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The Health of Migrants Passing through Serbia: the Threat of the Sick "Other"?

With the gaining influence of securitarian discourses, migrants in Serbia are increasingly presented as a threat to the health of the general population. The media and local authorities often present them as carriers of contagious diseases and use their poor health condition as a justification for repressive measures against them. But are the public concern and (an almost exclusive) focus on the ways the health of migrants influences public health really appropriate? Have migrants been a threat to the health of the general population? In this article, I present some observations from seven months of participant observation I conducted in Serbia as a Persian and French translator during medical consultations for migrants (both in a center for asylum seekers and in the setting of the medical humanitarian organization providing primary healthcare to illegalized migrants). The attention to ethnographic data reveals that migrants have not been the carriers of diseases "from far away", which would endanger the population, but that rather their health problems stem from the risk environment and conditions of structural violence they find themselves in.

Key words: migrant health, myth of the contagious migrant, securitarisation of migration, structural violence, risk environment, Serbia.

Здравље миграната на путу кроз Србију: претња болесног „другог"?

Паралелно са јачим утицајем секуритарних дискурса, мигранти у Србији се све чешће представљају као претња јавном здрављу. Медији и локалне власти их често представљају као носиоце заразних болести и користе лоше здравствено стање миграната као оправдање за увођење репресивних мера против њих. Међутим, поставља се питање да ли су брига и фокус који се ставља на начине на које здравље миграната утиче на јавно здравље заиста одговарајући? Да ли су мигранти претња широј популацији? У овом чланку ћу представити неке од закључака седмомесечног истраживања у Србији. Подаци су добијени методом посматрања са учествовањем (у својству преводиоца за персијски и француски језик током лекарских прегледа миграната,како у центрима за смештај тражилаца азила, тако и на местима где је хуманитарна организација за лекарску помоћ обављала примарну здравствену заштиту илегализованих миграната). Увид у етнографску грађу открива да мигранти не доносе болести које би угрозиле популацију, већ да у већој мери њихови здравствени проблеми произилазе из ризичног окружења и услова структурног насиља у којима се налазе.

Кључне речи: здравље миграната, мит о заразном мигранту, секуритизација миграција, структурно насиље, ризично окружење.

Introduction

The securitisation of migration, which we have been witnessing in Europe over the last few decades, is a process of seeing "migration increasingly [...] as a danger to public order, cultural identity and labour market stability" (Huysmans 2000, 752). This construction of migrants as a threat has different manifestations: one of its aspects is the presentation of migrants as a threat to the health of the "autochthonous" population. In the present article, I examine this construction of the migrants as the sick "other" and use ethnographic insight from my research on the health of migrants passing through Serbia to first shed light on this "myth of the contagious migrant" (Lipovec Čebron 2009), and then attempt to dispel it by presenting empirical observations on the health problems of migrants in Serbia.

The insights and analysis of this contribution are based on fieldwork carried out in Serbia between January and July 2015. I conducted participant observation as a part-time Persian and French translator for a medical humanitarian organisation providing primary healthcare to illegalised migrants, and as a volunteer translator during medical consultations of the initial screening examination that migrants receive upon being admitted to one of the centres for asylum seekers. In these roles, I witnessed hundreds of medical consultations, and gained an insight into health issues migrants have been facing on their way through Serbia. I did not have the chance to conduct in-depth interviews with migrants or ask any follow-up questions – but I did get rather broad data, keeping a daily fieldwork diary, documenting data on all consultations and conversations. While the conclusions are limited to the time period before late summer 2015[1], there might be elements that generalise on the period after that, too, or at least invite their examination in the period post summer 2015.

The treat of the sick and contagious "other"

The "myth of the contagious migrant" (*mit o kužnem migrantu,* Lipovec Čebron 2009, 190) largely dominates the interest of the Serbian media for the health of migrants – thereby revealing the xenophobic and racist connotations that are evoked with the focus on the migrants as carriers of contagious diseases. The media often reproduce the rhetoric of the local authorities – this is illustrated on two ex-

[1] In the late summer 2015, the situation along the Balkans migratory route changed dramatically, when the so called "corridor" of relatively quicker and safer passage was established and along which around a million people travelled, before it was gradually closed, when first all but nationals of Syria, Afghanistan and Iraq were excluded from passing through it since the 18th of November 2015, and completely closed on the 8th of March 2016. After its closure, increasing repressive measures towards migrants on the Balkans route can be observed. For some reflections on the corridor and the events of 2015, see Lunaček Brumen and Meh (2016) and the other articles in the same publication.

amples, from the towns of Bogovađa and Zaječar, in which the "health status of migrants becomes relevant (exclusively) because of it supposed threat to the health of 'autochthonous' or 'indigenous' population," (Lipovec Čebron 2010a) and where this threat is used for the justification of repressive treatment of migrants.

