“Everybody just tries to get rid of us.”

Access to health care and human rights of asylum seekers in Malta.
Experiences, results and recommendations.

MdM France survey and final report of the humanitarian mission in Malta 2007
November 2007, MdM France, Paris:

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1. Summary

Background: After an exploratory mission in September 2006, *Médecins du Monde* (MdM) France decided to plan and to implement an international humanitarian mission concerning the access to health care of asylum seekers in Malta for a duration of 5 months starting from April 2007.
Médecins du Monde (MdM) is an international humanitarian aid organisation with 11 country offices in Europe. MdM provides health care in situations of acute and chronic crisis and intervenes in issues of access to health care of vulnerable persons in more than 50 countries around the world. It has, since its foundation in 1980[1], been focusing on issues of health care among asylum seekers and refugees who certainly belong to one of the most vulnerable populations, especially with regard to their right to access adequate health care (for further information: www.medecinsdumonde.org/gb/).

Objective and activities: The main objective of the mission was to foster the right to access health care among the migrants living in detention and in the Open Centres. The humanitarian mission in Malta was started on April 18th 2007. The MdM team – consisting of a nurse and a medical doctor (with a Master of Science in Public Health) - offered medical consultations between June 1st and August 30th in the two biggest Open Centres. The consultations were held twice weekly in Marsa Open Center (consultations offered on Thursdays from 5pm to 8pm, and on Sundays from 12am to 5 pm) and Hal Far Tent Village (consultations were offered here on Wednesdays and Fridays between 5pm and 8pm). The MdM team offered moreover preventive workshops for women on sexual and reproductive health and rights in several Open Centres, distributed information material and male condoms during their medical consultations and trained - in collaboration with UNHCR and JRS - cultural mediators on health related issues.
Through its work, MdM was able to cure, orientate and guide patients to complementary services and support the vulnerable asylum seeker population. The project guaranteed as well an improved detection mechanism for diseases of great importance to public health, including Tuberculosis, HIV/AIDS and psychiatric disorders. Moreover, providing medical services in close proximity to the refugee population was shown to significantly reduce the pressures on the main policlinics in Floriana and Paola and ambulance services. During its work MdM registered 410 medical consultations and 325 new clinical cases. The field team conducted in total 167 structured face-to-face interviews on questions of access to health care and 59 on issues of psychosocial health.

Open Centres. Data collection and recommendations: The most prevalent disorders found during the medical consultations were – in order of frequency – dermatological disturbances, pathologies of the respiratory tract system, musko-skeletal disorders, gastro-enterologic and psychiatric diseases. The results and experiences of MdM's work in the Open Centres show that the pattern of distribution of most prevalent pathologies among the consulted patients is certainly linked to the continuum of precarious living conditions and psychosocial stressors.
A rather high number of hospitalisations in general and more specifically to psychiatric wards, especially during detention, is linked to the fact that detention itself – especially under the conditions in Malta – causes or aggravates a variety of somatic and psychiatric symptoms and diseases that are difficult to treat.
The analysis of the questionnaires on access to health care revealed furthermore that the main problems of asylum seekers are related to experiences of discrimination, the access to free medical treatment and to specialised care.
The analysis of the questionnaires on psychosocial health strongly suggests that a considerable number of persons suffer from a diverse range of symptoms regarding their mental health. The most frequently reported symptoms were sleeping problems, problems of concentration and decreased appetite. As mentioned above, the living conditions and psychological stressors in detention and in the Open Centres certainly contribute to this picture.

[1] Project « Ile de lumière » ("Island of light"), targeting the boat people taking flight from Vietnam.

In the light of its epidemiological data, the results from its survey and the observations during its mission, MdM recommends strongly the continuation of the primary health care medical consultations in proximity to the asylum seekers in Hal Far Tent Village and Marsa Open Centre. It furthermore recommends the continuation of preventive workshops with women on reproductive health and of the health promotional activities linked to the medical consultations in the Open Centres. Finally, it calls upon the government to ensure that the living conditions of asylum seekers in the camps are improved.

Detention centres. Data, observations and recommendations: During the whole humaitarian mission MdM has not been granted access to detention by the Maltese government in order to provide medical and preventive care. Only at the end of the mission the field team was granted the right to visit the two main detention centres for one day. The report elaborates the main difficulties concerning the health and health care of detained asylum seekers in Malta, based on its own observations during this visit and a strong collaboration with the Jesuit Refugee Service (JRS) Malta. This collaboration provided space for the exchange of experiences and observations on health related issues in detention and in the Open Centres.
The living conditions in Maltese detention facilities for third country nationals remain detrimental. Main areas of concern are the existing conditions of overcrowding and cohabitation, disastrous sanitary facilities, a lack of bottled drinking water especially for pregnant women, lactating mothers and babies and the lack of meaningful activities. A major point of concern is the detention of single women together with men in Hal Far Detention Center.,
Therefore MdM calls for an immediate change in the existing detention policy, especially as the detention of men, women, children and minors under current conditions for a maximum period of 18 months is a clearly inhuman and degrading practice that harms the somatic and psychosocial health of the detainees. More specifically, MdM calls upon the government to ensure that single women are at no time detained with any men.

Moreover, since the beginning of 2007 a regular half-day medical service provided by a private company has been made available to the asylum seekers in Hal Safi and Lyster Barracks. Problems remain in the area of communication, immediate access to medical consultations, treatment and specialised care.
Very severe problems remain with regards to the identification and release of the most vulnerable asylum seekers. Besides improvements in 2007, the evaluation of systematic data revealed that pregnant women, babies and children are still sometimes detained for up to 6 weeks. Moreover, very vulnerable adults remain detained often for the whole time span, especially because there is no clear existing regulation on the identification of and procedure for vulnerabilities on medical grounds.
In the light of these severe issues MdM calls upon the government to ensure that pregnant women and mothers with their babies and children are not detained for more than the absolute minimum period of time. The identification of unaccompanied minors should be given absolute priority in order to avoid longstanding detention of unaccompanied minors. MdM further more calls upon the government to extend the definition of vulnerable persons in the respective policy paper to all persons who are inapt to remain detained on medical grounds. This should include persons with chronic medical problems, including mental health problems. MdM finally recommends to extend the existing medical care in the respective detention facilities, and offer it on a 24 hour basis. Medical treatment should be made available to all patients after a maximum time span of 24 hours and access to translators and specialised care and follow-ups should be generally assured.

Even though the Maltese authorities are responsible for a variety of inadequacies regarding reception, detention and integration of aszlum seekers, it is important to note that the migration politics of the European Union have continuously increased the burden of migration on the most southern countries of the continent. Thus countries with limited resources - such as Malta and Cyprus - are facing a relatively high annual burden of asylum seekers.

In this light MdM france calls additionally upon the European Union to show more interest for the inhuman and undeserving conditions of reception which asylum seekers are facing on the continent.

2. Introduction

Médecins du Monde France has undertaken a humanitarian mission regarding the access to health care of asylum seekers[2] living in the Open and Closed Centres in Malta between April and September 2007. This report was written in order to systematically outline the experiences, observations and results of different data and testimonies collected during this time. The report will finally highlight a number of recommendations in order to improve the access to health care of asylum seekers in Malta.
This introductory chapter aims at giving a short overview over the general political and social context of the mission and over the basic facts concerning the Maltese health care system and the entitlement of asylum seekers to health care in Malta. It moreover aims at outlining basic facts on detention and Open Centres. In chapter 3 then a short outline of the objectives and the implemented activities will be given. Chapter 4 will deal with the different data and observations the MDM field team has collected and analysed. Here, a central focus will be put on the results and findings that were produced during the field work and medical consultations in the Open Centres. Only a smaller part will describe the material and observations we analyzed regarding the detention centres. Besides our many indirect observations and testimonies we will therefore refer to our visit to the two main detention centers - conducted at the end of the mission - and to diverse data and experiences made by collaborating local associations, especially the Jesuit Refugee Service (JRS) Malta. This main chapter will also include recommendations in order to improve the physical and psychological health and the access to health care of asylum seekers in Malta.

A note on terminology: The term ***asylum seeker*** in the context of this report refers to all migrants who are detained or who live in the Open Centres or the community in Malta. The term therefore includes migrants with refugee status, humanitarian protection, rejected or pending asylum cases and others. Almost exclusively all of them arrived by boat to Malta. The term has mainly been chosen for this report to avoid the terminology "illegal immigrant" that has to our knowledge a very negative connotation in Maltese society.

2.1. Context

Malta is the smallest (both in area and population) and most southern member state of the European Union. The Maltese national state consists out of three inhabited islands, Malta, Gozo and Comino. These cover an area of 316 sq km, and its total population was estimated to be 402.000 in 2006 - making Malta one of the most densely populated countries (1282 persons/ sq km) in the world[3]. Malta is a parliamentary republic that gained independence from British rule only on September 21st 1964. It is governed by the ruling Nationalist Party since 1998. The current Prime Minister is Lawrence Gonzi[4].

For many decades Malta has been a country of emigration and Maltese citizens did seek a better life especially in Australia, the States and England. Nowadays, the country itself is facing an increasing immigration of asylum seekers arriving at its shores since several years. The vast majority of asylum claims are made by persons arriving at the shores of Malta by boats of normally 20 – 30 persons coming from Libya. The Libyan cost lies around 360 kilometres south of the Maltese archipelago. The vast majority of the people on the boats are coming from the Libyan costs and are aiming to go to Lampedusa or Sicily in order to reach Italian territory to claim asylum there. As Malta has historically a proportionally very large national sea and rescue area, a certain proportion of the boats that get into distress in Maltese national waters on their way to Italy are rescued by the Maltese military forces (AFM) and brought to Malta. It is important to

[2] Asylum seeker is used throughout the whole report in order to refer to a population defined just a bit further down in this chapter (A note on terminology).
[3] Wikipedia, the free encyclopedia. Malta. [cited August 7th 2007] Available from: URL: http://en.wikipedia.org/wiki/Malta.
[4] Wikipedia, the free encyclopedia. Malta. [cited August 7th 2007] Available from: URL: http://en.wikipedia.org/wiki/Malta.

note that a boat trip apparently takes between three to six days and means a considerable risk to the lives of the migrants. Just between January and the end of August 2007, 223 people died off the shores of Malta[5].

In reaction to the growing numbers of asylum seekers coming to Malta, and in the absence of a national mechanism to process asylum claims, the Maltese government drew up the Refugee Act as a legal basis for the procedure of asylum claims in Malta. This came into force on October 1st 2001, and provided for the Office of the Refugee Commissioner and the Refugees Appeals Board. The Office of the Refugee Commissioner became only fully operational on January 1st 2002, and is since then the responsible body for the procedure of asylum claims on Maltese national territory. Similarly in 2001, Malta lifted its geographical restriction to the 1951 Geneva Convention - according to the EU requirements in the framework of the accession procedure.

Since its full entry in the European Union on May 1st 2004, Malta became part of the "Dublin-space", meaning that its policies, regarding persons seeking political asylum in Malta, had to be aligned to the Dublin-II treaty[6]. This treaty obliges the first country of arrival of almost all asylum seekers to examine and to decide on his or her demand. Therefore almost all asylum seekers landing deliberately or un-deliberately on the shores of Malta have to ask for asylum in Malta itself, and do not have the right to enter any other European country to ask for political asylum.

A total of 4817 asylum applications have been processed by the Refugee Commission between its foundation in 2002 and May 31st 2007. A total of 192 persons have been granted refugee status in all this time. Thus the total acceptance rate amounts to around 4% between 2002 and May 31st 2007. This rate has been significantly decreasing in the last years, being 2.2% in 2006 and 2.8% in 2005.
Table 1 shows the numbers of asylum seekers that arrived by boat on the island between 2002 and 2006[7]. The table highlights moreover the number of asylum cases that have been processed during the whole year. Moreover, it enumerates the number of persons who have been granted a refugee status according to the Geneva Convention from 1951[8], the number of persons who have been granted humanitarian protection after their asylum claim was rejected, and finally the number of persons who's claim has been rejected completely.

	2002	2003	2004	2005	2006	2007
Arrivals	1686	502	1388	1822	1780	1072[9]
Asylum applications processed	474	568	997	1199	1272	340[10]
Refugee status granted	22	53	49	34	28	6
Humanitarian protection granted	111	328	560	484	522	190
Rejections	286	187	259	580	637	191

Table 1: Arrivals, asylum applications and different status granted for asylum claims 2002 – 2006

In 2007 the Refugee Commission registered 1072 arrivals until August 5th. The majority of people were coming from Somalia (351), Eritrea (162) and Ethiopia (106), reflecting somehow the increasing political instability of the whole horn of Africa. The rest of asylum seekers were

[5] Fortress Europe [cited October 28th 2007] Available from: URL: http://fortresseurope.blogspot.com
[6] The Council of the European Union. Dublin II Regulation. 2003 [cited August 7th 2007] Available from: URL: www.udi.no/upload/Regelverk/Konvensjoner/Dublin-eng.pdf
[7] All the data has been provided directly to MdM France by the Refugee Comissioner and the Ministry of Justice
on August 8th 2007.
[8] United Nations High Commissioner for Refugees (UNHCR). Convention and protocol relating to the status of refugees. Geneva, Switzerland. 2006.
[9] The number reflects the arrivals of immigrants in 2007 until August 5th.
[10] The numbers regarding asylum procedures and status reflect the procedures processed between January 1st and May 31st

coming mainly from other sub-saharian African countries, including the Democratic Republic of Congo, Ivory Coast, Nigeria and others.

A similar number of undocumented migrants arriving in Malta must be expected in the coming years, as more and more asyulum seekers try to reach the Italian coast from Lybia, after the reinforcement of the border fence around the Spanish enclaves of Ceuta and Melilla and the overall protection of Spanish borders. Taking this route undocumented migrants often end up in Malta. For the EU, the Maltese border represents a very important issue, because it is one of the roads taken by undocumented migrants to enter the continent, and because the number of arrivals substantially increased during the past few years.

At a national level, the migratory politics of the ruling government focused so far most strongly on policies designed to deter migrants to come to Malta. Its most prominent and controversial policy is the detention of all asylum seekers - migrating irregularly to Malta - for administrative reasons for a maximum period of time of 18 months (for more details see further below in this chapter).

Especially during the summer months, when most of the migrants arrive at the shores of Malta, the topic of "illegal immigration" is extremely present in Maltese society as well as in national papers, and the island faces a raising level of racial discrimination and racist, public opinion. The government applied again a clear hardline position regarding several incidents of boats in distress coming from Libya in 2007. Especially in June 2007 the Maltese government has been criticised a lot by other European countries and international NGOs for its way of proceeding with regard to diverse incidents in international and national waters near the Maltese coastline. Similarly, the government did not change its detention policy, even though it has been criticized widely for its length of merely administrative detention and the inhuman conditions in the detention centres.
The regular and numerous arrivals of asylum seekers to the small island certainly pose an important challenge to the society as a whole, but the current politics that still concentrate most of its efforts on deterring asylum seekers from coming to Malta, possibly foster in the same time a climate of racism and criminalisation. The current politics regarding migration are fully supported by the Labour opposition, and migration is possibly the only area of political agreement between the governing Nationalist Party and the Labour opposition.

