RESPONDING TO "MIXED" MIGRATION FLOWS: A HUMANITARIAN PERSPECTIVE

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Médecins Sans Frontières' (MSF) worldwide work with refugees reveals a transition toward ever more mixed forms of migration of both political and economic backgrounds. "Mixed flows" of displaced people might suggest population movements including both people fleeing political persecution or violence and people migrating for economic reasons. Yet in many cases, these distinctions remain blurred as people seeking refuge from conflict and oppressive regimes likewise seek jobs and economic opportunities in order to survive.[1] The terminology and the distinction between "political" refugees and "economic" migrants remain fundamentally artificial constructs.

At the same time, MSF witnesses the weakening and/or lack of direct applicability of refugee law to those fleeing persecution and violence but unseen or intentionally ignored, within such mixed flows – leading to real and worrying impact on their lives and health.

The changing nature of government response to migration and displacement, in particular refugee flows, represents a fundamental new challenge to humanitarian assistance. In this article, MSF documents the concrete impact of these changes and our evolving operational approach in response.

We argue that these profound changes represent a fundamental challenge to humanitarian aid actors in terms of accessing and assisting people fleeing violence to seek refuge, assistance and protection in other countries. It is paramount for humanitarian actors to re-consider the governments' changing responses to population movements today in order to re-define and re-gain humanitarian space to independently access and assist those fleeing from violence.

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1. Background: MSF response to refugees in changing contexts

Founded in 1971, MSF has a long history of assistance to refugees, with or without legally recognised refugee status. Starting with some of its first large-scale projects assisting Cambodian refugees in Thailand in 1975 and Salvadoran refugees in Honduras in 1980 (MSF, 2003a), MSF responded in many of the major refugee crises worldwide in the following decades, including assistance to Rwandan refugees in camps in Zaire, Somalis in camps in Kenya, Afghans in Pakistan and Iran, Darfur refugees in Chad, to name a few. In addition to its operations, MSF also continuously informed public opinion about the precarious situation of refugees and its own humanitarian work in refugee camps.[2]

Today, *de facto*, authorities in host countries as well as some international agencies and donors frown on the development of new refugee camps due to misplaced concern about potentially protracted refugee situations (UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES [UNHCR], 2006; PONT, 2006)[3] with camps acting as a pull factor for additional influxes and about refugee "dependency" on relief in such settings where local integration may remain impossible.[4] In reality, protracted refugee situations are more the combined result of the prevailing situations in the country of origin, the policy responses of the country of asylum and the lack of sufficient donor government engagement in these situations (LOESCHER; MILNER, 2006).

As a result of these ground-level political realities, refugees often no longer receive assistance in camps, but have to move on to urban settings where they live in hiding and try to survive in the informal sector. Urban refugees experience the same protracted refugee situations – just not in camps. As a result, they remain more vulnerable both in terms of mental health, due to stress and continuous fear of deportation and in terms of physical health provoked by poor living conditions and a lack of access to basic services including health care.

Unrecognised refugees and undocumented migrants in urban settings often lack protection and become targets for xenophobic and other violence, as we have recently witnessed on a large scale in South Africa (MSF, 2008d) and in specific incidents in other contexts. In Malaysia, of 248 incidents of violence recorded by MSF, 26% were committed by ordinary Malaysians against undocumented migrants and refugees living in their midst. These abuses were met with impunity because refugees and undocumented migrants were too scared to assert their basic rights or to pursue legal action. Reporting incidents to the Malaysian police would not have benefited refugees and migrants as they would face charges of being "illegal" (MSF, 2007d).

The last ten years have seen ever more restrictive refugee policies in host countries worldwide, as well as at the regional level of neighbouring countries where refugees might seek protection. Refugees enjoy several far-reaching rights enshrined in the 1951 Refugee Convention and elsewhere in international law (the definition of a refugee itself was enlarged on a regional basis by the 1969 Convention of the Organization of African Unity [OUA] and the 1984 Cartagena Declaration). These rights include the right to cross borders to seek asylum in other countries; the right to apply for asylum and to enjoy at least temporary protection if return to the country of origin involves danger

to life and limb; and the right to be free of forcible repatriation (*refoulement*). Yet, these rights have been interpreted in ever more restrictive ways, including by closure of borders by states and belligerents and politically targeted use of in-country humanitarian aid.

