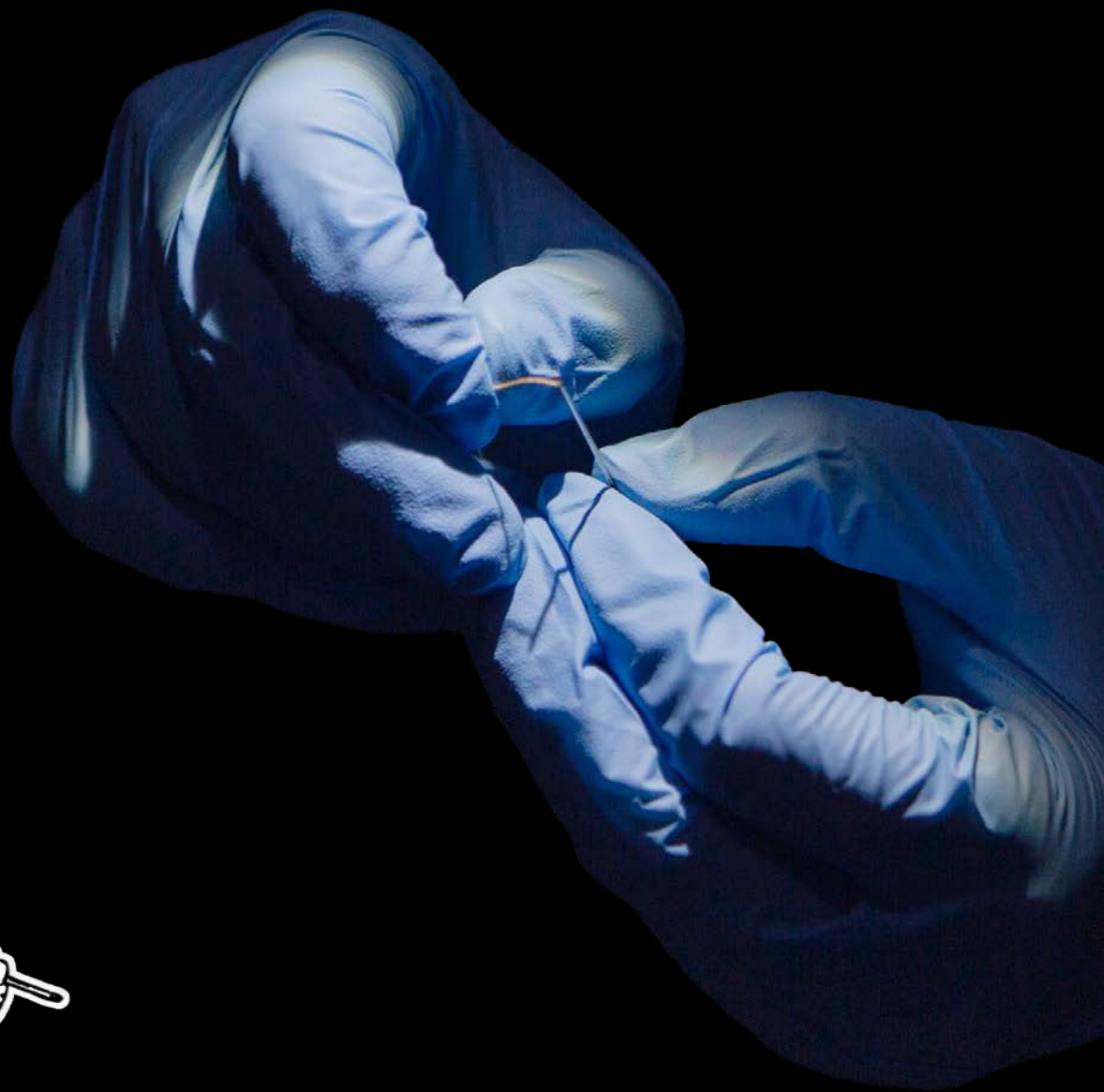


# BLOCKED FROM CARE

THE WEAPONISATION OF HEALTH  
AS BORDER VIOLENCE



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## Disclaimers

- The views expressed in this report fully and necessarily reflect those of No Name Kitchen.
- This report **contains explicit content**, that includes graphic violence, images of injuries, and testimonies of painful experiences.

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**No Name Kitchen (NNK)** is a grassroots movement that has maintained a continuous field presence on Europe's borders since 2017. NNK operates across the Balkan, Mediterranean, and Maghreb routes, providing direct support to PoM – food, medical assistance, legal accompaniment, and psychosocial care. Over nearly a decade, NNK has documented the experiences of up to 17,000 PoM, establishing itself as one of the main civil society watchdog actors in the region and building one of the most sustained border violence monitoring and advocacy systems in Europe. This report is part of that work.

This investigation would not be possible without the trust and courage of the PoM who shared their firsthand experiences, exposing their current wounds to fight for

a healing future, and the collaboration of countless activists, donors, and supporters who boost NNK actions with humanitarian passion and political commitment.

**A heartfelt thank you to everyone involved.**

No individual credits are listed in this publication. Every NNK report is the result of collective work – built from violence survivors sharing their testimony, contributions of field activists, researchers, documenters, designers, translators, legal experts, healthcare professionals, and the many others whose effort makes this work possible. To single out some would be to render invisible the essential contributions of others. This report belongs to everyone who made it.

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# KEY TERMS

## B

### **Border violence**

Border violence The many forms of violence produced through border regimes and migration control — physical, psychological, administrative, and symbolic — as well as the conditions of neglect, exposure, and exclusion through which harm is inflicted. The term highlights that this violence is systemic, cumulative, and politically produced rather than incidental.

---

## C

### **Criminalisation of solidarity**

The prosecution, harassment, or penalisation of individuals and organisations providing humanitarian assistance to PoM. It seeks to suppress civil society monitoring and deter humanitarian action at Europe's borders. NNK's activists were subjected to this practice in Bulgaria in January 2025, when authorities blocked rescue efforts that could have saved three children's lives.

## D

### **Deterrence**

Policies and practices that obstruct movement by making journeys, border crossings, and access to protection harsher, riskier, and more exhausting. In this report, deterrence is approached as a political logic that foreseeably produces suffering and health harm — not as an unfortunate side effect, but as a mechanism through which it operates.

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## F

### **Fiction of non-entry**

A legal construct introduced by the EU Pact on Migration and Asylum whereby people processed at the border are deemed not to have legally entered EU territory, even when physically present. This allows states to deny rights and protections ordinarily triggered by presence on EU soil — including access to healthcare.

I

**Irregularised migration**

NNK uses this term in preference to "illegal migration" to reflect that it is state policies — not the act of moving — that render migration irregular. The criminalisation of movement is a political choice, not a natural fact.

L

**Learned helplessness**

A psychological state in which a person, repeatedly subjected to conditions beyond their control, stops attempting to change their situation even when escape becomes possible. It is a well-documented pathway toward depression and suicidality, and a direct consequence of the structural conditions produced by the border regime: legal immobilisation, indefinite detention, and the systematic denial of agency and dignity.

M

**Medical neglect**

The refusal, delay, dismissal, or withholding of necessary medical care, medication, referral, or emergency assistance. In this report, medical neglect is not only an individual failure but a structurally produced pattern enabled by legal

ambiguity, institutional complicity, and political indifference.

N

**Non-refoulement**

A core principle of international refugee law prohibiting states from returning a person to a country where they face a real risk of persecution, torture, or serious harm. Pushbacks — conducted without individual assessment — violate this principle by definition.

P

**People on the Move (PoM)**

A term that recognises movement as a human reality rather than a fixed legal or administrative category. It includes people with different lived experiences, statuses, and reasons for moving. NNK uses it in preference to "migrants" or "refugees" because those categories are legally contingent and often weaponised to determine who deserves protection.

**Prolonged grief disorder**

A clinical condition recognised by the World Health Organization (WHO), characterised by an inability to process loss, persistent sense of unreality, and lasting psychological impairment. It is particularly prevalent among families of people who die in transit or detention, where

bodies are inaccessible, funerals impossible, and deaths officially unacknowledged.

### **Pushback**

The forced return of people across a border without individual assessment, access to asylum procedures, or legal safeguards. Pushbacks are illegal under international and European law yet are systematically practiced across Europe's borders. They frequently involve physical violence, confiscation of belongings, destruction of medication and documents, and abandonment in remote or dangerous locations.

## **S**

### **Social determinants of health**

The conditions in which people are born, grow, live, work, and age

— including access to food, shelter, clean water, and safety. For PoM, these conditions are systematically undermined by border enforcement practices, making the border regime itself a determinant of ill health.

## **W**

### **Weaponisation of health**

The deliberate use of healthcare denial, obstructed treatment, or harmful living conditions as tools of migration control. It differs from systemic neglect in that it involves a conscious choice: to withhold care not due to lack of resources, but as an exercise of power over people deemed undeserving of protection. The death of Mukter Hossain at Lipa TRC on 23 November 2025 is one documented example in its most extreme form.

# EXECUTIVE SUMMARY

Mukter was 41 years old. He had been illegally pushed back from Croatia. He returned to Lipa – a transit reception centre in the north of Bosnia and Herzegovina – in severe pain, vomiting, unable to eat or leave his bed. He had suffered a heavy blow to the right side of his ribs. For three days, the people around him begged guards to call an ambulance.

||

*I can't breathe. i feel very cold.*

**Mukter Hossain, 23 November 2025 – his last words**

When residents ran to the guards to report that Mukter could not breathe, the response was: "We are eating right now. We will check tomorrow." At 17:15 on 23 November 2025, Mukter died in his bed. There was no funeral his family could attend. There was no body they could hold.

**Mukter did not pass away. He was left to die. That difference is what this report investigates.**

No Name Kitchen (NNK) has maintained a field presence on Europe's borders since 2017. In nearly a decade of work, NNK's teams have stitched wounds in forests, distributed medicines in makeshift camps, documented beatings that left people blind in one eye, and listened to thousands of testimonies describing what the European border regime does to human bodies. This report draws on that accumulated experience – including a database of **336 first-hand testimonies of**

# 336

first-hand testimonies  
of border violence

# 1,500

days of field operations

# 64 %

of pushback testimonies

# 54 %

of first aid treatments

**border violence** collected between January 2022 and December 2025, and an internal record of healthcare interventions documenting medical needs observed directly in the field over approximately **1,500 days of field operations**.

What NNK found – across forests, rivers, reception centres, detention facilities, and emergency rooms – is a pattern so consistent, so widespread, and so foreseeable that it cannot be described as failure. It must be described as policy.

The numbers speak plainly. **64% of pushback testimonies** document beatings – fractures, head trauma, permanent eye injuries, blows to the throat and chest – inflicted by officers whose salaries are paid by European taxpayers. **54% of first aid treatments** provided by NNK in 2025 involved walking-related injuries – wounds, frostbite, infected blisters – sustained on routes that only exist because safe and legal alternatives have been systematically dismantled. People are pushed into freezing rivers, stripped of their shoes in sub-zero temperatures, denied food for days, locked in cells without heating, and turned away from emergency rooms. Three children died in Bulgaria while authorities blocked the activists trying to reach them.

This investigation has been built with rigour and fury. Given what it documents, there was no other way. Across six chapters, the report maps the anatomy of this violence: from the environmental harms of clandestine journeys through forests and mountains, to the conditions in camps and detention facilities across the Balkan route, to the direct physical assault of beatings and sexual violence, to the particular targeting of people with pre-existing conditions and disabilities, to the psychological devastation of prolonged exposure to humiliation and terror, and finally to the systematic failure – and complicity – of healthcare institutions that were designed to save lives and instead turn people away.

What emerges, consistently, is that this is not a border crisis with health consequences. **It is a health crisis produced by design.** Health has been weaponised: denied, obstructed, and withheld as an instrument of deterrence. The border does not end at the fence. It reaches into the ambulance that doesn't come, the triage room that looks the other way, the camp doctor available once a week who refuses to treat new arrivals citing administrative delays.

Mukter Hossain deserved to live. So did the three children in Bulgaria. So did every person whose name NNK does not know because they did

not survive to tell us.

**This report calls on European institutions, national governments, health authorities, humanitarian agencies, and civil society to stop describing this as a crisis and start treating it as a crime – with enforceable standards, independent oversight, and real accountability for those who deny care to people whose lives depend on it.**

**The evidence is here. What comes next is a choice.**





## Roadmap

The report opens with an analysis of how deterrence strategies, baked in Brussels and carried out by border police, shape the physical environments and underlying determinants of health that PoM experience throughout their journeys. The testimonies in **Chapter One** make unequivocally clear that the lack of safe and legal routes to claiming asylum in Europe is a calculated attack on migrants' health.

**Chapter Two** focuses on physical violence against the bodies of those on the move. Although this violence has long been understood as a backbone of the European deterrence agenda, NNK's data sets reveal that border violence is also dis-abling: if the regime of terror itself does not scare you out of moving then then border forces will ensure you physically cannot.

