otherwise considered the health issues reported by the migrants similar to those of the Maltese population. These facets of migrant health support the healthy migration theory.[76] Their health often deteriorates during their stay in transit countries such as Libya (JRS, 2014), during the boat journey and during their stay in detention and open centres where there is lack of proper support.

"Just like everybody [Maltese] else, the common things. There isn't anything special with any nationalities. It is the same. They have problems with the diet. They start to have problems with constipation because our diet is different."
(HP)

The Department of Health (DH) recognised the need to specifically address the health of the migrant population and therefore established a **Migrant Health Unit** within the DH and under the department of primary health.[77] The main objectives of the unit include providing health education for migrants, introducing the Maltese health system and providing translated materials related to health promotion, including healthy lifestyle and prevention, or education session on female genital mutilation or tuberculosis (TB). However, the services provided by the migrant health unit were discontinued for a while in the recent past and only recently reinstated. The assessment team was made aware of plans for the creation of a migrant health hub in Floriana, to allow the best use of human resources devoted to migrants' health.

A recently conducted study by Padovese et al. (2013) reported skin diseases and respiratory diseases as the most widely diagnosed conditions among migrants living in open centres. Among the 2,216 migrants from open centres who participated in the study, there were only 18 cases of active tuberculosis and two HIV patients: though the incidence of tuberculosis among migrants is higher compared to the Maltese population, it remained low (Pace-Asciak, Mamo, and Calleja, 2013). During 2002–2010, the proportion of total TB cases in Malta from irregular African migrants increased from 33 per cent in 2002 to 72 per cent in 2010; the TB notification rate was therefore 347/100,000 person–years compared to 2.7/100,000 person–years for Malta-born people.[78] Scabies was reported as a common issue among migrants from closed and open centres.

Around 40 per cent of the migrant women, who participated in the study conducted by Padovese et al. (2013), had undergone female genital mutilation. This has great implication on

[76] It is assumed that migrants who make it to Europe after a dangerous journey are usually healthy. Unhealthy individuals are less likely to embark upon the journey or perish during the journey.

[77] More info available from https://ehealth.gov.mt/HealthPortal/health_institutions/primary_healthcare/migrant_healthunit.aspx (accessed 20 December 2013).

[78] Data from the ECDC conference "Public health benefits of screening for infectious diseases among newly arrived migrants to the EU/EEA", Athens, 19–20 March 2014, contribution for the Maltese case done by Dr Tanya Melillo.

their sexual and reproductive health since it increases their risk of having health complications such as cysts and recurrent bladder and urinary tract infections. UNHCR reports an increase in women getting pregnant while being detained (2013a:9), while the Government is concerned about reproductive health issues within detention centres. One female migrant said that she became pregnant while in detention specifically because she was aware that vulnerable individuals such as pregnant women were detained for a shorter period.

"If you don't get pregnant you don't leave detention. The only people that leave the detention are the pregnant women, the women that are 70 years old, the children and those that came with children or a health problem. You get to leave in time…otherwise we stay there for 18 months. If you get pregnant while you are there, you come out but if you don't get pregnant, you stay. I stayed in detention for two months, I got pregnant in two months and I told them immediately and the following week they released me. My partner also came out with me."
(Migrant)

For **mental health disorders**, migrants from detention centres are admitted to Mount Carmel hospital. Admitted migrants usually have psychosis, depression and insomnia. There were also attempted suicides in detention centres in which case the migrants are transferred to the hospital for medical assistance.[79] According to the health professionals at Mount Camel hospital, there are mainly three reasons for the migrants' mental health disorders: 1) physical and mental trauma suffered in their country of origin; 2) physical and mental trauma and the exploitation suffered in the transit country (mainly Libya); 3) trauma suffered during the boat journey. They, along with NGO representatives, reported that often migrants who were released back to detention/open centres often reported being stigmatized by fellow migrants for being treated at the "crazy" hospital. A forth reason outlined during the assessment by health professionals and NGOs is the impact of detention on migrants' mental health. One of the CSO representatives explained it as follows:

"I was working in the detention centres before I started working here and my job was to do in-depth interviews with migrants about their reasons why they left and their whole journey and then their current status. I could see a remarkable deterioration in their health…I could see how people change completely and it is a scary experience to actually see it."
(CSO)

Health-care professionals at the hospital also reported that migrants often request not to be sent back to the detention centres since they would like to avoid being stigmatized by fellow detainees due to their ethnicity or sexual orientation. **Around 90 per cent of those who arrive in the hospital do not need any specific treatment**, according to the indication of HP at the mental health hospital, as they mainly suffer from PTSD.

Physical altercations between different groups of migrants are a common problem, especially in detention centres. This has been highlighted in a recent study (DeBono, 2013) and it sometimes led to riots.[80] Some migrants attributed this to the inaction of DS and AFM personnel at the

[79] See at: www.timesofmalta.com/articles/view/20120212/local/Dying-for-freedom.406324#.UrwagdJDvTo
[80] See at: www.unhcr.org.mt/news-and-views/press-releases/729-detention-review-needed

detention centres. According to the migrants, if there is a brawl among detainees, staff members nonetheless wait for everything to calm down before they take any action.

III.II Provision of health-care services and social assistance

As already indicated in the previous paragraphs, the first screening is done at disembarkation where all migrants are screened for emergency cases to be referred to the hospital, and a second screening is done within the policy HQ for any dermatological or infectious disease.

Detention centres

Health care services

Medical services at detention centres are provided by a doctor and a nurse from a private medical provider (UNHCR, 2013a:7; CPT, 2013:28). There are five doctors available to visit both detention centres and 5–6 nurses. The doctor is available on weekdays from 8 a.m.–12 p.m. and the nurse from 8 a.m.–3 p.m. Any health concerns reported after 3pm are either addressed by the doctor on the next day or the migrant is taken to Floriana Health Centre, although this in reality is rarely done. In practice, in case of emergencies, migrants are taken to Mater Dei hospital. In case of mental disorders, the detainee is first referred to Mater Dei and if found to require further care, the patient will be transferred to Mount Carmel hospital where they will be admitted to the Asylum-Seekers Unit (ASU).

During interviews, migrants reported that it might take some time before they were transported to the hospitals by the DS personnel. According to the migrants the DS/AFM personnel wait till the health issue gets severe and intervene only if informed/requested.