Thus in Bogovađa, in 2014 for example, protests took place, when the inhabitants of a village in which a centre for asylum seekers was located took to the streets in response to the fact that many migrants had been left to sleep outside. The newspapers quoted Dragana Lončar, president of the local authority, who said that "we are also afraid of the dangers of the Ebola virus [...] and we are protesting because of the threat of other types of infectious disease, which can be spread because illegal border crossing does not bring adequate health controls."[2]

The second example is the town of Zaječar, where the local administration had been publicly presenting the presence of migrants as a "problem" since autumn 2014, when many more illegalised migrants began entering Serbia from the Bulgarian side and passing through Zaječar, where they stopped temporarily to express an intention to seek asylum. On 25 of October 2014, when a larger number of migrants had been arrested there, mayor Velimir Ognjenović called for a meeting of the Committee for Emergency Situations (*Štab za vanredne situacije*) in order to, according to Saša Mirković, president of Zaječar city council (*predsednik Skupštine grada*), "find a way to protect the citizens of Zaječar from illegal migrants, who are arriving every day on the territory of Zaječar".[3] Media reporting compounded the fear-inducing rhetoric by saying that "many of the illegal immigrants are in fact carriers of the biggest contagious diseases in the history of humanity" and that "the fear of Ebola is one of the biggest problems affecting the whole world"[4], citing information on Ebola casualties published by WHO. The article emphatically ends with a statement that "illegal immigrants are more than a real threat in this case"[5], while giving no concrete data or evidence to confirm this claim. In another example from a few months later, when a dead body was found in a village close to Zaječar in March 2015, the death of the migrant was assigned to an unspecified "contagious disease", again with no concrete evidence or source of information.[6]

From these examples we can see that, with the spread of securitarian discourses (see for example Meh 2016a), migrants are presented as a threat to health of the "body politic" (Scheper-Hughes and Lock 1987). This perceived threat to the body politic operates on a symbolic level, but also manifests itself in concrete concerns for public health. As Scheper-Hughes and Lock point out, building on the

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[2] Source: http://www.novosti.rs/vesti/srbija.73.html:518061-Bogovadja-Peticijom-teraju-azilante-iz-Afrike. All translations of quotations from newspaper articles in this section are mine.

[3] Source: http://www.tvbest.rs/93980-mirkovic-plasim-se-za-gradjane-zajecara-zbog-ilegalnih-imigranata-i-zaraznih-bolesti-koje-nose.

[4] *Ibid.*

[5] *Ibid.*

[6] Source: http://www.telegraf.rs/vesti/1466303-sirijci-kod-zajecara-pronasli-bezivotno-telo-mladica.

work of Douglas (1966) on the importance of boundaries and the corresponding conceptions of "clean" and "unclean": "When a community experiences itself as threatened, it will respond by expanding the number of social controls regulating the group's boundaries. [...] In these [...] instances the body politic is likened to the human body in which what is 'inside' is good and all that is 'outside' is evil. The body politic under threat of attack is cast as vulnerable, leading to purges [...]" (Scheper-Hughes and Lock 1987, 23–24). This is also the case with the symbolic representations of migrants in Serbia: they are represented as an unclean, unhygienic and possibly contagious threat against which the borders/boundaries need to be protected and of which the territory needs to be "purged". This symbolic and discursive basis is used as justification for the concrete repressive treatment of migrants (for more on this justification, see Meh 2016a; for documentation of repression against migrants, see Stojić Mitrović 2012 and 2013, Stojić Mitrović and Meh 2015, Human Rights Watch 2015, Amnesty International 2015).

The perception of migrants as a contagious "other" goes hand in hand with their exclusion from "medical citizenship" – which determines "who is excluded or sacrificed when health resources are rationed or restricted" (Nichter 2008, 183) – and with that from their almost complete exclusion from the public healthcare system. At the time of my research, the undocumented migrants were entitled to emergency health care only, and to non-emergency healthcare only in the cases of (some) communicable diseases.[7] Those migrants who seek asylum are in principle included into the healthcare system, but in practice there are many obstacles to this (see Meh 2016b). The only systemic and proactive measures related to the health of migrants, is an obligation to undergo an initial health examination, upon being admitted to the centre for asylum seekers[8] and a more detailed look into this (*Ibid.,* 72-84) shows that, while this check includes some possibility of curative treatment, its main rationale is to screen a portion of the migrant population for disease. This shows that, even in the public provisions related to migrant health, the focus is on the concern that the potentially sick migrants have on the public health: the asylum seeker's health is screened, only emergency and contagious conditions are treated for undocumented migrants. The concern for the health problems of undocumented migrants, which are not contagious or strictly life threatening, is missing from public healthcare policy and confined to the sector of the humanitarian organisations (*Ibid.*, 84-93). In what follows I want to first show that the focus on the "threat" that migrants present to the public health with communicable diseases "from far away" is not justified – and that instead much more real "threats" to health are those, that threaten the health of migrants themselves.

[7] Articles 238 till 242, The Healthcare Act (*Zakon o zdravstvenoj zaštiti 2005*).

[8] Article 40, Law on Asylum (*Zakon o azilu 2007*) – the details of the health examination are specified in the Regulation on the Health Examination of Persons Admitted to a Centre for Asylum seekers (*Pravilnik o zdravstvenim pregledima lica koja traže azil prilikom prijema u centar za azil 2008*).

Communicable diseases?

