CSP CADERNOS DE SAÚDE PÚBLICA
REPORTS IN PUBLIC HEALTH

ESPAÇO TEMÁTICO: POPULAÇÕES REFUGIADAS E SAÚDE
THEMATIC SECTION: REFUGEE POPULATIONS AND HEALTH

Border policies and health of refugee populations

Políticas de fronteiras e saúde de populações refugiadas

Políticas de fronteras y salud de poblaciones refugiadas

Débora de Pina Castiglione [1]

doi: 10.1590/0102-311X00006018

[1] *Instituto de Migraciones, Universitad de Granada, Ogíjares, España.*

Correspondence
D. P. Castiglione
Polígono Tecnológico Ogíjares. C/Zamora. Parcela 111-112, Universidad de Granada, 18151 Ogíjares (Granada), España.
dpcastiglione@gmail.com

The current "refugee crisis" has been called the most serious humanitarian crisis in recent decades, with more than 22 million refugees worldwide, the largest contingents coming from Syria (5.5 million), Afghanistan (2.5 million), and Sudan (1.4 million) [1]. Much recent media attention has focused on the arrival of refugees on Europe's borders – especially Greece and Italy. However, the approximately 2 million people that have reached Europe are proportionally few compared to those in Lebanon (1.1 million), Pakistan (1.4 million), and Turkey (2.9 million) [1]. The vast majority of persons currently in situations of forced cross-border or internal displacement are in countries of the Global South, 67% of whom in Africa, Asia, and the Middle East [1].

Although forced displacement of populations is probably as old as war itself, most of the legal mechanisms on the issue are recent, having emerged soon after World War II. The United Nations Convention on the Status of Refugees, from 1951, is still the world's main reference, defining refugee as someone who has to cross international borders due to well-founded fear of suffering persecution based on race, religion, nationality, political opinion, or membership in a given social group [2]. The convention was created in a historical context in which millions of European had sought asylum around the world. However, the direction changed in the 1980s, with a sharp increase in migratory flows from the countries of the Global South to the Global North [3,4,5].

The so-called "no-entry" system has been consolidated since then. Many of the system's initial practices have been challenged in courts (and condemned) in recent decades, and several so-called developed countries have begun dodging such legal hurdles by "outsourcing" their border control policies. The latest generation of policies is anchored in the territories around Europe and focuses on containing refugees – and migrants – in their home countries or countries of transit, through increasingly intense collaboration with such nations as Turkey and Libya [6]. The countries rely on various strategies for this purpose: prison construction, technical assistance, and technology transfer, among others. Such policies shape the paths needed to obtain asylum. It is essential to keep these paths in mind when we speak of the refugee population's health, since many of the health risks and outcomes are related to the spaces, times, and institutions comprising the "no-entry" systems: countries of origin and of transit, the border, the camp, the "asylum office", sometimes the detention or deportation center.

Contexts that lead to forced migrations – both internal and cross-border – are associated with the violence that results in specific health problems. In the midst of war, as in Syria, the increase in the number of casualties takes place in parallel with the rapid breakdown or even destruction of the health system, to the extent that hospitals and other infrastructures are affected by the hostilities, so that sometimes the closest healthcare can only be found in a neighboring country. From 2011 to 2015, the Turkish health system treated more than 7.5 million Syrians; the healthcare provided to refugees by Turkey in those four years is estimated at more than USD 880 million [7]. Not surprisingly, mental health problems like depression, anxiety, and posttraumatic stress are common among refugees around the world [8].

Under an increasingly restrictive "no-entry" policy, crossing borders involves not only aggravating health conditions and barriers to access to services, but a number of additional risks. Refugees and migrants attempting to reach Europe normally face an extremely hazardous crossing on the Mediterranean Sea, with a million arrivals and 3,771 persons (0.3%) having died or disappeared at sea in 2015 [9]. In the following years the arrivals decreased abruptly (some 360,000 in 2016 and 170,000 in 2017) as a consequence of agreements signed between the European Union and Turkey, Italy, and Libya, who cracked down with their coastal patrols and placed substantial obstacles against NGOs dedicated to human rescue operations. Deaths at sea skyrocketed as a result: at least 5,096 persons died in 2016 (1.4% of arrivals) and 3,081 in 2017 (1.8%) [9].

A person's stay in a refugee camp can either happen while the request for asylum is being processed, or as part of a quasi-permanent situation. In Greece, the precarious health and security conditions in such installations create high-risk situations [10,11]. In the summer of 2016, during a regional coordinating meeting, NGO representatives in northern Greece denounced that rape was so widespread in the refugee camps that prophylactic kits had run out in the local hospitals, jeopardizing the victims in general, including migrants, refugees, and local residents. In winter, temperatures dropped to -17ºC, leading to several deaths from hypothermia, in addition to suicides and carbon monoxide poisoning from makeshift heating systems. Only then, the canvas tents were replaced with lock-and-key containers in a few camps, a relatively simple and low-cost measure, but efficient in improving living conditions and that could have been implemented much sooner.

Conditions in some refugee camps favored the installation of drug trafficking gangs that resell psychiatric medicines on the clandestine market, along with illegal substances. Due to the inability of the Army and the NGOs to deal with the situation, the supply of medicines was suspended again, and some patients were even arrested because they did not have a medical prescription to show during police raids (all of which are issues that extend far beyond the camp's perimeter). Despite the isolation symbolized by militarized camps, the links between the refugees' health and that of the local population are complex: for example, prolonged hospitalizations due to war injuries, with intensive antimicrobial treatments, can facilitate the development and spread of multi-resistant bacteria, affecting the wider border areas [7].