Besides its often criticised detention policy and its national migratory politics, it is important to know that the Maltese government has been lobbying for a proportional burden sharing of all migrants found or rescued in international waters. Because of the Dublin II Regulation, the asylum seekers arriving in Malta can ask for asylum in Malta only, and in no other European country. The Maltese government stresses repeatedly that the island is unable to assume the responsibility for all the people arriving on its shores. If we relate the number of undocumented migrants to the Maltese population (only 400 000 inhabitants), the arrival of 1800 asylum seekers in 2005 is approximately equivalent to 270 000 people coming to France in a years time. The authorities underline that since Malta is the smallest country of the new EU member states, and has a GDP that represents only 55% of the average GDP of EU-15, the arrival of such a large number of asylum seekers represents a very high burden for the country. A solution to this and other propositions of the Maltese government at European level has not been decided upon yet.
In conclusion, it is important to outline that Malta is certainly responsible for its particular and harsh detention policy, but the EU also has a part of responsibility and could be more involved in the fair and human reception and integration of asylum seekers in Malta.[11]

2.2 The collaborating local partners during the MdM mission

MdM has systematically exchanged experiences and discussed observations and results with a variety of Maltese associations and NGOs. MdM collaborated for the purpose of this mission with

[11] Claire Rodier, Catherine Teule. Mission internationale d'enquête, Enfermer les étrangers, disuader les réfugiés : le contrôle des flux migratoires à Malte. Septembre, 2004. FIDH, p.7

local partners that have been involved and engaged in a diverse range of support and advocacy activities in detention and the Open Centres during the last years. The main collaborating partners in a range of organizational issues, planning of advocacy and exchange of experiences and data have been:
Jesuit Refugee Service (JRS) Malta, Kopin, Movimento Graffitti, Integra Foundation and Amnesty International Malta.

2.3. Arrival of asylum seekers in Malta and detention policy

2.3.1. Arrival in Malta

Asylum seekers landing at the shores of Malta are generally accompanied by the national Armed Forces (AFM). Upon arrival a medical team of nurses and medical doctors who are on call provides first emergency care and examines every asylum seeker individually in order to determinate if the persons can be transferred directly to one of the detention centres or if the person needs immediate medical care in hospital. Arriving asylum seekers are not assessed for possible medical vulnerabilities or chronic diseases at that point in time.

2.3.2. Detention policy and procedure

The detention policy, procedure and practice - as it exists nowadays – is imposed in terms of the Immigration Act and regulated as such by the policy on *Irregular Immigrants, Refugees and Integration*[12] published by the Ministry of Justice and Home Affairs and the Ministry for the Family and Social Solidarity in 2005.
Generally, Malta applies a policy of administrative detention with a maximum length of 18 months. In reality, most of the asylum seekers are released after 12 months as the Regulations enacted in terms of the Refugee Act state that every asylum seeker (namely all those who have been either accepted as refugees or whose case is still pending or processed for an appeal) should be granted access to the labour market after 12 months. As the majority of first asylum interviews are done around 9 to 12 months after arrival most of the asylum seekers are in reality released after around 10- 12 months from detention.

Even though migration to Malta without the necessary documents is not considered a criminal offence the Ministry of Justice and Home Affairs states in its main document on Irregular Immigrants, Refugees and Integration, that "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. Irregular immigrants who, by virtue of their age and/or physical condition, are considered to be vulnerable are exempt from detention and are accommodated in alternative centres" [13].
At the moment of report writing, there were three detention centres in use. Hal Safi Detention Centre consists of two warehouses and a supplementary block in which as off July 5th 567 persons were living. Hal Far Lyster Barracks Detention Centre consists out of an area with tents and another one indoors with prison zones. As off July 5th 734 persons were detained in the whole complex. One smaller detention centre run by the police exist in Ta' Kandja.
Detention policies vary greatly in all European member states, but Malta is together with Cyprus the only member state that foresees a systematic detention of asylum seekers until "their identity is established and their application for asylum processed"[14]. Even though England, Sweden, Holland and Denmark for example have an undetermined time for the length of detention, people

[12] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005.
[13] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005; page 11
[14] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005; page 11

there are in most cases only detained after the asylum claim has been rejected, or right after the fast asylum procedure upon arrival, or after a reject later on, in order to repatriate or deport the migrant. Persons with an asylum claim that is still under process are normally not detained in these countries.

With regards to special cases and vulnerable persons the Maltese detention policy earmarks that the "detention of minors should be no longer than what is absolutely necessary to determine their identification and health status."[15] The ministries in charge can still require the individual to undertake an age verification test, if "there is a good reason to suspect the veracity of the minority age claimed by the immigrant."[16] Furthermore according to the same document persons, with disabilities, lactating mothers, pregnant women and families (meaning the spouses and their minor children) should not be detained for longer than absolutely necessary.
A procedure for proving the inability of staying in detention on medical grounds, including chronic illness or a history of political torture in combination with a traumatic stress disorder, is not earmarked by this document. Still individual cases may be theoretically brought to the attention of the Immigration Appeals Board in order to assess if a person is too vulnerable to stay in detention. The document only states in these regards that "monitoring is to be conducted on particular cases to confirm whether detention remains admissible."[17]

In conclusion the existent detention practice remains one of the most criticised ones around Europe because of the systematic detention of asylum seekers for administrative purposes up to 18 months, and because of its procedural problems and the very problematic living conditions in the closed centres. For example, after a visit of a delegation of the European Parliament to the two main detention centres in Hal Safi und Hal Far in 2006, the delegation itself strongly condemned the living conditions in the detention centres and even demanded their closure.

More detailed information regarding the living conditions, access to medical treatment, problems of assessing and processing cases of vulnerable persons properly and the immediate harm to health caused by systematic administrative detention practice in Malta will be given in the results section.

2.4. The Open Centres

After release from detention the asylum seekers are most commonly settled in one of the different Open Centres that are located in different areas of the island. The persons are re-divided in different Open Centres according to their age, marital status, sex and vulnerability. The Centres are run by different stakeholders including the church, the government and a NGO.

2.4.1 Basic facts and living conditions

The following list provides a short overview over the main centres and enumerates a breakdown of its different populations (numbers of registered residents were still raising during the month of August, as a considerable number of persons have been released from detention). An assessment of the sanitary conditions with regards to the fundamental vital needs in the two main Open Centres in Marsa and Hal Far has been made.

- Marsa Open Centre (as off July 5th); around 600 registered persons, exclusively male residents (single or not accompanied by their wives if not single). The actual "population" of Marsa Open

[15] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005; page 13
[16] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005; page 13
[17] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005

Centre is certainly higher, as it is the oldest and most convenient centre, especially for the large male population of sub-saharian asylum seekers in Malta.

The centre is run by the big Maltese NGO "Suret-il-bniedem". Its general manager Terry Gosden coordinates the team of care workers, assistants and social workers. The NGO employs an excellent Somali assistant coordinator and cultural mediator, and two care workers from Somalia. Marsa Open Centre is rather centrally located and is the central point of African live and living in Malta. Over the years it developed in a kind of small village, including several restaurants, shops, a laundry, an internetcafé and a coiffeur. It is as well a central point for socializing and entertainment among the different migrant communities.
Residents live in rooms of about 16 persons divided by communities. There are 76 showers (on average 1 shower for 8 persons) and 64 toilets (on average 1 toilet for 9 persons). Hot water is current. The maintenance of the sanitary facilities is assured every day by 3 residents employed by the association. The proximity of the harbour as well as the conditions of hygiene lead to the presence of numerous rats in the centre. A stove is made available in each room. No refrigerators are provided, so fresh food can not be preserved. There are 3 restaurants where the residents can have a meal for a small amount of money.

At their arrival to the centre, the residents receive 3 bed sheets and a cover. The sheets can be washed in the only laundry of the camp which is owned by a resident. Considering the overcrowding and cohabitation and the heat in summer, rooms can be very hot and residents must buy their own fans. There are not any radiators but it seems that it is not very cold in the rooms during winter. One room is used as a mosque, and private evenings are organized for religious feasts. There are as well two TV rooms and one gaming room.

- Hal Far Tent Village (as off August 20th), 764 registered persons (720 men and 44 women), single male, couples and single women. Residents are living in military tents that have been built on top of concrete platforms. At the moment of report writing the government started to build an extra 8 tents on the grounds of the camp. The overall capacity will therefore in the future amount to a maximum number of around 1000 residents.
The centre is run by the Organization for Integration and Welfare of Asylum Seekers (OIWAS) that is part of The Ministry for the Family and Social Solidarity. The centre has been opened up only around one year ago,
There are 35 showers and 35 toilets (1 for 21 persons) in the camp. The water is drinkable and hot, even though Maltese tap water is of rather bad quality. No one is responsible of the maintenance of the sanitary facilities. This can lead to a deplorable standard of hygiene of the facilities. The presence of rats is observed regularly and it seems that there is no systematic rat poisoning taking place.
Stoves and refrigerators are not made available to the residents. Therefore residents must organize themselves. A mobile shop comes to supply the centre every day with food. There's also a restaurant but the conditions of hygiene are not in conformity with the relevant regulations.
Up to 24 people are living in one tent; some tents host couples, some are merely for single women and the rest is for single men. No sheets are provided, but a sleeping bag is given upon arrival.
There is no laundry but some fresh sheets are provided in case of scabies in order to avoid any transmission.
The temperature in the tents regularly reaches up to 40 degrees in summer and can decrease up to 8 degrees in winter; no fans are provided. During heavy rainfalls rainwater repeatedly penetrates inside the tents, especially during the winter months. A mosque and a TV space have been improvised close to the restaurant. The centre is located far from all important administrative and health care institutions and those can be reached only by one public bus.

- Hal Far (EX-Appog) Centre (as off August 15th): 131 residents, mainly accommodating families and single mothers with their children. The centre is run by OIWAS.

- Liedna House (as off August 10th), 26 residents, including children and unaccompanied minors, single parents and couples. The centre is located in Fgura and is run by OIWAS.

- Quwasala House (as off August 14th), 32 residents, including children and unaccompanied minors, single parents and couples. The centre is run by OIWAS.

- Emigrants Comission, a main stakeholder of the Catholic Church runs a small number of centres, with a total of 322 residents.

2.4.2. Living conditions in Marsa and Hal Far tent Village

The two largest Open Centres in Marsa and Hal Far are facing the most serious problems regarding living conditions, hygiene and lodging. Even though the main problems may not be exactly the same, both of the centres are inhabited by a large number of residents, including a majority of young, sexually active, single male. In both centres the residents have to share a common room or tent in between a maximum of 25 persons. This certainly favours the spread of certain skin conditions, such as scabies, and minor and major communicable diseases. A lack of any privacy and intimacy contributes to severe, existing problems concerning psychosocial health of many residents. Especially under the tents in Hal Far these difficulties are increased by the fact that during the summer months it becomes almost impossible to stay inside a tent during day time as it gets incredibly hot. Similarly during winter times residents complain a lot about the fact that they are freezing, especially during the nights. Thus, residents in Hal Far Tent Village have even less of an appropriate living space and their lodging has to be considered as very precarious. As the centre is even extended in the future and the capacity will amount to around 1000 persons, living conditions may further deteriorate there.

2.5. The Maltese health care system and the control of communicable diseases: a short overview

2.5.1. Short overview of the Maltese health care system

The Maltese health care system shows several similarities to the British NHS and operates by means of an integrated health service that is organized at the national level. The system is publicly financed and is free at the point of use. Main service providers are a diverse range of health care centres (policlinics) in different towns around the island. Those are providing primary health care services and family medicine for their communities. The primary health care services face a considerable problem of human resources and at the moment of report writing only 65 general practitioners (GPs) were employed in the primary health care system which normally should be run with more than 100 GPs. Public hospital services and specialist out-patient services are centralized in St. Lukes Hospital in Msida. A new hospital has been built during the last years near the university and will be opened in very near future. Most of the specialised services face similar problems of human resources as does the primary health care, as wages for medical doctors in the public system are rather low and junior doctors tend to migrate to different mainly English speaking countries. The waiting time to see a specialist can amount to several months, sometimes up to one year.
All primary health care services as well as all hospital services are free at the point of use for all Maltese citizens. Prescribed medications have to be purchased by all citizens who are not entitled to free medicines. An entitlement for free medical prescriptions exists for the chronically ill (yellow health card) and people living in precarious living conditions who can not afford to buy their drugs (pink health card). Free medications have to be collected from government pharmacies in the main hospital or the health care centres.
Even though the Maltese health care system is free for all citizens at the point of use with regards to primary and emergency health care, private health care provision plays an increasingly important role. Main reasons therefore are that patients have to wait longer and may get better quality care in some cases. Most of Maltese who can afford to see general practitioners and specialists privately prefer to do so.

2.5.2. Entitlement to health care of asylum seekers

According to information obtained from the Ministry of Health accepted refugees are currently entitled to "full access to health care services provided through our national health service." All other asylum seekers are similarly entitled to free medical primary and emergency health care on a humanitarian basis. In reality this means that asylum seekers, independently of their refugee status, are entitled to the same range of services a Maltese Pink Card-holder is entitled to, even though a Pink Card is not issued to asylum seekers. As described more in detail further below, a main problem regarding in daily reality is that a considerable amount of doctors and other health care workers are not precisely aware of this form of entitlement.

2.5.3. The control of communicable diseases

2.5.3.1 Tuberculosis

The Maltese Public Health Division concentrates it efforts in terms of prevention of communicable diseases almost exclusively on the screening, diagnosis and treatment of Tuberculosis of asylum seekers. The prevalence of Tuberculosis in the overall Maltese population is very low and amounts to an estimated TB burden of 4.5 per 100 000 persons[18]. On contrary the prevalence in the most frequent countries of origin of the asylum seekers coming to Malta (Somalia, Sudan, Eritrea, Ethiopia) are much higher, amounting to between an estimated 286 cases per 100 000 persons in Somalia[19] and an estimated 546 cases per 100 000 persons in Ethiopia[20].

In order to detect and to treat active pulmonary Tuberculosis, all arriving asylum seekers are screened for Tuberculosis during the first days after arrival by X-ray. If found to suffer from active pulmonary TB they are started on treatment in a specialized unit in St.- Lukes-Hospital. Before their release from detention everybody is again screened for active Tuberculosis, and treated in case of a positive result. Up to May 2007 all those found to be diseased by active pulmonary TB during detention or upon release have been detained until the finalization of their 6 months treatment course, meaning that persons were detained for 6 more months only because of their TB-disease. This policy has now been changed and all those persons found to be reliable enough to take their short course treatment in a setting of an Open Centre are released from detention as everybody else, once their treatment was started. Table 2 shows the overall number of cases of pulmonary TB of "irregular migrants" (meaning all persons who came by boats in order to claim political asylum or not) between 2002 – 2006[21]. It shows as well the number of asylum seekers screened during the same period of time. The number in the second column therefore refers to all cases screened per year, namely all screenings after arrival and all screenings before leaving detention.

Year	No of cases of pulmonary TB	No of irregular migrants screened
2002	8	1595
2003	0	949
2004	9	1965
2005	9	2773
2006	10	2600

Table 2: Number of cases of pulmonary TB in irregular immigrants 2002-2006

[18] World Health Organization (WHO). TB country profile, Malta. 2005 [cited August 13th 2007] Available from: URL: http://www.who.int/globalatlas/predefinedreports/tb/PDF_Files/mlt.pdf

[19] World Health Organization (WHO). TB country profile, Somalia. 2005 [cited August 13th 2007] Available from: URL: http://www.who.int/globalatlas/predefinedreports/tb/PDF_Files/som.pdf

[20] World Health Organization (WHO). TB country profile,Ethiopia. 2005 [cited August 13th 2007] Available from: URL: http://www.who.int/globalatlas/predefinedreports/tb/PDF_Files/eth.pdf

[21] The data has been provided the Disease Surveillance Unit of the MoH, Malta.