When the centre for asylum seekers Krnjača, where I conducted participant observation, opened in August 2014, a doctor of the local health care centre was given a task to work in the centre 2 days a week, carrying out preventative checks for asylum seekers. An epidemiologist was chosen for this task – they had assigned her the role of "asylum seekers' doctor" because she had relevant specialisation in the branch of medicine concerned with identifying the patterns, causes, transmission and effects of diseases that might affect larger populations. This reveals again the trend whereby interest in migrant health is often directed towards the question of spreading epidemic and less towards providing good health outcomes for migrants. Or, as Mladovsky writes: "the role of migration in the spread of epidemics has long been of interest in public health" (Mladovsky 2007, 1), while less interest is paid in the health of migrants more broadly.

Yet the epidemiologist told me that, so far, there have been no signs of any of the migrants carrying any contagious diseases that would endanger the wider population. The fear of migrants bringing "diseases from far away" is thus less justified than the securitarian discourse of the health of migrants presents it.

It sometimes takes migrants weeks to travel from their home countries, but mostly months and commonly even years. Those who might have suffered from a serious (communicable) disease had probably never been able to leave their country of origin, or never made it to Europe: illegalised travel takes either very good health or substantial financial resources. All of this decreases the chance that migrants would indeed bring a disease "from far away". In the contemporary world of "ethnoscapes", where an ethnoscape is understood to be "the landscape of persons who constitute the shifting world in which we live: tourists, immigrants, refugees, exiles, guestworkers and other moving groups and persons" (Appadurai 1990, 297), the concern that migrants would be the main carriers of disease reveals a degree of racism and xenophobia. Indeed, Serbian tourists who travel to "faraway" places for holidays, travel more quickly and present a more serious threat to public health than migrants, most of whom have arrived from Greece – yet an alarmist discourse is not present in relation to the tourists in the same way as it is in relation to migrants.

The two types of communicable disease which the doctors at Krnjača and at the humanitarian medical organisation indeed saw on a regular basis were scabies (*šuga*) and lice (*vaške*). The two conditions, however, were of no danger to the general population. Scabies is transmitted by prolonged skin-to-skin contact and the sharing of clothes and sleeping places. Persons from the general population, which do not sleep where migrants sleep, do not get infected. The same applies to lice: only prolonged contact can expose someone to infection. Moreover, the two diseases are easily treatable, especially when adequate washing and hygiene facilities are available.

In the case of infection with both these diseases, the lack of proper sleeping and living conditions, and inadequate hygiene and sanitation facilities, were at the

root cause of migrant infection, and were also the reason why it was so difficult to treat these diseases effectively and why reinfection rate was high.

A useful concept for understanding why the prevalence of scabies and lice was so high among the migrant population is that of "risk environment" (Žikić 2013a, 405). Its aim is to "help understand and explain sociocultural and economic conditions in which the members of the most endangered populations for certain diseases live" (*Ibid.,* 406). On their way along the Balkans route, migrants often had no choice but to sleep outside, being illegalised. They often slept by fires in the forests, especially when walking through Macedonia[9] or Bulgaria, and possess very few blankets, which they usually shared. In some places, close to the border, where many people congregated before crossing the border (be it in Macedonia, just before the Serbian border, or in Subotica and Kanjiža, before the Hungarian border) migrants constructed makeshift shelters in which blankets piled up for the migrants who would arrive afterwards. Hundreds of people therefore slept in the same blankets, which had been lying about the shelters for weeks or months. If only one person has lice or scabies, they can be transmitted to a large number of people.

[9] Throughout my fieldwork I heard testimonies from migrants who said that they had walked through whole Macedonia, or sometimes bought a bicycle and cycled through the country. Apparently, it was not possible to take public transport (this was supposed to have changed after Macedonia adopted a new law on asylum on 18 July 2015, giving people who had expressed an intention to seek asylum the right to travel by public transport for 72 hours, supposedly to reach the centre for asylum seekers, as in Serbia (source: http://www.blic.rs/Vesti/Svet/568845/Migrantice-imati-pravo-na-72-sata-legalnog-boravka-u-Makedoniji). It was risky to travel by taxi because if the police caught the taxi in which the migrants were travelling, the migrants could have been detained for several months, for the duration of the taxi driver's trial. While I heard testimonies from migrants travelling through Macedonia in November 2014, who said that they knew people who had been detained for months in Gezi Baba prison, the information first became public knowledge when Amnesty International published a letter on 26 February 2015 in which they called on their supporters to take urgent action and stated that:

> "Hundreds of refugees, asylum seekers and migrants of all ages are being unlawfully detained in the Reception Centre for Foreigners "Gazi Baba" in Skopje, the capital. The centre is overcrowded and conditions are inhuman and degrading, with extremely limited access to adequate sanitation and healthcare. In some cases, people are having to sleep on the floor. They have no access to legal aid or protection. Most of them, including whole families, are fleeing armed conflict in Syria and are detained for the authorities to establish their identity and so that they may serve as witnesses in criminal proceedings against smugglers. In some cases, they are arbitrarily detained for months, sometimes for more than six months, without the possibility of challenging their detention in court."

The letter is available online at: http://webcache.googleusercontent.com/search?q=cache:3OpVSZh2F8UJ:https://www.amnesty.org/download/Documents/EUR6510832015ENGLISH.pdf+&cd=1&hl=en&ct=clnk&gl=rs.

On 27t July, Amnesty International announced the following: "the Reception Centre for Foreigners 'Gazi Baba' has been closed. This brings an end to the detention of hundreds of refugees and migrants, in inhumane and degrading conditions. The last detainees were released on 24 July."