"The people here…some are nice and others treat us badly. If somebody is sick, we tell them that one person is sick, they will not take us to the hospital...they wait till it gets severe...when the person is about to die. That is when they take the person to hospital."
(Migrant)

At the detention migrants are all screened for active tuberculosis. The infectious health department carries out an **X-ray screening** for tuberculosis for all migrants at the entry, after 6 months of detention and also before their release. The X-ray machine at Lyster was recently installed as part of an EU funded project and the information are sent directly to Mater Dei Hospital for analysis.[81] Children are screened with a mantoux test, and if required also a chest x ray. Vaccinations against Diphtheria, Tetanus and Polio are provided to all at arrival, while children are given vaccination per the Maltese immunisations schedule. Once migrants are transfer to open centres or released into the community, though DOTS is organised, some challenges arise as they move without informing health or are not at home when the nurse goes. Some do not go to their follow up appointments and stop taking their treatment.[82] Though the Maltese officials reported that all the migrants receive vaccinations, some of the migrants interviewed reported receiving vaccinations only if specifically requested.

[81] Before that date, radiographic examination of the chest was done shortly after arrival and taken at St. Vincent de Paule Hospital.

[82] Data from the ECDC conference 'Public health benefits of screening for infectious diseases among newly arrived migrants to the EU/EEA', Athens, 19–20 March 2014, contribution for the Maltese case done by Dr. Tanya Melillo.

HIV testing is done only if requested or when it is clinically indicated, given the informed consent is obtained (IOM and Department of Public Health Malta, 2007). Treatment is provided to HIV patient.[83]

"If the patient asks, we refer them and they are screened for sexually transmitted diseases. For example we refer anyone with a history of rape and then you would refer certain people because they have a rash on their private parts; so you screen them. They are all not screened, but if they ask me or I think they need, they are referred."
(HP)

On average, every day around 25 people are visited by the doctor at the detention centre. As indicated by health professionals at the detention, migrants mostly suffers from common diseases, such as digestive problems; however HP informed that they have to deal a lot with mental health *"because of the conditions, if you had to lock me up, I will react like that."* There are no formal measures established to provide psychological support for the migrants. Volunteers from NGOs often come and try to provide the much needed support. However this was not enough to satisfy the needs of all the migrants in the detention centre. If the doctor identifies a detainee who requires psychological help, he/she will be taken to Mater Dei hospital. If the problem persists or if the migrant needs further care, he/she will be transferred to Mount Carmel hospital. While NGOs are granted regular access to detention centres, family and friends of the migrants find it difficult to get permission for a visit.

Health professionals working at the detention centre indicated the need for a pharmacy at detention centres. They reported that often migrants at detention centres have to wait a couple of days before the medicines are made available to them.

Social Assistance
NGOs organize and conduct activities such as English classes at the Lyster Barracks. They have also created a library at the detention centre. JRS visits the detention centres regularly with a team of professionals who can provide legal and psychosocial assistance. They have interpreters with them in order to facilitate the communication between the migrant and the volunteers. JRS also acts as focal point for other NGOs to refer cases of vulnerability to AWAS. Other than the limited activities provided by the NGOs, there were none offered by the detention management (ICJ, 2012). The migrants are allowed to engage in physical activities such as playing football for 2 hours a day in the courtyard and are locked up for the rest of the day.

Migrants reported receiving a basic kit containing soap, shampoo, and toothpaste once a month, which according to them is hardly enough. NGO volunteers visiting the centres reported that they frequently provide additional basic personal hygiene items as needed.

Migrants are given a telephone card preloaded with EUR 5 every month. Some of the detainees reported being unable to use these cards since they had all the contact information about their relatives and friends saved on their mobile phone which is kept by the immigration police from

[83] As a general rule, if whenever treatment for a specific disease is not available in Malta, migrants are resettled abroad as it is the case for Maltese.

the first phase of the reception process. There is almost no opportunity for the detainees to contact the outside world, except for volunteers from NGOs.

Open Centres

Health care services

There are no health care services provided at the open centres except for the centre in Marsa. This centre has a doctor once or twice per week *on voluntary basis*. At the open centres managed by AWAS, a public health nurse comes once a week and prepares the medicines prescribed for the migrants during their previous hospital visit.

There are **no proactive measures from the open centre managements to screen for diseases**. This raises severe concerns considering the crowded living conditions, unhygienic toilets and lack of drinking water.

If a migrant reports a health issue or if an open centre staff member happens to notice any health concern, the migrant is asked to go to the hospital. **Residents of the Hal-Far tent village and Hal-Far hangar centres reported that they find it difficult to access the health services at Mater Dei hospital or Floriana Health Centre since buses from Hal-Far to the city were infrequent. Some of them also reported that the buses drive past them without stopping even if the buses were not full and drivers had seen them waiting for the bus.**[84]

Some of the most recurring problems mentioned by migrants are the stress and the difficulty to relate to other migrants, *"no one say 'hi' to you, I prefer to be a numb."* In case of **mental health concerns**, the care workers at the open centres can contact the social workers at AWAS who will come and interview the migrant at the open centre. An evaluation by the AWAS staff member might take time since the open centres are covered only by the three social workers at AWAS to come and assess the specific case. Moreover, mental health concerns might not be readily visible which might cause serious delay in providing assistance in the absence of a regular support. The mental health screening follows the same mechanism as in case of screening for other diseases: it is up to the migrant to request for help.

Some drawbacks in the present system are illustrated through the following example:

"So many people fall through the cracks... like I mean there was a case of a guy last year a Malian guy [a national of Mali. He was shot by the police, he was living in a cave and the police received a report from the public like there is a mad man in the cave. And when the police went there, he attacked them with a knife and the police shot him. He didn't die but he nearly died. And it turned out that he had serious mental health issues. I traced back to the people who knew him and they said he had been in detention, he went to Mount Carmel [mental health hospital] and they then just released him to the community. The guy was obviously so vulnerable and he was living at the open centre but not living at the open centre. No one knew where he was going and what he was doing and suddenly he vanished from the open centre living in a cave. How could he fall so completely through the system? First of all he is released without any assistance and made to live in an open centre with hardly any money." **(CSO)**

[84] This was also highlighted in the HUMA report (2011:89).

Social Assistance

Migrants with protection status are allowed to work in Malta. Migrants whose asylum claims have been rejected can obtain a work permit from their employer. This, however, concurs to create dependency for the migrant on the employer which increases the chance of exploitation. Working migrants do not receive the subsistence allowance. The rest of the migrants receive daily allowance depending on their protection status (see Table 5 above). Migrants could register themselves at the Employment and Training Corporation (ETC) for jobs. However most of the migrants find it difficult to find jobs mainly due to language barriers and mismatch of skills.