**Chapter Three** compounds the severity of the need for freedom of movement and regularised routes, demonstrating that even on breaks between journeys (whether that is in squats/informal settlements, reception centres, or even detention centres) European irregularised migration routes offer no opportunity for meaningful rest and recovery.

Drawing on these three chapters, **the fourth** then focuses on the targeting of individuals with pre-existing vulnerabilities. It examines how physical and structural violence are especially harmful and life-threatening for people with underlying health conditions and disabilities, demonstrating that the European deterrence regime seeks to reduce irregular migration by targeting the most vulnerable.

In the **fifth chapter** of the report, we examine psychological torture and mental health.

Here, we uncover the systematic nature of humiliation and dehumanizing treatment, then draw on in-depth narratives to illustrate the severity of suffering this produces, and finally examine some of the specific psychological and psychiatric afflictions we encounter on the ground. This Chapter demonstrates the lasting psychological impacts of life on Europe's borders are calculated and orchestrated by border forces - seeking to humiliate and degrade individuals in line with a racial order.

**The sixth** and final chapter examines mistreatment and neglect at the hand of medical institutions and professionals. It analyzes how what are supposed to be life-saving medical infrastructures—emergency hotlines, ambulances, triage systems, and clinics—instead become instruments of violence through neglect, exacerbating otherwise preventable harm. This Chapter questions the neutrality of the healthcare sector, and demonstrates the all-encompassing nature of the border regime: co-opting structures such as the healthcare industry to ensure the oppression of migrants does not end on the physical border.



Finally, we must acknowledge that the people most affected by health-related violence, the ones whose experiences would be most vital to this report, are largely absent from its pages. They are the ones whose suffering unfolds beyond documentation, whose medical needs go unrecognized, and whose lives are too often cut short before their stories can be told. **As one testimony illustrates:** “one of the people pushed back was disabled, [he] was beaten, attacked by police dogs and thrown into a river (...) it seemed as though the police who were beating them wanted to kill these people.” In this report, the absence of those who suffer the most severe health consequences of migration should be taken as the most potent evidence. The silence of those who do not survive, and the systemic conditions that ensure the erasure of critical voices, stands at the heart of how violence is defined and analyzed in this research.

## II

**Throughout these six chapters, it will become clear that border violence must be considered a health crisis, and more specifically, a crisis which is a foreseeable outcome of deterrence policy orchestrated in Brussels and by member states of the EU.**

## Policy Context

The right to the highest attainable standard of physical and mental health is a fundamental human right (International Covenant on Economic, Social and Cultural Rights (ICESCR), Art. 12(1); see also Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14). . Several legal instruments, such as the Constitution of the World Health Organization, the International Covenant on Economic, Social and Cultural Rights, and the European Social Charter, repeatedly emphasize that the right to health is **universal and non-discriminatory**, applying to everyone regardless of race or ethnicity, gender, age, disability, socioeconomic position—or migration status.

Within the EU, the ‘*health in all policies*’ approach is legally mandated by Article 168 of the Treaty on the Functioning of the European Union (TFEU), and the right to healthcare is further established in the EU Charter of Fundamental Rights - a key legislative instrument that should precede migration policy. The right to health not only obliges states to facilitate access to healthcare services but also mandates them to uphold dignified living conditions that are conducive to healthy lives; these conditions are called the **social determinants of health** (WHO). The WHO has **then further clarified** that an indicator of health is “*migration policies that facilitate orderly, safe, regular and responsible migration and mobility of people*”, echoed by **PICUM’s findings** that health inequality cannot be reduced without radically transforming approaches to migration.

In this context, rights are established not only via the right to health but also through basic guarantees of access to justice, the rights of the child, and the rights of persons with disabilities. EU countries have historically spearheaded the development of these moral and legislative frameworks, a fact that **European leaders** have expressed pride in on countless occasions, despite violating it daily on the borders.

### LAW REQUIRES

### NNK OBSERVES

Universal right	→	Selective access
Dignified conditions	→	Camps / neglect
Protection	→	Pushbacks
Healthcare	→	Exclusion

PoM are already some of the most vulnerable groups when it comes to health outcomes and access to healthcare services. Individuals migra-

ting to Europe in search of safety and opportunity often carry the physical and psychological burdens of poverty, war, and exploitation, as well as further risks of trafficking, violence, and human rights abuses whilst on the move. Yet, their needs are systematically ignored. Health systems in transit and receiving countries are organized according to a nationalistic ethic, with most countries defining their health obligations towards non-citizens in terms of “essential care” or “emergency health care” only, **according to the UN**. As a result, displaced communities, PoM, and other non-citizens endure medical neglect and suffer from **poorer health outcomes** compared to other sectors of the population.

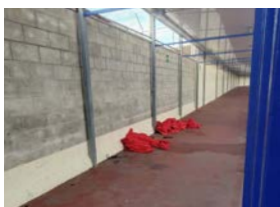
With the adoption of the Global Compact for Safe and Orderly Migration in 2018, international bodies and European states have paid increasing attention to “migrant health.” In October 2023, the WHO Regional Committee for Europe adopted the ***“Action Plan for Refugee and Migrant Health 2023–2030.”*** In line with the GCM and international law, the plan recognizes the need to broaden migrants' access to healthcare services, improve living conditions for PoM, develop physical and social environments that support health, and establish effective monitoring mechanisms to fill the lacunae of data on migrant health. **This document also explicitly addresses the need to safeguard the right to health for PoM, not just those with refugee status.**

Yet, its language is symptomatic of a broader issue in discussions of “migrant health:” the neglect of **structural violence** as a key determinant of health. The Action Plan states that: “*The processes of displacement and migration are cross-cutting, and health and well-being are greatly influenced by policies and conditions beyond the health sector.*” Yet, nowhere in the document is there mention of border violence as a driver of lasting injury and trauma.



## II

### **We maintain: an effective policy to protect migrants' health must address border violence and pushbacks.**



That need to address border violence and health crises in conjunction is exacerbated by recent migration policy developments. Significant measures have been reduced over recent years to either reduce migrants' access to healthcare or to reduce their access to EU territories overall through **deterrence** agendas. The EU Pact on Migration and Asylum - the most significant overhaul of EU migration law in decades - **introduces accelerated border procedures and extended detention-like arrangements**, whereby asylum-seekers processed at the border may be legally deemed to not have entered EU territory. These processes create a **'fiction of non-entry'**, implying people have not entered the country when they have. This places people in **legal limbo**, often in inadequate facilities, whilst excluding them from rights to healthcare and Developments in the **Returns Directive** threaten to funnel people directly back into these inadequate reception systems if they do manage to escape. Other elements of the pact, such as the Instrumentalisation Regulation, permit states to bypass procedural safeguards such as the rights to medical screening in cases of *'instrumentalisation'*.

At national levels, various Member States have enacted legislation that explicitly curtails healthcare access for undocumented people, posing serious risk also to people in transit. Budget cuts in France **reduced access for undocumented people**, whilst Italy (under legislative decrees introduced by the Meloni government) **curtailed the scope of "special protection" status**<sup>1</sup>, removing a category that had previously allowed many undocumented people or people in transit to access the national health system. Whilst many healthcare providers continue their work anyway, states are also introducing measures mandating them to report undocumented patients to authorities, such as the **German Residence Act**<sup>2</sup> or Sweden's proposed **'Snitch law'**. These reporting obligations are neither morally nor legally permissible - instrumentalising healthcare providers in a violent border regime whilst violating the **Council of Europe's ECRI General Policy Recommendation No. 16** on safeguarding irregularly present migrants from discrimination.

<sup>1</sup> Decree-Law 20/2023 and 133/2023, the so-called Cutro Decree.

<sup>2</sup> Section 87

These recent changes are only the tip of the iceberg, representing the consolidation of the multi-decade long project of *'fortress Europe'*; **a migration agenda that relies on death and physical violence as the**



**backbone of ‘deterrence’.** The progressive expansion and strengthening of Frontex (European Border and Coast Guard Agency), infamous for their human rights abuses and pushbacks, alongside the militarisation of border surveillance through systems such as EUROSUR and EURO-DAC have further strengthened enforcement capacities without any accompanying accountability for violence. Simultaneously, clusters of deals which outsource migration control to countries such as Turkey, the Balkans, and Libya (where oversight is sometimes more limited and inherently complicated by the externalisation deals themselves) have gradually entrenched a system where deterrence is pursued through extreme normalisation of violence. Within this policy architecture, the (often lethal) use of force, harm, and lasting psychological damage cannot be understood as a by-product of border management, but rather as a predictable outcome of a system designed to make migration routes dangerous enough to discourage movement. As [Harsha Walia](#) **argues**: “The doctrine of deterrence requires mass border deaths to instill fear and prevent migration”. And even when deterrence measures do not result in death, the physical and mental harm they cause alone can act as a deterrent for the victims and those who hear their stories.

If, as the WHO (2018) states, data on “migrant health” is limited, then accounts connecting PoM’s health outcomes to structural border violence are almost entirely absent.

## II

**This report responds to this silence. It brings the structural violence of the border regime into view by showing how it is ultimately expressed as wounds, illness, and trauma on the bodies of PoM.**

In doing so, it demonstrates that this violence is neither accidental nor isolated, but a **systematic and ongoing breach** of states’ obligations under the right to health. The failure to adequately take these factors into account in public health policy for migrants leads to a protection gap and deep contradiction: wherein the healthcare industry, inadvertently or through external positioning, becomes an enabling condition of the EU border regime.

# METHODOLOGY

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## 336

first-hand testimonies  
of border violence

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## 1,500

days of field operations

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<sup>3</sup> Data for the full 4-year period is not available due to a change in reporting methodology.

This report draws upon **two primary data sources** to investigate the role that healthcare (or the lack thereof) plays in European deterrence practices. These sources are:

- NNK's database of **first-hand border violence testimonies** comprises **336 testimonies** collected by interviewers between **January 2022 and December 2025**. This includes **296 testimonies of pushbacks** (including deportations) and **40 testimonies of internal violence**.
- An internal database of **healthcare interventions** provided by NNK between January 2022 and December 2025 which documents medical services or supplies provided to PoM. This includes 654 specialised incidents or case referrals logged over the 4-year period, and 6988 first aid incidents in 2024-2025<sup>3</sup>.

Together, these two sources allow for a **qualitative examination** of the lived experience of border violence, alongside **quantitative and operational data** documenting the health consequences which NNK has observed in the field.

The analysis was organised around six thematic categories of health-related border violence, which have formed the structure of the chapters in this report:

- **Journeys:** the physical and environmental harms experienced during transit.
- **Stays:** the health consequences of living conditions in camps, informal settlements, or reception facilities.
- **Injuries:** the enactment of physical injuries by border forces and public officials.
- **Disabilities and pre-existing health conditions:** forms of violence (or disproportionately grave experiences of violence)

described by people with disabilities or pre-existing conditions.

- **Psychological impacts:** the mental health consequences described by survivors of border violence or irregular migration journeys.
- **Access to formal healthcare:** barriers experienced in accessing professional medical care.

These categories were developed through a **deductive coding approach**, grounded in NNK's extensive experience as a watchdog and a provider of direct aid to survivors of border violence. The themes reflect recurring patterns documented over approximately **1,500 days of observation, active listening, and systematic documentation** by NNK teams during field operations.

- **Stg.01**  
Keyword grouping
- **Stg.02**  
Qualitative review of testimonies
- **Stg.03**  
Corroboration with NNK healthcare data
- **Stg.04**  
Internal verification
- **Stg.05**  
External verification

## Stage 1: Keyword grouping

Following the establishment of the thematic framework, testimonies from the database were grouped using a keyword-based search process. Keywords related to each theme (for example, terms relating to injuries, environmental exposure, medical care, or psychological distress) were used to identify testimonies containing relevant descriptions.

This process enabled the research team to systematically filter and group testimonies according to the six thematic categories. Because testimonies frequently describe multiple forms of harm, individual testimonies could be included in more than one thematic category.

## Stage 2: Qualitative review of testimonies

Six thematic working groups, composed of activists who had previously been on the field in one of NNK's projects, were formed to analyse the grouped testimonies. Each working group reviewed testimonies relevant to its assigned theme. Testimonies were read in full, with reviewers identifying:

- **Recurring patterns of violence or neglect**
- The **context** in which health harms occurred
- The immediate and longer-term **consequences** described by survivors
- **Illustrative quotations**

The aim of this stage was to identify patterns in how health harms

occur within border enforcement practices and the broader migration environment.

### **Stage 3: Corroboration with NNK's healthcare intervention data**

Findings from the testimonial analysis were then **cross-referenced** with NNK's healthcare intervention database.

This dataset records injuries, illnesses, treatments, and other medical needs encountered by NNK teams while providing primary healthcare assistance in the field. By comparing qualitative data with operational medical data, the research team was able to **corroborate patterns of harm** described by survivors with documented health needs observed by NNK's teams.

While the healthcare database does not constitute a comprehensive medical record of all PoM, it provides important evidence of the types and prevalence of health conditions encountered on Europe's borders.