These policies and practices have resulted in a change in patterns of flight from violence and conflict – ever more internally displaced people (IDPs), urban refugees, "mixed" flows of refugees, migrants and *sans papiers*.

The past years have seen an overall increase in internally displaced people to 24.5 million people worldwide at the beginning of 2007. Even with the looser legal and operational framework to assist IDPs in their own country (not to mention often absent measures toward protection), MSF has been able to be present to assist and advocate in the interest of the displaced in many of the large-scale IDP crises including in Angola, Sudan, Afghanistan, Colombia, DRC, and Liberia.

As a result of ever more restricted policies and gaps in assistance towards asylum seekers and undocumented migrants, MSF increasingly launched operations in host countries since the late 1990s, in parallel with assistance to refugees and displaced in their own regions. Initially, these efforts focused on European settings (Belgium, France, Spain, Italy, Sweden, Greece etc.), but have more recently been enlarged to recognize analogous situations in prosperous countries of the South, including South Africa, Malaysia, Thailand and transit countries such as Morocco and Yemen (MSF, 2005a; 2008a; 2007d).

These relatively new MSF operations treat a symptom of globalisation, which enables increasing international flows of goods, capital and services, but not always of persons – especially not refugees. Ever stricter legal interpretations in the status definition of refugees,[5] as well as concrete obstacles blocking their access to legal status and basic services – such as medical care – render refugees and migrants vulnerable at every step of their journey.

As a humanitarian organization, MSF provides medical care to these mixed migrant and refugee populations without regard to patients' legal status, as for MSF there is no concept of "illegal people" or "illegal patients". MSF interventions are a response to human beings in need of assistance. While MSF teams generally treat newly arriving refugees and migrants, rejected asylum seekers and *sans-papiers* (undocumented migrants), the primary criterion for MSF is humanitarian need – responding to a lack of access to basic medical care, as well as to often appalling living conditions and abuses impacting on people's physical and mental health. In an approach often not unlike those found in refugees' regions of origin, MSF teams in such project provide first aid and medical screening, facilitate access to national health care services and tackle psychological consequences related to their flight and situation of distress in the receiving country. MSF also denounces and points out to the host governments the gaps in assistance for asylum seekers and undocumented migrants and the inhumane manner in which many are treated in order to improve their situation.

In Malta[6] and the Italian island of Lampedusa,[7] Somalis, Ethiopians, Nigerians and others wash ashore in unsafe boats. They cross the Mediterranean Sea in dangerous conditions, in overcrowded, flimsy dinghies and boats, with little food on board. They stay at sea for many days and nights, exposed to extreme conditions and at the mercy of the wind and waves. The often life-threatening conditions of the journey are a traumatic experience in themselves. New arrivals often require immediate care for shock, dehydration,

hypothermia, skin burns or other physical injuries sustained during their travels. Due to the lack of adequate assistance by the local authorities, humanitarian presence is needed on Europe's shores. MSF provides access to health care and emergency medical assistance at landing points, while also advocating for increased government involvement to assist and protect new arrivals by guaranteeing access to asylum procedures.

In Yemen, Somalis and Ethiopians arrive after risking their lives to escape from conflict and extreme poverty. Both the sea crossing from the Horn of Africa and the landing on the Yemeni coast itself are very dangerous. To avoid being caught by the Yemeni military, many boats arrive at night and smugglers force passengers to jump into deep water far from the shore. As a result, many people drown as they cannot swim and/or can not move because of numbness in their limbs. Many of these people told MSF that they were aware of the risks, but had no choice other than this survival strategy to escape from violence and destitution.

In Mytilini, Greece, MSF visits to the local detention centres revealed the desperate living conditions of refugees and migrants, many of whom had fled war, persecution, hunger and extreme hardship in Afghanistan, Somalia or Palestine. MSF's emergency intervention focuses on improving the living conditions and infrastructure at these centers and providing primary health care and psychological support.