There are only a limited number of social activities, such as playing football or watching television, available for the residents at the open centres. One of the open centre managers reported that the TV room at the centre was currently not available for migrants since the room was used to keep clothes and other donations received. Marsa open centre was reported to conduct annual cultural events where residents from other open centres were also allowed to participate. There are no regular educational activities conducted at the open centres except for Marsa open centre where computer lessons are provided. Most of the activities are carried out by volunteers from NGOs and they reported the lack of **spaces conducive** to such events at the open centres. Some of the NGOs reported to have conducted activities in rooms where there was water leakage or in closed spaces with grilled doors resembling prisons. Availability of suitable spaces at the open centres to conduct activities was a major request from NGOs.[85]

There was a **serious shortage in the number of social and care workers in open centres.** There are 6–8 staff members at any given time to provide care for around 550 migrants. Social workers (or *care workers* or *support workers* depending on the centre and the level of engagement/responsibility within the centre) are tasked with helping the migrants to familiarize themselves with the Maltese system. Their mission is to help the migrants to find employment, to support various social activities, and to respond to any other relevant requests.

III.III Data Collection

AWAS is responsible *"to maintain data and draw up reports that are considered relevant for its own function and to provide statistics to appropriate policymaking bodies".*[86] It was reported that consolidated data are present in the hospital's annual report and are further transferred to the responsible Government authorities.

When a migrant is taken to the hospital, DS personnel might be present in the consultation room and therefore could become aware of the detainee's health condition. This is a breach of privacy and of health data and could lead to discrimination against the migrant in certain cases such as infectious diseases. NGO representatives raised concern regarding the **referral/transportation process** from the detention centres to the hospital where the DS personnel can access confidential health information about the detainees' health. NGOs reported that the DS personnel sometimes warn them not to go near a particular migrant since he/she has an infectious disease. This lack of privacy and confidentiality raises concerns since the may lead to improper care and discrimination.

[85] See also (Durick, 2012:32–33) similar examples.

[86] Subsidiary Legislation 217.11 Agency for the Welfare of Asylum Seekers Regulations 6.2 (F).

If migrants have any health problems while detained, open centres, despite lacking health personnel, will receive a copy of the migrant's health information, prescribed medicines and upcoming medical appointments. Files related to health topics are compiled in case of migrants mentally or physically sick and they are kept by the manager of the centre. At Marsa open centre the data collected are related to birth, country of origin, date of arrival, date of departure from the centre.

While visiting the hospital/clinic migrants receive a card which has details about their upcoming appointments at the clinic. Based on the information on the card, care workers at the open centres can remind the migrants about their upcoming appointments. It also happens that the nurse from the clinic calls and requests the care worker to remind the migrants about the upcoming medical appointments. The nurses do this on their own initiative.

There are no specific indicators or benchmarks for services for migrants which made it difficult to monitor any change in migrants' health status. **NGOs further stated that there were no disaggregated data on migrants' utilization of health care system depending on their protection status**.

III.IV Discussion Section - III

Medical and Social Assistance

Although generally speaking health issues reported by the migrants were similar to those experienced by the Maltese population, the assessment team noticed a deterioration of the physical and mental health of migrants during the reception process. Critical to be urgently addressed is in particular the psychological support offered and/or available to migrants.

In terms of medical assistance at **open centres, proactive measures are not foreseen and the health care is mainstreamed to the public system.** This raises severe concern considering the crowded living conditions, unhygienic toilets, and lack of drinking water. In addition, especially if a single hub for the assistance of migrants will be operational – while human resources and capability will be certainly concentrated at the same place – this could create difficulties to access them, especially for migrants living in far from the hub.

Care/social workers are not able to fulfil all the requests due to their extended scope of responsibilities and to the large number of migrants accommodated in open centres. This results in migrants not receiving proper information on health care services and other similar services available to them, which in turn marginalises them.

Due to the lack of vocational training such as English lessons at the open centres (and due to the relatively better access to medical services and food at the detention centres), some of the **migrants said it was better to be in detention except for the lack of freedom.** In detention they received free food and medical care, whereas in open centres they have to manage everything with the limited subsistence allowance they receive, supposed (but failing) to cover all other expenses – from public transportation to food to clothes, etc.

Lack of interpreters and cultural mediators

Both health professionals and migrants who participated in the study reported a severe lack of interpreters and cultural mediators. Even though interested migrants were trained for a while by the MH unit to be cultural mediators, they tended to be the first ones to be chosen for the relocation programmes. The ORC uses interpreters to conduct interviews during the asylum seeking process. Other than this, there is hardly any formal system which ensures systematic translation services. There were no interpreters present at the port, at the police HQ or at the detention centres. The authorities usually depend on a migrant who has some understanding of English. When the migrants are taken to the hospital they are often requested to bring a friend along who can help with translation. In other instances, other hospital staff who could speak the migrant's language will be requested to translate the information. This raises serious **concerns regarding authenticity, privacy, and availability of the translation services used**.

A health professional working at one of the hospitals said that he cannot completely trust the translated information since it was translated by migrants' friends and not by an official interpreter. Using a friend as an interpreter also raised concerns regarding privacy. There were cases where confidential information such as results of HIV test or information that the migrant was homosexual was known to the migrant's community through the unofficial interpreter. Depending on the migrant community and their cultural system and practices, this type of sensitive information can result in stigmatization. Since there was no official system for translation, sometimes the health professionals had to wait for a while (sometimes even days) before an interpreter was made available. Lack of interpreters and cultural mediators posed a serious challenge to the health care staff in delivering care to the migrants, especially in case of emergency. One of the health care staff considered the language barrier which created limited understanding for the detainee as the main reason for migrants' non-compliance medical appointments and medicine intake.

"Sometimes it is very difficult to communicate because if there is nobody [no interpreter] here, I mean they get frustrated and we get frustrated. We don't know what he wants, he cannot explain to us. So it is very frustrating."
(HP)

The language barrier also hindered the effective uptake of health care services. One migrant who worked as an interpreter explained it as follows:

"You can imagine when a person is not able to communicate with a person in that locality, it is hard. You feel sad because you couldn't communicate with that person. Doesn't know what is going on and it happens a lot of time. Sometimes, as I am working as an interpreter,…the patients they don't really believe the doctors because of the language...the first thing I hear from the patients is like 'please stay with me I don't believe what is going on'"...those people doesn't speak English at all. There is fear, they are scared of the doctor...they wouldn't believe. When you understand what is going on, there will not be any fear."
(Migrant)

Fragmented Data

The team assessment was informed about the **fragmentation of data** due to the use of different ID numbers. The ID number assigned by the immigration police on arrival follow a specific structure linked to the boat arrivals, date, number of people, etc. It cannot be used in the hospital since the hospital database uses a different ID number format, hence a new health number is provided to the patient. This resulted in the loss of continuity of migrants' health data, as there is not a system in place to match the two numbers. In addition, HPs reported that often migrants forget their health number or provide different names and there is a need to create a new health number. This also became an issue when the hospitals wanted to follow up a particular patient once released from detention centres. A workaround adopted by the health professionals was to collect the patient's mobile phone number.