### **Stage 4: Internal verification**

The preliminary findings were subsequently **reviewed** through a consultation process involving individuals with current or previous field experience within NNK. The aim was to **verify** that the report's findings accurately reflected recurring patterns of violence, healthcare needs, and barriers to access observed across different contexts. Participants were also invited to contribute additional examples and propose relevant policy, protection, or legal recommendations.

### **Stage 5: External verification**

The final stage of the methodology involves external verification through consultations with partner organisations and experts – including medical and legal organisations such as MSF, MDM, MSI, DONK, and PICUM – working on migration and humanitarian healthcare. **These actors were invited to review preliminary findings, share comparative insights, comment on patterns identified, and contribute recommendations for policy, protection, or legal reform.** The report incorporates feedback from PICUM and MSI, and acknowledges their support.



CH.01


# THE ROUTE IS THE WEAPON

How deterrence turns nature  
into an instrument of harm

# LANDSCAPES OF DETERRANCE

This map reflects types of environments and harms documented in testimonies collected by NNK. It does not depict exact routes.



 **EXTREME COLD**  
Hypothermia, frostbite  
dehydration, winter  
deaths

 **FORESTS**  
Sleep deprivation, injuries,  
exposure, deaths

 **MEDITERRANEAN SEA**  
Shipwrecks, dehydration,  
deaths at sea

 **MOUNTAINS**  
Cold, exhaustion,  
forced trecks

 **PUSHBACKS & VIOLENCE**  
Abandonment in remote  
areas, beatings, theft

Pathways to Europe are carved through mountains, seas, forests and rivers. **The physical, psychological, and sometimes deadly harms that PoM suffer as they cross natural barriers are often labelled as ‘tragedies’ or ‘accidents,’ absolving the EU of its responsibility in actively shaping these outcomes.** At times, smugglers or even migrants themselves are blamed—their deaths cast as the inevitable outcomes of reckless decisions. Yet, research has consistently shown that it is deterrence policies that push migration routes deep into remote areas, where PoM are forced to endure extremely harsh conditions to avoid the bloody dragnet of state violence and reach safety inside Europe <sup>4</sup>.

<sup>4</sup> See, for example, [Chau and Garip’s research](#) in the US context that ‘border enforcement’ forces people towards hazardous crossing channels, or [Massey et al.’s](#) research that deterrence policies make smuggling and transborder crime lucrative and put migrants at risk, or [Weber and Pickering’s research](#) which demonstrates deterrence policies push people towards treacherous risks.

NNK’s teams have extensively documented the various harms that PoM suffer as they navigate these dangerous environments. Remote routes are devoid of infrastructure, making journeys physically arduous, basic necessities scarce, and living conditions extremely poor. In recent years, the Mediterranean has become the center of attention in our tragic border spectacle, as the EU’s failed deterrence policies have turned its pristine waters into a blue graveyard. Along the Balkan Route, dense forests and merciless winters take lives and extract a hefty physical toll on those seeking safety and a better life in Europe. Whether along the Mediterranean or the Balkan Route, exhaustion, hunger, dehydration, and sleep deprivation—all linked to negative health outcomes—are chronically present in PoM’s journeys.



*The respondent stated that the bread they had with them had been finished for three days and, since then, they had been walking without food, only eating small apples from trees they passed on the way.*



*They walked through forests and mountains for seven days, experiencing high temperatures during daytime and cool weather at night. They ate one piece of bread every day and drank rain water, as they ran out of drinking water soon after their departure. Due to the fluctuations in weather conditions, one man caught a cold and had to continue the journey while having fever.*



*All three patients were severely dehydrated, exhausted and weak. It was obvious that they had not eaten for several days and had just gone through extreme physical activity*



*The respondent explained that they were so tired that they slept for some hours in the snow. She stated that they all slept together laying on top of the biggest coat they had, trying to keep warm and not die because of hypothermia*



*The group had planned to rest and sleep from midnight to 3.30 am. However, due to the cold temperatures (minus 7 degrees), this was not possible. The respondent described shivering and being afraid of freezing to death*

Throughout this Chapter, it will become clear that the lack of access to safe and legal routes to asylum, combined with the clandestine and often perilous journeys which people have to take to avoid pushbacks, detention, or other violence, result in serious and lasting health consequences.

### **Walk until you bleed**

Key clandestine routes which the lack of safe routes exposes people to are often devoid of infrastructure. **The only way to cross some of these routes is walking: often days of walking through forests, mountains, and rivers, with heavy bags and poor quality shoes.** One respondent described needing painkillers after two uninterrupted days of walking through the forest, stating he would have been physically unable to continue without.

At other points, people are forced to walk for hours or days after violent pushbacks. Particularly along the Balkan route, many testimonies describe border police dumping people in remote locations:

II

*The police then hit and kicked the Bangladeshi men down and afterwards forcibly stripped them of all their clothes and belongings, leaving them with only their underwear. Amongst their belongings stolen were wallets, money (undisclosed amount), phones, and backpacks. After the violent altercation had occurred, the authorities chased the men back to the Bosnian border with dogs. After escaping the authorities and their dogs, on their walk back to Bosnia, the group encountered several wild animals that also started chasing them. (June 2025)*

1,529

people treated

54 %

of first aid treatments involved walking-related injuries

Once stranded, people had to walk (or run) to survive, often without shoes or clothes. Of **1,529 people treated** for minor first aid problems by NNK’s health teams in 2025, **54% of treatments involved walking-related injuries**, such as wounds, frostbite, inflammations, or fungus infections. Particularly concerning case reports describe instances of volunteers disinfecting wounds caused by burst blisters on people’s feet after police had pushed them back and taken their shoes. In one of these instances, the patients had to be taken to a doctor, as they also displayed fever, pus, and swelling—symptoms of an infection gone septic.

**i BURST FOOT BLISTERS, PUS, SWELLING, FEVER**

*Simple injuries caused by long walks, such as blisters on the feet, can quickly develop into a more serious medical condition if not treated properly. A wound is a tear in the skin and acts as a gateway for external agents to enter the body. Therefore, in poor hygienic conditions, even a small tear can quickly develop into a localised infection causing pain, swelling and difficulty moving. In more serious cases, the infection may spread from a localised to a systemic condition, causing fever and potentially requiring hospitalisation.*

## Sleep Deprivation

Environmental violence, whether in the form of extreme weather (snow, rain, cold, or unbearable heat), hostile terrain, or wildlife, **forces people to spend sleepless nights in the ‘Jungle’** (slang commonly used by PoM to describe the forests along irregular routes). The fear of being intercepted by police authorities or criminal gangs also compels people to stay awake, keeping watch to prevent and avoid violent encounters.

Most people reported **suffering from sleep deprivation especially in border zones, where they were forced to keep moving in order to remain invisible and therefore safe**. A person who had safely reached “Europe” said that the most vulnerable in this regard were children:

||

***Some kids traveling with me died of cold and exhaustion: they were very, very tired, they hadn’t eaten much. One night we stopped for a few hours, but in the morning they were dead. (May 25)***

Lack of sleep is further intensified by prior trauma and fear. Some reported that their fellow travelers would scream or cry during their short periods of sleep, recalling violent scenes they had witnessed. Similarly, intense physical pain and discomfort — from severe toothaches, broken bones, dog bites, foot wounds, infected fingers, or parasitic infections — further prevent people from sleeping and resting.

**26 %**

of pushback testimonies contained sleep deprivation indicators

When respondents were apprehended by police officers, pushback incidents themselves frequently took multiple hours or even an entire night, further depriving people of sleep after long journeys. Of 231 testimonies of pushbacks in the data set of this report, **26% contained indicators of sleep deprivation**. Whilst sleep deprivation is persistent at various stages of the journey and reception process, as this report will explore later, in the context of journeys this kind of deprivation is particularly acute. After being detained, transported, or even abandoned in remote areas, movement must continue to avoid interception again or to reach to safety and avoid further environmental risks such as the cold. Yet, the acute sleep deprivation at this stage seriously impairs cognitive functioning, slows reaction times, reduces spatial awareness, and comprises decision-making capacity. In hostile border environments, this can be life-threatening, and the immediate physical danger and vulnerability is compounded at precisely the moment when clarity, coordination, and strength are most needed.

## SLEEP DEPRIVATION

*A major health stressor that can have serious effects. It weakens thinking, emotional control, and decision-making, and over time can lead to cardiovascular, metabolic, immune, and neurological problems.*

[Source study](#)

## Starvation

Along irregular routes in harsh environments, food is scarce, if available at all. Access is then often deliberately restricted when people are held in custody when apprehended along the route. One report mentions that “over the course of six days [a group of 49 people] walked through the forests, sustaining themselves by only small rations of food since they were avoiding cities and other places of attention.”<sup>5</sup> Testimonies of survivors of pushbacks frequently show that on top of physical injuries, exhaustion, and psychological distress, survivors are often left starving.

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<sup>5</sup> This testimony was provided to NNK in 2019 - and is therefore outside the sample of this report but provides an example of food deprivation on irregular routes nevertheless.

Some reports even report the withholding of food as a humiliation or control tactic. [One testimony](#) shows how authorities used food to enact islamophobic violence:

||

***[Her] children started crying, since it was cold and they were hungry. The police officers ate even in front of the kids. They ate, they shared milk and biscuits between them... and if a mother asked for food for her kids, they would say no.***

**The respondents said they have been starved, repeatedly beaten, and verbally abused [in administrative detention].** They requested water reportedly in Turkish, Arabic, and English due to severe dehydration after three days without fluids. However the officers denied these requests and refused to give anything. Instead of receiving assistance, the detainees were mocked and told to “fuck off.” Eventually, a superior officer arrived at the facility. The respondent stated that they finally

received water, but the only food offered was canned pork. As the detainees were Muslim, it was not possible for them to consume the food, and their refusal was answered with further beatings and verbal abuse specifically targeting their religion. Eventually, they were provided a single packet of biscuits for every three to four people. Respondents describe children being exposed to this same taunting. **A respondent pushed back from Croatia states:**

Whilst on routes, a lack of financial resources can compound this risk of starvation. A lack of legal pathways to Europe often forces people to pay exorbitant amounts to 'smugglers' or to land themselves in debt; administrative barriers for undocumented individuals lead to an inability to access banking services or to receive transfers; and formal jobs are limited or restricted (even to those regularised in the asylum procedure) which exposes people to exploitation or unemployment. **These factors compound to deteriorate individual financial situations and further undermine people's ability to eat sufficiently, with many reporting they survived on just one small meal a day.**

## Exposure to the Elements

# 84

testimonies mention cold exposure

---

Exposure to extreme cold is also particularly common and dangerous, especially in the Balkan Route. Our database contains **84 testimonies** where respondents mention enduring cold temperatures, with some mentioning direct medical and life-threatening consequences. The isolation, extreme conditions, and their physical consequences on PoM are not merely accidental nor the inevitable results of people's individual choices. They are foreseeable consequences of the normalization of illegal pushbacks and indiscriminate violence on Europe's borders.

# 44 %

mention abandonment in rivers, forests or remote areas

---

Furthermore, our data shows that exposure to the elements is not only politically manufactured. Authorities on the ground also wield it as a tool of cruelty. After detaining and sometimes physically beating and psychologically torturing PoM, border authorities routinely abandon them in remote locations. **44% of testimonies grouped into the category of 'journeys' during the deductive coding process (96 testimonies in total)** directly mention officers pushing people PoM back into rivers, forests, and other desolate areas.

During summer, extreme heat and limited access to clean water sources can cause severe dehydration, additional fatigue and worsen health conditions (e.g. inflammations, infected wounds, skin rashes, etc.). In the winter, temperatures dip below freezing point, making travel even more precarious.

Once they started to walk back to Bosnia, at around 9am, the respondent declared that they were really wet, shivering and tired, they were not feeling their legs anymore, they could not take it anymore, they were lost and did not know where they were going since there was no telephone signal. ... When NNK's team found the transit group members, **they were all close to hypothermia, shivering, they couldn't feel their hands nor toes, they had lost their appetite and it took some days until they fully recovered.**

A key example of the deadly impact of this practice was reported on in the Frozen Lives report, in January 2025. **Bulgarian authorities not only refused to trigger ambulance responses for the three children at risk, but blocked the rescue efforts of activists, subjecting them to heavy criminalisation and degrading treatment. As a result, the three children died.**

As aforementioned, in many of these instances border guards also strip PoM of their means of protection and survival. Several testimonies mention authorities burning and confiscating shoes, food, phones, and other belongings, exacerbating harm and putting the lives of PoM at risk. These testimonies reveal how the violence of border enforcement and exposure to natural hazards are mutually entangled, injuring, traumatizing, and threatening the lives of people attempting to exercise their right to claim asylum.



## The forest kills

In everyday conversation, PoM refers to the forests that run along the Serbo-Croatian border as "*the jungle*." Here, **the dangers lurking under the cover of the trees--taking the form of wild and venomous animals, buried landmines from Yugoslav wars, swamps, and rivers--layer onto the constant stress of being 'hunted' by border authorities.** Being in such stressful, dangerous situations has an impact even on those lucky enough to complete their journeys physically uninjured.