A main problem of the current TB screening and prevention practice from an epidemiological point of view is that asylum seekers who have not been screened yet after arriving in Malta are staying together with those who arrived earlier and who have already been screened for some days in the detention centres.

2.5.3.2 HIV/AIDS and Sexual Transmitted Diseases (STD)

Contrary to the systematic approach regarding TB among asylum seekers, no activities were identified in the field of HIV/AIDS and STDs towards this population. Malta lacks any sexual health policy and visibility of general prevention on issues around sexual health and HIV/AIDS is generally very low. Dr, Philip Carabott, head of the Genito-Urinary-Clinic in Boffa Hospital, mentioned in an interview with MdM France that *he was trying to introduce a policy on sexual health for around 8 years, but this idea was never realized, mainly because of the strong influence of the Catholic Church in Maltese politics.*
As for Tuberculosis the HIV prevalence rate is very low in Malta and amounts to an estimated 0.1% among adults aged 15 to 49 years[22]. The countries on the horn of Africa on the contrary face all generalized epidemics, even though they do not belong to the high prevalence countries of the more southern African nations. Prevalence rates in these countries vary between an estimated 0.9% in Somalia and an estimated 2.4% in Eritrea among adults aged 15 to 49 years. Therefore a certain risk exists that the arrival of asylum seekers may increase the prevalence of HIV in the overall Maltese population, especially if no appropriate preventive programs are provided.

Regarding prevention or testing of STDs among asylum seekers, there was no evidence for any kind of systematic action - upon arrival of the MdM mission in April 2007. Asylum seekers are not systematically tested upon arrival, nor are preventive materials, such as male condoms, distributed, nor are there preventive activities, educational workshops or peer-to-peer support provided in the Open or Closed Centres by government entities or NGOs.
Table 3 shows the only available data[23] on HIV/AIDS among "irregular immigrants". All the cases of HIV-infection or clinical AIDS disease have been detected through general health care procedures.

Notified disease in irregular immigrants	**2002**	**2003**	**2004**	**2005**	**2006**
HIV	1	0	1	6	8
AIDS	0	1	0	0	2

Table 3: Number of cases of HIV in irregular immigrants 2002-2006.

♦ In the light of HIV and TB prevention and the assessment of vulnerabilities MdM France calls for the implementation of an individual, exhaustive medical assessment within 1 week after arrival. This assessment should include the proposition of a voluntary, confidential and anonymous HIV-test and guarantee the identification of vulnerabilities on medical grounds in a confidential manner.

[22] Joint United Nations Programme on HIV/AIDS (UNAIDS). 2006 Report on the global AIDS epidemic, A UNAIDS 10th anniversary special edition. Geneva, Switzerland, UNAIDS; 2006.
[23] The data has been provided the Disease Surveillance Unit of the MoH, Malta.

3. The MdM-project: Concrete action and collection of evidence

After a week long exploratory mission in September 2006, conducted by Fabrice Giraux, General Secretary of MdM France, and Valerie Checcherini, International Secretariat MdM France, it was decided to plan and to implement an international humanitarian mission in Malta for a duration of 5 months. The mission was started on April 18th 2007. The field team consisted of Malika Bouhénia, nurse and volunteer of MdM Nantes, and Niklas Luhmann, medical doctor and Master of Science in International Health.

3.1. Objectives

The following main and specific objectives were established before the mission:

1. Main objective:
    a. Foster the right to access health care among the migrants living in detention and in the Open Centres
2. Specific objectives:
    a. Assure medical consultations in the Open and Closed Centres in order to ameliorate access to health care of the residents during the presence of MdM.
    b. Develop an epidemiological overview of the most common diseases and health problems in the Open Centres and in detention.
    c. Collect evidence on the main problems in accessing health care – as perceived by the migrants.
    d. Provide different types of prevention in the Open Centres and in detention
    e. Support local NGOs and associations in their advocacy regarding health care of asylum seekers.
    f. Train cultural mediators on issues around health and prevention.

The main problem in meeting the above mentioned objectives was that MdM France was not allowed to access detention in order to provide health care or prevention there. This decision was taken by the Ministry for Justice and Home Affairs, even after the President of MdM France, Dr. Pierre Micheletti, had directly written to the Minister of Justice and Home Affairs, Dr. Tonio Borg. MdM France visited the two main detention centers for 1 day at the end of the mission in order to assess the living conditions and the hygienic conditions.

3.2. Activities

In order to achieve the objectives of the mission, the following activities were planned and implemented during the time of the mission:

1. Medical consultations: Primary health care and medical consultations were started on June 1st in Hal Far Tent Village (consultations were offered here on Wednesdays and Fridays between 5pm and 8pm) and on June 14th in Marsa Open Center (consultations offered on Thursdays from 5pm to 8pm, and on Sundays from 12am to 5 pm). In order to start consultations in Marsa Open Centre a new clinic room was selected, renovated and equipped in collaboration with the Maltese NGO “Sutret-il-bniedem” and the department of Primary Health Care and Family Medicine.
2. Questionnaires: All persons coming to the consultations for the first time were asked to answer questions on access to health care or psychosocial health. The structured face-to-

face interviews were conducted by the MdM nurse, Malika Bouhenia. For more detailed information on the methodology of the questionnaire based survey please see further below.

3. Prevention: Preventive workshops for women with a main focus on sexual and reproductive health were held in diverse Open Centres from mid may onwards. Leaflets on TB, STDs, HIV/AIDS, and chronic Hepatitis were displayed during the medical consultation in Arabic, French and English. Moreover condoms were offered and distributed for free.
4. Training of cultural mediators: From July onwards two women (one asylum seeker from Somalia and one from Eritrea) were trained in collaboration with JRS as cultural mediators on issues of confidentiality and sexual and reproductive health. A medical dictionary was developed and provided to the medical services in detention and different public health care services, including the main public hospital.
5. In cases of communication problems, emergencies, reported difficulties of accessing health care and chronic diseases asylum seekers were regularly accompanied to the main public hospital in order to testify main problems of accessing emergency care and specialist consultations.
6. Several presentations for the staff on TB, HIV/AIDS, hepatitis and scabies were held in three Open Centres by the MD of the program, Niklas Luhmann.

4. Health care and prevention in detention and the Open Centres: Methodology, observations, findings and recommendations

In this fourth part of the report the findings and results concerning access to health care of our humanitarian mission in Malta will be outlined and recommendations for further improvement will be highlighted. In a first section, an overview of the main issues regarding the living conditions and access to health care in the detention centres in Malta will be given. Therefore MdM refers to its own experiences and testimonies made during a visit to the two main detention centres in Hal Far and Hal Safi on 6th of September. Furthermore we made use of the diverse data and material that was provided for these purposes by JRS Malta and other stakeholders.
This is followed, in a more extensive second part, by the description of the development, methodology and analysis of the survey on access to health care in the Open Centres that was carried out by the MdM field team between June 1st and August 19th. Moreover, more findings and experiences regarding prevention and accompaniments will be presented. Recommendations regarding access to health care and prevention of asylum seekers will be outlined throughout the chapters on the end of each section.

4.1. Detention

In the beginning of its mission in May 2007, MdM France requested access to detention in order to provide medical assistance and prevention on a regular basis. Even after an intervention by the president of MdM France, Dr. Micheletti, at the end of June, the field team was never given access to provide professional support in the closed centres. Only after a first publication of the results of this report, the MdM field team was granted the right to visit the two main detention centres on September 6th 2007. The observations and testimonies gathered during the visits to different parts of the detention centres are outlined further below. The main argument for deciding not to permit any service provision (as given by the Ministry of Justice and Home Affairs) was, that since the end of April a new private company had been contracted out in order to provide medical services on weekdays between 8 am and 1 pm. The Ministry argued that it wanted to avoid to create two parallel systems, especially as the new setting had only just started. The alternative proposition to offer for example only preventive workshops on sexual and reproductive health, was not really considered as an alternative.
MdM France strongly condemns and regrets this decision of the Ministry of Justice and Home Affairs, as the association is well aware that the closed centres pose great difficulties for the asylum seekers in terms of access to health care and assessment of vulnerabilities. On the other hand MdM acknowledges that the Ministry has granted the field team a full day of access in order to visit the centres and to assess the situation and the living conditions.

It remains important to state that there are several organizations that access detention regularly, including the Jesuit Refugee Service (JRS) and the United Nations High Commissioner for Refugees (UNHCR). JRS Malta has focused almost its entire work on the legal, social and medical support of asylum seekers living in detention. As the main service provider in the closed centres and as an independent NGO the organization has published policy recommendations on the reception of asylum seekers in Malta[24] in 2005. Since then, JRS has even strengthened their professional presence in the closed centres, and is employing since the beginning of 2007 a nurse, seconded from the public service, who looks into the medical aspects and issues in detention.

In this section we want to outline our own observations during our visit to detention at the end of the mission. Moreover, we had the possibility to discuss repeatedly the experiences of our clients

[24] Jesuit Refugee Service Malta (JRS). Reception of asylum seekers in Malta, Policy Recommendations. Birkakara, Malta. 2005

in the detention centres during our clinical assistance and our preventive workshops. We see all their stories and experiences as a clear indirect testimony to the reality of the closed centres. Furthermore, we collaborated with JRS on gathering material from their own everyday interventions in detention, and we use their latest figures on the follow-up of vulnerable persons. Another source of information regarding the medical services inside the closed centres is the private company Medicare Services Ltd. that is in charge of providing medical consultations weekdays in the closed centres.

4.1.1. The MdM visit to Hal Safi and Hal Far Detention Centre

On Septmeber 6th the MdM field team, consisting of Malika Bouhenia and Niklas Luhmann, visited the two main detention centres in Hal Safi and Hal Far.

At the beginning of our visit the Head of Detention Services Mr. Brian Gatt gave a short introduction on the principles of the detention procedure and on the possible developments envisioned for the near future. He highlighted that even though the relatively new medical services were a great improvement for the detainees and their access to health care, this new set-up was putting a great pressure on the workload of his staff as – according to him – the referrals to policlinics and public hospitals had increased. He outlined as well the fact that detainees who asked for a doctor in the evenings still need to be transported by soldiers to one of the policlinics or hospitals. In these cases, he added, people who are consulted by a doctor and found not to be sick, are put into solitary confinement in order to punish their "fraud".
In response to the question if there were any activities offered to the detainees, Mr. Gatt said that - in collaboration with OIWAS – activities (including sports, language training etc.) will be started in the beginning of 2008 in the Hermes building in Hal Far Detention Centre. Only later will these activities be offered eventually in Hal Safi Detention Centre as well. He mentioned as well that the sanitary facilities in the tent compound of Hal Far Detention Centre have been recently refurbished and that the Detention Service now had asked for funding in order to refurbish two rooms for medical quarantine - as in cases of infectious diseases people were still separated in the cells for solitary confinement.

- **Hal Safi Detention Center:**

We started our visit at Hal Safi Detention Centre where up to approximately 800 single men can be detained. Here we visited only Block C and Block B as the authorities recommended not to enter the warehouses, as the situation there seemed to be rather tense. The Safi Barracks are managed by the Detention Service (DS) and are composed of two warehouses and "Block B" and "Block C". The two warehouses have a maximum capacity of 400 persons (200 persons in each, however, it was noticed at some point that 230 persons were accommodated in one warehouse). It can be described literally as two warehouses divided into 12 dormitories each; the corridors and dormitories are divided by wooden partitions measuring approximately 2m by 5m; at the end of the corridors there are 2 bathrooms in each warehouse. Block C (3 rooms) has a maximum capacity of 220 persons and is divided into 3 adjacent rooms. Each room is divided into 1 common room, 2 dormitories, 2 bathrooms and 2 washrooms. Block B is a 2 storeyed-building. On each floor there are around 6 rooms with 8 bunk-beds each. In the middle of each floor there are the sanitary facilities. Block B has as well a maximum capacity of about 200 persons.

First, we visited one of the 3 areas in Block C were around 85 persons were detained in very overcrowded conditions in 2 separated dormitories and a smaller living room at the entrance. The detainees have access to a smaller ground outside that is adjacent to the dormitories. The outdoor area is protected by high fences and can be used mainly for exercise and sports. The dormitories were clearly overcrowded and about 10 persons were sleeping on mattresses on the floor. In the whole area no chairs, tables, small cupboards or any other furniture was available. The television in the "living room" had only one Italian channel. Moreover the sanitary facilities were in detrimental hygienic conditions. In total 4 toilets and 4 – 5 showers were available for the whole of 85 detainees.

During a long discussion with a large group of detainees those complained about the difficult living conditions and the violation of their human rights. The detainees put a great emphasis on the fact that they felt treated "like animals" under the conditions they faced here. Some of them said that "its is unfair and a violation of our human rights to detain us for one year, just because we migrated from our countries to seek asylum in Europe." Moreover the detainees complained that they had not been given the possibility to contact their families (most of the asylum seekers in the room were just arrived around 2 – 3 months ago) in order to tell their relatives that they were alive and in Europe. They furthermore highlighted that the food they were served was sometimes not cooked well or even not cooked at all, that they did not have any tools for cleaning the sanitary facilities, that they were suffering from the lack of activities and that they had not even some table games or anything to read. One of the detainees showed the deflated football explaining that they could not even do any sports any more and that sometimes when they shot the ball over the high fences of the outdoor area the soldiers ignored them when they were asking them to throw the ball back. The vast majority of the asylum seekers described problems of sleeping and accessing medical health care and treatment. They outlined that among the whole 200 – 230 detainees of Block C (which consists of further 2 areas that are very similar to the area visited and that contain as well around 85 detainees) the soldiers choose around 10 persons in the morning to see the doctor. Therefore it can sometimes take a couple of days to be chosen and to see the doctor. More importantly the detainees claimed that after having been consulted it takes most of the times a couple of days until the treatment was provided.
In general the asylum seekers showed a certain anger and suffering related to the combination of a lack of activities in a very overcrowded area with a low standard of hygiene. The conditions described here do certainly not align to the standards proposed and stipulated in different human rights instruments, such as the standards for imprisonment compiled by the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)[25].

After the visit to one of the 3 areas in Block C we continued to visit both floors in Block B. We started in the upper floor where people complained about very similar problems, especially the lack of activities, reading materials and the quality of food. The detainees outlined that around 110 persons had to share 4 toilets and 4 showers and that no hot water was available in the moment. The sanitary facilities were clearly more hygienic than in Block C, cleaning material avbailable. After a short while the detainees of the upper floor let us understand that it would be important to visit the ground floor as there have been some incidents happening during the last days.
On the ground floor we have been immediately welcomed by a group of seemingly nervous men that brought us into their room at the end of the floor. There they showed us immediately a spot of dried blood on the floor. The started to explain that – according to them –the soldiers had beaten and hurt a couple of detainees on September 4th after they had asked to see the a responsible soldier in charge, in order to hand him over a letter that contained about 14 demands. The soldiers had then ordered them to go back in their rooms and to be quiet. They had seemingly told them as well that no responsible person was available to take the letter. The detainees revealed that the situation had then got out of control and that the soldiers started to push them in the direction of their rooms, insulting them. They claimed as well that they had beaten some people with sticks and once in their rooms the soldiers had broken the glass and sprayed teargas in the room. Visibly the lower window of the door to the last room was broken. 2 persons had to be transported to hospital in order to be treated for their injuries. The main demands on the original letter were referring to the fact that the detainees felt that they had not enough clothes (only 1 pair of trousers, 1 t-shirt and 1 pair of flip-flops is given to them upon arrival), that they have not had the possibility to phone their relatives, that it sometimes took a long time to see the doctor, that they wanted at least some basic furniture, that they had no access to table games, newspapers or reading material. The detainees said that this letter was never received by any responsible person. They outlined as well that 17 persons were now entered in hunger-strike until the letters were

[25] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The CPT standards, "Substantive" sections of the CPT's General Reports. Strasbourg, France. October 2006.

received by the authorities and they were given an explanation of the violence they had undergone. We promised them to inform the authorities about their basic requests and to ask them to receive the letter of the persons in hunger-strike. We did so the next morning and we informed as well UNHCR and JRS Malta about the incident. They outlined clearly that similar incidents about violence towards detainees happen relatively regular and are never well investigated. The soldier in charge told us during the visit that the soldiers of the Detention Service had not attacked any detainees and that they had hurt themselves this morning.
As mentioned above, we were recommended not to visit the warehouses in Hal Safi Detention Center. Thus we continued our visit in Hal Far Detention Center that is as well run by the Detention Service.