However, the presence of medical personnel in the centre improve the quality of migrants' health files as indicated by HP, **when a migrant comes from the detention, some preliminary information about her/his health status accompany the migrant, but that this is not the case if the migrant comes from an open centre**. Nevertheless, flow of information during the passage from detention to open facilities might be interrupted for two main reasons: 1) No medical unit available at the open centres; 2) Passage from a private company to the health public system.

No disaggregate data on migrants' health care utilization depending on their protection status is available, this impeding further analysis on migrants' health.

IV. MIGRANT-SENSITIVE HEALTH SYSTEM

IV.I Infrastructure and physical conditions

Closed and open centres

The detention centre visited by the assessment team, Lyster Barracks, is divided into 5 zones (two zones for single males, two for single females and one for families). The migrants in detention are housed in groups of 20–30 in the dormitory style rooms. They reported lack of privacy, overcrowding and conflicts between detainees from various cultural groups. Some detainees mentioned that they were not provided with shoes during the initial period of detention, which made it difficult for them to use the toilets. They also have two isolation rooms in the main building (Hermes block) and three newly installed isolation units outside the building. The isolation units in the building are mainly used to confine those detainees who exhibit violent or aggressive behaviour. The newly installed isolation units, installed as part of an EU project,[87] are mainly used to confine detainees with communicable disease such as scabies or tuberculosis.

As similarly observed by the International Commission of Jurists during their visit to Malta (ICJ, 2012), and based on the interviews conducted with the detainees and the migrants who were released from detention, the detention rooms **are overcrowded.**[88] There are 20–25 people in each room in detention or open centre. Some of them reported having toilets in the common sleeping room.

The majority of the open centres visited by the team had sub-standard living conditions.[89] Some of the most relevant concerns are linked to the following observations: - there was no proper sewage system in one of the open centre and - there were water puddles on the cement floors; - the assessment team found dead/live rats in some of the open centres; - toilets and showers in the open centres were dirty, overflowing, and unhygienic. One of the open centre managers attributed this to the migrants' behaviour of not maintaining the toilets and other premises clean. If the migrants do not maintain the premises clean, they are required to pay an amount to the open centre management to account for the cleaning costs. Managers reported that even if the toilets and showers are cleaned using chemicals and water, they get dirty within a couple of hours. The ratio of migrants per toilet (see Annex III) is around 20 people per toilet or shower, and some of them are not working properly, thus making the ratio worst. Migrants need to wait an hour to be able to take a shower.

[87] EUR 700,000 investment in public health. The Independent. Available from www.independent.com.mt/articles/2013-06-27/news/700000-investment-in-public-health-1931739137/ (accessed 15 December 2013).

[88] The assessment team did not visit the sleeping quarters in Lyster Barracks.

[89] A news article published in a local newspaper on the conditions in an open centre. Dilapidated buildings, poor sanitary conditions at Marsa Open Centre, Malta today. www.maltatoday.com.mt/en/newsdetails/news/national/Inside-story-Dilipidated-buildings-poor-sanitary-conditions-at-Marsa-Open-Centre-20120818 (accessed 28 December 2013).

"For instance we have 6 toilets and there are so many ladies here...so many ladies. Some toilets don't even flush well, you try flushing many times it doesn't work and you leave it like that. They clean it twice a week, but imagine there are 6 toilets and hundreds of ladies. How do you think it is going to be?"

(Migrant)

No personal care and hygiene items are provided upon admission in the centre (soap, comb, towel, toilet paper, etc.) There was also a lack of clean drinking water. In Hal-Far tent village, there were two water taps where approximately 450 migrants could collect drinking for the daily use. Some of the migrants, however, indicated that the water was too salty to be potable; therefore they buy drinking water. In Hal-Far hangar open centre, there was no provision for clean drinking water and the manager was hoping to get it installed during the following year.

Containers (structures similar to shipping containers) are usually used to accommodate migrants living in open centres.[90] Even though, this is an improvement from the tents and hangars used earlier to accommodate migrants, they are still not suited to meet the basic needs of the migrants. Between 6–8 migrants are accommodated per container. Most of the migrants complained that the containers are hot during the summer and cold during the winter.

"The container is freezing. In the morning you wake up, you see water on the wall inside your room because it is cold. When it is hot it is something else. It is too hot and there are flies."

(Migrant)

There is also a lack of security in some of the open centres. The open centre in Marsa has a system where migrants are issued a photo ID card which is to be used to get into the centre. Other centres do not have this system. Often incidents related migrants who are not residing in the open centres come into the centre to meet friends and may end up causing trouble for the residents.

Health professionals at hospital said that the **living conditions of migrants in open and closed centres posed a threat to their health.**

"Putting a number of people in a closed space with suboptimal health and hygiene services in itself is a health risk and also when you are putting people in detention when they are not criminals; that is a mental health risk."

(HP)

It is worthwhile mentioning the Good Shepherd open centre in Balzan run by Emigrants' Commission, Malta. The centre – although being autonomous – hosts vulnerable migrants indicated by AWAS and receives minimal funding support from the Government. The residents do not share rooms and they have their own cubicles, which includes a table, chair, a shelf, and a window. The assessment team found this open centre better suited for the migrants when compared to other open centres.

[90] This is not always valid, for example for Marsa open centre, which has dormitory-type sleeping facilities where 25 migrants sleep in the same room.

The assessment team noted that infrastructure facilities at open centres in Marsa and Hal-Far were financially (75–80%) supported by the European Refugee Fund.[91] This creates a scenario where projects are highly dependent on EU funds and the sustainability of the projects is therefore at stake. One CSO representative explained it as follows:

"I used to work (in a project that stopped after the project period)…I used to feel that it might have been good that perhaps there were more constraints on the organisations to try and implement it in future as well...you were free to do a project and not ever plan to find other ways to continue...and sometimes it (funding) is more harm than good."
(CSO)

Health care facilities

The assessment team found the infrastructure and the physical conditions at Mater Dei and Floriana Health Centre to be satisfactory. However, there was concern about the facilities at the ASU in the Mount Carmel hospital,[92] where both female and male migrants from detention are accommodated along with substance abusers and prisoners. The patients in ASU do not have access to any physical or social activities. They are never taken outside of ASU for any activity or fresh air and the only physical activity they have is walking along ASU corridor, which is approximately 15 metres long. There was one consultant psychologist, two nurses and a care worker employed at the ASU. There is also DS personnel for security purposes. Similar to the hospital staff and the volunteers visiting the migrants in ASU, the assessment team found the ASU to be non-conducive for the recovery of a mental health patient, especially for migrants who might have gone through torture and trauma in their host country, during their journey to Malta and/or in detention (DeBono, 2013:62).[93]