Rivers are some of the most dangerous elements of the forest. Water multiplies the effects of the cold, exacerbating the risk of hypothermia. Sudden river overflows due to extreme weather conditions such as climate-change induced summer storms can be treacherous or deadly for PoM crossing or walking on the riverside. And obviously, water can also kill by flooding into the lungs. **Multiple testimonies detail how border enforcement is entangled with the deadly potential of rivers.** Sometimes, officers refuse to act when people get carried away by the current, weaponizing its deadly qualities through neglect. In one testimony, a respondent recounts how he sought the help of Croatian border guards after his friend fell into the river:

The police made fun of them, saying: Other times, police deliberately and violently toss people into rivers, turning them into direct instruments of border violence:

He then states "*after that, they pushed us with their feet in the river*" and describes that he was kicked in the neck whilst being forced into the river. The respondent describes that the minor began to drown. One of the Algerian men, the respondent's friend, had already crossed the river, but he re-entered the river to help rescue the boy and brought him to the other side. The respondent describes that the authorities were watching but "*did nothing*". He states:

**||**

***This happens a lot of times around here, go away. This is what happens when you try to come to Europe.(December 2021)***

When tragedies do occur and people become injured or even die, those around them also suffer psychologically. Death, for most people, is followed by ritual. A body washed and prepared. A community gathered. Words spoken over a grave or a pyre. The specific form varies

across cultures and traditions — but the shared function is constant: **to mark the end of a life with dignity**, and to allow those who loved the person to grieve.

## II

***They saw that this Moroccan boy was drowning, and nothing. They did nothing. (August 2024)***

**For people who die in transit, in reception centres, in detention facilities, or in hospital rooms where no one knew their name, that ritual is almost always denied.** Repatriating a body across international borders is slow, expensive, and bureaucratically complex under the best of circumstances. For families of people who died without documents, in contexts where authorities are reluctant to acknowledge the circumstances of the death, the barriers are categorically different. **Deaths go unreported for days. Official causes of death are recorded in ways that obscure what actually happened.** Consulates of origin countries may lack the capacity or the will to advocate for families without resources. And those families may have no legal mechanism to compel action, no lawyer, no money, and no one in the country of death formally obligated to represent their interests.

In practice, repatriation often does not happen. **Bodies are buried in local cemeteries, sometimes in graves marked only with a number.** Families are notified late, if at all, and the psychological consequences are profound. Grief research consistently identifies the presence of a body, the performance of funeral rites, and communal mourning as critical to what clinicians call adaptive grieving. **When those elements are absent, the result is frequently prolonged grief disorder: an inability to process the loss, a persistent sense of unreality, and lasting psychological impairment.**

The impossibility of these rites is experienced not only as loss, but as desecration. **This violence continues after death, visited on the living who cannot grieve.** It is almost entirely absent from policy discussions. Deaths are counted, sometimes, in aggregate figures. But the cascading consequences for families left without a body, without a grave, without a funeral, are rarely documented and almost never addressed. They are the invisible wound left by a system that treats people as problems to be managed and, when they die, as incidents to be contained.

A particularly harrowing testimony details the psychological aftermath of witnessing a washed up body. This testimony shows how different

forms of harm are closely interlinked, and how violence against one person can ripple and affect others. In-depth narratives on how respondents' experience violence are usually beyond our data collection protocols, but we can only begin to imagine the depth of the emotional scars left by consonantly witnessing violence and being on the edge of survival for prolonged periods of time.

The respondent and his friends still proceeded with their walk in the Croatian forest until they reached a river. During this time they suffered from the cold weather and snow. After eight days they reached a Croatian river, in which they had found the dead body of another person on the move in a previous transit attempt a few weeks before. The respondent described the experience of having to cross that river as very troubling and partially retraumatizing to him and his friends. He related that the last time they crossed this river a close friend of his started bleeding from his nose and mouth from the shock of seeing the dead body in the water.

Another testimony describes walking for four days through a vast forest, his legs worn down from the endless journey. He described that on the path he saw the bodies of many people - only bones and skulls remained. *“That sight hurt me deeply in my heart,”* he says. **The absence of safe migration routes and the EU's enabling of violent practices on its borders (BalkanInsight) places millions of PoM in situations of protracted mobility where their bodily integrity, health, and even their survival are threatened**--direct and foreseeable consequences of the border regime's escalation of deterrence (Border Trilogy Podcast).

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*The bodies found in the forests and rivers of the Balkan route are not the victims of geography. They are the victims of a political choice: to close safe routes and force movement underground, into terrain that kills. Every blister, every case of hypothermia, every bone broken on a forced trek – these are not the costs of migration. They are the costs of deterrence.*

*The EU has the data. It funds the Missing Migrants Project. It receives the reports. It knows what the Plješevica mountains, the Korana river, and the Bulgarian forests produce in December. It has decided, repeatedly and deliberately, that this is an acceptable outcome. That decision is not a failure of the system. It is the system. A killing one.*



CH.02

# THE BODY AS BATTLEFIELD

Beatings, weapons, sexual violence —  
the body rendered vulnerable by design

Whilst the route itself kills, it is generally perceived that those who encounter only nature on their routes are the lucky ones. Before denial of care, bureaucratic obstruction, or psychological degradation take effect, the body is very often first restrained, struck, exposed, and violated. NNK's research reveals that **this violence is not incidental to migration control but fundamental to it**: the body is rendered vulnerable through direct, deliberate, and targeted harm.

What emerges from the data is a form of violence that is neither random nor undifferentiated, but methodical, and near-systematic. While beatings are widespread, they do not exhaust the picture. **Physical force is applied in ways that systematically target specific bodily functions and capacities.** Breathing, movement, and temperature regulation are repeatedly compromised, while bodily integrity and dignity are directly assaulted through forced undressing and sexualised violence. Furthermore, oftentimes, even when direct assault does not occur, threats of violence are deliberately wielded over the body, keeping it in a state of constant intimidation and destabilisation.

**The body is not simply injured; it is strategically undermined with lasting physical consequences,** made to bear the weight of control, fear, and authority.

## Beating as baseline violence

**64 %**

of testimonies record beating

**50K +**

people potentially affected in 2025

Across the testimonies, beatings emerge as the most common and normalised form of police violence against PoM. Whilst the **2025 Annual Pushback Report** estimates an average of 221 pushbacks a day on Europe's borders, **64% of NNK's testimonies record beating**, meaning that the real number of people affected by police beatings during pushbacks in 2025 **may amount to over 50,000. Physical assault appears not as an exceptional response to resistance, but as a routine practice that structures encounters from their outset.** Crucially, these assaults frequently occur in the absence of provocation. Respondents repeatedly describe being beaten while compliant, stationary, or attempting to protect themselves:

**||**

***The police fired guns in the air to scare the people from crossing the border, to make them go back. Then, when the people squatted with their hands above their heads (for protection), the police kicked them with their feet.***

**(September 2024)**



Many accounts highlight the extreme severity of beatings, which often result in long-term injury. One respondent describes a particularly violent episode:

***The respondent describes how they were first beaten up with batons, mainly on the body, while later they were pushed on the ground and kicked multiple times, also in the face. One of his companions suffered a particularly violent assault, resulting in the permanent loss of vision in one eye, likely due to one of the mentioned kicks. Afterwards the group got thrown into a big pit.***

***(November 2024)***

Several testimonies describe the intensity of the beatings in language more commonly associated with torture than with policing. Respondents emphasise both the physical pain and the profound sense of degradation, confusion and powerlessness inflicted during these assaults:

**||**

***They gave me the beating of my life, I have never had this kind of torture. I was treated like an animal. I was beaten so hard, I was tortured, they beat me like a snake. I was just trying to protect my face because I didn't want my face to be smashed. Why did they do this to me? I am not a criminal.***

***(July 2024)***

Furthermore, beatings are frequently accompanied by verbal abuse, mockery, and the denial of assistance. Physical violence is paired with humiliation:

**||**

***We have been starved, repeatedly beaten, and verbally abused (...) Instead of receiving assistance we were mocked and told to fuck off.***

***(January 2025)***

The beatings described - with such frequency that they are a near-certainty of life on Europe's borders, repeatedly result in fractures, severe bruising, head trauma, eye injuries, or untreated wounds from police assaults. In many cases, people continue their journey without adequate access to medical care, meaning injuries that might have otherwise been treatable become prolonged or even a permanent disability. **The cumulative effect is the widespread production of injury and disability amongst PoM**, affecting tens of thousands of people each year, with consequences that extend far beyond the initial moment of violence.

### PHYSICAL IMPACTS

*A fracture that hasn't healed properly (malunion or nonunion) can lead to chronic pain and long-term functional problems such as stiffness, reduced mobility, and joint instability. In more severe cases, especially when a joint or weight-bearing bone is involved, it can cause permanent disability, due to lasting loss of function or significant physical limitation.*

**Source study**

### LEGALITY OF BEATING

*Beating and the use of physical force, as described in the testimonies, often violates fundamental human rights and breaches several international laws and standards, including the European Convention on Human Rights (ECHR), particularly Articles 3 (prohibition of torture, inhuman or degrading treatment) and 8 (right to respect for private and family life), as well as the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Furthermore, beating individuals can violate national laws related to the use of force by law enforcement officers.*

*Although law enforcement officials may, under certain circumstances, use force, international human rights law states that it must be applied in a manner that respects the principles of ne-*

cessity, proportionality, and humanity. It must be the minimum necessary for certain permitted aims like 'maintaining public order'. The violence reported goes far beyond this: it is excessive, systematic, indiscriminate, unprovoked, and is a clear violation of international human rights law. The scale on which we see and hear beating happening on the borders proves there it is systematically being used as a mechanism of terror and control.

## Tools and weapons

NNK's data shows that **violence is not confined to bodily force alone, but is intensified and mediated through the use of tools and weapons**. Objects such as batons, sticks, knives, and other implements are deliberately deployed to inflict pain, intimidate, and assert control.

*One of the officers was fixing his head, and another one was entering his nostrils with two long pieces of metal far inside, turned and extended them harshly, and pulled them out rapidly. This caused the respondent an enormous pain.*

*(December 2022)*

*The respondent described the moment of the apprehension as violent and chaotic: the police officers were very aggressive and threatened the group by shooting three times in the air. The officers beat most of them with batons, and took shoes, clothes, bags, phones, and power banks, which were never returned to the group.*

*(January 2024)*

*After being denied food and water, the authorities started to assault the group physically. One man was first slapped in the face and then slightly stabbed in*

*the left arm with a small knife. Another man was hit in the left knee with a stick.*

(June 2025)

**These instruments significantly increase the severity of injuries sustained:** strikes with rigid objects such as batons and sticks concentrate force onto specific parts of the body, increasing the likelihood of fractures, ligament damage, blunt force trauma, head injuries, and internal trauma.

||

*While blunt force weapons are meant to be used against the extremities, they often hit more sensitive body parts. When used against the head, neck, and torso, severe injury or death may occur. Blunt force trauma to the head can lead to traumatic brain injury, while strikes to the torso, face or genitalia can fracture bones, damage organs, and lead to internal hemorrhaging. Choke holds using the weapon as a lever pose the risk of asphyxiation.*

Note on batons and similar weapons from Lethal In Disguise, a project that monitors the health impacts of some of the weapons used by security forces.

**Use of tools and weapons in this way transform physical force into a calculated and institutionalised practice**, shaping how pain is inflicted and how authority is asserted. Some uses of weapons, such as firing shots into the air, function less to injure and more to perform power. Other actions, such as the insertion of metal rods into the body or targeted blows with knives and sticks, inflict acute pain and potential permanent if not fatal injuries.

## **Deliberate assaults on vital functions**

Very often, the violence inflicted is highly targeted. **Fundamental bodily functions – those most essential for survival – are deliberately**

**compromised.** Functions such as mobility, breathing, and the body's ability to regulate temperature are attacked in ways that weaken individuals at their most vulnerable, with each assault designed to inflict both immediate suffering and longer-term vulnerability.

*The respondent recalls that they beat his friend on a leg with a baton, and that afterwards he was not able to walk because of the pain.*

(February 2023)



*[Recounting several attempts to cross within consecutive days] The third time, he reported having been hit several times in the ankle with the metal part of the stick. The respondent recalls that he thought his ankle was broken. The sixth time he was pushed back across the river, he was almost unable to walk, because of his ankle.*

(March 2023)

**60 +**

targeted mobility attacks

Across NNK's data, **more than 60 cases of targeted disruption to movement, like those above, were recorded.** These testimonies show a deliberate targeting of mobility, aimed not just at causing momentary pain but at preventing people from crossing borders or con-

**tinuing their journey across countries.** By striking legs and ankles, authorities aim to directly impede the ability to stand, walk, or navigate difficult and unfamiliar terrain, effectively weaponising injury as a deterrence mechanism.