- **Hal Far Detention Center:**

Lyster Barracks in Hal Far is managed by the Detention Service (DS) and is composed of the Hermes building and the Tent compound. The centre "shelters" single men, women, children, couples and families. The Hermes Building has an estimated overall capacity of 550. The building is an old army barracks split into three floors and each floor is further split by means of a metal gate to create different zones. People sleep in rooms made up of 8 bunk beds which they divide for privacy purposes, with bed sheets. Single females are still detained with other single males, families and couples, especially during summers when all of the detention centres get very overcrowded. People living in the different zones are allowed to only 1 hour of "sunshine" - twice weekly - in a yard without bushes, trees, on soil, surrounded by barbed wire. The Tent Compound has a maximal capacity of 390 persons. The 13 tents are built on raised concrete platforms with 30 beds each, and one building divided into a common room and the sanitary facilities. People sleep in common tents, composed of 30 bunk-beds, which they divided for privacy purposes with bed-sheets. During our visit we have only seen three different zones and the cells for solitary confinement near the tent compound. We did not have the time to visit the tent compound.

We spent a considerable amount of our time on the ground floor of the Hermes Building in a very overcrowded zone where people were even sleeping on the corridor and sometimes seemed to share a bed. In this zone couples, single women and pregnant women were detained together. The detainees complained severely about the humiliations they were facing on a daily basis. One of the detainees stated that "if they really have to detain us for such along time, let them imprison us, but we do not want anymore to be treated like animals without a minimum of respect and basic living standards." The detainees mentioned moreover that it was unbearable for them to see that some of the pregnant women were detained for several weeks and that one single women remained detained even though she had lost 2 brothers and her husband on the boat to Malta. A main complain was again the total lack of activities and the problems in accessing medical consultations and especially treatment. The asylum seekers explained as well the difficulties that they were only granted a recreation time on fresh air twice a week for one hour.
On the other zones detainees seemed to have similar complains and we met a couple with three children that claimed that they have been detained already for around 4 weeks with their children and that other children that have arrived after them had been already released. This was confirmed by JRS Malta later on.

4.1.2. The living conditions in the detention centres. A short summary.

This section tries to highlight once again the main concerns with regards to the living conditions in the two main detention centres in Hal Far and Hal Safi. We therefore clearly refer to our own observations during our visit on September 6th and to the vast experiences of JRS, UNHCR and other stakeholders.
The living conditions in these centres are generally marked by cohabitation and promiscuity in very overcrowded rooms or dormitories and a total lack of privacy or intimacy. Moreover, sanitary facilities are in bad state, most of the flushes are broken, in some of the areas even cleaning material was missing – as mentioned above. In most of the showers no privacy is

respected, as there are no curtains. Detainees have only access to Maltese tap water which is of rather bad quality and quite salty. Pregnant women, lactating mothers and babies an children similarly have no access to proper bottled drinking water. In both centers exists a lack of basic furniture like chairs or armchairs to sit on, and shelves or cupboards to store personal items in. Detainees are generally only given 1 t-shirt, 1 pair of trousers and 1 pair of shoes upon arrival. Especially in the zones of the Hermes building in Hal Far Detention Center detainees a granted only 1 hour recreation time outside the zones twice a week. According to the authorities and Mr. Brian Gatt, head of Detention Service, the amount of recreation time will be soon at least doubled, as they plan to open up a second recreation area for the detainees of the Hermes Building. Up to date, no activities at all are organized in the detention centers. Disciplinary action against asylum seekers in detention can be taken rather arbitrarily and no clear rules regarding disciplinary action have been defined or are publicly known. Furthermore no independent board exists that can address detainees' appeals or complains. Even though the policy document on Irregular Immigrants, Refugees and Integration clearly states that "single women asylum seekers and those not travelling in the company of their spouse should be accommodated separately from male asylum seekers"[26], in reality there are still single women living together with single men, couples and families in Hal Far Hermes Building. This may cause severe problems of sexual harassment and sexual or gender based violence. This is very different to avoid during the periods of summer time when the centres get very overcrowded, argued the authorities in talks with MdM.

Longstanding experiences of NGOs and the UNHCR, reports and accounts of asylum seekers themselves and the observations of the MdM field team strongly suggest that the systematic detention of asylum seekers – who certainly do not see their own migration as a criminal offense – in the above described inhuman, very precarious circumstances gives rise to diverse problems, including especially psychosocial and mental health (re-traumatization and chronification as well as causation of mental disorders).
We therefore refer as well to the latest data on the hospitalisation of asylum seekers in Mount Carmel Hospital: Between the beginning of the year up to August 20th 2007 a total of 43 male asylum seekers were admitted to the psychiatric department in Mount Carmel Hospital. 27 out of these admissions have been re-admissions and 16 were new cases. In total 29 admissions of male asylum seekers had been done from detention centres (17 from Ta' Kandja Detention Centre, 5 admissions from Lyster Barracks, 3 admissions from Police General Headquaters, 4 admissions from Safi Barracks Detention Centre). Only 1 women was admitted from Lyster Barracks Detention Centre in the same period of time[27]. These figures show clearly that most hospitalizations of asylum seekers are concerning individuals living in detention at the moment of admission. They therefore reflect the immense impact of the detrimental living conditions on the mental health of asylum seekers, as it has been described as well in scientific publications[28].

In conclusion MdM believes that the detention of persons for a maximum of 18 months in the above described conditions has to be considered an inhuman practice that poses a severe threat to the physical and psychological well-being of the detainees.

4.1.3. Access to health care

Medicare Ltd. has been contracted by the Ministry of Justice and Home Affairs to offer medical consultations in closed centres from end of April 2007 onwards. The company provides services in the both big detention services in Hal Far and Hal Safi between 8am and 1 pm from Monday to Friday. The services are provided by a medical doctor and a nurse.

[26] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005 ; page 14.
[27] All the mentioned figures have been provided directly to MdM by the Department of Psychiatry, Mount Carmel Hospital.
[28] Sultan A, O'Sullivan K. Psychological disturbances in asylum seekers held in long term detention: a participant-observer account. Medical Journal of Australia. 2001; 175; 593-596.

These services certainly mean an improvement, especially regarding access to medical consultations. Before their implementation medical consultations were offered by government doctors on a far less regular basis.
The responsible staff of Medicare reported to MdM that *they provide around 20-30 medical consultation in each centre per day.*
Even though the regular presence of these medical services provide seemingly a basic standard of primary health care in detention, clearly important problems remain with regards to accessing health services and treatment. For the following points we refer to experiences of Medicare, JRS, MdM and the testimonies of asylum seekers in detention:

1. There remain problems concerning access to treatment for acute medical conditions, as the drugs are prescribed by the doctors and have then to be collected by the soldiers from a government pharmacy. Between the consultation and the start of treatment normally lies a time span of 2 days, sometimes the delay may be 3 days as well. During our visit to the detention centers we were regularly confronted with reports of detainees who testified that they had to wait for a couple of days after their medical consultation, even though their condition was acute. Drugs are generally not kept in the detention centre's clinic as both government and the Medicare agree that there would be a pharmacist needed for such a setting. This delay for starting treatment, especially in acute conditions, is simply unacceptable.
2. Patients of the clinics who need to be seen in hospital or by a specialist consultant need to be accompanied by soldiers to the according facility. Whenever detainees are accompanied they are brought handcuffed. We collected clear evidence that people repeatedly miss appointments with specialists or other healthcare professionals during their time in detention; this is often due to lack of resources including transport and manpower. Thus specialist consultations and follow-ups of acute and chronic conditions remain a main problem regarding the access to health care of asylum seekers.
3. The detainees themselves reported that it was sometimes difficult to consult a medical doctor as the soldiers choose a defined number of patients per zone, area or block. Sometimes sick people may thus not be able to consult the doctors because they had not been chosen by the soldiers or because they had not "been fast enough".
4. Problems of communication remain very prevalent during medical consultations.
5. No prevention in form of health care education or for example in form of condom availability is offered.
6. The medical services offered are very limited and would need to be extended to be able to offer adequate services.
7. Regular violations of issues around medical confidentiality have been observed.
8. Repeatedly persons with communicable diseases, including scabies, shingles and others have been put in medical quarantine. No appropriate facility or room exists in the centres in order to quarantine people in a humane way. According to the authorities the refurbishment of 2 rooms for medical quarantine is planned for the next months.

4.1.4. Vulnerabilities

Since the foundation of OIWAS as main institution responsible for the identification and release of vulnerable persons in 2007, procedures have certainly improved and became more efficient. Problems remain in two main areas. Firstly, the policy paper on Irregular Immigrants, Refugees and Integration[29] does not provide a sufficiently clear framework for the identification and release of vulnerable populations, especially for the identification and release of vulnerable persons on medical grounds. Secondly, the processes and procedures put in place regarding this issue remain under-effective and could be furthermore standardized and made more efficient.

[29] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005; page 15.

4.1.4.1 The policy paper: An incomplete framework

The policy document mentions, as outlined further above in the introduction chapter, a number of groups that are clearly considered as being vulnerable. This includes unaccompanied minors, persons with disability, elderly, families, pregnant women and lactating mothers. Very importantly, the policy does not state anywhere that persons with serious or chronic medical problems and people with mental health problems have any explicit guarantee of being recognised as vulnerable persons. The document is thus missing an important sub-group of asylum seekers who should definitely be considered as vulnerable in the given context. The only, somehow diluted, part in the document that refers to vulnerable persons besides the more or less clearly defined groups, states that "monitoring is to be conducted on particular cases to confirm whether detention remains admissible."[30]
MdM clearly believes that the policy document should explicitly add a paragraph defining that an independent board should be established in order to identify all those persons who – on a variety of medical grounds, including mental health – are inapt to remain in detention. Only such an independent board can proceed similar requests in a fully confidential manner.

4.1.4.2 The identification and handling of vulnerable persons

The identification and handling of all vulnerable persons falls under the main responsibility of the Organization of Integration and Welfare of Asylum Seekers (OIWAS). The most obvious cases such as pregnant women and children are – at least in most of the cases – transferred to OIWAS by the immigration police after their first identification procedure upon arrival. All other vulnerable persons are taken up by OIWAS itself or they are transferred to OIWAS by JRS staff. The procedures with regards to the identification of vulnerable persons has become more efficient during the last 12 months, on the other hand an important fraction of vulnerable people remain in detention for definitely too long, or in some cases even for the full time of detention. Generally, it revealed to be difficult to identify an alternative accommodation outside the closed centres, after having been defined as being vulnerable. This organizational issue is clearly unacceptable given the importance of immediate release of a vulnerable person from detention.

The following figures show the main vulnerable groups and outlines shortly the procedures that have been taking place in 2007:

1. **Children:** Approximately 28 children arrived at the shores of Malta between May 8th and August 8th 2007, accompanied by their mothers or their mothers and fathers. As off August 16th, 4 children remained still detained. 3 out of the 4 children have only arrived on august 8th. The fourth, a 2 year old child arrived already on 22.06.2007 and was still detained – for almost 2 months – at the moment of report writing. Another case is well worth to be mentioned because of its inhumane aspects. A child that was born on one of the boats on July 24th was first hospitalised together with her mother for a couple of days after arrival. Mother and child were then detained and only released on August 14th. Most of the children in 2007 were detained for around 2 weeks, but several children remained detained up to 5 or 6 weeks. Similarly MdM witnessed during its visit to Hermes Building in Hal Far that 3 children remained detained around 4 weeks after arrival, even though other children that have arrived after them had already been released.
2. **Pregnant women:** Out of 11 pregnant women who arrived between May 15th and August 8th, 4 women are still detained. 1 Somali women who had arrived in her 8th month of pregnancy was detained after arrival and gave birth on August 1st. She remained detained up to August 14th. This shows another example of very inhumane practice regarding the detention of pregnant women, as this Somali women should most certainly have been

[30] Ministry of Justice and Home Affairs, Ministry for the Family and Social Solidarity. Irregular Immigrants, Refugees and Integration. Valetta, Malta. 2005.

accommodated in an open facility before birth and similarly not been detained with her newborn after giving birth.

3. **Other vulnerable persons:** Even though several problems exist regarding the detention of children and pregnant women, the release of all other vulnerable groups reveals to be much more complicated and inefficient. Still in 2007 several persons with physical disabilities and histories of severe war injuries, remain detained, even though the social worker of JRS has obtained a medical certificate for them. Other cases of clearly vulnerable persons include people with chronic medical conditions like epilepsy and diabetes and those persons who have been victims of torture and trauma. In practice it shows to be very difficult to process these cases and only very rarely persons with chronic medical conditions or a personal history of torture and trauma are considered as vulnerable and thus released earlier. All together at least between 10 – 15 people with evident vulnerabilities remain detained in the moment of report writing.

4.2. Recommendations: Detention in Malta, an inhuman practice

In principle, MdM strongly believes that asylum seekers should not be systematically detained, and that all possibilities to create non-custodial alternatives for the reception of asylum seekers should be considered. Moreover MdM firmly regrets the inhuman conditions in which asylum seekers are detained in Malta.

If, anyhow, the government decides to continue to detain asylum seekers, MdM - as a medical humanitarian aid organisation - calls upon the government to ensure that meaningful changes, especially regarding the health and health care of asylum seekers are achieved and implemented. Any developments and policies adopted with regards to detention of asylum seekers should be in line with the standards defined in the various human rights instruments to which Malta is a party.

In this light MdM France wants to outline that - from a viewpoint of public health and clinical medicine

the detention of men, women, children and minors under the above described conditions for a maximum period of 18 months is a clearly inhuman and degrading practice that harms the somatic and psychosocial health of the detainees.

We relate to the experiences made on a daily basis by the staff of JRS Malta, to our own observations during our visit and to the report to the Maltese government by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), that states that "the medical members of the CPT's delegation once again observed the detrimental impact on the physical and psychological state of health of detained foreign nationals…..Unsurprisingly, many of the problems noted were of psychosomatic nature. In addition, the accumulation of such factors was conducive to the development of reactive disorders"[31].

MdM therefore recommends that:

- **the following living conditions should be immediately improved: Overcrowding and cohabitation should be restricted to a minimum, bottled drinking water should be provided to pregnant women, lactating**

[31] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Report to the Maltese Government on the Visit to Malta. Strasbourg, France. 2005.

mothers and babies, all detainees should have regularly the possibilities to go outside and meaningful activities should be offered to everybody on a regular basis.