In Musina, South Africa (MSF, 2008b; 2008c), MSF medical activities centre on a community of Zimbabweans who fled desperate conditions in their home country only to face a lack of assistance, along with the threats and violence connected with the border crossing, police raids in areas where Zimbabweans seek refuge, and the constant menace of arrest and deportation. MSF has documented similar situations in Yemen, Morocco, and elsewhere (MSF, 2005b; 2008e).

In Thailand, Rohingyas arrive weak and traumatised. Persecuted in Burma and often fleeing horrible camp conditions in Bangladesh, they seek a safe heaven in Malaysia after transiting through Thailand. Those who make the journey to Thailand find their suffering far from over, as detention, deportation or life in overcrowded and unsanitary refugee camps awaits them. MSF monitors their situation and assists them in their access to health care, in both detention centres and open settings.

Where does the problem lie? For those refugees who do knock on the doors of states, the reaction is alarming. In response to worldwide movements of refugees and migrants, states have increasingly advanced and implemented a wide range of restrictive policies. Recent policies include stricter border controls and interception measures preventing irregular entries,[8] restrictive interpretations of refugee law, and deterrence measures like the use of detention centres and limits in access to basic services including health care. The real consequences of these policies cannot be understated. They have a direct impact on the health of new arrivals and people who become destitute during their stay.

2. Concrete impact of restrictive refugee and migration policies

Restrictive interpretations of refugee law leave people in a legal limbo resulting in a constant fear of deportation. Not only can States argue to return refugees to "safe third

countries" through which they have transited, or argue that their country of origin is either entirely safe, or that refugees might enjoy an "internal flight alternative" to seek safety elsewhere inside their own country rather than refugee status abroad. As a result of these strict interpretations, only 0.03% of the asylum seekers in Greece are being granted protection (HUMAN RIGHTS WATCH [HRW], 2008). In South Africa, during the first quarter of 2008, more than 10,000 Zimbabweans applied for asylum, of which only 19 were granted refugee status.

This in itself then directly leads to barriers to access medical care: either people are not legally entitled to full access to health care or fear deportation when seeking medical care. Zimbabweans in South Africa live in a constant state of fear that they will be deported. Although the South African constitution theoretically guarantees access to health care and other essential services to all those who live in the country, this policy is not always respected, and the fear for deportation – and more recently xenophobic violence – keeps many Zimbabweans from accessing health care.

Such restrictive readings of international law, combined with legal migration stops have also contributed to ever more mixed migration flows. Diverse migrants -- voluntary or forced migrants – and refugees may all find themselves forced to flee and stay in other countries outside any legal framework, as opportunities for regular migration are limited or even non-existent in host countries.

Refugees may lack information, legal aid or other assistance to enable their access to asylum procedures and so end up without legal status and the rights connected with it. In Italy, MSF witnessed the expulsion of 300 people to Libya who had not been informed and/or had not had the chance to request asylum. MSF has witnessed similar situations with Zimbabweans in South Africa, Rohingyas in Thailand and sub-Saharan African refugees in Morocco. At the same time, *in situ* or diplomatic asylum is often refused, as MSF witnessed in Zimbabwe in 2008, as hundreds of people were denied asylum and ejected from the South African Embassy in Harare, into the hands of the national authorities.

Such situations are in clear violation of international legal obligations to provide access to legal procedures, including asylum for refugees. These situations could also constitute a breach of the key principle of non-*refoulement,*[9] which represents the practical defence of an individual's right not to be forcibly returned to a country where s/he is in danger. The principle of *non-refoulement* establishes that any individual who enters another state's territory, even illegally, has the right to submit a request for asylum and have his/her case heard. It is of primordial importance that people have access to asylum procedures upon arrival.