***One member of the group was threatened with drowning, had a knife held to his neck, was pinned down with a foot on his throat, and punched repeatedly in the face.***

***(March 2025)***

***They beat him seven times on the thorax, and afterwards on the head (...)***

***(December 2022)***

**50 +**

attacks affecting  
breathing

---

**In over 50 cases across NNK's data, breathing and respiratory function are deliberately targeted.** Blows to the thorax or throat restrict airflow, causing acute physical pain and potentially serious internal injury including rib fractures, lung trauma, and prolonged respiratory conditions. Moreover, compromising respiration also amplifies psychological distress, as individuals confront the immediate threat of losing control over one of their most basic survival functions.

**||**

***It was cold outside already. It was so cold.”(...)  
During the journey, they were not allowed to keep  
their belongings and were left barefoot.***

***(January 2022)***

**||**

***The van was very very hot. And they drove very  
badly. Banging us from side to side.” The children***

*and two adults threw up. It was hard for them to breathe. While they were feeling sick, the respondent recounted that the group heard the policemen laughing.*

*(June 2022)*

**70 +**

sexual violence / dignity violations

**Attacks on temperature regulation reveal another dimension of bodily vulnerability.** Both extremes, freezing cold and unbearable heat, create physical distress, nausea, and discomfort, directly compromising the body's capacity to function.

### EXPOSURE TO EXTREME TEMPERATURES

*Whether high or low, it poses significant risks to human health, ranging from mild discomfort to life-threatening conditions. This depends on the duration of exposure to high or low temperatures. Physical damage can be temporary, become chronic, or even fatal. The body functions best within a narrow temperature range, and exposure to extreme temperatures forces it to work harder to maintain its internal balance.*

[Source study](#)

## Sexual violence

**Sexual violence along migratory routes emerges not simply as an extreme form of physical harm, but as a deliberate instrument of power that targets the body, identity, and dignity of those on the move.** These acts carry serious and lasting physical consequences as well as psychological, including genital infections or injuries, involuntary pregnancies, and severe psychological trauma. Across the testimonies, sexual violence is closely intertwined with practices of searching and surveillance. What is officially framed as a “security procedure” becomes, in practice, a vehicle for violation. **The act of searching is weaponised in a way that strips PoM of autonomy, privacy, and safety:**

## II

*I was shaking but he didn't care, he was like an animal(...) He thought I was putting money inside of me, so he put his finger [inside her genitalia](...) That was the worst thing to happen to me. I prefer he beat me, than to search me in that way".*

(January 2024)

Furthermore, beyond invasive searches, sexual violence also manifests through **forced nudity and exposure**. **Stripping people of their clothes emerges as a tactic of humiliation that transforms individuals into powerless spectacles**. Being made to stand partially or fully naked in front of others erases privacy, intensifies shame, and reinforces the absolute control of authorities over migrant bodies:

*Several group members were beaten and ordered to take off their clothes. Most disturbingly (...) two male officers isolated the [sole] woman and ordered her to undress completely, forcing her to stand naked in front of the entire group.*

(June 2025)

Above, the deliberate singling out of the sole woman by male officers illustrates how sexual violence disproportionately targets women and reinforces patriarchal power within migration control. At the same time, her forced nudity is not only an individual violation but a collective one: the entire group was made to witness her degradation.

### LEGALITY OF STRIP-SEARCHES

*Forcing individuals to undress is a degrading and dehumanizing practice frequently reported in testimonies. People who experience this often stripped in public or semi-public settings, either as part of body searches, as a form of humiliation, or as a*

means to exert control. The act is often accompanied by verbal abuse, mockery, and, in some cases, violence, creating a deeply traumatic experience.

The violation of privacy and dignity inherent in such acts contravenes both the ECHR (Article 3) and the United Nations Convention against Torture. Forcing people to undress strips them not only of their clothing but also of their sense of autonomy and humanity, turning a basic search procedure into a method of psychological torture and intimidation.

Forcing individuals to undress during border procedures can legally occur under certain circumstances, such as during strip searches aimed at uncovering contraband or ensuring safety. According to international and national legal standards, strip searches must adhere to strict guidelines: this includes legal grounds (like 'reasonable' suspicion that the person is concealing prohibited items (like weapons, drugs, or evidence of a crime), necessity (by the least intrusive means necessary), and with respect for dignity. Instead, in the context of pushbacks these legal conditions are entirely violated. People report being forced to undress where there is no reasonable suspicion of a crime (recall that irregularly crossing a border is not a crime which would justify the use of strip searching). Testimonies make clear that strip searches are motivated more by a desire to intimidate, humiliate, or degrade than by any legitimate security concern. In addition, they are frequently humiliated, with people stripped entirely naked or in public. The use of strip searches in this way is absolutely and unequivocally violent and illegal.

This type of violence occurs to people of all genders, although gender also appears in a as a motivator or a compounding factor in humiliation in many testimonies. Removal of clothes to further expose people to the elements or humiliate them is also commonplace, even aside from the context of strip-searching::

**Once they arrived, the police took them out of the cars and removed all the people's clothes - even their shoes. They just left them in their underwear.**

**(November 2024)**

In such cases, stripped of basic protection, individuals are rendered physically vulnerable, especially when left without shoes or clothing in exposed areas, and the act itself is a violent attack on the dignity of PoM.

In addition to gross violations of the right to health, the described cases of sexual abuse are violations of the right to privacy (Article 8 ECHR) and freedom from inhuman and degrading treatment (Article 3 ECHR). Survivors also have rights under the Victim Rights Directive, and the Violence against Women's Directive, and the EU has also ratified the Council of Europe Convention on preventing and combating violence against women and domestic violence.

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*Across more than 70 recorded cases, testimonies such as the above illustrate how sexual violence and the destruction of dignity are systematically deployed to regulate movement. The practices described – forced nudity, invasive searches, and gendered isolation – have lasting physical and psychological consequences for survivors, but also mark bodies as sites of control, asserting the absolute power of those in authority.*

*What the data in this chapter shows, taken together, is that the European border regime has developed a precise and practiced knowledge of the human body – its vulnerabilities, its thresholds, its breaking points – and deployed that knowledge systematically. Ankles are struck to prevent walking. Chests are beaten to compromise breathing. Clothes are removed to weaponise cold. Sexual violence is used to assert total dominion. This is not the violence of disorder. It is the violence of expertise: calibrated, repeated, and institutionally protected. The body of the person on the move is not an accidental casualty of enforcement; it is the terrain on which enforcement operates.*

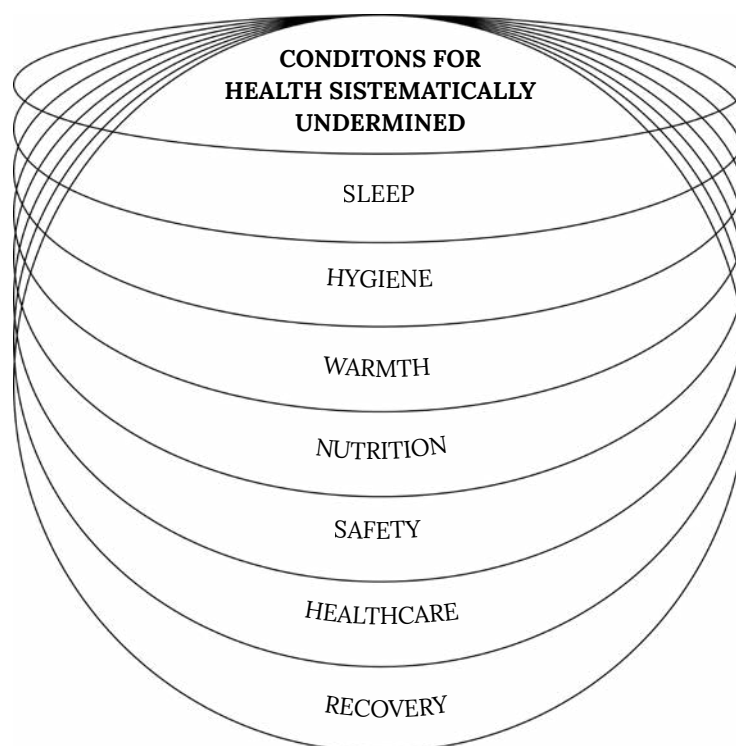


CH.03

# NOWHERE TO HEAL

**Squats, camps, detention: manufactured environments of exhaustion and disease**

In this chapter, we analyze how the border regime manufactures exposure to dangerous and toxic environments, undermining states legal obligations and placing PoM in situations that threaten their health and lives. The living conditions and underlying determinants of health during displacement are shifting and fluid, making environmental harms difficult to track. Despite this, there are patterns as to the types of environments that PoM are exposed to as they navigate the European border landscape. This chapter focuses on three: **squats and informal settlements, conditions in reception centres, and detention facilities**. Across these three, people are exposed to scarcity, stress, and other dangers that undermine their ability to maintain mental and physical health. Particularly for those in situations of protracted displacement, exposure to these conditions can last for months.



**CESCR General Comment No. 14 (2000)**, which is widely considered to be the authoritative interpretation on the right to health, states that governments' obligations under this convention are not limited to providing access to healthcare. They extend to the **underlying determinants of health**, which include "a wide range of socio-economic factors that promote conditions in which people can lead a healthy life." The comment mentions access to "food and nutrition, housing, access to safe and potable water, and adequate sanitation" as illustrative determinants. As this Chapter will make clear, those standards for the

underlying determinants are rarely present whilst on the move, and even when people do have access to official facilities such as reception centres conditions are frequently so poor that people cannot maintain their health or recover from journey-related injuries.

## Shelter in abandoned buildings and makeshift camps

Along these routes, and after pushbacks, people need a place to rest, muster resources, and prepare for a subsequent attempt. Official reception facilities are often overcrowded, and some prefer to stay away from authorities altogether. Furthermore, most reception systems in Europe only permit access for those registered in the national asylum-system, putting those that access reception centres in transit at risk of later 'returns' to these countries <sup>6</sup>. As a result, **people pool around abandoned buildings, makeshift encampments, or wherever they can find even the barest bones of shelter.**

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<sup>6</sup> This risk is particularly compounded by recent developments to the 'safe third country' principle and the [2026 Returns regulation](#), which risk amplifying 'returns' to transit countries even without connections, let alone when PoM have accessed reception centres in those countries.

For as long as NNK has been in the field, makeshift camps and temporary settlements have repeatedly mushroomed along border chokepoints, such as in the areas surrounding Velika Kladusa on the Bosnian-Croatian border, only to be evicted and sprout elsewhere. Locations might change but **living conditions across sites remain dire**. NNK's teams in the Balkans are constantly present on these sites providing food, toiletries, first aid, and psychosocial support. The lack of facilities in these squats exposes people to a range of health risks: such as bites from ticks, spiders, and other bugs that can carry various bacteria and viruses that are hard to diagnose or treat in resource-limited and emergency-orientated health structures offered by NGOs.

Scabies is one of the most common and feared conditions among POM. It spreads through shared clothes, bedding, and prolonged skin contact, and requires a two-step medical treatment combined with disinfection of clothes and sleeping areas. Such measures are nearly impossible for POM in transit, who lack safe shelter, washing facilities, and time. **Uncontrolled scabies leads to persistent itching, open wounds, and scars, resulting in sleep deprivation, anxiety, isolation (often reinforced by stigma), and severe overall mental health deterioration.** Similarly, bed bugs thrive in overcrowded, communal sleeping areas. They bite, hide in fabrics, and spread quickly through contact. Infestations are difficult and costly to eradicate. Bites may appear days later and cause intense itching and discomfort. Bed bugs are commonly reported in transit and detention facilities and other temporary accommodation such as squats.

## SCABIES

*A highly contagious skin infection that causes intense itching, caused by the microscopic mite *Sarcoptes scabiei* var. *hominis*. Treatment is simple and straightforward, but good hygiene must be maintained; access to clean clothing and a sanitary environment is necessary. Furthermore, because it is contagious, it can spread rapidly, making it not only an individual problem but also a public health and community issue. The typical symptom of scabies is itching, and a common consequence is so-called “scratching lesions,” or skin lesions caused by scratching due to the itching associated with scabies. Under poor hygiene conditions, a skin lesion can lead to more serious consequences, such as a localized or systemic infection.*

[Source study](#)

# 6,800

*hygiene kits provided  
(2022–2025)*

NNK field teams in Bosnia have been providing access to mobile showers in squats and makeshift camps, depending on need. In February 2025, NNK provided showers in various squats; in all the instances the people supported described that they had not showered in a long time and in one case the people supported had not showered in ‘months’. From 2022 to 2025, NNK provided **6,800 hygiene kits - averaging 534 medical kits annually and 2300 shower kits**. This indicates high levels of dependency on non-state interventions along the Balkan route, where NNK and other actors are forced to provide access to showers in the face of a state policy that fails to provide this core necessity.