In the light of the reality of overcrowded detention services for asylum seekers in Malta with rather low standards of hygiene and sanitary facilities MdM France calls upon the government to align to the standards recommended as well by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Their report on general standards regarding imprisonment states that "all the services and activities within a prison will be adversely affected if it is required to cater for more prisoners than it was designed to accommodate; the overall quality of life in the establishment will be lowered, perhaps significantly. Moreover, the level of overcrowding in a prison, or in a particular part of it, might be such as to be in itself inhuman or degrading from a physical standpoint"[32]. The report later continues: "Ready access to proper toilet facilities and the maintenance of good standards of hygiene are essential components of a humane environment…The CPT would add that it is particularly concerned when it finds a combination of overcrowding, poor regime activities and inadequate access to toilet/washing facilities in the same establishment. The cumulative effect of such conditions can prove extremely detrimental to prisoners"[33].

The report calls as well upon the establishment of regular activities and the guarantee of a minimum time for outdoor exercises ("A satisfactory programme of activities (work, education, sport, etc.) is of crucial importance for the well-being of prisoners...However, prisoners cannot simply be left to languish for weeks, possibly months, locked up in their cells, and this regardless of how good material conditions might be within the cells. The CPT considers that one should aim at ensuring that prisoners in remand establishments are able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activity of a varied nature….Specific mention should be made of outdoor exercise. The requirement that prisoners be allowed at least one hour of exercise in the open air every day is widely accepted as a basic safeguard"[34]).
These guidelines and standards are clearly not met in the current situation of systematic, administrative detention of asylum seekers in Malta.

♦ the detention of single women together with any men should be under all circumstances avoided.

MdM France refers here fore again to the guidelines and standards outline by the CPT report that was published in 2006. The report develops a certain range of guidelines regarding women who are deprived from liberty. The report states that "as a matter of principle, women deprived of their liberty should be held in accommodation which is physically separate from that occupied by any men being held at the same establishment"[35].

[32] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)**.** The CPT standards, "Substantive" sections of the CPT's General Reports**.** Strasbourg, France. October 2006; page 17.
[33] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)**.** The CPT standards, "Substantive" sections of the CPT's General Reports**.** Strasbourg, France. October 2006; page 18.
[34] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)**.** The CPT standards, "Substantive" sections of the CPT's General Reports**.** Strasbourg, France. October 2006; page 17 - 18.
[35] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)**.** The CPT standards, "Substantive" sections of the CPT's General Reports**.** Strasbourg, France. October 2006; page 77.

MdM welcomes the improvements achieved through the introduction of medical consultations in the beginning of 2007. It is still concerned about issues related to the access to medical consultations, to treatment and specialised care.
MdM therefore recommends moreover that:

♦ the existing medical care in the respective detention facilities should be extended and offered (as in the Maltese correctional prison facilities) on a 24 hour basis. Medical treatment should be made available to all patients after a maximum of 24 hours and access to specialised care and follow-ups should be generally assured. Professional translators should be used during the medical consultations. Moreover, the detainees should be offered preventive health education and preventive materials, such as male condoms.

With regards to this recommendation we refer to the standards outlined by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) concerning medical services in imprisonments. The report argues that "the CPT wishes to make clear the importance which it attaches to the general principle - already recognised in most, if not all, of the countries visited by the Committee to date - that prisoners are entitled to the same level of medical care as persons living in the community at large. This principle is inherent in the fundamental rights of the individual"[36]. In the same chapter later on the report recommends that "while in custody, prisoners should be able to have access to a doctor at any time, irrespective of their detention regime…The health care service should be so organised as to enable requests to consult a doctor to be met without undue delay. Prisoners should be able to approach the health care service on a confidential basis, for example, by means of a message in a sealed envelope" [37].

These standards a clearly not met by the existing medical services in the detention facilities in Malta.

MdM acknowledges the improvements achieved regarding the identification and release of vulnerable persons. With regards to the great amount of remaining problems concerning this issue, MdM finally recommends that:

♦ pregnant women and mothers with their babies and children should be detained – if ever - only for an absolute minimum amount of time in order to identify them and to examine them medically. The identification of unaccompanied minors should be given absolute priority in order to avoid longstanding detention of unaccompanied minors.

[36] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)**.** The CPT standards, "Substantive" sections of the CPT's General Reports**.** Strasbourg, France. October 2006; page 29.
[37] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)**.** The CPT standards, "Substantive" sections of the CPT's General Reports**.** Strasbourg, France. October 2006; page 30.

Clear evidence exists that pregnant women and mothers with their babies and children are still deprived of their liberty for up to 5 or 6 weeks. In line with paragraph 37 of the Convention on the Rights of the Child, paragraph b ("No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time"[38]) and the report of the CPT to the Maltese Government from 2005 article 12[39], MdM calls upon the Maltese government to ensure that pregnant women and mothers with their children as well as unaccompanied minors are released from detention after the shortest period of time possible.

♦ the definition of vulnerable persons in the respective policy paper should be extended to all persons who are inapt to remain detained on medical grounds. This should include persons with chronic medical problems, including mental health problems. An independent board involving a range of medical experts should be established in order to assess medical vulnerabilities regularly, confidentially and independently.

4.3. The Open Centres: The MdM survey, daily experiences and prevention

4.3.1. The MdM survey

Between June 1st and August 19th MdM France collected systematically data and conducted a questionnaire based survey among all asylum seekers who were coming to the medical consultations offered by the field team.

4.3.1.1. Methodology of the survey in the Open Centres

MdM France conducted a kind of two step survey during their medical consultations in the Open Centres in Malta. Generally, the study population for both survey steps consisted out of all asylum seekers living in the Open Centres or anywhere else in Malta at the time of the survey, and coming to the medical consultations. Access to the medical consultations was not restricted by any mean.

4.3.1.1.1. The first step: Medical diagnosis, referrals and chronic diseases

In a first step the team established a medical diagnosis of every patient coming to the medical consultations. This was done in order to gain a principle understanding of the main pathologies presented among asylum seekers living in the Open Centres. Furthermore such a "diagnostic overview" allows to give a first understanding of how these epidemiological findings may be linked to the difficult and often inhuman living conditions of asylum seekers in Malta.
All asylum seekers coming to the medical consultations offered by the MdM field team were included in the data collection in order to establish the epidemiological and diagnostic survey. Upon consultation the age, sex, country of origin, consultation number, health card number, date and place of the consultation were recorded.

[38] Office of the High Commissioner of Human Rights. Convention on the Rights of the Child. New York, USA. 1989.
[39] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Report to the Maltese Government on the Visit to Malta. Strasbourg, France. 2005.

For the purpose of the medical diagnostic survey, all patients were divided in three categories during the medical consultations:
Firstly, patients who came for the very first time were recorded as new cases who never consulted before. They were recorded as NCB. Secondly, all patients who did not come for the first time were accordingly recorded - or as coming again for a new pathology, thus being a new cases who consulted already before, labelled and recorded as CB - or as coming again for a known pathology, being labelled as a follow-up or FU. For all patients the most important (suspected) pathology that was diagnosed by the field team during the consultation was noted and coded accordingly for analysis.

After that, a set of questions was asked to all those patients who never consulted before (NCB). In all these cases it was recorded if he or she is suffering from a chronic disease (according to their own knowledge), and if so what chronic disease the patient is suffering from. We recorded further more in this subgroup if the patient has ever been hospitalised since his or her arrival in Malta. Later on during the survey, three questions were added in order to specify the circumstances of the hospitalisation. From July 13th on, all those NCB-cases who had been hospitalised before in Malta, were asked if they had been hospitalised during their stay in detention, or after that, or both. They were furthermore asked what the main reason for their hospitalisation(s) was and for how long they have been hospitalised.

We recorded, moreover, for all patients, including NCB-cases, CB- cases and follow-ups, if the patient was referred to another health facility or a specialist by the MdM team, and if so we recorded where and for what reason he or she was referred.

From June 15th on, all new cases, namely all NCB-cases and CB-cases were systematically asked, when their symptoms had started for the very first time.

4.3.1.1.2. The second step: Questionnaires on access to health care and psychosocial health

After recording the clinical data in a first step, two different descriptive surveys were conducted among the asylum seekers who were coming to the consultations for their first time (NCB-casea). Every NCB-case was asked to participate in a questionnaire-based interview or on access to health or on psychosocial health.
A questionnaire on different aspects of access to health care was designed in order to gain an objective idea on the main problems asylum seekers faced during their former consultations in Maltese health care facilities. Besides the assessment of a socio-demographic status, this questionnaire evaluates the physical, financial, economical, cultural, linguistic and social problems of accessing curative health care in Malta.
The questionnaire on psychosocial health was designed in order to get a basic understanding of the prevalence of psychosocial symptoms among the study population. It furthermore assesses the question, if those patients who have been suffering from a specific number of symptoms at the moment of the interview, have consulted any medical doctor with regards these symptoms.

The two different samples were identified and selected in the following way:
For every medical consultation taking place, the number of consultation starting from one was recorded, independently of the fact that a patient had consulted before or not. Every NCB-case was then asked to participate in the questionnaire on psychosocial health if his consultation number was dividable by five, meaning that this questionnaire was proposed to a patient under the condition that he or she was a NCB-case and that his consultation number was 5, 10, 15, 20, 25 and so forth. Therefore the sample of persons who answered to the questionnaire on psychosocial health is much smaller than the sample of the persons who answered to the questionnaire on access to health. This was decided before the start of the research, as the primary objective of this survey is to gain a deeper understanding of the main problems of accessing health care in Malta.
The general questionnaire was offered to all those NCB-patients meeting the inclusion criteria mentioned below, and who's consultation number was not dividable by five.

For all those cases who had consulted the medical team before, being CBs and FUs, no questionnaire was proposed, as they had been proposed a questionnaire on their first visit already, if meeting inclusion criteria.

Included in both questionnaires were all those asylum seekers who came to the medical consultation for the first time, who were older than 18 years, and spoke fluently Arabic, French or English. The MdM team explained the purpose of the study and the fact that the survey was conducted anonymously and in full confidentiality to every possible participant. The consent of every participant was obtained orally, before starting the interview.

In both cases (the questionnaire on general access to health care and the one on psychosocial health) the data was obtained by a fully structured face-to-face interview containing mainly closed questions, and some open questions.
The questionnaires were developed in different steps. A first draft of the questionnaire on general health care was developed by the MdM field team, after having met different staff in the Open Centers and having made five semi-structured informal interviews with several asylum seekers in the Open Centers on their main problems in accessing health care services. Moreover the questionnaires used in a MdM survey on access to health care in the Gaza strip[40] was used for the development of the questionnaire on access to health care of asylum seekers in Malta.
The first draft was re-evaluated by the Department for Technical Support of Operations (STAO) in the headquarters in Paris for content validity, and changes were suggested. After the re-elaboration of a second consistent version of the questionnaire, the original English version was translated by the MdM nurse into French and Arabic (both mother tongues of MdM nurse). The different language versions were then pre-tested in 12 different asylum seekers in the smaller Open Center in Hal Far and in Marsa Open Center. After this quality test the last version of the questionnaire was established and remained unchanged throughout the survey.

The questionnaire on psychosocial health was only developed with the help of scientific literature on Post Traumatic Stress Disorder and political trauma in order to cover the main symptoms related to psychosocial health and trauma. Nor validity testing, nor pre-testing were done with this questionnaire.

For the full versions of both questionnaires that were used in this survey, please see the annex.

4.3.1.2. Results of the MdM survey

As described above medical consultations were started on June 1st in Hal Far Tent Village and on June 14th in Marsa Open Center, twice weekly in each centre.
In this section the findings and results which derive from our epidemiological data collection and from the questionnaires will be presented.

4.3.1.2.1. Medical diagnosis, referrals and hospitalisation

As already outlined in the methodology chapter we divided the patients coming to the medical consultations in three different groups for the purpose of this study:

- Never consulted before (NCB): All patients who came for the first time and who have not been consulted by our team before.
- Consulted before (CB): All patients who have consulted our team before and who are coming for a new problem now. They have not been seen for this specific problem before.

[40] Médecins du Monde France. Impact of the international embargo and the attacks by the Israeli army on the population's health status, Médecins du Monde Survey 2006. Paris, France; 2006.

- Follow-ups (FU): All patients who came to the medical consultations in order to be treated or counselled for a condition they have been already consulted for by the MdM team.

The addition of NCBs and CBs is equal to the total of new clinical cases (NC).

Between June 1st and August 19tth the MdM team consulted 410 persons in the two Open Centres. 188 consultations have been registered in Hal Far Ten Village and 222 consultations in Marsa Open Centre. Out of the 410 cases 325 were new clinical cases (280 NCB-cases and 45 CB-cases) and 85 were follow-ups.
The persons coming to the medical consultations were between 18 and 53 years old and their mean age was 29.12 years (SD +/- 6.42 years). 380 men (92.7%) and 30 women (7.3%) were registered. The patients were coming mainly from East-African countries: 143 patients (34.9%) were from Sudan, 121 patients (29.5%) from Somalia, 39 patients (9.5%) from Eritrea and 19 patients (4.6%) from Ethiopia. Other main countries of provenance of the patients were Ivory Coast, Nigeria, Democratic Republic of Congo and Niger.

4.3.1.2.1.1. Medical diagnosis

During every consultation a diagnosis was noted. In the following, the diagnostic groups of all 325 new cases (NC) are discussed by order of their frequency.

- **Dermatological pathologies:**

Out of the 325 new cases 65 patients (20%) consulted the MdM team for dermatological diseases. In this subgroup 17 patients (26.2%) were suffering from minor and more severe bacterial skin infections, 11 (16.9%) from eczema, 8 (12.3%) from fungal skin infection, 7 patients (10.8%) from scabies and 22 (33.8%) from a variety of other skin conditions, including mainly unclarified pruritus and haemorrhoids.

- **Pathologies of the respiratory tract:**

Similarly a large proportion of patients coming to the MdM consultations suffered from diseases of the respiratory tract. Out of the 325 new cases 57 patients (17.5%) were diagnosed and treated for such disorders. 24 out of these 57 patients (42.1%) consulted for acute higher respiratory tract infections and 6 patients (10.5%) for acute lower respiratory tract infections. 20 patients (35.1%) were treated for allergies of the higher respiratory tract and 4 patients (7%) for asthma. 1 patient was suffering from pulmonary TB and 2 patients were treated for other complains concerning the respiratory tract system.

- **Musco-skeletal pathologies:**

45 patients (13.8%) were treated for different musco-skeletal complains, especially back pains and different forms of joint pains.

- **Gastro-enterologic diseases:**

All together 42 patients (12.9%) of the 325 new cases were treated for gastroenterologic pathologies. Among those, 30 patients (71.4%) complained about symptoms related to heartburn, gastritis or functional dyspepsia. Only 5 patients (11.9%) presented with acute diarrhoea, and 7 patients (16.7%) with other gastroenterological problems, including parastic infections.

- **Psychiatry/Neurology:**

30 patients (9.2%) were diagnosed of having neurological or psychiatric disturbances. 11 patients out of those (36.7%) were treated for somatoform complains, 5 patients (16.7%) for a depressive episode, 2 (6.7%) patients for suspected Post-Traumatic-Stress-Disorder (PTSD). 7 patients (23.4%) were treated for chronic headaches and 5 patients (16.7%) for other neurological and psychiatric problems

- **Injuries:**

23 patients (7.1%) among the 325 new cases were treated on site for mainly minor injuries. The injuries were mainly not-related to the work place.

- **Ophthalmology:**

20 patients (6.2%) reported ophthalmologic problems. The majority of the ophthalmologic disorders were not very severe and included pterygium, allergic reactions and minor bacterial infections of the conjunctivae.