(Source: https://www.amnesty.org/en/documents/eur65/2166/2015/en/)

Prisons, detention centres and centres for asylum seekers are also places where scabies and lice can be transmitted. The mattresses and sleeping facilities are not washed and replaced regularly, and migrants often report having experienced a rash in the week or two after they arrived in prison; this is the incubation time for scabies.

The concept of risk environment is especially useful here for shifting the focus away from the more individualistic concept of "risk behaviour", which suggests that the risk could have been avoided with the individual's different behaviour. This "individuation of risk reduction and responsibility fails to capture the contradictory and situated pressures of risk decision-making and obscures power inequalities in risk negotiation" (Rhodes 2002, 86). In this sense, migrants in Serbia are not engaging in any sort of risky behaviour; on the contrary, they are situated in a risky environment. Migrants often do not have a choice but to sleep in places already infested with lice and scabies-causing mites.

Most common health problems of migrants

If the presentation of migrants as a "threat of the contagious other" is a myth, then what does the focus on the most common health problems of migrants show us? In the final part, I want to talk about the health problems I observed migrants facing, and give priority to the field notes and testimonies describing their perspectives and their lived experience. My aim is to suggest that their health-related vulnerabilities are produced by migration policies. This section might therefore be understood as an attempt to use "ethnography's potential to link individual human experience with macrolevel social, political, and economic structures" (Holmes and Castañeda 2016, 9).

Of course, as in any population, many different types of ill health exist among migrants. Migrants can have all sorts of illnesses and disabilities that occur in any population, but these are usually made substantially worse by the migration process, whether because of difficult material conditions or because of a lack of access to healthcare services. I met people with diabetes, heart conditions or severe chronic diseases who had run out (or feared they would run out) of their medicine before they arrived at their destination. There were people disabled from birth or early childhood who needed special assistance, which they did not get on their journey: for example, Fariba, a ten-year-old blind girl, traveling with her mother, who hoped that her daughter could have a more dignified life in Europe and go to school, which was not possible for her in Afghanistan; or Mehdi from Iran, who had injured his back as a child and had had a series of operations which left him with only a partial ability to walk and only partial lung capacity and whose wish was to get adequate long-term healthcare. There was a middle-aged Kurdish man who had lived as an illegalised person in Greece for over 15 years and had been operated there for stomach cancer; because he could not receive follow-up treatment in Greece, he was continuing his journey towards Germany in the hope of receiving life-saving treatment there. These are examples of people whose conditions had been made worse during the migration process. The health needs of migrants, as of

any other population, include those cases that are "utterly unpredictable and absolutely urgent" (Castañeda, 2009, 1557).

However, there are certain observations that can be made about the prevalence of certain types of health problem. There is a substantial lack of reliable and comprehensive data of any sort about the health situation of migrants, as they constitute a "hidden" population (Castañeda 2009, 1554). My analysis is based on months of field notes – and it is, as such, a necessarily impoverished and reduced version of the data. To organise the analysis, I first discuss those most common health problems: common colds and their complications, blistered feet and injuries from walking, digestive problems and skin rashes. I then discuss the more extreme forms of injuries, and even death, that resulted from structural and police violence. Due to the lack of space I finally only mention the psychological problems and point out to some of the specific problems that women, as a particularly vulnerable group, face.

Common colds and blistered feet, digestive problems and skin rashes

While there were a few cases of lice and scabies in almost every field visit recorded in my field- diary, most notes documented "the usual: common cold" or "blistered feet". At the beginning I tried to write down a short note on the details of the cold or blistered feet (where the person felt they had caught the cold or how their feet had become blistered), but the notes turned out to be very repetitive. Sleeping in the woods, without proper tents and in cold, damp and windy conditions, whether in Macedonia, or Bulgaria, or on unsuccessful attempts to cross over to Hungary, resulted in most people catching a cold somewhere along the way. Inappropriate and often wet shoes, and a lack of socks, resulted in blistered feet.

In the cold season, almost everyone had a cold, sometimes with complications. People would often say: "I've had a cold since Greece, a runny nose, sneezing... But the last two days, I can't stop coughing". Often people had serious throat infections, fever was also common.

The walking itself left many signs on migrants' feet and legs: "A group of people with foot pain, leg pain, back pain: The group told us that they had walked for days in the snow from Bulgaria and also that they had walked for 12 hours the previous night, as they had no money for a taxi, and had walked from the jungle straight towards the border. They were unsuccessful, got lost and came back the next day. As a result of all this walking, one boy's shoes had been wet for days without ever getting dry." (Field notes, 6.2.2015, Subotica)

Similar descriptions abound in my field notes. While blistered feet were most common, there were also some cases of frostbite in winter. A variety of injuries from walking were documented. For example: "Again the usual: colds, blisters, feet problems, painful joints and muscles... Another type of injury: nails of people who walk a lot get bruised and very painful, like they will eventually fall off. As they walk, their feet swell and the shoes become too tight (even if they were the

right size when they got them). They continue to walk and their nails bump into the front of their shoes, bruising. The more they walk, the more it hurts." (Field notes, 23.3.2015, Subotica)