## LACK OF ACCESS TO SHOWER

*Months without showering can lead to serious health risks, especially in harsh or crowded conditions, where the chances of bacterial or fungal infections, scabies, and body lice increase significantly; it can also cause a build-up of sweat and oil, along with skin irritation and odor.*

[Source study](#)

## Reception Centres

The conditions that PoM endure in forests and squats are the foreseeable and preventable consequences of violent deterrence policies. However, **conditions in formal reception centres are rarely better:** Over recent years, international media and NGOs have documented the dire conditions of many reception and transit facilities across the Balkan Route - few and dirty toilets, broken showers, leaking pipes, and contaminated water systems. People NNK supports have reported unsanitary living conditions, lack of access to necessary care and resources, and neglectful, harsh, and sometimes violent treatment by staff. These carceral environments, poor maintenance, and lack of access to medical, nutritional, and psychosocial support systems has harmful consequences for the health and wellbeing of residents, even for short periods of time.

In certain reception centers, the camps themselves lack capacity for the number of people that need to be hosted, their vulnerabilities, their needs, and the weather conditions of the location. In Lipa transitory camp in Bosnia and Herzegovina, the current structure of residential pods made out of storage containers was built to replace the tents that were put in place by the army after the big fire of December 2020 (add dates and quotes). In the descriptions and introductions of the camp, Lipa centre was presented as a hyper efficient and modern structure with many services. In reality, one of the many problems is its basic **inability to resist the extreme temperatures of the area it was built in, such as extremely low temperatures (eg. -13 degrees celsius) or snow storms.** This environmental inadequacy caused a major power failure in January 2026, resulting in the living containers being temporarily devoid of heating and electricity. As most people do not have the right equipment for snow and/or being wet from the pushbacks into the rivers by Croatian police, **the lack of heating was life threatening for the residents of the camp.** Similarly, NNK's investigation into inhumane conditions in the CARA Di Gradisca D'Isonzo near Italy's border with Slovenia found that hundreds of residents had been living in tents for months - and even these tents were overcrowded.

Facilities themselves are often poor, risking serious infections or infestations. **Residents at Lipa reported that the showers are only cleaned once a year,** and in both Gradisca CARA and Harmanli Reception Centre residents have shared evidence with NNK of grossly unsanitary facilities and often broken sanitation systems. The way unhygienic conditions are structured into camp life and can create the perfect environment for skin infections - such as rash or fungus - and parasi-

1 / 1

showers cleaned once a year

tic pests such as bed bugs or scabies to proliferate. Dirty showers and toilets, the potential for crowded rooms, and the lack of bed sheets or access to a proper laundry service makes it very hard to eradicate parasites from beds and people's skin, or to maintain the clean and dry environments necessary to clear up fungal and bacterial infections. **This can result in the fast spreading of the parasites within the camp community, which manifests in the body as severe itching and the consequent secondary infections from scratching.** Parasites and other skin infections can also be detrimental to psychological wellbeing. In particular regarding bed bugs, the feeling of crawling on one's skin and the intensified itch at night often leads to insomnia, frequent waking, and restless sleep. This can create a further lack of safety and rest, as people are now at dis-ease within their only personal space (their bed) within the reception centers.



A further often-recounted complaint regarding health and wellbeing is the lack of access to adequate nutrition. The same meagre portion of food is served to everyone, regardless of their metabolic needs, and the food is not attuned to the accustomed diet of the culture of origin of most inhabitants of the camp. One person in Lipa camp reported in

March (2026) that **you have to show your ID card to receive a serving of food, and if you are caught with someone else's card you are beaten by the guards.** Although there is a market inside where people can also buy food, it is twice as expensive as stores in the nearby town of Bihac, it is owned by the camp director and his wife, and it has a limited variety of food. Though there is a kitchen for use by residents, it is currently closed and people have to buy electric cookers from the market if they want to cook for themselves.

In Serbia, residents of reception centres described similar situations: according to several testimonies from Krnjaca, for a few weeks the Commissariat only served hot dogs as a meal, with no other halal options. This forced Muslim residents to buy food from outside, even if no cooking was allowed inside the camp. In Sombor, residents described that only a small minority of residents were being provided with food. In the minors centre in Šid, children described that their only breakfast was bread and milk. **Residents across various centres in Serbia described a lack of halal food which left them starving,** and the remote location of some camps makes buying nutritious food from outside almost impossible - if it is even permitted, and if the resident even has financial resources to do so.



Photos of Šid minors camp food. Source: Watch the Camp

## Detention

Whilst Reception systems themselves are rife with abuse, the EU's increasing reliance on detention (particularly during the asylum procedures) exposes a significant majority of people moving irregularly on Europe's borders to the isolation, abuse, and torture that are rife in European migration detention structures. Under international law, law enforcement authorities have the obligation to ensure the health and safety of the people they take into custody (UN Code of Conduct for Law Enforcement Officials (1979), Article 6). Instead, NNK's teamss have documented how **in detention PoM are systematically denied food, water, access to the toilet and other basic necessities; endure extreme temperatures, overcrowding, and other inhumane conditions; and are subjected to violence, harassment, and humiliation.** These conditions occur both in administrative detention and judicial detention, and these conditions are particularly concerning given the dependency on detention which the new EU Migration and Asylum Pact and the Returns Regulation embed.

# 36 %

of Journeys/Stays testimonies mention denial of food or water in detention

Testimonies reveal that PoM are systematically denied their basic necessities and medical treatment under custody. Authorities usually apprehend PoM after they have been travelling and enduring harsh conditions for days; thus, they are often hungry, thirsty, exhausted, and traumatized when police take them in. Despite this, seventy-seven testimonies, **36% of all entries categorized under Journeys or Stays, mention people being denied food and water when detained.** NNK's data further shows how guards weaponize food beyond deprivation, using it to enact psychological torture. The most common example of this are times when pleas for water or food are met with laughter and humiliation. In one occasion, authorities denied detainees water, telling them to "*drink from the ground.*" Later, these same officers provided them with what they claimed was chicken but actually turned out to be pork. "*They (the Romanian officers) forced five or six guys to eat pork. They were also making jokes of our religion,*" a respondent recalls. Another time authorities denied a mother and her crying children sustenance as they shared food and mocked them.

## II

### *Drink from the ground*

In detention environments, poor living conditions compound with constant exposure to stress, humiliation, complex administrative procedures, fear of deportation, and the threat of violence. Such condi-

tions are not only detrimental for detainees' medical but also mental health. One of NNK's teams took a testimony from a PoM who had endured such conditions:

## II

***A month felt like a year' the respondent tells me. In the detention centre psychological and physical abuse were used against the respondent. He reports being told repeatedly he would be returned to Iran, being forced to pick up litter, being called a criminal, and being threatened with beatings. The only good day was Christmas day, the respondent tells me, the one day where guards did not harass or abuse him.***

In Bulgaria particularly, NNK has documented the widespread use of migration detention, where respondents have described being denied access to toilets, as well as overcrowding, poor hygiene, and infestations so severe that some detainees rely on spiders to cause bedbugs. The conditions caused both infections and wounds in the respondents<sup>7</sup>.

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<sup>7</sup> The testimonies used in this paragraph are available as part of the [Bulgarian Trap report](#). Full testimonies were not published on the Bloody Borders website due to confidentiality and protection concerns.

In March 2025, one detainee reported that **the detention centre had lacked heating and hot water since early February, leaving residents in freezing temperatures for at least a month**. Meals are often reduced, and dinner is sometimes canceled, causing constant hunger among detainees. One interviewee recounted how storing food was prohibited, and those caught hiding it faced physical punishment. An asylum seeker deported from Germany faced food deprivation for days as punishment for leaving Bulgaria, and a 19-year-old woman was deprived of food after receiving her second asylum rejection in Harmanli, relying on aid from NNK. Two respondents deported to Bulgaria reported being confined in an unfurnished room in Harmanli for 15 days without food, receiving only occasional provisions from other detainees.

Detainees also face inadequate healthcare and lack psychological support, which was the basis of NNK's submission to the Universal Periodic Review for Bulgaria in 2025. At Busmantsi Detention Centre, interviewees report that **medical care is limited to painkillers, with only one doctor available and no healthcare services when the doctor is absent**. The Bulgarian Helsinki Committee and the Committee

1 / 1

doctor once a week

for the Prevention of Torture have confirmed these issues, citing insufficient nutrition, medical care, and psychiatric support. A detainee with cancer reported being systematically denied medical attention and essential medications; his requests for specialist consultations were dismissed, and any attempt to seek medical attention was met with threats. With the progression of his disease, authorities accused him of feigning illness to avoid detention, pressuring him to return to Turkey. He compared his experience to Saydnaya prison in Syria. Another detainee with a chronic illness faced neglect and was denied essential healthcare and medication, causing the deterioration of his health. **The only doctor, available once a week, refused to treat him, citing bureaucratic delays in registering new arrivals.**

*Taken together, the evidence in this chapter shows that these are not accidental shortcomings, but structurally produced environments of harm. Across abandoned buildings, makeshift camps, reception centres, and detention facilities, PoM are systematically denied the basic determinants of health: sleep, hygiene, warmth, nutrition, safety, and the chance to recover. This is not peripheral to the border regime but central to how it operates. For people already carrying the wounds of war, displacement, and border violence, these conditions do not simply obstruct healing; they intensify suffering, worsen existing injuries, and transform exposure, exhaustion, and degradation into instruments of migration control.*

*In 2023, residents at Lipa TRC reported that the showers were cleaned once a year. EU public health standards require daily cleaning in any budget hotel. Bosnia is not incapable of cleaning a shower. These facilities are not designed to support recovery. The degradation is not a side effect. It is the point.*

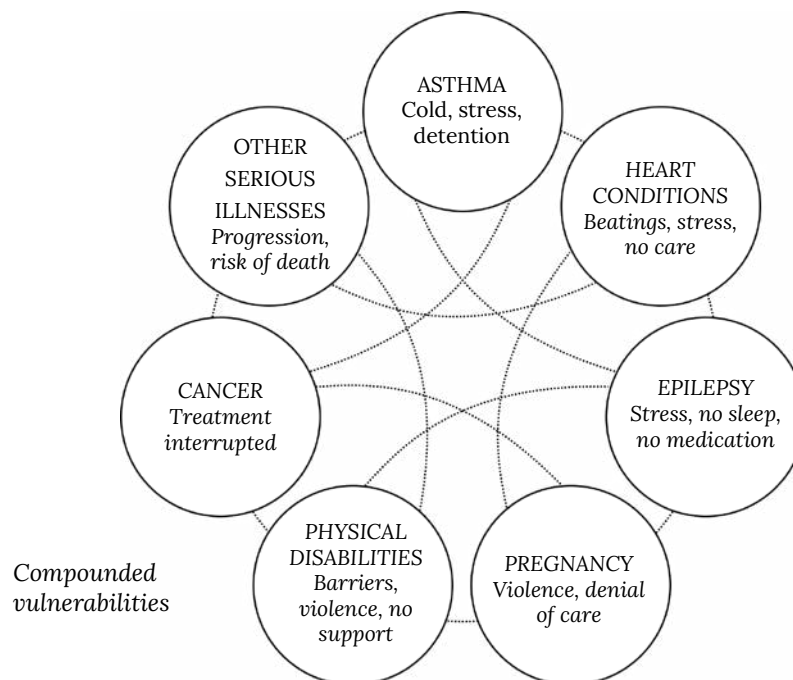


**CH.04**

# **AN EASIER TARGET?**

**How the border regime targets  
those least able to survive it**

In Chapter 1 and 2, we explained how the border regime produces unlivable environments for PoM. The conditions that people are forced to endure in open and closed camps, detention centers, informal settlements, vehicles, border zones and other spaces they have to survive through are incompatible with human dignity and wellbeing. Even those in good physical health struggle to withstand these environments. **For people with chronic or complex health needs, conditions on the move are exponentially more severe, lead to predictable and preventable crises, and sometimes threaten their lives.**



Despite the compounding vulnerabilities, states are obliged to ensure the right to health for disabled people without discrimination, as established in the [UN Convention on the Rights of Persons with Disabilities \(CRPD\)](#). Crucially, this applies based on jurisdiction, not legal status - meaning the obligation falls on states to protect these rights within their territories, regardless of immigration status. Within reception structures, these obligations are further secured by the EU Reception Conditions Directive (2013/33/EU) which mandates individual assessment of special reception needs and, if necessary, adapted material reception conditions and necessary access to services or procedural guarantees during the asylum process.

In practice, NNK's datasets reveal not only a failure to adhere to these standards but also a deeply rooted ableism – a term that [crip theory](#), developed by disability scholars, helps to define with precision. Crip theory argues that **ableism is not simply the failure to accommodate disability, but a structural logic that assigns value to bodies based on**

**their perceived productivity, independence, and conformity to dominant norms.** Within that logic, the disabled body is already marked as a problem before it encounters any institution — a burden, a deviation, a life deemed worth less. As this chapter will show, that logic does not stop at the border. It is waiting on the other side.