- **GU-pathologies:**

9 patients (2.8%) among the new cases were treated or referred for problems of the urinary tract or suspicion of exually transmitted diseases (STD).

- **Others:**

34 patients (10.5 %) were consulted for a variety of other disturbances. 8 patients (23.5%) in this subgroup complained about dental problems. Other main disorders were disturbances of the ears, diabetes, and arterial hypertension. Only one woman consulted for a gynaecological disorder during the whole time of the MdM clinics.

Figure 1 shows again the prevalence of different pathological groups among the 325 new cases which have been consulted during the MdM consultations.

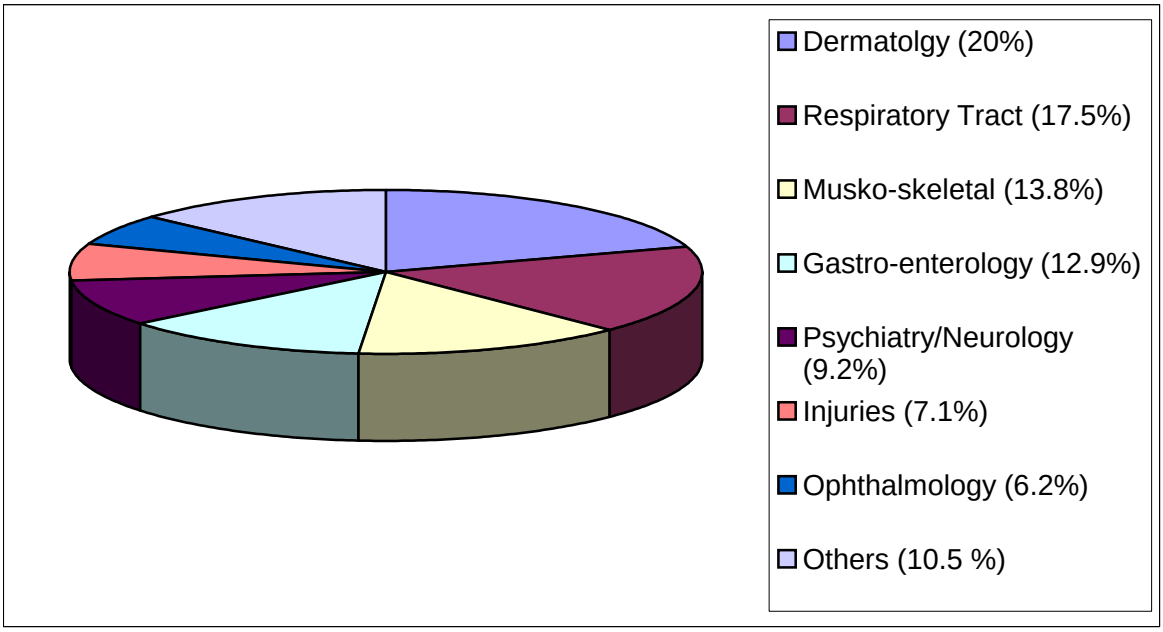

Figure 1: Prevalence of different pathologies among 325 newly diagnosed asylum seekers

- **Follow-ups:**

Of the whole 410 medical consultations performed and registered by the MdM field team 85 consultations were follow-ups of patients who have been consulted and treated before by our team. The majority of the 85 follow-ups have been done for patients suffering from neurological or psychiatric diseases (18.8%), gastroenterologic disorders (16.5%) and disturbances of the respiratory tract (15.3%).

4.3.1.2.1.2. Start of Symptoms:

Every patient who consulted the medical team was asked when he or she first experienced the symptoms he or she came to see the doctor for. It was noted if the symptoms had started already in the patient's home country, if they started during the migration phase (meaning from the time leaving the home country until the arrival in Malta), if they started during the time in detention in Malta or after that (during the stay in the Open Centres or in the community). This item was only introduced shortly after the start of the data collection process. Therefore the information on when the symptoms started at first was only collected in a subgroup of 291 new cases out of all 325 new cases.
In total, out of the 291 patients, 171 patients (58.8%) reported that their disorder had started after the release from detention. 66 patients (22.7%) reported that the condition had started in detention, 30 persons (10.3%) reported that the pathology started during their migration and 21 persons (7.2%) reported that they had first noted the condition/disease in their home country. These findings clearly show that the vast majority of disorders the MdM team treated was developed during the last years and after leaving the country. The data therefore contradict a widespread misconception that a considerable proportion of asylum seekers leave there country in order to get treated in Europe.

4.3.1.2.1.3. Referrals

During all 410 medical consultations the MdM team noted if a patient was referred to another health facility for further examinations or specialist treatment. In total 13.7% (56 persons) of the patients were referred further on. This means at the same time that the MdM team was able to treat and to counsel 86.3% of patients directly on site.
The majority of these 56 patients (29 persons; 51.8%) was referred to one of the Outpatients' Departments in St. Lukes or Boffa Hospital in order to see a specialist. The MdM team referred mostly to the department of Dermatology, the Genito-Urinary-Clinic, and to Medical Outpatients. A smaller part of the 56 referrals was done to the policlinics in Paola and Floriana (16 patients; 28.5%) and to the casualties in St. Lukes Hospital (11 patients; 19.6%).

4.3.1.2.1.4. Hospitalisation

For all those patients who consulted our medical team for the first time (NCB-cases), we registered if they had been hospitalised since their arrival in Malta. Among all 280 NCB-cases 39 persons (13.9%) had been hospitalised during or after detention.
As we found a similar proportion of hospitalisations during data analysis for an intermediate monitoring report, and as we felt that this is a considerably high figure for such a rather young population, we introduced three supplementary items from July 13th onwards. From then on we asked every NCB-case - if the patient had been hospitalised before - how long he or she has been hospitalised, what the reasons for the last or the last two hospitalisations have been, and if the patient has been hospitalised during detention, or afterwards or both.
In this subgroup we included 139 NCB-cases. The MdM team noted among those 139 patients 19 persons who have been hospitalised since their arrival in Malta. This amounts to a proportion of 13.7% which is very similar to the prevalence of hospitalisations in all 280 NCB cases (13.9%). In this small sub-sample of 19 patients, 12 patients (63.2%) reported that they have been hospitalised during their stay in detention, 6 patients (31.6%) reported that they have been hospitalised after their release from detention, and only 1 patient (5.3%) has been hospitalised both, during detention and afterwards. The vast majority of the patients reported that they have been hospitalised only for 1 or 2 nights (12 patients 63.1%). Only 3 patients (15.9%) reported to have been hospitalised for 6 nights or more. Main reasons for the hospitalisations were gastroenterologic and heart and chest related pathologies.

4.3.1.2.1.5. Chronic diseases

Patients have as well been asked if they were suffering from a chronic disease, especially diabetes, arterial hypertension or asthma. In total 10 patients (3.6%) among the 280 NCB-cases reported to suffer from a chronic disease. Patients with chronic disorders related to psychosocial health or longstanding gastroenterologic problems were not included in this list. It is important to note that there were several patients found to suffer from arterial hypertension and/or diabetes during the medical consultations. These newly detected cases are not included in this group.

4.3.1.2.2. The questionnaires: access to health care and psychosocial health of asylum seekers in Malta

In this section the results of the data collected by two different questionnaires on access to health care and psychosocial health will be presented. In a first part the most important findings of the questionnaires regarding access to health care will be highlighted, and in a second part the findings of the questionnaires dealing with issues around psychosocial health will be presented.

In general one of the two questionnaires – according to a specific selection process which is described further in detail in the methodology section - was considered for every patient who came for the very first time to consult the medical MdM team. During the 410 medical consultations conducted by the MdM team for this survey, 280 patients were registered as coming for the first time (NCB-cases). If the patient met inclusion criteria and accepted to participate in the respective questionnaire, the MdM nurse conducted the structured face-to-face interview with the patient. In total, 167 patients responded to the questionnaire on access to health care and 59 to the questionnaire on psychosocial health. People were registered as non-responders in case they did not meet inclusion criteria or did not accept to participate. The main reasons for not responding to the relevant questionnaire were: the patient did not speak fluent English, French or Arabic, the patient refused to participate or the patient was too sick to participate.

4.3.1.2.2.1. The Questionnaires on Access to Health Care: the asylum seekers' perspective

In total 221 patients consulted our medical team for the very first time (NCB) and fell at the same time under the general selection criteria of answering to the Questionnaire on Access to Health.
In total 167 patients (75.6%) responded to the Questionnaire on Access to Health in both Open Centres. 24.4% (54 patients) did not participate. The response rate of the Questionnaire on Access to Health amounts thus to 75.6%. The most prevalent reason for non-participation was by far communication problems related to language. 48 persons (88.9%) among the non-responders did not speak Arabic, French or English well enough to conduct a face-to-face interview.

<u>Socio-demographic profile of responders and non-responders:</u>

Among the 167 participants 162 were male (97%) and only 5 women (3%) participated in the survey. The proportion of women among the non-responders was considerably higher and amounts to 22.2%. This occurred due the fact that participants were not included in the survey in case they did not speak one of the required three languages well enough to answer the questions themselves. As women, coming from Sub-Saharian Africa, have on average lower educational levels, more female patients had to be excluded from the survey to avoid a certain amount of bias due to problems of translation.

Responders were between 18 and 53 years old and mean age was 28.9 years (SD +/- 6.1 years). Mean age of non-responders (28.7 years (SD +/- 7.3 years)) was similar. Main country of origin of the participants were Sudan (41.9%), Somalia (24%), Eritrea (10.2%) and Ivory Coast (6%). Among the 54 non-responders, on the contrary, 32 patients (59.3%) were Somalis and 7 patients (13%) Eritreans. This is again related to problems of communication, as a considerable part of Somalis did not speak one of the three languages needed in order to participate in the survey.

Sudanese on the contrary do generally speak fluent Arabic. This is one of the reasons why the majority of participants in this survey on access to health care are Sudanese.
Regarding their refugee status, 2 patients (1.2%) among the 167 responders had been granted a refugee status and 85 persons (50.9%) had humanitarian protection. 36 persons (21.6%) had had one reject of their asylum claim, meaning that they could still appeal that decision. 34 patients (20.4%) were fully rejected and 10 persons (6%) had not had their first interview yet.
Almost one third of the respondents (52 participants; 31.1%) reported that they did not feel in good health at the moment of investigation.

Experiences during medical consultations

In the second, main part of the questionnaire participants were asked a set of questions regarding their experiences during medical consultations and in pharmacies after their release from detention. A majority of questions relate therefore to the last sickness or the last medical consultation in order to elaborate the experiences more precisely.
First of all, the participants were asked how many times they have seen a medical doctor since their release from detention. For 71 respondents (42.5%) the consultation of the MdM doctor was the first after their release from detention. They had thus not seen a medical doctor in a government health facility before – after their release from detention. In these cases the questionnaire was not continued, as personal experiences with health care services in Malta after release from detention did not exist. An important part of this group of participants consisted out of patients who have just been released from detention during July and August and who consulted the MdM team as first medical contact after release.

The remaining 96 respondents (55.1%) answered the rest of the questionnaire and form the core group of responders. Among those 96 responders, 36 patients had seen a doctor once before the consultation of the MDM team, 45 patients had seen between 2 and 4 times a medical doctor before and 15 patients 5 times or more.
Among the 96 respondents of the second part of the questionnaire a third (32 patients) had seen a medical doctor for the last time during the last 4 weeks before the investigation. 25% of the patients had seen a medical doctor for the last time between 1 and 3 months ago, 21.9% between 3 and 6 months ago, 11.5% between 6 months and a year ago and 8.3% longer than a year ago. Most patients had been or to a public policlinic (45 respondents, 46.9%) or to St. Lukes Hospital (42 respondents; 43.8%) for their last medical consultation. The rest of the participants (9.4%) had seen a private doctor or a doctor coming to the Open Centres.

Participants were asked moreover, if they had consulted a medical doctor the last time they felt sick. Among the 96 respondents to this item, 82 (85.4%) reported that they have seen a medical doctor the last time they felt sick. Those participants who reported that they had not consulted a medical doctor gave a variety of reasons for not going. Some participants outlined that they did not feel severely sick at that time, others said that they directly went to a pharmacy and some revealed that they feel that they are not treated well or in an appropriate way by Maltese doctors.

Patients were then asked if they had experienced problems in going to or coming from the health facility they went to for their last consultation and if they had communication problems during this consultation. For the latter item it is important to note that Maltese is a Semitic language that resembles Arabic very much. Therefore persons speaking Arabic can usually manage with Maltese doctors and health personal. With regard to these issues, the vast majority (90.6%) reported that they did not face any problems in going to the last consultation or in coming back. Similarly, most of the respondents (81.3%) did not feel that they had major communication problems during their last medical visit. The highest rate of communication problems if stratified by country of origin was found among participants from Ivory Coast (33.3%) who often speak only French.

The following items investigated the experiences regarding prescription and access to medication and the prescription of further clinical examinations and specialist consultations. Out of the 96

respondents, 73 patients (76%) have been prescribed drugs and 28 patients (29.2%) have been referred for further exams or to a specialist during their last medical consultations. Among the 73 patients who have been prescribed drugs during their last medical consultation more than half of them (58.9%) reported that they faced problems in getting these drugs for free. This is a considerably high fraction of people, especially as all asylum seekers - independently of their current refugee status - are entitled to free basic primary health care and emergency care (see introductory chapter). The respondents of the survey highlighted diverse reasons of not accessing their prescribed drugs for free. Main reasons were the fact that the doctors had not prescribed the drugs on the right prescription form for free drugs, that the respondents were told to go to a private pharmacy and that the drugs were not available according to the pharmacy staff. Moreover the respondents reported that they were asked to present a pink health card (only accepted asylum seekers are entitled to have the pink health card) and that they went to the private pharmacy as they did not know that they were entitled to free medicine.
Moreover, among the 28 patients who had been referred for further clinical exams or a specialist, a quarter reported problems to access those. The most frequently reported problem was that the patients found it difficult to understand where to go for the specialist consultation or the examination. Figure 2 shows the prevalence of these different problems in accessing health care, as reported by the participants of the MdM survey.