Despite the lack of options at home and abroad, virtually every major humanitarian crisis in sub-Saharan Africa has sent people fleeing to Europe from violence-affected regions, as seen in specific influxes through our projects around the Mediterranean Sea. As a result of conflict in regions of origin, MSF teams witnessed Liberians arriving in 2003 and South Sudanese in 2004 and 2005 (MSF, 2003b) while in 2008, 30% of MSF consultations in our project in Italy were sought by people who had fled from the Horn of Africa as fighting in the region intensified.

Often repeated border controls and deportations – at times involving violence

or the threat of violence – result in physical trauma, stress and anxiety. In Morocco, injuries caused by violence at the hands of the police, other authorities and smugglers are one of the most frequent reasons for migrants to seek medical treatment from MSF.

These non-arrival policies also force refugees to take higher risks to reach a safe haven – resulting not in fewer new arrivals, but ever more deaths and risks to the health of those seeking refuge. In Yemen, over 1400 persons were reported dead and missing trying to cross the Gulf of Aden in 2007 alone. In Morocco, MSF teams have noticed that the increase in border controls between the coasts of Morocco and Spain has had a marked impact on the routes taken by migrants. People used to try to cross the razor wire fence at Ceuta and Mellilla, the two Spanish enclaves bordering Moroccan territory, or sail over the narrow strait of Gibraltar with "pateras" (small boats). Now, they increasingly travel with bigger ships from southern Mauritania and Senegal toward the Canary Islands – making their journey longer and more dangerous. At the same time, despite increasingly strict counter-measures, 2008 saw a dramatic increase in the number of boats landing on Lampedusa, Italy. By August 2008, 17,340 persons had landed – compared to 11,889 people in total throughout the previous year.

Not only did these refugees face additional and greater risks to reach safety, but restrictive policies also culminated in a failure to distinguish people seeking protection from other migrants arriving with the help of smugglers. Indeed, by forcing people to flee with the help of smugglers in order to reach safety, such restrictions also expose refugees both to the criminal violence of smugglers (e.g. *gumaguma* gangs in South Africa, mafia in Malaysia and Yemen), as well as to a public and political perception of refugees and migrants less as victims of smuggling than as criminals by their association with smugglers.

In recent years, MSF has also seen states intensifying their use of detention as a deterrent measure toward asylum seekers and undocumented migrants. As seen in most of MSF projects, detention often involves harsh living conditions – sometimes in the longer term – in which people's health is unnecessarily put at risk. In Malta, MSF medical figures confirm that over 30% of new arrivals are in good health. Yet, follow-up consultations reveal a different pattern of morbidity, much of which is directly linked to living conditions in detention centres. Among refugees and migrants in these detention settings, MSF finds widespread skin diseases, diarrhoea, respiratory tract infections and mental health needs, all mainly connected with overcrowding and poor hygiene conditions. While most refugees and migrants have survived traumatic life events and developed effective coping mechanisms and strategies, further stress related to detention, such as overcrowding, lack of privacy, harsh conditions and uncertainty regarding their future can impact profoundly on individuals' mental health, well being and ability to function. The longer people stay in detention, the higher the incidence of mental health disorders such as anxiety and depression. Inside detention centres, MSF supports health authorities to ensure medical care for people temporarily held there, while monitoring the living conditions affecting the health of the detainees. Finally, MSF works to ensure specific attention and/or release to more open settings for particularly vulnerable individuals in the centres – the sick, minors and pregnant women.

By opening more projects in detention centres, MSF finds itself walking the fine

line between providing much-needed care and becoming a service provider on behalf of states. Documenting and going public about the conditions in these centres and their impact is therefore an integral part of these MSF projects.[10]

From initial non-arrival policies and the lack of status determination frameworks to detention and deportation, such policies have direct and serious consequences on the health, well-being and dignity of people on the move, necessitating a humanitarian response where state responsibility has failed.