Common colds and blistered feet were so prevalent that I stopped noting every single case of it in my notes. Indeed, I would argue that they represent the most common syndemic health problem. The term "syndemics" is one of the central concepts of critical medical anthropology and "at its simplest level [...] refers to two or more epidemics (i.e. notable increases in the rate of specific diseases in a population) interacting synergistically with each other inside human bodies and contributing, as a result of their interaction, to excess burden of disease in a population" (Baer et al. 2003, 15). In the case of the migrants in Serbia, the increase in the rate of common colds and blistered feet interacted to contribute to the migrants' health problems. More generally, and entirely in the spirit of critical medical anthropology, the term syndemics refers not only to the "disease clustering in a location or population" (*Ibid*., 16), but "points to the determinant importance of social conditions in the health of individuals and populations" (*Ibid*.). In the case of migrants, seeing the living and travelling conditions as being of determinant importance to the prevalence of common colds and blistered feet is at the centre of this syndemic approach.

As Žikić argues, the concept of syndemics is practically inseparable from the concept of structural violence in contemporary medical anthropology, as syndemics are a "consequence of social, cultural, economic, political and historical factors" (2013b, 929). The concept, attributed to Galtung (see Žikić 2013c), was developed in anthropology by Farmer (2004) and refers to the way in which social, political, economic and other types of structure in our society result in violence for those excluded by them. As such, "the concept of structural violence is intended to inform the study of the social machinery of oppression" (Farmer 2004, 307). In this sense, the mechanisms that illegalise migrants are part of the structural violence against migrants. The global inequalities of mobility, the laws that illegalise some people and reduce them to illegal travel, and the economic, political and social inequalities that marginalise migrants all produce the extremely violent environment that migrants face. Sleeping outside, travelling "illegally", often by foot in bad weather conditions, being exposed to police violence, arrest, detention and deportation, as well as to the violence of local thieves and the harshness of the unregulated black market in illegalised border crossing – all these are the effects of structural violence and exclusion.

While most people traveling through Serbia were young men, there were also some older people, unaccompanied children, families, and single women with children. The stories of these vulnerable groups displayed the effects of structural violence even more distressingly. Here is another example of a 10-year-old boy: "He has been here for three days. He came to see the doctor because of pain in the legs and in the back, as well as throat pain. [...] He is also very skinny and complains that he is feeling very weak. Often his head spins when he gets up suddenly. The doctor asked if he was eating regularly and he said that he had not eaten for two days. […] The older boy [he was traveling with] said to the doctor: 'Doctor, don't

you have a pill that you could give us that would just fill our stomachs and not make us feel so hungry?" (Field notes from Subotica, 19.5. 2015)

Besides the syndemic combination of common colds and blistered feet, with their different complications and permutations, the other very common conditions, which also result from bad hygiene conditions and inadequate nutrition on the way, are stomach problems and skin rashes.

Many people were hungry and it was not unusual that many had stomach problems: "There was a big group of Afghan families and women. Most of them had diarrhoea, but only the women and a few men came to see the doctor. They told us they had all drunk the water in Macedonia and had had stomach problems since then." (Field notes from Subotica, 27.4. 2015)

Skin rashes were often a result of not being able to wash. A 17-year-old boy whose whole body was itching, but who did not have any signs of lice or scabies, told us he had not washed for 4 weeks. He washed his hair in the public sinks and looked rather clean, but has had no chance of taking a shower. The skin rashes were especially problematic with children who still used nappies. The nappies were scarce and to save the few they had left, the parents would change them irregularly.

Bigger dangers: injuries and death from walking and police violence

The structural violence of borders and illegalisation sometimes has even more grave, and fatal, consequences. During my stay in Serbia I heard of at least a dozen deaths[10] and four dozen life-changing injuries and accidents.

[10] To list just some of the deaths:

- the death of an elderly Afghan sometime in the winter of 2014–15, in the mountains close to Bosilegrad, death from exhaustion, combined with a chronic diseases. The health centre was asked by the police to confirm the death (Source: Field visit to Bosilegrad, 30 March 2015, interview with the head of the local health centre);

- the death of (probably) a Syrian migrant, around 25 years old, found in the village of Mali Jesenovac close to Zaječar, at the start of March 2015 (Source: http://www.blic.rs/Vesti/Hronika/540347/Pronadjeno-bezivotno-telo-stranog- drzavljanina-kod-Zajecara);

- the deaths of 14 Afghan and Somalian migrants on 23 April 2015, on the railway tracks between Veles and Skopje in Macedonia. The migrants were part of a larger group, with most managing to escape on time, but some being injured . (Source: http://balkans.aljazeera.net/vijesti/voz-pregazio-14-migranata-u- makedoniji),

- the death of a Syrian migrant who drowned in the river Tisa when trying to cross the Serbian-Hungarian border, around 19 July 2015 (Source: http://www.srbijadanas.com/clanak/nije-imao-snage-da-dopliva- utopio-se-migrant-u-tisi-madarski-granicari-mirno-posmatrali-19-07).