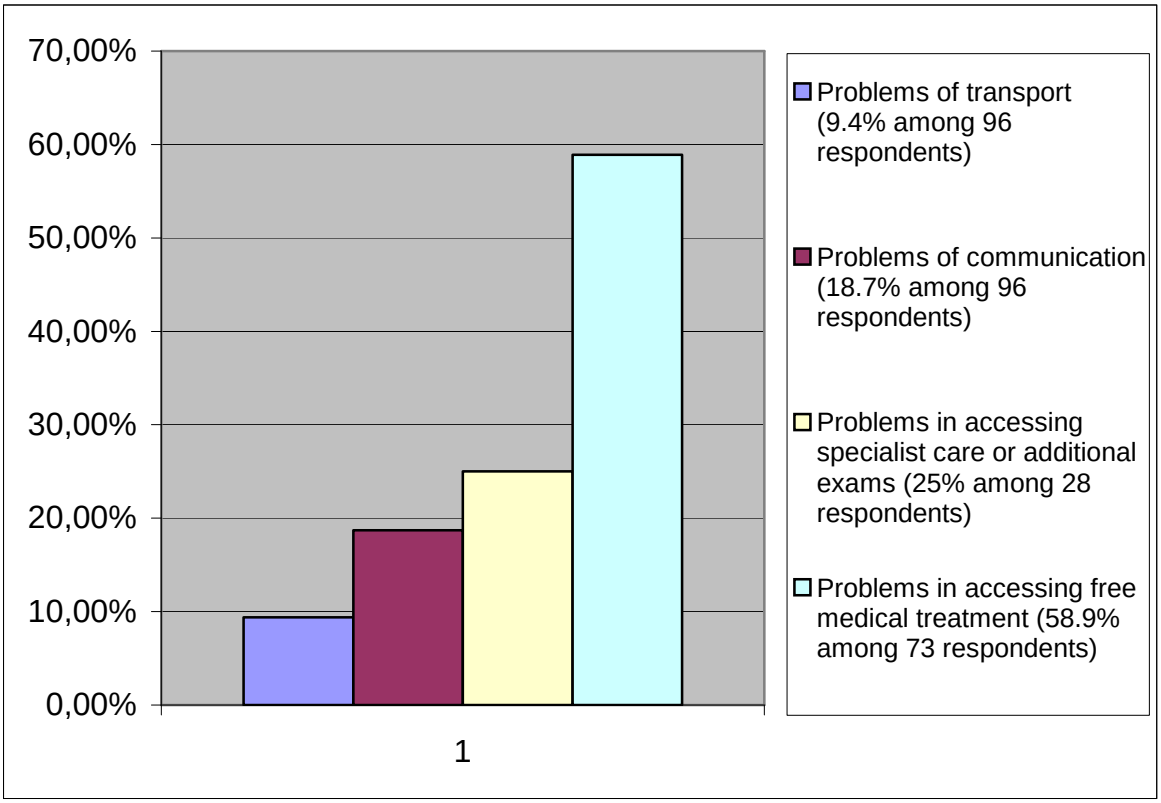

Figure 2: Prevalence of different problems in accessing health care. Results have been partly drawn from different sub-samples.

Participants were furthermore asked if their condition had improved since their last medical consultation. 45 patients (46.9%) of the 96 respondents to this item felt that their condition had not improved since then. All these patients were then asked an open question why they had not consulted a medical doctor again. We grouped the answers to this question in main categories in order to analyse the responses. It was highlighted repeatedly by patients that they actually did not see a medical doctor again because they decided to consult the MdM team for the persisting problem. Other common answers were that patients stated that they did not trust the doctors in Malta, because they always prescribe the same drugs or because the treatment did never help them. Several patients argued that they have been given an appointment in the near future and that

they therefore did not consult a medical doctor again. Other arguments were that participants felt that they can not afford the prescribed treatment, that it took to much time to see a specialist, that they did not have finished their treatment yet or that they thought that medical doctors treated asylum seekers in a racist manner.

As a considerable part of the questions on access to health care in the questionnaire were concerning the last medical consultation, the participants were asked in a last open question what problems they have had during other medical consultations. Consequently all those patients who have had only 1 medical consultation after their release from detention were excluded from this question. In total, all 60 patients who have had more then 1 prior medical consultation answered to this item. 24 participants highlighted 2 different problems and 9 respondents mentioned 3 different problems in accessing health care. As in former analysis of open questions we grouped the answers in different categories and analysed what types of answers we found to be mentioned repeatedly. To illustrate some of the categories described, some answers of asylum seekers are cited in brackets.
First of all, more than a third of the 60 respondents (23 respondents; 38.3%) to this last item answered that they did not face any problems during other medical consultations. The remaining participants mentioned a variety of problems. A very recurrent argument was that the participants reported that they had to pay for their drugs ("I always have to pay for my drugs and sometimes I can not afford them"). Similarly, participants mentioned regularly that the medical doctors gave them only paracetamol or always the same drugs ("They always give us paracetamol and that´s it.") whatever their problems were. Other regularly stated issues were that respondents reported that they did not trust the medical doctors ("They do not treat us well."), that they felt that the health workers treated asylum seekers in a racist way ("Everybody just wants to get rid of us.") and that it took a long time to see a specialist because appointments were given only after months. Other less often used arguments included problems of communication and a lack of available drugs.

4.3.1.2.2.2. The Questionnaires on Psychosocial Health

In total 59 patients consulted our medical team for the very first time (NCB) and fell at the same time under the general selection criteria of answering to the Questionnaire on Psychosocial Health.
A total of 46 patients responded to the Questionnaire on Psychosocial Health in both Open Centres and 13 patients did not participate. The response rate of the Questionnaire on Psychosocial Health amounts thus to 78%. All the non-responders did not participate in the questionnaire because of reasons related to communication and the language barrier.

Socio-demographic profile of responders and non-responders:

As in the questionnaire on access to health care, the vast majority of participants to this questionnaire was male (56 respondents; 94.8%) and only three women answered to the questionnaire on psychosocial health. Among the 13 non-responders 11 were men and 2 were women.

Responders were between 18 and 42 years old and mean age was 29.3 years (SD +/- 5.5 years). As in the questionnaire on access to health, main countries of origin of the respondents - in order of frequency – were: Sudan (19 respondents; 41.3%), Somalia (9 respondents, 19.6%) and Nigeria (4 respondents; 8.7%). Among the 13 non-responders again a majority came from Somalia (6 persons) and Eritrea (4 persons). This is related to communication difficulties as outlined already for the questionnaire on access to health care.

Prevalence of different symptoms and access to mental health care

In order to get an idea of the psychological well-being of the participants those were asked in a first part of the questionnaire a variety of questions regarding different symptoms of importance to the mental health of this population. Some of the symptoms relate more specifically to possible disturbances that may be related to Post Traumatic Stress.

Among the 46 participants, 9 respondents (19.6%) reported that they had always problems falling or staying asleep, 8 participants (17.4%) reported to have these problems sometimes and 1 respondent (2.2%) reported to have those problems rarely. A total of 28 participants (60.9%) reported to never have problems falling or staying asleep.

Among the same participants 39.1% reported difficulties of concentration during daily activities, 15.2% felt that they get easily angry in the moment, 6 participants (13%) felt regularly generalized pains and 28.3% reported a decreased appetite.
Moreover 17.4% felt often nervous (shivering hands, fast-beating heart) and 10 participants (21.7%) reported to make regularly nightmares. Only 3 participants (6.5%) reported that they had suicidal or para-suicidal ideas. Finally, a majority the 46 participants (36 persons; 78.3%) were regularly thinking about specific events that had happened to them in the past. This certainly does not reflect the fraction of persons who have intrusions. In this sense this item can not be considered as reflecting a kind of psychological symptom. Still it reflects that a very considerable proportion is regularly thinking about events of their past and about their home country.

Only 3 participants (6.5%) in total among the 46 reported to suffer from none of the mentioned 9 symptoms. Figure 3 shows the prevalence of 8 different mental health related symptoms in the sample of 46 respondents to the questionnaires on psychosocial health.

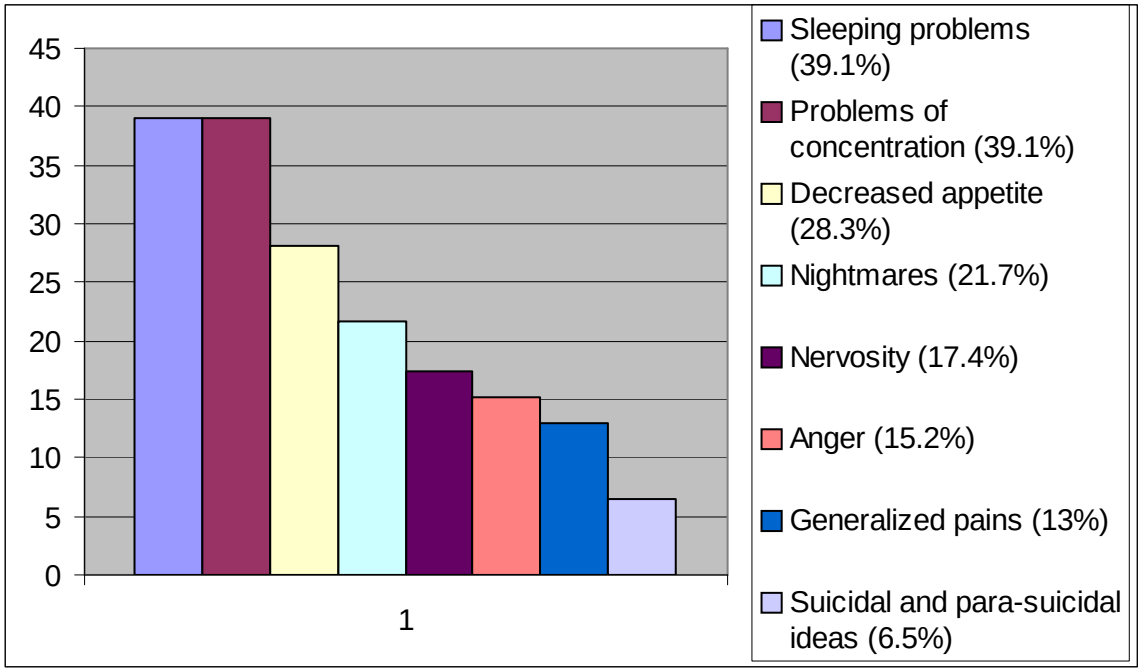

Figure 3: Prevalence of different symptoms related to the psychosocial health of residents (in a total of 46 participants)

All those patients who reported to suffer from 4 or more than 4 of the 9 different symptoms were asked a variety of additional questions concerning their mental health care. In total 8 participants (17.4%) out of 46 patients reported to suffer from 4 or more than 4 of the symptoms. Even though this allows not to make a diagnosis of psychiatric disorders, it clearly shows that a considerable fraction of this young mainly male population is suffering from problems related to their social and psychological conditions in exile.

In this small sub-sample of 8 patients only 1 had been hospitalised during detention because of these problem related to his mental health. Similarly only this and another patient had consulted a medical doctor regarding these problems during detention and only 1 of the 8 patients had done so after release from detention.

4.3.1.3. Discussion of the findings of the MdM survey

The medical consultations and the results of the collected data reveal a variety of considerations regarding health and the access to clinical health care in the asylum seeker population living in the Open Centres.

The prevalence of different pathological groups shows a rather particular pattern for the quite young, mainly male population of the MdM project and survey. Especially the high prevalence of a variety of skin conditions and allergies of the higher and lower respiratory tract could be certainly linked to the difficult hygienic standards and the cohabitation of 15 – 25 asylum seekers in one room or tent in the Open Centres. Similarly, the frequent occurrence of gastro-enteriological diseases (especially such as dyspepsia and heartburn) and a variety of other psychosomatic, somatoform symptomatologies (including e.g. generalized body pains or unspecified prutitus in combination with insomnia or loss of appetite) are most possibly linked to the continuum of extremely precarious living conditions and psychosocial stressors during migration, detention in Malta and in the Open Centres.

Other important issues were encountered by treating, counselling and referring for testing of patients for STDs and HIV. Several risk assessments revealed that patients reported to have had unprotected, transactional, heterosexual sex with mainly Maltese female sex workers. This stretches clearly the importance to continue and enforce prevention regarding sexual and reproductive health with a focus on STDs and HIV/AIDS among the asylum seekers and as well among Maltese prostitutes.

The analysis of the data regarding the diverse referrals that were done by our medical team shows that the most important services for the asylum seekers in terms of specialized medical care, are departments of dermatology, the Genito-Urinary-Tract Clinic and the Medical Outpatients including the Infectious Disease Department. Because of the general difficulties of accessing specialised care urgently a considerable fraction of patients had to be sent to the casualties in the main public hospital – even for not extremely urgent pathologies.

The results concerning the histories of hospitalisation show that almost 14% of asylum seekers have been hospitalised in Malta during detention or afterwards. This should be considered as a high fraction of patients with a history of hospitalisation. The analysis of the sub-sample of 19 patients among 139, who have been hospitalised in Malta before the investigation, shows that most hospitalisations have taken place during their detention and that the majority was only hospitalised only for 1 or 2 days. Main reasons for hospitalisation were disturbances of gasto-enterologic nature or disorders related to heart and chest pains. This is in line with the experiences during our medical consultations that the precarious living conditions and the stressors to the psychosocial health of asylum seekers certainly contribute to the fact that an important fraction of symptoms and pathologies are of psychosomatic nature and therefore quite often hospital admissions do not reveal important somatic findings. Sometimes even no treatment was given during the above mentioned hospitalisations of asylum seekers. This shows clearly that on the one side a part of hospitalisations especially during detention is linked to the difficult conditions in the closed centres. It underlines on the other hand as well the importance of clinics in the Open Centres in order to be able to avoid a certain number of hospitalisation through early detection and appropriate treatment of asylum seekers.

Besides the 3.6% of the patients (10 persons) who reported to suffer from chronic diseases (esp. arterial hypertension, diabetes and asthma), 2 more were newly diagnosed of suffering from

arterial hypertension. In general, the regular medical consultations in proximity to the asylum seekers allowed a personalised supervision of the chronic cases and collaboration with specialised services if needed.

The results and findings of the questionnaires on access to health show a certain number of methodological limitations which have to be considered in their evaluation and discussion. Firstly, the participants of the questionnaire do not represent the whole asylum seeker population in Malta, as the questionnaire was proposed and conducted only with persons coming to the medical consultations of the MdM team. The sample of 167 participants is therefore taken systematically from all patients coming to the MdM consultations in the two main Open Centres during the study period. Thus, the results reflect in the first place the experiences with health care in Malta of those persons who have consulted the MdM team in the given time span. We still believe that the results reflect important issues of accessing free medical care in Malta in the whole asylum seeker population.
More specifically the analysis of the socio-demographic profile of the responders and non-responders shows that female patients and patients coming from Somalia have been excluded from participation proportionally more often than men or patients from other countries of origin because of the language barrier. This selection bias poses the problem that a certain number of persons who generally have problems of communication - including during medical consultations – and who may be generally more vulnerable have not been included in the questionnaire.
Moreover, a large fraction of persons (42.5%) have not answered the second main part of the questionnaire as their visit to the MdM medical consultations was their first to a medical doctor after release from detention. These participants had therefore not made any experiences with health care in Malta after their release. The sub-sample size for the main second part of the questionnaire therefore amounts to 96 respondents.
The findings of the survey among asylum seekers regarding general problems of access to health care provide important first results and ideas that would need further investigation and research for clarification and specification.

The results show that asylum seekers reported generally rather little problems in terms of physical accessibility of health care. A vast majority (85.4%) had seen a medical doctor the last time they felt sick and less then 10% of participants reported to have had difficulties in going to the health care facility or in coming back. Regarding communication difficulties a larger fraction of participants (18.7%) reported problems related to language (or culture).
The main problems, on the contrary, seem to be related to the access of free treatment and specialist consultations (which is clearly reflected as well by additional experiences of the MdM team which will be discussed further below more in detail). Almost 30% of all participants have not been prescribed any drugs during their last medical consultation which certainly indicates a certain problem. Among those 73 patients who had been prescribed drugs 58.9% reported that they had problems in getting their treatment for free. Even though a certain number of drugs -. especially when prescribed in the policlinics – are not available in the government pharmacies or do not belong to the list of items prescribe able by general practitioners, the results show that doctors, pharmacists and asylum seekers themselves are not completely aware of the entitlement to free medicine of asylum seekers – independently of their refugee status. It therefore occurs regularly that the asylum seekers are not prescribed their treatment on the white form for free medication or that they themselves go directly to a private pharmacy as nobody told them about their entitlement. The situation has certainly been improved after the arrival of the MdM mission. At that time asylum seekers were systematically refused free medication in the government pharmacies in Paola and especially in Floriana, as the pharmacy staff was not clearly informed about the existing entitlements and as they staff had decided to restrict the access to free treatment on their own. These problems are certainly in parts reflected by the results of the MDM survey. MdM has since then enforced successfully a practice of free access to medical treatment in the main government pharmacies in collaboration with the pharmacists and the Ministry of Health.