Migrants often expressed concern that they were treated differently at the hospitals. This was mainly pertaining to the difficulty in getting treatment or consultation with the doctor. However, the health professionals emphasized that the migrants were not treated any different than a Maltese citizen. The delay in accessing care was attributed to the issues within the Maltese health system and not to discrimination against migrants, as perceived by the migrants.[94] This can be confirmed from an anecdote reported by HPs about migrants complaining that the ambulance does not drive them back to the open centre. This is obviously a perception of discrimination, yet it belays a general frustration with the distance and practical obstacles to access health care. Indeed, migrants sometimes spent the whole day for a medical appointment, due to scares transport connection; sometimes other patients at the hospital pay them a taxi to come back. Another perceived discrimination – the one of not receiving medicine for free – it is instead related to the fact that only inside the hospital medicine are available for free, but sometimes those medicines that migrants need are not available. As already reported, lack of information on both side can create frustration for both migrants and the staff and impinge a full enjoyment of the service.

[91] Under the same ERF, a number of other projects have been implemented aimed at providing various renovation works and the purchase of other supplies to residents of open centres (i.e. sheets, beds, mattresses, pillows….). The fund also supports other activities, such as information session at open centres.

[92] The hospital administration informed the team that a new facility is under construction meant for female substance abusers. However, asylum-seekers will continue to be admitted in the ASU.

[93] This was also highlighted in the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) report to the Government of Malta (CPT, 2013:42).

[94] This was similarly reported in other studies (Cuadra, 2010; HUMA, 2011).

IV.II Occupational health of staff

All actors interacting with migrants, especially during the early phases of the reception process (AFM, immigration police, health professionals) are instructed to use protective gears such as hand gloves and faces masks and these instructions were reported to be followed. However, this was not always the case in open centres. Based on the available information, staff had very basic amenities in their hygiene quarters and offices. Some of them reported to have their lunches in their own offices due to the lack of an open space. They also reported lack of proper ventilation in their office since opening their office windows will result in bad odour from the kitchen filling up their offices.

Armed Forces of Malta

AFM personnel states they were vaccinated for TB (every two years) and for Hepatitis and Polio (every three years). **They expressed concern over their psychological health** since they are exposed to highly emotional situations, especially when they deal with dead bodies of migrants in the sea. They also expressed concern about their own safety as migrants rescued from sea can have a weapon with him/her while on board the rescue vessel. AFM personnel are not allowed to perform any body search on the rescued migrants.

Thus the assessment team found the AFM personnel engaged in rescue missions lacking psychosocial support. A Maltese NGO working with improving the mental health of people living in Malta conducts occasional group sessions for AFM personnel. If an officer wants to consult a psychologist, he/she has to report to the Commander in chief and then go ahead with the consultation. This might affect the anonymous nature of seeking care and might prevent the officer from seeking psychological assistance.

Staff at detention centres

Personnel working at the detention centres were not satisfied with their job responsibilities and work circumstances. According to them, they were not trained to manage people under stress.[95] Moreover, CSO representatives reported that DS personnel are often on the verge of burnout. This is mainly due to the multitasking nature of their job. Though they were trained soldiers or security personnel, they were supposed to maintain security at the centre, provide food, clothes and other basic amenities to the detainees, *identify vulnerabilities,* take migrants to the hospitals and in some cases distribute medicines prepared by the nurse.

"The fact that we have soldiers looking after people in detention is not beneficial for either party. Detention Services are not professionally trained to cope with the needs they find in detention… So there is not that capacity to be able to cope with people in a care setting… there had been training sessions for the DS and the army personnel... but we are still talking to people who had no interest in working in this field… for some people this was seen as a punishment in a way, to be assigned to the DS or there are retired soldiers who have been invited back to work again, to work in the DS. So the people are generally quite exhausted or feel like they are being punished." **(CSO)**

[95] The assessment team did not conduct any structured interview with any DS personnel.

This shows that the staff currently present at the detention centres feel not qualified or trained enough to provide services to the migrants,[96] and that they do not usually have personal interest/incentive to work in this setting.

Staff at the open centres

One of the open centre managers reported the lack of regular psychological support for his staff. Some of the everyday stress factors have been indicated as follow:

"400 people inside of the centre and everybody will try to get something out from you. There is the language barrier, the cultural barrier; these things sometime frustrate you and they will give you a hard time."

AWAS provides individual and group supervision to AWAS staff every four weeks, and some NGOs contribute in the provision of counselling.

Care workers at the open centres are instructed to use proper protective gear. However, this has not been observed as applied. One of the care workers reported not using protective gears regularly since it was considered as degrading to use them while interacting with migrants. Majority of the staff working at open and closed centres seemed to be stressed or overwhelmed by the job. Some of them, especially female staff at open centres, were afraid to be alone with male migrants.

Staff at the hospital

Health professionals working at the hospital also expressed the fear to go into the open centres alone, especially during night time suspecting that the migrants could be violent. Moreover, it was mentioned that their labour union does not want them to go in to the open centres and provide treatment. Hence they invited the migrants to the hospital for health check-ups.

The nurses working at ASU in Mount Carmel hospital were satisfied with the available psychological support. The services at ASU are managed by a private company on a contractual basis. Depending on the type of employment (private company or hospital contract), employee benefits were different, especially with respect to counselling and psychological support. Privately employed staff had limited psychological support. For the staff at ASU, the lack of facilities for the patients such as facilities for exercise or recreation made their job stressful since it affected the patients' health and wellbeing.

There was a lack of psychosocial support for the medical staff working at the emergency department at Mater Dei hospital, although it has been requested several times.

IV.III Health knowledge, attitudes and practices

The staff working at various facilities providing service to migrants seemed to have the technical know-how to provide the service. However, all of them highlighted their limited cultural

[96] Some training to DS and open centre staff has been provided including by IOM, under EU funded projects, such as SPARKLET.

awareness which prohibited them from delivering proper service. One of the health professionals exemplified it as follows:

"I think the communication problem is not the language, but it is the culture. Because with language, I always find interpreters within their community. So their friend will come; there is always someone who speaks English. So it is not a problem. But the culture differences...no language will help...till they get used to our methods or we get used to their methods."
(HP)

They expressed the need for cultural awareness training programmes. Whenever health professionals participated in cultural training programmes, they expressed full satisfaction. However, these types of trainings were reported not to be regular, but high in demand. One of the NGOs, with the support of other NGOs offered a cultural training programme for health care professionals. There was a high turnout, and the personnel who attended the training expressed their desire for more such activities.