While the list of the deaths on other migration routes is better documented (for example on the United Against Racism list, available online at http://www.unitedagainstracism.org/pdfs/listofdeaths.pdf, or on the Gabriele Del Grande Fortress

I want to mention here the death of Musa, a young Gambian who was found dead on 10th of December 2014 in an abandoned house at the Danube dock. The cause of death, according to the pathologist, was carbon monoxide poisoning. He had been heating himself in a closed room with a fire, fallen asleep and died in his sleep.[11] The question of why Musa died, however, cannot stop with a simple explanation that he died of carbon monoxide poisoning. This would be reductionist and would ignore the structural causes that caused Musa to live in the conditions he ended up dying in.

First of all, Musa had been illegalised: his journey into Serbia was illegalised and his continuation onwards towards Germany, his destination, would also be illegalised. He told us that, while in Serbia, he did not want to be a recipient of the victimising and degrading treatment migrants received in the centres for asylum seekers and would not seek asylum – or perhaps he fell into one of those administrative traps whereby, if you miss the deadline of the 72 hours by which you are obliged to report to the right centre, you lose the right to be accommodated there. In any case, he found himself illegalised and homeless. He ended up living with almost no money in an abandoned house, waiting for his chance to travel onwards. The winter was cold and the living conditions inadequate. His death could have been avoided, but it was not – and a large part of the reason for this lies in the structural conditions that illegalised him.

In addition to the fatalities, there have also been many injuries that have left people with permanent damage to their health and that have resulted from police violence and structural violence.[12] It was often not clear at first sight whether the health consequences and the injuries would heal or whether they would have lifelong consequences. In front of the *Savska* police station close to the main Belgrade railway station, where several hundred people waited every day to register

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Europe blog's (http://fortresseurope.blogspot.de/2006/01/press-review.html), there is a specific lack of information on the deaths along the Balkans route.

[11] For mainstream media reporting, see http://www.politika.rs/rubrike/Hronika/Smrt-naseg-komsije-Gambijca.lt.html. For the report from an activist collective, see https://noborderserbia.wordpress.com/2015/01/06/this-border-regime-kills-granicni-rezim-ubija/.

[12] Perhaps the most catastrophic was the car crash close to Leskovac where a van with 54 illegalised migrants from Nigeria, Bangladesh and Syria, all packed tightly against one another, crashed at around 4.30 am on 24 February 2015 (Source: http://rs.n1info.com/a37690/Vesti/Saobracajna-nesreca-kod-Leskovca.html). Forty-five people were injured, with two suffering life-changing injuries and spinal cord damage (updates on Raad from Syria and Olond from Bangladesh, who are still in hospital a few months later, see http://www.apc-cza.org/en/component/content/article/8-vesti/791-prica-migranata-koji-su-dozivjeli-nesrecu-u-leskovcu.html. Of course, an argument could be made that car crashes can always happen and that this "unfortunate event" does not have anything to do with the border and illegalisation regimes. However, once you consider the fact that the driver of the car, a paid smuggler, was probably under much stress and might have been driving recklessly, and the fact that 54 people were packed into one van, these are all indeed factors that contributed to the crash and the fact that it had such dramatic consequences.

their asylum claim, I often observed migrants who were limping, tired and muddy, and sometimes some who had been beaten up: these were the signs of police violence, the violence of the journey itself and sometimes the violence of local gangs. A young Afghan boy had injured his foot jumping off the railway tracks in Macedonia to avoid a passing train. He could barely step on it and will likely suffer the effects in his knee for a long time. A middle-aged Syrian woman had her hip dislocated during her journey from Turkey to Greece, where she was sitting in an overcrowded inflatable boat for the whole night. She did not get any subsequent treatment and had been limping for several weeks, walking for several days in a row, which made her condition worse and caused her excruciating pain. A six-year-old Syrian boy, travelling alone with his father, was detained for two months in a Macedonian detention centre, where he scalded himself with boiling hot water over his stomach and thighs as a result of a faulty shower. He was unable to walk because his clothes rubbed on his thighs; he was carried the whole way by his father. Because they were travelling on foot for many days, sleeping in the forests and hiding from the police and local gangs, the wound could not be tended to regularly and it did not heal properly. Another man in the Subotica jungle was cutting wood for a fire when he accidentally struck his foot with the axe. He bled heavily and had problems walking for several days as a result. One young Afghan boy showed me his cut hands and told me he was cut by a knife while trying to escape from a local gang that attacked him and his friends and tried to rob him somewhere in the forests in southern Serbia. The list could go on and on. Many migrants had physical injuries of differing degrees and visibility.

"Illegal syndrome"

Another way in which the structural conditions of migrants imprint themselves on their health is through the varieties of psychological problems, which often manifest themselves physically. Years of illegalisation and "being on the road" had severe consequences on migrants. Castañeda mentions one of her informants calling the impact that the stress of illegality had on mental (but also physical) health the "illegal syndrome" (Castañeda 2009, 1558). The evidence of this "illegal syndrome" were commonplace in Serbia. 16-year-old Amin, for example, who had been on the road from Afghanistan by himself for almost a year, spending over two months in detention and sleeping in the jungle for most of that time, had developed a nervous tic when speaking about anything remotely difficult for him. If he spoke of his family, or of what happened to him when he was running away from the police in Patras, or how a kind police officer in a detention centre in Greece had given him some water when he was really thirsty, his upper lip would tighten and crumple up, making it difficult for him to articulate certain sounds. He had lost some of his hair, which had started to go gray on the side. He told me he had lost over ten kilos since leaving Afghanistan.