3. Barriers to Accessing Health Care

Complicating an already precarious situation, numerous legal and practical barriers block refugees and migrants from accessing basic health care. In some countries, access to health care for undocumented migrants is explicitly restricted by law to emergency health care. In others, undocumented migrants have full access to health care, but even then, in practice this access remains complex due to costs, administrative obstacles and the global lack of available legal and practical information for both migrants and those assisting them. In addition, undocumented migrants may face language or cultural barriers, fear of being reported and facing deportation and/or the need to navigate complicated and changing procedures. If refugees and migrants arrive in an already weakened state, these barriers only further contribute to the deterioration of their health. Some states also impose fines or other sanctions against people, including doctors, who give assistance to undocumented migrants without denouncing their legal status to the authorities.

In Thailand, where MSF has assisted Burmese refugees and migrants since March 2005, Burmese face a complicated registration process together with barriers of discrimination, language and transport costs when seeking medical care. The complex and expensive procedure for legal registration in Thailand is complicated by almost annual changes in regulations for immigration and refugee status determination. In some cases, migrants turn to paid brokers to help with the necessary paperwork and contacts with the authorities. Without legal status and a health card, migrant workers must pay the full and usually unaffordable cost of medical treatment. For example, a caesarean delivery in the hospital could cost over 10,000 baht (US$300 or 200) – the equivalent of over three months' wages for an average migrant. Seeking medical care also exposes migrants to possible detection while travelling to health care structures and to being reported by hospital staff, both of which could result in detention and deportation.

Besides registration, many other barriers prevent Burmese refugees and migrants from seeking medical care: language differences, costs of travel and care and a lack of confidence in the public health system due to language differences and compounded by the unwelcoming attitude of some medical staff. All these factors come together to prevent many migrants from seeking treatment until their condition is very serious. Burmese refugees and migrants in Thailand are just one example, MSF has witnessed similar problems in South Africa, Belgium and other contexts.

As a humanitarian organization, MSF responds to the lack of access to care, providing medical and other basic needs of refugees and migrants, without regard to their legal status.

Many of those seeking care with MSF have fled war and violence, arriving in a vulnerable state from their countries of origin where MSF also works to address the impact of violence. Yet, at the level of host countries, the concrete result of legal, policy and practical barriers facing migrants leave MSF with multiple barriers to access and assist them.

4. In conclusion: "mixed" flows and the challenge to humanitarians

With the current pressures, refugees and migrants – arriving in mixed flows – remain hidden in urban settings and are practically impossible to openly and safely target for assistance. By contrast to classic refugee camp settings, few legal frameworks outline this population's rights to assistance, state obligations to grant access to humanitarian actors or general guidelines for the negotiation of humanitarian access. Also by contrast to typical refugee camp settings of the past, many host countries are headed by stronger governments that may resist recognition of refugees or humanitarian needs within their borders.

In contexts of violence and displacement, MSF has long advocated for a preservation of humanitarian space – states' and other actors' recognition and respect for humanitarians' independent action to assess needs and assist the most vulnerable. The ever more restrictive legal and practical barriers facing refugees and migrants challenge us to find ways both to reach them where they are – but also to find language and means to advocate toward states for greater responsibility to assist and protect refugees and to ensure that humanitarian actors have space to access and assist them where gaps remain.

Providing medical care and advocating for access to health for migrants in mixed flows is one starting point, but we and other humanitarian actors are challenged to remain vigilant and responsive to the needs of populations on the move, who remain vulnerable and too often hidden from view.

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NOTES

1. E.g. Refugee from Burma – patient at an MSF project in Malaysia: "Life back home was impossible. We had virtually no income. We would only have meat once a month. My father had a small plot of land and grew food. But when he died, the government took our land away. If I wanted to use my father's land, I would need to rent it. I could not afford this. I left because I had to survive." E.g. People leaving Zimbabwe often recount to MSF staff stories of flight, which include both political persecution and flight for economic survival.

2. For more information on MSF public campaigns on refugees, see MSF ([n.d.]; 2002).

3. UNHCR defines a protracted refugee situation as: "one in which refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile. A refugee in this situation is often unable to break free from enforced reliance on external assistance" (UNHCR, 2004, p.1).

4. For a critical review on the question of aid dependency (frequently with a view toward refugee situations), arguing that transparent and reliable assistance to needs should be the focus of aid rather than avoidance of dependency, see Harvey and Lind (2005).