"It would be good to know more about migrant's background, where they are coming from, why they are coming. It is not simply because they want to go to Malta or Italy; they are escaping from wars, from difficulties. So it would be good if staff were aware of it, more sensitive to their needs."
(HP)

One of the health-care professionals mentioned that the newly graduated doctors were not familiar with the common diseases present among migrants. According to the interviewee, this was mainly because the medical curriculum had limited focus on tropical diseases widely present among migrants. This was further corroborated by other health professionals working at the hospitals, who expressed the wish to have refresher training on tropical diseases.

IV.IV Discussion Section - IV

Obstacle to access to health care

Migrants encounter both real and perceived obstacles to health-care access, which, in the worst case scenario, make them see the health care system as useless. Some of the logistical and substantial reasons could be summarized as below:

- Space: transportation/distance;
- Cost: access to medicine for free;
- Language: translation and mediation problems;
- Trust: lack of trust to the doctors;
- Discrimination: perceived discriminative practices.

As already reported by IOM,[97] health care workers have differing attitudes to accepting refugees. Negative attitudes can be associated with the special needs of migrant groups, general practitioners find it increasingly difficult to deal with tropical and imported diseases in which these have relatively little experience. In addition, some migrants are afraid of disclosing certain

[97] IOM and Department of Public Health Malta, 2007.

conditions as they are afraid either of being sent back to their country or of being kept in detention. Difficulties are also encountered due to the high rates of psychological distress in these immigrants and due to language difficulties.

Psychological and Training needs

Psychological support for the staff working with migrants should be given high priority. This could also have a spillover effect on migrants' health and wellbeing. As described above, not all staff members/categories receive this type of critical support.

Though most of the staff working with the migrants possessed the necessary professional skills to carry out their tasks, detention staff seemed to be an exception. They found it challenging and difficult to carry out their tasks. They need more training focused on the care giving aspect of their job as detention personnel. Moreover, civilian staff such as social workers could be added to the staff complement working in detention centres. Care workers at open centres are as well requested to cover a large number of tasks, which are often above their capacity.

Health professionals also expressed the need for cultural awareness training programmes and the wish to have refresher training on tropical diseases.

5. CONCLUSIONS AND RECOMMENDATIONS

V.I Conclusions

Mindful of the sovereign rights and national security concerns which accompany our actions, the International Organization for Migration (IOM) feels it is a collective responsibility – States, institutions, and organizations alike – to respond to these challenges in a humane, effective and sustainable way. The first priority is to save lives and uphold human rights, including the right to health.[98] Second, cooperation and dialogue within the EU and with countries of origin and transit is essential. Because some EU countries are undoubtedly under heavy pressure due to the large number or arrivals and asylum requests they receive, the concept of "responsibility sharing" needs to move from principle to action at all levels of international cooperation. Family reunification, adequate integration measures, relocation within the EU, and resettlement from third countries are efficient means to share responsibility and provide safe avenues for those seeking international protection within the EU.

Malta is a small country struggling to cope with the influx of migrants. There have been **improvements in the Government's effort to manage irregular migration and provide health care services to the migrants over the last few years**. Noteworthy is the recent establishment of a **Human Trafficking Monitoring Committee and development of the SOP** when dealing with potential or de facto victim of trafficking.[99] Moreover, Malta government representatives have indicated that Malta plans to introduce reforms to its migration and detention policies, as well as integration-oriented initiatives with a view to comply with the re-cast Reception Conditions Directive by July 2015.

Findings from the assessment have shown worsening physical and especially mental health of migrants due to overall conditions: the lengthy stay at detention centres, the overcrowding, the lack of social activities, the poor hygienic circumstances at open centres, and others are just some of the main causes.

Positive policy developments related to UAM have been prompted by the recent public statement of the Prime Minister and the President (March 2014) indicating that **UAM should not be kept in detention**. In the months following, a joint IOM–UNHCR mission was hosted by the Prime Minister to address the situation of UAMs in Malta. During the 2NCC in Malta, a representative of AWAS indicated the internal commitment taken by the agency to review the age assessment procedure to reach decision within ten working days (if no medical X-ray is required).[100]

[98] International Migration, Health and Human Rights, IOM/WHO/OHCHR. Available from http://publications.iom.int/bookstore/index.php?main_page=popup_image&pID=976&zenid=8igbf19ipge04pmj5ne28ij9c6

[99] The two achievements were supported by the IOM project LIMES (October 2011–May 2014) that intended to enhance the ongoing efforts of the Government of Malta to counteract trafficking in persons.

[100] The agency has indicated as well that they have reviewed the Vulnerable-Adults-Assessment (now called Adult Referral Assessment) widening scope of assessment beyond transfer from closed to open centres, and focusing on resiliency.

Fostering tolerance, social cohesion, unfettered access to adequate health and social services, and combating discrimination are among the core challenges in transforming migration into a stimulus for growth and development. Over the last decade, European health systems have faced increasing common challenges, including in particular health inequalities and unequal access to health care.

V.II Recommendations

The following policy recommendations are the results of the assessment done in Malta (November 2013) and integrated with the outcomes of the national consultative committee (September 2014).

I. Policy and Legal framework

EU Level

- Further to the EP resolution in response to the Mediterranean Sea tragedies,[101] expand and promote existing EU legislation and procedures allowing safe entry into the EU.

- Develop common and concerted EU operational responses for addressing root causes of forced and irregular migration.

- Dublin regulation was devised to prevent "asylum shopping", however, it has increased the pressure on border Member States as well as led migrants to remain in irregular status while trying to reach the country of actual destination where they aim to apply for asylum. Burden sharing among EU Member States is advisable not only during the first phase of application processing, but also in a later stage as to resettlement.

- Reception conditions and procedures should fully respect migrants' dignity and fundamental rights. To complement the Council Directive 2003/9/EC on Minimum standards on the reception of applicants for asylum in Member States, it is recommended to develop more specific indications as to provisions of health care and minimum standards to be applied during the reception process, such as what type of personnel should be guaranteed in the detention/reception centres or the ratio between health professionals and migrants.

- Develop specific EU Guidelines, taking into consideration the best interests of the child, prompt access to the asylum procedure and insurance of fair procedure. As indicated by the previous EC Commissioner for Home Affairs Cecilia Malmström: "the rights of the child must always come first. We need clearer and more predictable EU asylum rules for unaccompanied minors".[102]

[101] European Parliament resolution on migratory flows in the Mediterranean, with particular attention to the tragic events off Lampedusa (B7-0476/2013).

