Refugee crisis in Europe: health status, life experiences, and mental health problems of transiting refugees and migrants on the Balkan route in 2015

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Introduction

In 2015, >1 million refugees/migrants reached the European Union. Most arrived in Greece and moved northwards through the Balkans. In response, MSF established medical and mental health (MH) care in outpatient clinics at major entry and exit border points in Greece and Serbia. In a retrospective analysis, we aimed to determine the demographics, health status, and experience of transiting refugees/migrants.

Methods

We analysed routine patient (Jan-Dec 2015) and individual MH session (May-Dec 2015) data from MSF projects in Greece (Dodecanese Islands, Lesvos, Idomeni) and Serbia (Subotica, Belgrade, Presevo, Sid). Patients were self-referred or identified through MH group sessions, medical consultations, patients’ social networks, or referral. Collected information included socio-demographics, morbidities, chronic diseases, traumatic life-events, and MH symptoms.

Ethics

This retrospective study met the criteria of the MSF Ethics Review Board for exemption from ethics review.

Results

We performed 81,868 medical consultations (Greece: 43,619 [53%]; Serbia: 38,249 [47%]). Of 81,768 patients, 22,165 (27%) were <18 years and 15,852 (19%) were women. Most were from Syria (36,729; 45%), Afghanistan (26,332; 32%), and Iraq (8848; 11%); 12,796 (16%) were considered vulnerable. Patients presented with respiratory tract infections (33,331; 41%), trauma (12,792; 16%), gastrointestinal complaints (8965; 11%), and skin diseases (8484; 10%); 93% (74,232/79,784) reported onset during migration. 6% (n=4560) reported a chronic disease. We proposed referral to 680 (0.8%) of whom 129 (19%) were trauma cases; 77 (11%) refused referral.

We performed 1064 individual MH sessions (Greece: 733 [69%]; Serbia: 331 [31%]); 116 (11%) were <18 years and 330 (31%) female. Patients came from Syria (510; 48%), Afghanistan (215; 20%), and Iraq (125; 12%); 31% (n=329) were considered vulnerable. Patients had experienced a median (IQR) of 3 (2-4) traumatic life events: 866 (81%) forced to flee; 281 (26%) bombing; 210 (20%) life-threatening event; 170 (16%) family member(s) killed; 203 (19%) physical violence; and 156 (15%) ill-treatment. State authorities were the perpetrators for 12% (123/1064) of violence and 7% (74/1064)
of ill-treatment reports. 831/1052 (79%) presented with MH symptoms: anxiety (246; 30%); adjustment/acute reactions (198; 24%); depression (165; 20%); post-traumatic symptoms (60; 7%). We followed-up 120/1064 (11%) patients (median [IQR] follow-up sessions: 1 [1-2]) and referred 356/1064 (33%) for social, medical, and psychiatric care.

Conclusion

Most acute symptoms were related to migration. Patients reported multiple traumatic life-events, including violence/ill-treatment by state authorities, and demonstrated symptoms of anxiety and depression. The results suggest that refugees/migrants are exposed to increased risk of medical conditions and have unattended MH needs. Relevant authorities in transit/destination countries need to ensure the safety and access to health services of refugees/migrants and the identification and assistance of vulnerable groups. Proactive detection and free access to long-term MH services is essential.

Conflicts of interest

None declared.