I saw the elements of distress in many people travelling through Serbia. The effects of prolonged detention were particularly devastating. Suleyman, a 21-

year-old Afghan, spent a year and a half in detention in Greece[13]; when I met him in Serbia, he had been out of detention for less than two months. He told me that his time in detention was horrible – for the first four months, he was detained in a cell in the police station, where the conditions were really bad. He was not allowed to go into an inner courtyard and was inside all the time; worse, his cell did not have any windows, so he did not see any daylight for four months. A neon light shone above his head 24 hours a day and sometimes he did not know whether it was night or day. After he was transferred to the detention centre, where he stayed for a further 14 months, he became severely depressed. He felt that he had lost a year and a half of his life – and the best years of his life, as he said – and felt lost. When he left Afghanistan, his wish was to get some professional training in Europe and to start a new life. When I met him over two years later, he had no money, was in debt, had "lost" two years of his life to the road, and still had a couple of countries to cross before reaching his destination in Germany. He tried to stay positive and to joke with his friends, but when I spoke with him alone, he told me he was no longer the person he had been before detention.

The Afghans and Pakistanis often talked of "tenshon"[14]. *Tenshon* was the word used for a psychological state that was often accompanied by physical symptoms; these symptoms included mild to severe headache, lack of sleep, an inability to concentrate or to stay still in one spot, and the need to move around and, frequently, to provoke discord among friends. *Tenshon* would often be given as an explanation for someone's behaviour: "Let him be, he has *tenshon*", or "Sorry I did not call you, I had too much *tenshon*". *Tenshon* was also shorthand for "don't ask me more questions about this topic". I came to understand this particular way of speaking about *tenshon* as an instantiation of "idioms of physical, verbal, emotional and behavioural distress as culturally accepted modes of expressing mental anguish" (Massé 2007). In this way it can be analysed in a similar way as the comparable idioms of the "widely disseminated cultural category of nerves/nervios/nervos/nevra, usually classified as a culture-bound or culturally-interpreted syndrome" (Lock 1993, 142 – see the article for a literature review on this cultural category). While it does not make sense to essentialise migrant "culture" or make generalisations about the application of the category of *tenshon* to everyone who classified as a "migrant", the term *tenshon*, and what some Afghan and Pakistani migrants mean by it and when they use it, can tell us a great deal

[13] At the time I was conducting my fieldwork, Greek law permitted the detention of illegalised migrants for up to 18 months. This was not only a legal possibility but common practice, and in Serbia I met many people who had been detained in Greece for several months, and as many as 18 months, if they did not have sufficient funds to pay for a "good" lawyer to get them out. The people I met often had severe psychological problems stemming from this prolonged detention, and they testified that for the first several months they had not been detained in a detention centre but in a police cell, where they had no access to daylight and where sanitary conditions were inadequate.

[14] While *tenshon* probably comes from the English word "tension", I am writing it here in the way that the Persian word is transliterated into Latin script, to denote the fact that I was first introduced to it by Afghans.

about the difficult conditions in which they live and the ways in which these conditions affect their mental states and psycho-physical wellbeing.

As in the case of *tenshon*, other forms of illness experience that could be understood as "illegal syndrome" would need much more analysis – and a different methodological approach, than the one adopted here. Nevertheless, it feels important to include these health problems, which are not purely physical, to the list of common ailments experienced by migrants, as the prevalence of this type of illness experience was commonly reported, mentioned or alluded to by the migrants I met. Moreover, it needs to be remembered that many migrants flee from war, violence and repression, facing imprisonment, torture and persecution in their own countries. The conditions of migrants in Serbia, which includes police violence and degrading treatment by the authorities, only make any psycho-physical problems and traumas more acute.

Women and migration

At the end, I mention specific problems faced by women.[15] Women often suffered from the health problems listed above, but in addition faced various other problems. Some problems were gynaecological, such as vaginal infections, which often resulted from difficult conditions and the lack of opportunity to wash. While men could more easily wash themselves in a forest with just a little warm water, the shame put on women about possibly being seen made their showers much rarer. Those travelling with children prioritised the children when it came to using the limited supply of wet-wipes and tissues, so maintaining hygiene was very difficult. Many complained of various rashes and itches. The younger and unmarried women refused to use any sort of vaginal tablets that could help the infection, as they were afraid this would compromise their honour.

The exhaustion of walking for several days with little food and water, and often having to carry small children for part of the way, was another thing that contributed to women's health problems. The mother of a 3-year-old had suffered from occasional haemorrhoids ever since her child was born, but the symptoms had become much worse because she has not been eating regularly and had been exerting herself physically for months. A young Afghan woman, who had been travelling for 4 months with her family, told me that for the last month of the journey she often had a type of seizure or convulsion (*tashanoj*), where she would lose consciousness

[15] I want to avoid any kind of essentialisation of women or any biomedical grounding of the difference between men and women in their biologies. This singling out of "women" as a category is based on an understanding of gender differentiation as a different social construction of the gender binary, as well as the supposedly biological sex binary (see Deger 1998, Holmes 2003, Moore 1994: 12–17). I see this differentiation as embedded in the power relations of the patriarchal system of oppression. Because of this and other intersectional systems of oppression, it is necessary to "single [the category of women] out as different in order for them to receive the same critical attention" (Ticktin 2011: 250). This is "what Joan Scott calls 'the paradoxes of feminism': one must emphasise one's difference (as women) in order to claim one's sameness (as equal human beings)" (*Ibid.*).

and her whole body would shake, her muscles contracting and relaxing. She had not suffered from this before and the symptoms usually developed when she was very exhausted.