[102] EC Press Release: *Clearer EU rules for unaccompanied minors seeking international protection, Brussels, 26 June 2014*. Available from http://europa.eu/rapid/press-release_IP-14-723_en.htm

National Level

- Provide a solid legislative framework on migration management and health care entitlements for migrants.

- Ensure appropriate vulnerability screening and referral for treatment of vulnerable groups (disabled, elderly persons, pregnant women, single parents, and victims of torture, rape or other serious forms of violence) within the legal framework. The responsibility to identify and refer to AWAS potential vulnerable people early in the reception process and/or held in detention should be delegated to one specific actor, with the right competences to monitor such cases.

- Develop a comprehensive approach as to age assessment of UAMs considering the social, psychological, and educational aspects in the assessment.
    - Experts involved in the age assessment procedure should not be responsible for the placement minors in respective accommodation facilities.
    - During the age assessment procedure, potential minors should not be hosted in detention centre(s) or with adults.
    - The possibility to host minors aged 16–18 in facilities with adults should not be applied as a solution to lack of proper accommodation places for UAM.

- Inform and educate health care providers and other relevant operators (i.e. pharmacists) of migrants' health care entitlements as to access to health and social services. In the same time, increase the awareness of migrants on their health rights and promote communication between both groups.

- Ensure that the results of various decision processes i.e. on legal and/or social issues are provided in a language that is understood.

- Update and simplify actual legislation as to social benefits in line with migrants needs.

- Ensure that migrants' right to access their individual medical file(s) is respected and fulfilled.

II. Partnerships, networks, and multi-country frameworks

EU Level

- Promote policies that uphold migrant health by strengthening transnational/cross border networks/bilateral agreements

- Enhance dialogues, exchanges of practices and effective cooperation and solidarity at Regional, EU level and globally.

- Facilitate accessibility to the solidarity funds for social and health service provision for local and regional stakeholders working in the migration field

- Base EU funding of facilities on the evaluation from national and international monitoring bodies, incl. for the prevention of torture and ill-treatment.

National Level

- Ensure respect of human rights and be responsive and adaptable to migration flux/numbers based on the recognition that migration is a steady phenomenon and responses characterized by urgency/emergency mode should be avoided and used only for limited period of time.

- Establish a structured response, involving multiple sectors and levels, during the entire reception process by developing shared/horizontal protocols outlining specific roles and responsibilities.

- Foster more fluid information and coordination between ministries and facilitate inter-ministerial communication, as well as among various entities working with migrants. The development of "who-does-what" map is a good example developed in this respect.

- Promote cooperation between AWAS and MoH.

- Allow/encourage international organizations and NGOs to contribute during the reception process in support of the monitoring, provision of assistance to migrants and identification of vulnerable individuals including institutionalization and ensuring sustainability of essential services provision. Cooperation arrangements to be formalized rather than ad hoc.

- Promote an overall constructive discourse and reporting on migration and public health as important in fostering social integration, while at the same time addressing misperceptions in the community. Malpractices and miscommunication lead to fears of infection epidemics both among local authorities and the public. In this respect, the socially responsible collaboration with the media is key and information campaign on the positive contribution that migrants make to the community should be promoted.

III. Monitoring migrant health

- Develop a systematic and comprehensive health assessment, data collection (for communicable and non-communicable diseases) and referral mechanism. In cases data is collected (i.e. TB numbers), there is need of professionals to process and analyze the data (i.e. PHD students or others can be engaged if there is no in-house capacity), respecting confidentiality principles.

- Ensure permanent and institutionalized presence of medical/paramedical staff during the reception process from apprehension and rescue at the border to detention/reception centres.

- Ensure independency of health professionals and continuity of care in the health system.

- Draw attention to psychosocial needs and ensure timely and systematic provision of psychosocial support to migrants in detention and reception settings.

- Promote the collection of disaggregated data based on migrants' status to anticipate needs and analyse service utilization outside centres.

- Implement guidelines for border management, detention and reception centres with special reference to securing a public health perspective.

- Promote an appropriate share of health-related data locally, nationally and at EU level. This implies to set up an information system able to encourage a more "global" take on responsibility and a better continuity of care to the migrant.

- Increase the number of care workers and AWAS staff and increase the pool of professional interpreters and cultural mediators to support the work of health care professionals to deliver care, especially in cases of emergency.

IV. Migrant-sensitive health system

- Reinforce the health and social support systems, including interpretation, cultural mediation psychosocial assistance and trained staff throughout the reception process (in the centres and also within the national health system). It is strongly advised to develop standardized procedures in order to guarantee the presence of competent/fully trained interpreters and cultural mediators for all the steps of the reception system.

- Ensure humane and dignified conditions in in reception facilities (both short-term and long term) in line with international, CoE and EU recommendations. Alternatives to detention should be sought.

- Small (but perceived as significant) changes are suggested by migrants to improve their living conditions in detention centres: access to open air and sport, cultural and social activities, training courses incl. language classes, media in multiple languages (TV,

newspapers). Such developments would improve migrants' well-being while minimizing psychosomatic conditions, as well as ease tensions and improve environment for the staff.

- Improve hygiene at open centres, especially showers, toilets, sewage mechanism and minimal set of items incl. the the infrastructure at ASU, Mount Carmel.

- Improve the provision of information related programmes focused on some key health aspects, such as sexual and reproductive health and mental health could be further improved for migrants in detention and open centres.

- Continuous training for health professionals and law enforcement officers on the broad range of topics identified by respondents; intercultural competencies, languages, first aid, tropical diseases, human rights, safety and security at the workplace, etc.

- Address issues in occupational health of staff incl. vaccinations, information of possible risks at work and on self-protection and hygiene measures that need to be taken.

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ANNEXES

ANNEX I. 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 II. List of participants to the NCC Malta 18 September 2014

Governmental Actors

- Agency for the Welfare of Asylum-Seekers (AWAS)
- Armed Forces of Malta (AFM)
- Malta Police Force, Detention Services
- Ministry for Health, the Elderly and Community Care, Primary Health Care Department

HP, CSO, IO and others

- APPOGG
- Integra Foundation
- IOM Malta
- IOM Regional Office in Brussels
- Jesuit Refugee Services (JRS)
- Malta Emigrants Commission
- Marsa Open Centre *(run by the Foundation for Shelter and Support to Migrants)*
- Mater Dei Hospital
- Medicare Services Ltd
- Mount Carmel Hospital
- People for Change Foundation
- UNHCR Malta Office
- University of Malta
- University of Seville

*****Regrets**

- Aditus Foundation
- Dar il-Liedna (open centre for unaccompanied minors and families)
- EASO
- EC Representative in Malta
- Hal Far (Hangar) Open Centre (HOC)