## Violence and brutality

### 7

testimonies: medication  
confiscated

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Like other PoM, individuals with pre-existing conditions also routinely experience direct violence. Due to their health conditions, they are often more vulnerable than others during violent encounters. We have previously documented how **Croatian police forces systematically confiscate** and burn PoM's belongings, but among the items that border authorities routinely destroy are life-saving medications. **Seven testimonies explicitly mention authorities deliberately confiscating medication and medical documents, despite the obvious consequences this can have for people's health.** During one pushback, *"the police then started a fire, and threw everything the people owned into the fire: all their documents, their phones, bags, ID cards."* One of the victims had documents proving that he suffers from a heart condition for which he takes medication. *"He told this to the police, but they just laughed at him and threw everything into the fire in front of him,"* the testimony states. Across testimonies, a persistent line said by police officers emerged as the kernel of violence:

||

### ***I don't care.***

### 9

testimonies: police  
informed of condition,  
still beat them

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This violence does not stop at items. Several testimonies show how authorities refuse to show restraint when PoM makes them aware of their vulnerabilities; instead, they target their cruelty where they know it will hurt the most. **Nine of the testimonies explicitly mention that police were made aware of people's conditions and proceeded to beat them regardless.** In one occasion [320], a respondent told the police that he had a heart issue. *"If you do this, beat me and unleash the dog, my heart can stop."* Despite this, they continued. *"They did not care,"* he told NNK's field reporters. In a separate instance [367], another patient with heart issues disclosed his condition during a beating. Having already accepted that officers would likely beat him, he begged them to at least not target his left side due to his heart condition. *"The three policemen took no notice of this and the one policeman even hit him specifically on the left side of his back,"* the testimony states. And yet another time [691], a patient with heart issues made this known to officers, but they still beat and even tasered him, despite how dangerous electric shocks can be for people with heart conditions.

Incidents reported by pregnant women suggested that pregnancy is a significant risk factor in the inciting of abuse or degrading treatment. **In one case**, when the group asked for asylum after being apprehended in the forest the officers reportedly said: “fuck you”, and “If your wife is not pregnant, I beat her”. Although this suggests pregnancy may have excluded the survivor from beating, in the vast majority of cases it does not prevent violence or even incites it. **One group reports** that after sharing their location with IOM, they were instead apprehended by the police who transported them in a hot car without enough oxygen: The pregnant woman described feeling pain on the drive to the border, and told the officers. The respondent reported that the officers began to joke about her, stating: “She feel pain, but police laughing, joking about it.” **In another incident**, after being transported in a hot car, the group was taken out of the van and they were all beaten on their legs and backs, including the children and the pregnant woman. In **a particularly harrowing testimony**, an officer threatened to rape a pregnant woman before inserting his fingers into her in front of the rest of the group. These accounts suggest a troubling pattern in which pregnant women are singled out or mistreated in a way which implicitly seeks to control who is able to survive, reproduce, or move across borders.

### PHYSICAL VIOLENCE DURING PREGNANCY

*Including actions such as hitting, slapping, kicking, punching, or pushing. It increases the risk of pregnancy complications like vaginal bleeding, premature rupture of membranes, and preterm labour. It can also cause maternal injuries, which may be severe or life-threatening, and may lead to long-term consequences such as chronic pain, disability, and psychological trauma, affecting maternal well-being and mother–infant bonding.*

*Sexual violence during pregnancy involves any forced or non-consensual sexual activity. It can result in unwanted pregnancy, infections, physical injuries, and significant psychological effects such as anxiety, depression, and post-traumatic stress disorder, with potential long-term impacts on maternal mental health and bonding with the infant.*

*Psychological and emotional abuse during pregnancy includes verbal abuse, threats, intimidation, and isolation.*

**Source study**

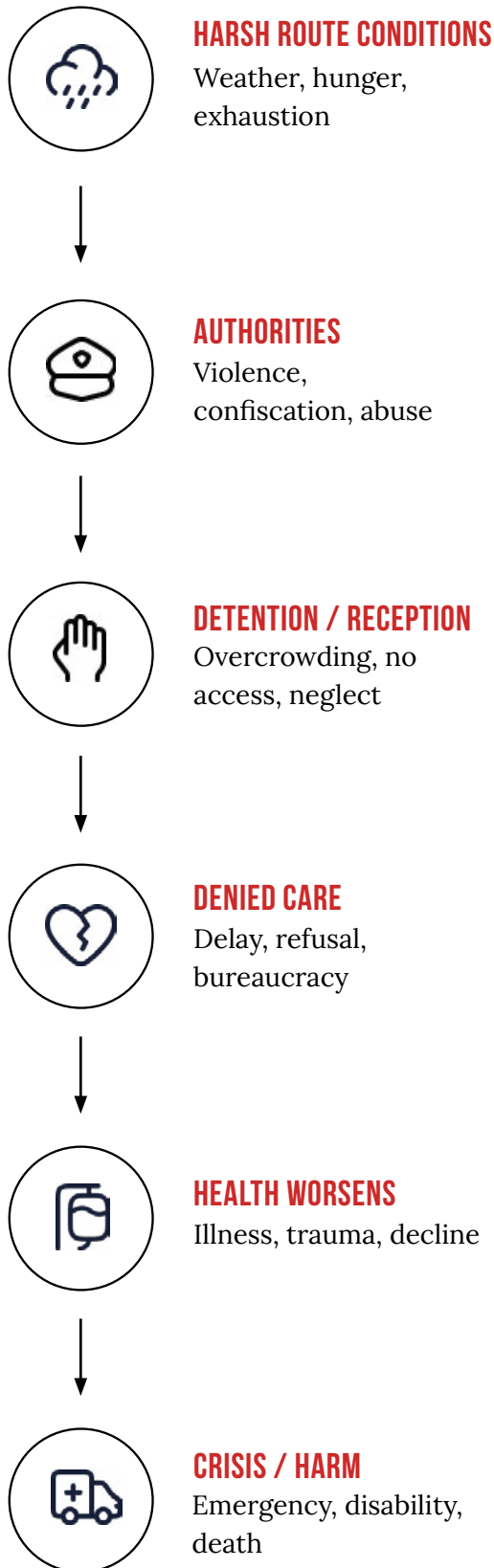


Children are targeted too: **On the 2/12/2025**, a 21-year-old man experienced a pushback from Croatia to Bosnia, together with his 14-year-old brother - who had a pre-existing disability affecting his ability to walk and used a crutch to war. The respondent stated they had experienced s many pushbacks they had lost count. The respondent was brutally beaten, on the throat and over the head. When he begged the Croatian officers not to beat his brother, they beat the respondent harder. He stated: *“I could not speak, I cried too much. It was the first time in my life, I see people like that. They treated me like an animal”*. His younger brother was then also beaten with batons, their belongings were stolen including their shoes, and they were forced into the river even though the brother could not swim. The respondent could not remember how long they were in the river, but remembered thinking he was about to die. In this testimony we see the intersection of compounding risk factors at play: childhood, race, and disabilities. **Even visible markers of childhood, vulnerability, and need for support are subordinated to a violent agenda, illustrating how racialised border enforcement operates with such force that it disregards basic human empathy.**

In NNK's data, asthmatic patients are repeatedly shown to suffer from the harsh conditions on the move. On one **occasion**, a woman with asthma experienced difficulty breathing while officers detained her group, forcing them to wait outside in the cold while they confiscated their belongings. **Another record** contains the story of another asthmatic patient: Detained in a cell for 11 hours with only a small window that was blocked, the respondent suffered from an asthma attack. She was forced to endure the pain while waiting for a doctor that, despite the officers' promises, never arrived. Here the testimony shows how the border machinery (from deterrence policies that push people deep into harsh environments to the asphyxiating conditions of detention) leads to **stress** and **exposure to the cold** both of which have been scientifically linked to asthmatic attacks.

The data also contains evidence of PoM with life-threatening conditions who were endangered by state abandonment. NNK's data records such situations concerning people with **epilepsy, heart problems**, and even **cancer**. In all these cases and more, people with extreme vulnerabilities encountered life threatening situations that halted their journeys. Without the support of humanitarian networks, many would have been at risk of death. Though sometimes labeled 'accidents,' these types of situations are completely politically created and not inevitable. As Europe escalates deterrence instead of facilitating safe migration routes, it is also knowingly putting vulnerable PoM at risk of death.

## A JOURNEY MARKED BY RISK



### **i** VIOLENCE AFFECT PEOPLE WITH ASTHMA CHRONIC CONDITION

*Stress and violence can significantly affect people with Asthma by triggering or worsening their symptoms. Strong emotions like fear, anxiety, or trauma can cause the airways to tighten, leading to breathing difficulties, wheezing, or asthma attacks. Exposure to violence—whether physical or psychological—can also increase long-term inflammation and make asthma harder to control, especially in individuals who already have sensitive respiratory systems.*

**Source study**

In a system where pushbacks are not only encouraged but institutionalized, singling out the most vulnerable may be understood as the pursuit of perceived ‘easy targets’. The EU **pumps heavy investment** into accession states willing to display extreme shows of force against irregular crossings, Frontex has curated an **institutional culture of under-reporting**, and member states **act with impunity** for pushbacks. The EU has, for years, incentivized and institutionalized pushbacks, and the heightened aggression against vulnerable people is therefore a foreseeable outcome.

### **Lack of physical and social infrastructure**

In NNK’s data, asthmatic patients are repeatedly shown to suffer from the harsh conditions on the move. In one occasion, a woman with asthma experienced difficulty breathing while officers detained her group, forcing

them to wait outside in the cold while they confiscated their belongings. Another record contains the story of another asthmatic patient. Detained in a cell for 11 hours with only a small window that was blocked, the respondent suffered from an asthma attack. She was forced to endure the pain while waiting for a doctor that, despite the officers' promises, never arrived. Here we can see how the border machinery (from deterrence policies that push people deep into harsh environments to the asphyxiating conditions of detention) leads to **stress** and **exposure to the cold** both of which have been scientifically linked to asthmatic attacks.

The data also contains evidence of PoM with life-threatening conditions who were endangered by state abandonment. We have records of such situations concerning people with epilepsy, heart problems, and even cancer. In all these cases, people with extreme vulnerabilities encountered life threatening situations that halted their journeys. **Without the support of humanitarian networks, many would have been at risk of death.** Though sometimes labeled 'accidents,' these type of situations are completely politically created and not inevitable. As Europe escalates deterrence instead of facilitating safe migration routes, it is also knowingly putting vulnerable PoM at risk of death.

Conditions at reception camps are also particularly dire for people with chronic health issues. **Facilities lack the physical and social infrastructure necessary to accommodate people with pre-existing conditions, leading to a deterioration of their health.** For example, one person with cerebral palsy expressed that the help he is provided with "is aimed only at surviving in this camp, but [it] is not aimed at integrating a person into society." He described his living conditions in the camp as impossible: the constant sleep deprivation, malnutrition, and the hopelessness of his situation due to the lack of social and medical support for his condition, has led to him crying on a regular basis and suffering from suicide ideation.

Another respondent, a man with asthma, **had been detained in Croatia for a month before being returned to Bosnia.** He described the conditions under which he survived, under which

## II

### *A month felt like a year*

as 'disgusting,' with overcrowded cells, lice infestations, no ventilation in vehicles, which would trigger his asthma, and physical and psychological mistreatment. In that month, he suffered a heart attack, and, at the time of the interview (3 months after the detention), skin damage

from beatings was still visible. Such conditions and abuse are in obvious breach of fundamental human rights frameworks, such as the European Convention on Human Rights (ECHR) and the UN Convention against Torture (CAT), as well as the right to health as enshrined in the ICESCR, which includes an obligation to ensure timely and appropriate healthcare for all, regardless of migration status. Crucially, the lack of appropriate health infrastructure - in these and numerous other examples - exposes ways **health becomes a tool of control where mismanagement is systematic and intentional. Those who cannot withstand the physical and psychological toll of migration are effectively selected out.**

## Medical Neglect and Bureaucratic Violence



**People with complex health needs often experience acute crises due to subhuman conditions in detention.** Instead of following the law and providing them treatment, testimonies reveal how **patients in distress experience bureaucratic violence - a weaponisation of 'proper' procedures by authorities to withdraw or withhold vital medical care.** Waiting itself becomes a form of violence, particularly for those with pre-existing health issues. Although the person is already 'legible' to the system, supposedly being afforded access to healthcare systems, this institutional violence persists in the form of neglect. This can take the form of blatant discrimination, but also of enforcement of regulations in a way which is deliberately inflexible, or refusing to adapt procedures to people's disabilities and chronic conditions - exacerbating suffering, sometimes fatally.