5. For instance, in 2007 Greece alone received more than 112,000 migrants. However, from a total of approximately 25,000 registered asylum claims, only eight persons were granted refugee status – the main nationalities in MSF consultations were people originating from Iraq, Afghanistan, Somalia and Pakistan.

6. MSF has been active in Malta since August 2008.

7. MSF worked on the southernmost island of Italy, Lampedusa, from 2002 to 2008 (MSF, 2007a).

8. For instance, within the European Union there are now common visa policies, carrier sanctions on carriers carrying undocumented migrants, and extra-territorial controls conducted by airline staff and immigration officers stationed abroad to hinder unwanted arrivals. An EU agency, Frontex, was created to increasingly cooperate on border control. For more info on Frontex, see European Union ([n.d.]).

9. Art. 33 of the 1951 Refugee Convention and considered to be customary law.

10. See, e.g. MSF (2007c), together with a more in-depth documentation report MSF (2007b). Similar work in detention centres was carried out in Malaysia (see above).

RESUMO

A atuação internacional de Médicos sem Fronteiras (MSF) com refugiados revela uma transição que cada vez mais entrelaça as diversas formas de migração de origem política e econômica. A evolução da natureza das migrações e dos deslocamentos, em particular os fluxos de refugiados, e as respostas dos governos a essas movimentações, representam um novo dilema para a assistência humanitária. Nesse artigo, MSF documenta o impacto concreto dessas transformações e a reação de nossa abordagem operacional. Argumentamos que essas transformações representam um desafio às organizações humanitárias com relação ao acesso e à assistência prestada às pessoas fugindo da violência e em busca de refúgio, assistência e proteção em outros países. Em contextos de violência e deslocamento, MSF há tempos defende a preservação de espaços humanitários, o reconhecimento e o respeito por parte dos Estados e de outros atores pelas ações humanitárias independentes, para que avaliem as necessidades e assistam os mais vulneráveis. As barreiras legais e operacionais cada vez mais restritivas enfrentadas pelos migrantes e refugiados nos confronta a encontrar meios para alcançá-los onde estiverem, como também a encontrar uma linguagem e caminhos que nos possibilitem advogar junto aos Estados a ampliação de suas responsabilidades na promoção de assistência e proteção aos refugiados, garantindo que os agentes humanitários tenham espaço para acessar e assistí-los onde ainda seja necessário.

PALAVRAS-CHAVE

Migrantes – Refugiados – Deslocamentos – Direito à saúde – Acesso a cuidados médicos – Médicos sem Fronteiras.

RESUMEN

El trabajo mundial de Médecins Sans Frontières (MSF) revela una transición hacia formas mucho más mixtas de migración tanto política como económica. La naturaleza cambiante de la migración y el desplazamiento, en particular del flujo de refugiados, y la respuesta gubernamental a éste, representa un nuevo dilema para la asistencia humanitaria. En este artículo, MSF documenta el impacto concreto de este desafío y nuestro abordaje operacional en respuesta. Argumentamos que este desarrollo representa un desafío fundamental para los actores de ayuda humanitaria en términos de acceso y asistencia de personas huyendo de violencia y en búsqueda de refugio, asistencia y protección en otros países. En el contexto de violencia y desplazamiento, MSF tienen una largo pasado de defensa de la preservación de espacios-estado humanitarios y otros actores de reconocimiento y respeto por las acciones humanitarias independientes para evaluar las necesidades y asistir a los más vulnerables. Las barreras legales y prácticas más restrictivas afrontadas por refugiados y migrantes nos confrontan a encontrar maneras para localizarlos y contactarlos, pero también a elaborar un lenguaje y hallar medios para abogar para que los Estados con mayor responsabilidad asistan y protejan a los refugiados y garanticen que actores humanitarios tengan espacio para acceder y ayudar donde permanezcan espacios vacíos.

PALABRAS CLAVE

Migrantes – Refugiados – Desplazamientos – Asistencia médica – Médecins Sans Frontières.