- Hal Far Tent Village
- KOPIN
- Lyster Barracks (detention centres)
- Migrant Network for Equality, Employment and Training Corporation (ETC)
- Ministry for Home Affairs and National Security (MHAS)
- Red Cross
- Richmond Foundation
- SOS Malta

ANNEX III. Open centres checklist

HTV: Hal-Far Tent village open centre
HOC: Hal-Far Hangar open centre
MOC: Marsa open centre
DIL: Dar il-Liedna open centre

	HTV	HOC	MOC	DIL
Under whose authority is the centre? (e.g. Ministry of Interior/ regional/ police)	NA	MHAS	MHAS	MHAS
Under whose management is the centre?	AWAS	AWAS	Foundation for shelter and support to migrants (FSM)	AWAS
Total number of employees at the centre:	6	8	26	7+1
Short description of the centre's environment: (i.e.: geographical situation, distance from the closest town/village; features of the countryside, etc.)	3 km from the nearest town	Situated in Halfar 2.5 km away from Birzebugia village	Centrally located and close to the town of Marsa	Situated in the town of Fgura on the southern part of the island; a 30 minutes bus ride to Valletta.
How many stayed in the centre last year?	700	612	600	*NA*
What is the average time spent at the centre?	1 year	8–12 months	10 months	*NA*
7. What is the maximum capacity of the site?	550	580	550	23
Are then migrants separated by:				
a. Gender?	Yes	Yes	Yes	Yes
b. Family status?	Yes	No	Yes	Yes
c. Age? (Unaccompanied minors from adults)	Yes	Yes	Yes	Yes
d. Vulnerability? (I.e. pregnant, elderly, etc.)	Yes	Yes	Yes	Yes, when feasible
e. Nationality?	Where possible	No	No	Yes, when feasible
f. Religion?	No	Yes	No	No
g. Healthy and ill?	Yes	Yes	Yes	No
h. Suspected contagious and non-contagious persons?	No	Yes	Yes	No

Health care provided

	HTV	HOC	MOC	DIL
Is there a health care facility available at the centre?	No	No	Yes	No
Short description (e.g. facility/ equipment, permanent/non-permanent staff, etc.)	NA	NA	A medical clinical manned by 1–2 doctors and a part-time nurse	NA
Are there NGOs or international organizations working with the centre?	Yes	Yes	No	Yes
List/short description.	Primary health care and English lessons	Language and Sport		Individuals visit DIL so as to deliver lessons to the children.[5]
Who do you inform first in case of critical health incidents (events) at the centre (e.g. hunger strike, violence, emergency)?	Emergency 112	Police and ambulance services	The Management, Police, Health authorities, Ministry	Either ambulance services and/or the police; internal direct line managers are on call
Are there any regulations for handling "health incidents (events)" at the centre?	Yes	No	Yes	Yes[6]
Is there a protocol or procedure in place in case of outbreaks? (e.g. SARS or Avian Flu procedures?)	No	No	Yes	No
Have you been trained/ informed as to the lines of responsibilities in the centre as to the WHO IHR (International Health Regulations) health event notification procedure?	NA	No	Yes	No
Location of the nearest public health service/office station:	Floriana	Floriana or Poala	Floriana	Paola
Distance (in km and in time) from the centre:	12 km 15 minutes	10 km 6 km	21 mins	2 km

Conditions at open centre

	HTV	HOC	MOC	DIL
Has the staff received training on personal hygiene? If yes, please provide further details.	NA	No	No	No
Is disinfection performed after the discharge/transfer of a migrant with an infectious condition?	No	Yes	Yes	No
Has the staff received training on infection control and prevention?	Yes	No	Yes	No
Which basic hygiene supplies are available in the lavatories?				
a. Liquid soap	No	No	Yes	Yes (staff)
b. Bar soap	No	No	No	No
c. Paper towels	No	No	No	No
d. Cloth towels	No	No	No	No
e. Hand dryer	No	No	No	No
f. Toilet paper	No	No	Yes	Yes (staff)
Short description and number of lavatories in the centre:	36 Turkish	26, 1 for	30	7
Are there separate facilities for women and man?	Yes	Yes	Yes	No
Ratio in relation to hosts (question 7)	**15.3 per toilet**	**22.3 per toilet**	**20 per toilet**	**//**
Short description and number of showers in the centre:	36 showers	26, 1 one for disabled	32	7
Are there separate facilities for women and men?	Yes	Yes	Yes	No
Ratio in relation to hosts (question 7)	**15.3 per shower**	**22.3 per shower**	**17.2 per shower**	**//**

Conditions for staff

	HTV	HOC	MOC	DIL
Location and short description of staff's sleeping and hygiene quarters and offices?	NA	//	Central	Support workers' office on first floor is more basic than the one on second floor which incorporates a kitchen sink; there are no wash hand basins in either of them; both Coordinator's and Social Worker's office do not have adequate ventilation since when windows are opened the offices are filled with pungent smells of cooking from the kitchens.
Is a separate lavatory unit ensured for the staff?	Yes	Yes	Yes	Yes
If yes, short description and number of lavatories for the staff:	1 female 1male lavatories	1 female 1male lavatories	5	2 rooms on 1st and 2nd floors respectively comprising of toilet, sink and shower
Number and types of hand wash stations for staff:	2	3	7	2
Number of showers for staff:	1	1	1	2

Living conditions of migrants

	HTV	HOC	MOC	DIL
Do all migrants receive:				
a. A plastic dinner set?	No	No	No	No
b. A mug?	No	No	No	No
c. Duvet cover?	No	Yes	Yes	No
d. Sheets?	No	Yes	Yes	No
e. A blanket?	No	Yes	Yes	No
f. A bed?	Yes	Yes	Yes	Yes
g. A towel?	No	No	No	No
h. Night clothes?	No	No	No	No
i. Slippers?	No	No	No	No
j. Extra clothes?	Yes	Yes	Yes	No
k. Soap?	No	No	Yes	No
l. Tampons? Sanitary pads?	No	No	No	No
m. Toilet paper?	No	No	Yes	No
n. Toothpaste? A toothbrush?	No	No	Yes	No
Do you ensure the weekly change of:/every two weeks or according to needs:				
a. Shaving foam? Razor blades?	No	No	No	No
b. Night Clothes?	No	No	No	No
c. Duvet cover?	No	No	No	No
d. Sheets?	No	No	Yes	No
e. Towel?	No	No	No	No
Does the centre provide any of the following facilities?				
a. Library	No	Yes	Yes	No
b. TV room	No	Yes	Yes	Yes
c. Sport facility	No	No	Yes	No
d. Kitchen	Yes	Yes	Yes	Yes
e. Room with PCs	No	No	Yes	Yes
f. Other	Yes			