In Turkey, the resurgence of infections like measles, tuberculosis, and polio was associated with the Syrian Civil War, partly because once the hostilities began, the Syrian health system lost its capacity to maintain its immunization programs [7]. Refugee children that entered Europe through Greece almost invariably passed through Turkey. In the case of many Syrians, this meant having received the necessary vaccines in Turkish refugee camps. However, language barriers, difficulty in holding on to personal documents during the voyage, and other obstacles mean that many parents and guardians cannot guarantee that their children were vaccinated, or which vaccines and how many doses they received. In Greece, children's immunization was organized by Doctors Without Borders (MSF), but the campaign's efficiency was limited by organizational difficulties and the high price of vaccines on the market, since the pharmaceutical companies were charging up to 10 times the lowest available price [12].

Studies on the health of refugee populations tend to reproduce the prevailing focus on the development and evaluation of humanitarian intervention policies [13], virtually ignoring the macropolitical contexts in which population displacements take place – and where the humanitarian aid apparatus is a key component. However, trends in refugee policies are inseparable from the broader context of political-organizational forms [14], and the health issues of refugee and migrant populations are likewise related to this broader context and the place the human body occupies in conflicts, political

projects, and disputes for territory. Containment policies have impacts on the health of refugees and migrants (indeed, on life and death); this materializes in the thousands of deaths in the Mediterranean Sea, in the prolonged exposure to risk factors in refugee camps, in the barriers to adequate healthcare, and in the chronic stress from the bureaucratic process to obtain the protection provided for under refugee status.

Forced migration, territorial containment, and the increasingly efficient and bureaucratized control of migratory flows can be analyzed as part of the spatial dynamic of racism, defined by geographer Ruth W. Gilmore as "*the state-sanctioned and/or extra-legal production and exploitation of group-differentiated vulnerability to premature death*" (2007, *apud* Cheng & Shabazz [15]). In this sense, analogies are possible between the health and disease processes in refugee and migrant populations and the processes that affect racialized populations on other scales: the body, the city, regions of a country, or international migrations. In a context where the dimension of forced migrations in the world makes the health of refugee populations a central theme, it is necessary to look beyond a focus limited to specific situations and consider border policy itself as a global health issue.

Acknowledgments

I wish to thank my Syrian, Kurdish, Egyptian, Iranian, Moroccan, Algerian, Greek, and Turkish friends for sharing their experiences and discussing the issues addressed here in recent months.

1. United Nations High Commissioner for Refugees. Figures at a glance. http://www.unhcr.org/figures-at-a-glance.html (accessed on 10/Jan/2018).
2. United Nations High Commissioner for Refugees. Convention and protocol relating to the status of refugees. http://www.unhcr.org/3b66c2aa10 (accessed on 10/Jan/2018).
3. Chimni BS. The birth of a "discipline": from refugee to forced migration studies. J Refug Stud 2008; 22:11-29.
4. Chimni BS. The geopolitics of refugee studies: a view from the south. J Refug Stud 1998; 11:350-74.
5. Orchard P. A right to flee: refugees, states, and the construction of international cooperation. Cambridge: Cambridge University Press; 2014. http://ebooks.cambridge.org/ref/id/CBO9781139923293 (accessed on 07/Aug/2017).
6. Gammeltoft-Hansen T. The law and politics of non-entrée. https://www.rsc.ox.ac.uk/news/the-law-and-politics-of-non-entree-thomas-gammeltoft-hansen (accessed on 10/Jan/2018).

7. Doganay M, Demiraslan H. Refugees of the Syrian Civil War: impact on reemerging infections, health services, and biosecurity in Turkey. Health Secur 2016; 14:220-5.
8. Kane JC, Ventevogel P, Spiegel P, Bass JK, van Ommeren M, Tol WA. Mental, neurological, and substance use problems among refugees in primary health care: analysis of the Health Information System in 90 refugee camps. BMC Med 2014; 12:228.
9. United Nations High Commissioner for Refugees. Refugees/migrants response – Mediterranean. http://data.unhcr.org/mediterranean/regional.php (accessed on 10/Jan/2018).
10. Human Rights Watch. Greece: refugee "hotspots" unsafe, unsanitary. https://www.hrw.org/news/2016/05/19/greece-refugee-hotspots-unsafe-unsanitary (accessed on 12/Mar/2017).
11. Amnesty International. Greece: refugee women coping with fear and violence in the camps. https://www.amnesty.ie/greece-refugee-women-coping-fear-violence-camps/ (accessed on 12/Mar/2017).
12. Médecins Sans Frontières. Greece: MSF denounces high price of vaccines for refugee children. http://www.doctorswithoutborders.org/article/greece-msf-denounces-high-price-vaccines-refugee-children (accessed on 10/Jan/2018).
13. Black R. Fifty years of refugee studies: from theory to policy. Int Migr Rev 2006; 35:57-78.
14. Kleist JO. The history of refugee protection: conceptual and methodological challenges. J Refug Stud 2017; 30:161-9.
15. Cheng W, Shabazz R. Introduction: race, space, and scale in the twenty-first century. In: Cheng W, Shabazz R, editors. Occasion. v. 8 – race, space, scale. Stanford: Stanford University; 2015. https://arcade.stanford.edu/occasion_issue/race-space-scale.

Submitted on 14/Jan/2018
Approved on 23/Jan/2018