Both the answers to the open question why patients had not consulted a medical doctor again and what problems participants have faced in accessing health care have revealed similar kinds of problems. Participants reported again that they have experienced difficulties in getting treatment for free. More importantly the findings show that the participants did not feel consulted and treated appropriately and that they experienced discrimination and felt certain mistrust towards Maltese doctors. Even though MdM recognizes clearly the important shortage of human resources in the policlinics and the specialised services, our own experiences during accompaniments and other occasions confirm that asylum seekers face problems of accessing accurate medical care due to racist convictions and discriminatory practices. It is on the contrary certainly very rare that doctors really engage for asylum seekers. Another important problem remains the access to specialists, as in many outpatient departments appointments are given only after several months or up to one year due to shortage of specialist doctors in public services.

Furthermore the results from the questionnaires on psychosocial health reveal further evidence regarding the health and access to health care of asylum seekers in Malta. Even though the overall sample size of 46 participants and the size of the sub-sample are to small to draw final conclusions, the results give rise to clear evidence that a considerable amount of people is suffering from diverse symptoms regarding their psychosocial health. The most frequently reported symptoms were sleeping problems, problems of concentration and decreased appetite (see figure3). Moreover only a very small fraction of the more severely affected persons has consulted a doctor during detention or after release for these problems. The living conditions and psychological stressors in detention and in the Open Centres certainly contribute to this picture.

In conclusion, the results of the MdM survey show a variety of important facts on the health and access to health care of asylum seekers living in the Open Centres in Malta.
Firstly, the pattern of distribution of main pathologies among the patients who were consulted by the MdM team between June and August 2005 is certainly linked to the continuum of precarious living conditions and the psychosocial stressors from detention until the live in the Open Centres. A rather high number of hospitalisations especially during detention is most probably linked to the fact that detention is – especially under the conditions in Malta – harmful for the physical and psychological well-being of detainees and causes or aggravates a variety of psychosomatic symptoms and disorders who are difficult to treat.
Secondly, the questionnaires on access to health care prove that, besides the problems of accessing free treatment, asylum seekers in Malta face a variety of discriminations and problems in the access of primary and specialised health care.

On the basis of these and other findings and observations MdM recommends a continuation of the medical clinics in proximity to this very vulnerable population.

4.3.2. Prevention

4.3.2.1. Sexual reproductive health: workshops with female asylum seekers

During the exploratory mission of the MdM delegation in late 2006 and upon arrival of the MdM team in April 2007 there was clear evidence that only very few health promotion activities were offered to the asylum seeker population in detention and in the Open Centers in Malta. Generally, health promotional and preventive efforts for migrant populations must be aligned to particular approaches taking into account a variety of cultural differences and the social difficulties that migrants often face. In the light of the lack of existing preventive efforts and activities and under consideration of these dimensions, MdM France has proposed regular workshops focusing on issues of health with women living in the Open Centers. These workshops were offered by the MdM nurse once weekly in 4 Open Centres' hosting women (Ex-Appogg-Centre in Hal Far, Tent Village in Hal Far, Dar-al-Qwasala and Dar-el-Liedna) from mid May onwards. The objective of these workshops was to improve the access to information concerning different health topics and healthcare, and to support the social integration through activities.

The MdM nurse treated the following themes: the female genital body and anatomy, contraception, sexuality, sexually transmitted diseases, motherhood, breastfeeding, food, hygiene, femal genital mutilation (FGM), domestic and gender based violence. The workshops have been held in English, French and Arabic in order to facilitate the participation of as many women as possible. In collaboration with JRS and UNHCR within the framework of a project on Sexual and Gender based Violence (SGBV), MdM started from June onwards to train two women on issues around confidentiality, medical terminology and issues of sexual and reproductive health and SGBV. One of the women was Somali and facilitated mainly the contacts with the Somali community, the other women was Eritrean and translated from and into Tingrya and Amaric. From then onwards the workshops on sexual and reproductive health and SGBV were exclusively prepared and held in collaboration with JRS and the two women translators and mediators. Besides, a small medical dictionary has been developed and printed in French, English, Arabic, Somali, Amaric and Tingrya. It has been distributed to a range of services in public health care facilities and the medical agency operating in detention.
In general, the preventive workshops have been well appreciated and regularly followed by a number of participants. The women showed great interest in the diverse topics and asked a lot of things as most of them did not know the basic principles and concepts concerning the female and male anatomy and biology. The workshops also permitted to screen for health problems and to create a relation of trust with this population.
During our work main problems arising were: The presence of young children was unavoidable and made the workshops sometimes difficult. Because of cultural and religious barriers, some topics like HIV/AIDS were difficult to approach. Moreover, some Somali women who do not speak Arabic did not have the possibility to participate in the workshops due to communication difficulties. This changed after the start of working in partnership with JRS and the translators and mediators.
We generally experienced that the participants were most motivated when they felt concerned. The women did then participate a lot. Thus, for example some topics like motherhood have been strongly appreciated. On the other hand, the workshop about Sexually Transmitted Diseases (STDs) had less success.

In conclusion, MdM France believes that its pilot work and experiences underline clearly the need for regular preventive efforts for female asylum seekers. It has been shown that this population lacks basic knowledge regarding their sexual and reproductive health and rights. Any preventive efforts should be clearly extended to the male population as experiences show that a real impact can only be made this way. Similarly, preventive efforts should be as well extended to detention. Preventive programs and health promotion need to take into account the cultural particularities and provide information in the mother tongues of the population under concern. In order to provide proper information Maltese health care promoters should be trained on issues regarding the migrant populations. Ideally health care promoters should be identified and trained among the asylum seekers themselves.

4.3.2.2. Prevention in the Open Centres: Distribution of leaflets and male condoms

As already mentioned in the introductory chapter, Malta does not have a sexual health policy. Thus, the existence and distribution of prevention leaflets about sexually transmitted diseases in Malta is rare. Only the NGO Integra Foundation has yet published leaflets on the issue of STDs and HIV/AIDS in English. In order to reach a broader public, we printed some booklets on HIV/AIDS, STDs and Tuberculosis in French, English and Arabic. These booklets are strongly inspired by those published by the French National Service for the Prevention and Health Promotion (INPES) and the association Migration Santé. The leaflets and male condoms were made available in the waiting area of the medical clinic offered in the Open Centers. As some patients did read or take the leaflets before being seen in consultation, we used this occasion to open a discussion on sexuality and sexual health. MdM distributed 680 condoms during their clinics and preventive efforts in the Open Centers.

As mentioned above several risk assessments with patients coming to the clinics revealed that patients reported to have had unprotected, transactional, heterosexual sex with mainly Maltese prostitutes. MdM clearly calls upon the Maltese government to continue and enforce condom distribution and to promote testing for STDs and HIV/AIDS of asylum seekers in the GU-clinic in Boffa hospital.

Generally MdM believes that the department of Public Health and the Department of Health Promotion should enlarge their programs to the diverse migrant populations living in Maltese society in respect of the existing cultural and linguistic differences and particularities.

4.3.3. Accompaniments of asylum seekers to hospitals and policlinics

The medical program of MdM France included medical consultations, prevention and accompaniments of asylum seekers to public health care facilities. As the medical system in Malta is not always easy to understand for migrants, the MdM nurse made some accompaniments under particular circumstances: need of emergency care, problems of language and need of accurate follow-ups.
11 accompaniments have been made from June onwards to St Luke hospital, Paola and Floriana Policlinics and Boffa hospital. The objective of the accompaniments was to understand the health care system in Malta, to assure a good quality of follow-ups, and to testimony that difficulties prescribed and announced by the asylum seekers in the questionnaires are true. During the accompaniments, we have encountered many problems, especially in St. Luke Hospital.

In the first place, it can prove to be very difficult to make an appointment, especially for some specialized services. Some services, such as e.g. the Department of Dermatology and the Health Care centers provide the majority of their appointments by postal services. Repeatedly, asylum seekers did not get their appointments sent to their homes and centres. Some of the specialized services are so understaffed and overstrained that new cases have to wait for up to 1 year to see the specialist. Even on the phone it is sometimes very difficult to manage to talk to the concerned service. The experiences during the accompaniments gave the MdM team as well the possibility to testimony that some of the medical doctors feel a certain antipathy towards asylum seekers and that an important fraction of doctors try to get rid of the asylum seekers as fast as possible. We testified as well that most of the doctors put one or two pair of gloves for whatever medical examination. Even in cases of chronic illness the patients were not provided with appropriate follow-ups.
Other problems that seem to occur regularly are that medical doctors are not aware of the entitlement of asylum seekers to free medical health care and are therefore not giving always the white prescription paper to the asylum seeker patients. Whenever they were reminded about the rights of the asylum seekers to access free medical treatment, the doctors prescribed the drugs on a white prescription form in the end. It is finally very difficult for the majority of asylum seekers and migrants to find the appropriate services in St. Lukes Hospital, such as the x-ray department and some of the out-patient clinics.

In conclusion the accompaniments of asylum seekers to different public health care facilities testifies the experiences and problems described through the questionnaires with asylum seekers in our project. Main problems of access to health care seemingly are discrimination, specialist care and communication.

4.3.4 Additional experiences and observation regarding access to health care

Besides the observations and results which have been described so far through our medical consultations, data collection, preventive efforts and accompaniments, we would like to highlight

some remaining important points in relation to the access to health care of asylum seekers and our humanitarian mission in Malta.

One of the main and most important effects and results of our clinical consultations in the camps in Marsa and Hal Far Tent Village has been the fact that the pressure on the policlinics mainly in Paola and Floriana was reduced considerably. This was confirmed by the Department of Primary Health Care and Family Medicine. The statistics in Half Far showed as well that our medical consultations led to a decrease in ambulance services requested.

Another important aspect of our experiences during the medical consultations is related to the fact that especially during the second half of our mission and medical consultations an important part of the patients were released from detention only very shortly before they consulted the MdM team. These patients reported in majority that they had found the conditions during detention incredibly hard, and many reported that they had not lived under similar circumstances before. Some of the patients mentioned the fact that they had not had the possibility to access adequate health care during detention or that they had problems in following up their appointments. A considerable fraction showed clear signs of deteriorated physical and psychological health and reported very regularly to have had sleeping problems and problems with the offered diet and nutrition. A very common comment of several refugees regarding their time in detention was that they felt that they *"have seen a lot people going crazy in there."* Similarly a common argument on the conditions in detention was: *"The worst is that you have nothing to do. You sit or lie on your bed the whole day and watch the ceiling."* It seemed to be furthermore clear that many patients in general reported that their pathology or condition had started during their time in detention. These reports included a variety of patients that started to be affected by severe and chronic conditions such Diabetes, arterial hypertension and depressions.

MdM wants therefore to underline again that there is clear evidence that the overall conditions of the detention regime of asylum seekers in Malta are potentially harming the physical and psychological health of the detainees.

4.4 Health care of asylum seekers in the Open Centres: Conclusions and recommendations

First of all, the regular medical consultations in the both main Open Centres in Hal Far and Marsa proved to be well appreciated by the staff of the Open Centres and the residents themselves. The consultations were very helpful in order to start to meet the clinical and preventive needs on site and to support patients in their need to consult specialists or to be referred for emergency care.
In these regards the time schedule of offering consultations 2 times weekly for 3 – 5 hours in each centre was found to be well adapted as well. Normally between 10 and 20 patients were consulted during 3 hours of consultation, including longer counselling of patients with psychiatric problems.

Referring to all the results, observations and experiences described further above in chapter 4, MdM recommends:

♦ The continuation of the primary health care medical consultations in close proximity to the asylum seekers in Hal Far Tent Village and Marsa Open Center. Offering these services around twice weekly for 3 – 4 hours in each centre can be considered as sufficient and appropriate. MdM strongly recommends to offer medical consultations during the

late afternoons in the weekdays, or on Saturday or Sunday afternoons. An appropriate translator should be identified and employed for these consultations.

The main advantages of a continuation of these primary health care clinics for Maltese society as a whole would be as follows:

1. Medical consultations in the two main Open Centres should be generally seen as a gate-keeper setting in order to cure, orientate and support the vulnerable asylum seeker population. They may guarantee an early detection of diseases with a great importance to public health, including Tuberculosis, HIV/AIDS and psychiatric disorders.
2. The medical consultations in proximity have proven to reduce the high pressure and burden on the main policlinics in Paola and Floriana. They reduced as well the ambulance services requested by the Open Centres considerably.
3. A more personalised care – especially of chronic illness and psychosomatic disorders of the vulnerable asylum seeker population – can reduce the number of hospitalisations and the need of specialised care.
4. The costs of health care attributed to the cure and prevention of asylum seekers may be considerably reduced in the long term.
5. A regular medical service in the Open Centres allows a collaboration of the medical team with the social workers and the identification, cure and support of the most vulnerable residents.
6. The services may reduce the experiences of mistrust, discrimination and racism towards asylum seekers. They may therefore contribute to an overall well-being of the residents.

♦ The continuation and extension of preventive workshops on sexual reproductive health among women. These workshops should ideally be extended to the male population. Similarly, preventive efforts should be as well extended to detention in an appropriate way.

♦ The development and implementation of a sexual health policy in order to prevent and treat sexually transmitted diseases (STDs) in a scientific and appropriate way among all citizens living in Malta. The continuation of the health promotional activities and the distribution of male condoms in link with the medical consultations in the Open Centres can be seen as a first stepping stone.

♦ A continuous improvement of the living conditions in both main Open Centres in Hal Far and Marsa. The precarious living conditions remain a cause for diverse medical disorders as described in this report.

4.5 Final conclusion

In conclusion, the medico-social research conducted by MdM highlights a number of severe problems concerning the reception and integration of asylum seekers in Malta. With regard to the detention centres, the living conditions and overcrowding, the lack of meaningful activities, the weaknesses regarding the access to health care, the detention of vulnerable persons (elderly, pregnant women and children, unaccompanied minors and chronically ill) and the length of detention up to a maximum of 18 months, are incompatible with a minimum of respect of human rights that should be respected for all persons seeking asylum in Europe.

In the Open Centres the situation could be considerably improved by facilitating the access of migrants and refugees to health care and prevention. Moreover, a different politic regarding accommodation would foster a real integration.

Even though the Maltese authorities are responsible for these inadequacies, one should not forget that the migration politics of the European Union have continuously increased the burden of migration on the countries at the borders of Europe, especially in the south of the continent. Hereby countries with limited resources - such as Malta and Cyprus (formerly only countries of transit) - are facing a relatively high annual burden of asylum seekers. Malta itslef, an island with only 400.000 inhabitants, is facing – since 2002 – an increased immigration of asylum seekers, mainly from the horn of Africa.

In this context the European Union should show more interest for the inhuman and undeserving conditions of reception which asylum seekers, who left their homeland in order to find a saver place for them and their families, are facing on the continent.

In a final statement MdM France calls upon the European institutions to take notice of the problematic situation related to the relatively high amount of irregular migration to Malta.

Therefore,

MdM calls upon the responsible European institutions to take notice of the severe variety of problems related to health and human rights of asylum seekers and migrants during the systematic detention process and their stay in the Open Centres in Malta. MdM asks these institutions to engage proactively in an improvement of the human rights situation of asylum seekers in Malta.