Castañeda points out: "migrant illegality is constructed differentially for men and women, and the very fact that women can become pregnant while men cannot shifts the discourse" (Castañeda 2008, 172). Pregnant women face an especially difficult situation and it is particularly problematic that pregnancy care is not provided to undocumented women.

Another factor that contributes significantly to the women's health is the dangers associated with the sexual and gender-based violence they might face on the way.[16] I have heard indirect testimonies to the effect that women are sometimes victims of rape and sexual violence in Macedonia, in the jungles close to the Serbian border, and in the territory dominated by the Albanian and Afghan "mafia".[17] A

[16] It needs to be stressed that I discuss sexual violence here not as a "medical problem", or at least not in the physically reductionist sense often understood by humanitarian organisations. As Ticktin points out, in the last 20 years, gender-based violence has become constructed as a "poster-child for humanitarian aid" (2011, 250–251) and its victims "the model subject of aid" (*Ibid*., 250). However, "the shift to gender-based violence as the exemplary humanitarian problem could not have happened without the prior move to medicalise gender-based violence, and render it a medical condition like all others. Yet medicalisation has had the strange effect of erasing gender – that is, the power relations that produce and inform gender – leaving in its place suffering bodies, without perpetrator or causes, each of which can be treated by the universal 'humanitarian kit'" (*Ibid.,* 251). The medicalisation of gender-based violence has a focus on its sub-category of sexual violence, which "refers to certain forms of violence to specific parts of the biological body, which are then treated by biomedicine" (*Ibid*., 255). In this way, the issue is depoliticised, stripped of its social and economic context, the victims are treated as bodies and the questions of responsibility, justice and systems of oppression are ignored. "The mandate of humanitarianism [...] is not to reform or improve the kind of life one lives, only to preserve life itself. And yet gender-based violence is about the kind of life one lives" (*Ibid*., 254). It is in this sense that I understand gender-based violence: not only in its consequences for the body of a woman, but as a political and societal problem that affects women everywhere in this patriarchal world. It is not a problem specific or limited to women migrating through the Balkans. On the contrary, gender-based violence is ubiquitous. However, I am mentioning it here as a factor that has a significant impact on the lives of women migrants – a factor that is in need of further research efforts.

[17] I use the word "mafia" with unease. It is the emic term often used by migrants themselves, so I have used it in this text, but in quotation marks. Much more ethnographic insight and anthropological analysis would be needed to illuminate what exactly the "mafia" or "smuggling networks" look like and how they function. The mainstream media often blame "the smuggling networks" for migrant hardship without reflecting on the structural causes that enable this. A good example of this is a Channel 4 report on the "migrant crisis" where the "journalist Ramita Navai travels the migrant route through Greece and Macedonia to track down a gang of kidnappers who are holding migrants for ransom" (see: https://www.youtube.com/watch?v=A5fDgJP2G30). The report had a huge impact, resulting in a massive crackdown by the Macedonian authorities on these gangs four days later and – in terms of collateral damage – arresting and actively repressively dozens of migrants who were supposedly the victims of these gangs. However, the report spoke only of the evil Afghans, and ignored any sort of structural and broader conditions. Indeed, the dangers presented by the "mafia" and "kidnap gangs" are real, but it seems inappropriate to reduce the analysis to that level alone and to ignore all the structural factors that enable it.

few people alluded to the fact that it had happened to women they knew or had heard about. Because of the trauma and shame associated with sexual violence and the fact that it was often difficult to establish trust with women – with a lack of safe space and enough time, it is likely that women did not want to speak to me about this issue. However, it seems very likely that the prevalence of gender-based and sexual violence on the Balkans migration route is high. While some documentation of the gendered aspects of this violence exists for the period when the humanitarian "corridor"[18] was opened after the summer of 2015 (see Amnesty International 2016, UNHCR 2016 and Van der Zee 2016), violence against women remained largely undocumented on the Balkans route prior to this. One exception is Ivnik (2016), who documents a few cases of reported violence against women. Indeed, the documented violence is likely to represent but a small portion of what women go through. As Ivnik (2016, 313) suggests: "Sexual and other types of violence is [...] very common [...], but because it is a sensitive topic, it is often hidden."

Conclusion

The dominion of securitisation of migration can be traced in attitudes and policy on migrant health too: the myth of migrants as the contagious "other" informs the rhetoric and treatment migrants receive, but even in the area of healthcare, it determines the preoccupation with the impact of presence of migrants on the general population, rather than thinking how the treatment migrants receive impacts *their* health. In this article I tried to shift focus and present problems migrants really face. The attention to ethnographic data reveals that migrants' health problems, rather than being essentially linked with their "otherness" (as securitarian discourses tend to suggest), are instead inextricably linked to (or exacerbated by) the risk environment and conditions of structural violence they find themselves in.

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[18] See footnote 1.

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