For example, **on the 1st May 2025**, a 27-year old man from Syria died of a heart attack whilst residing in the Sjenica Asylum Centre. Before his transfer to Sjenica, his behaviour had been described as fluctuating between consciousness and unconsciousness, but this worsened after his arrival in Sjenica. Notably, other residents asked UNHCR representatives to intervene, but they were told that the camp was unable to provide medical care unless it was requested by the recipient and that somebody could not be forced to see a doctor or receive medication. Rigid and inflexible rules, supposedly put in place to protect the recipient, were enforced without consideration for the recipients best interest nor their capacity to make informed decisions (*compus menti*). **That lack of consideration, disability adjustment, and inflexibility, cost him his life.**

In the **Netherlands in July 2024**, a young asylum-seeker from Algeria had severe pain in his foot, and had requested to see a doctor. The Immigration and Naturalisation Department (IND) refused, citing con-

cern that it would delay his scheduled deportation. His infection progressed severely, he became unable to walk, and when he was finally permitted to see a doctor he was diagnosed with a severe infection. A person with asthma experienced similar denial of healthcare during a [deportation from Germany to Bulgaria in January 2025](#). The respondent reported that the police were violent against him and did not tell him he was being taken to the airport. His mental state was very bad and he was struggling to breathe because of his asthma. An ambulance had to be called. This deportation disrupted the inoculation therapy he was undergoing in a German hospital. This same respondent suffered further abuse after being deported to Bulgaria: his asthma worsened, he was not given medication, he was forced to stay in a damp and moldy room that worsened his health, and he was told that the State Agency for Refugees (SAR) would not help with his condition and if he wanted healthcare he should pay for it himself.

**The rigid enforcement of procedure - prioritized over the individual's health, demonstrates that the inflexible adherence to procedure causes severe physical harm, and even death, to those with acute or chronic conditions.** That consequence is one which state policy has reconciled themselves with: the [European Disability Forum](#) has outlined that disabled refugees and asylum-seekers are likely to experience inadequate access to healthcare across the entire European reception system. The described situations violate the UN Convention on the Rights of Persons with Disabilities (CRPD), particularly Article 25 which ensures the highest attainable access to healthcare without discrimination, and potentially also constitutes a violation of the prohibition of inhumane and degrading treatment (Article 1 UNCAT, Article 3 ECHR, Article 7 ICCPR) due to the deliberately prolonged suffering.

All of this amounts to what scholar Dr. Ruth Wilson Gilmore terms “*organized abandonment*,” or the intentional disinvestment from communities, which leads to increased criminalization and policing as a way to compensate for the inadequate infrastructure and to maintain hegemonic social order. The exemplified forms of neglect also directly contravene a range of human rights standards. The International Covenant on Economic, Social and Cultural Rights (ICESCR), particularly Article 12, as well as the previously mentioned Convention on the Rights of Persons with Disabilities (CRPD) oblige states to ensure accessibility to services and facilities and protect persons with disabilities from discriminatory treatment. In practice, however, these rights remain unrealized for many PoM, especially those in various forms of legal limbo or irregularized status. **The doctrine of deterrence relies makes examples of those who do not survive it to deter others, perpetuating ableism and enabling the death of disabled people on a mass scale.**

*The testimonies gathered in this chapter confirm, with empirical precision, what crip theory argues at the structural level: that ableism is not an attitude but an architecture, and that the border regime did not invent it – it inherited it, intensified it, and put it to work. Officers who know someone has a heart condition and strike their chest anyway. Staff who enforce consent procedures on a man fluctuating between consciousness and unconsciousness. Camp doctors who decline to examine visible injuries because paperwork is incomplete. A deportation prioritised over a foot infection because the schedule matters more than the person. These are not individual failures of empathy. They are expressions of a system that has already decided – structurally, racially, politically – that certain bodies are expendable, and that the border is a space where that decision can be enacted without consequence.*

*The doctrine of deterrence does not merely tolerate the death of disabled PoM. At some level, it relies on it. Every preventable death that goes unpunished confirms the hierarchy. Every case of organised abandonment sends a signal to those who might follow. That signal is calculated. And the calculation has authors.*



**CH.05**

# **BORDERS INSIDE THE MIND**

**Humiliation, terror, and  
the wreckage left behind**

> 30 %

of refugees suffer from depression and PTSD

4 %

global prevalence according to WHO

The mantra that “**there is no health without mental health**” has now been repeatedly adopted across human rights and public health policy spaces, revealing the centrality of **mental health international human rights** governance. As states scale up their responses to mental health epidemics, **migrant populations remain especially vulnerable** to negative mental health outcomes. Studies show that mental health conditions such as depression, anxiety, PTSD and suicide are more prevalent among refugees and migrants than host populations: One multi-country **literature review** revealed that **more than 30 percent of refugee populations suffer from depression and PTSD**, while the **WHO places the global depression and PTSD rates at four percent**. As a **WHO report** found, this massive gap is the result of several factors, including experiences of war and poverty, violence suffered in transit, discrimination in settling countries, and lack of access to opportunities and services.

Existing policy discourse often blames violent situations in refugees’ home countries or human trafficking networks for breeding trauma and mental illness. In this chapter, the report shows how the **European border regime is, too, responsible for creating suffering en masse**. In fact, studies show that European regularisation processes (including the journey) put people significantly more at risk of mental disorders: in **a study of undocumented and documented migrants in Belgium**, those who had not been able to regularise showed higher levels of trauma, anxiety, and depression. In the US context, **studies have found** that immigrants who cross the border tend to have higher rates of PTSD, depression, and anxiety. Pre-existing literature and internal datasets are clear: populations that came face to face with border regimes are also the ones with significantly higher trauma.

NNK data specifically shows that **across the Balkan and Mediterranean routes psychological distress emerges not only as a secondary effect of displacement, but also directly from the conditions imposed by border policing**. This includes, but is not limited to, humiliation, exposure, neglect, fear, and trauma. Even in the absence of direct physical harm, psychological assaults extend the reach of violence beyond immediate encounters, structuring behaviour, enforcing compliance, and reinforcing the authority of those who wield it. In this way, **fear is continuously rehearsed and internalised**. **The empirical record proves this assumption brutally: among 266 documented cases of pushback operations at European borders, fear appears in 220 instances, humiliation in 210, psychological trauma in 200, theft and confiscation of belongings in 190, forced witnessing of violence in 105, and deliberate disorientation in 20.**

# HOW BORDER REGIMES PRODUCE PSYCHOLOGICAL HARM

A process of risk and protection across the migration journey

## Risk factors

Forced migration and persecution

Poverty and lack of resources

Trauma and past experiences

Danger, violence and abuse

Loss, separation and uncertainty

Fear and dehumanization

Discrimination and racism

Isolation and social exclusion

Uncertainty and legal insecurity

## Mental health outcomes

PTSD

Psychosomatic symptoms

Anxiety and depression

Self-harm and substance use

## Protective factors

Preparation and information

Family and community support

Stability and opportunities

Support from others along the way

Humanitarian aid and services

Safe spaces and protection

Belonging and community

Positive cultural identity

Access to rights and healthcare

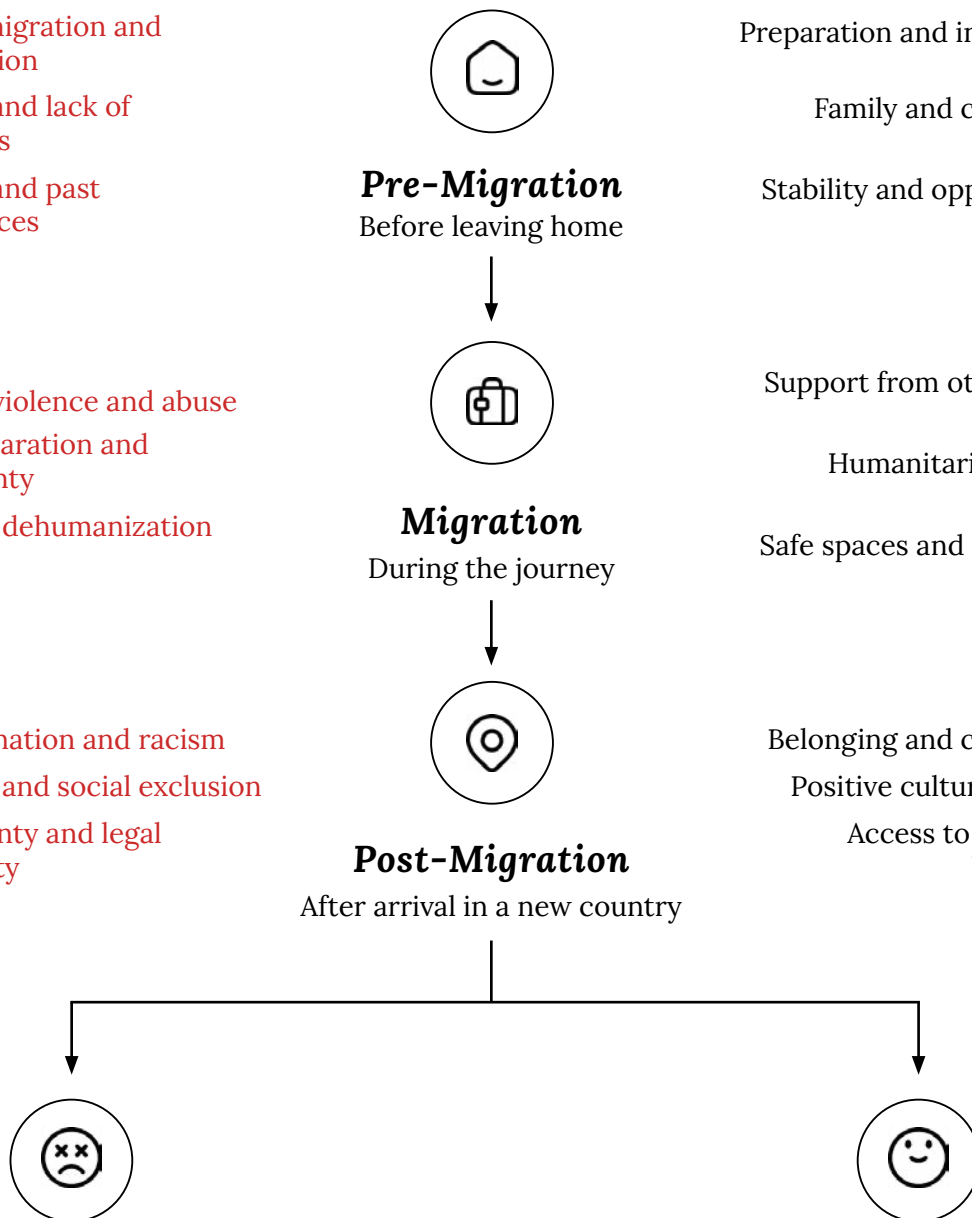
## Positive outcomes

Resilience and recovery

Well-being and stability

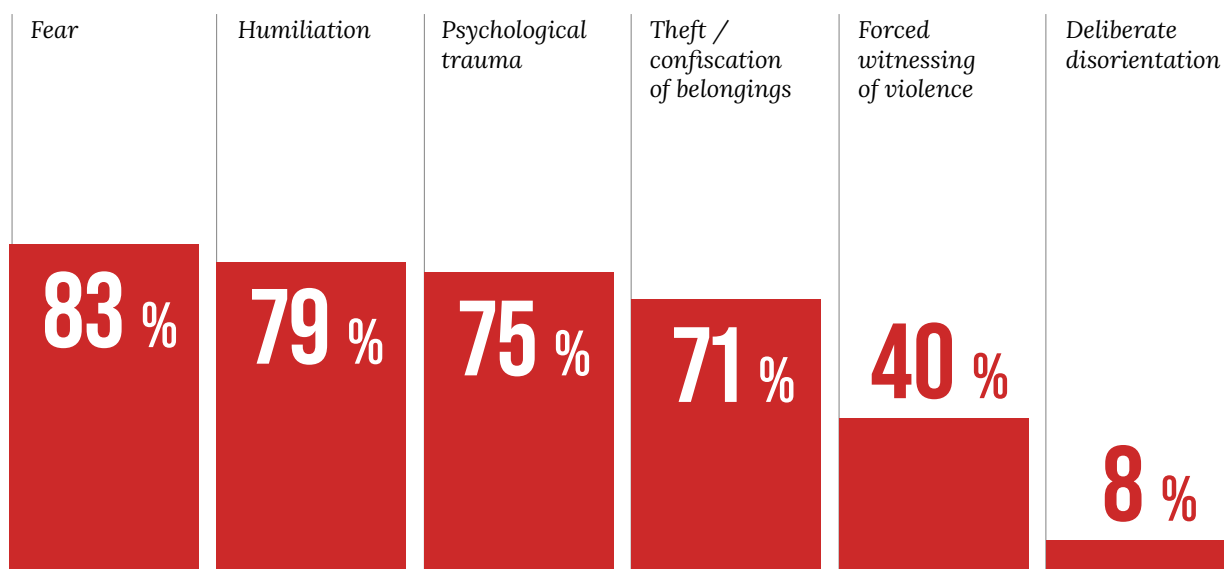
Sense of belonging

Hope and future opportunities



## CASES INVOLVING ABUSIVE PRACTICES IN PUSHBACK OPERATIONS

Systematic patterns across 266 documented cases



In the rest of this chapter, the report first analyzes the types of psychological violence and strategies for humiliation PoM suffer at the hands of EU border authorities. Second, the report draws on in-depth narratives to illustrate the intensity of the suffering that these practices cause. And finally, the report focuses on how these patterns of suffering fester into specific psychiatric conditions that NNK field teams often encounter in the field.

***The group sat down on the Bosnian side of the border, hoping to avoid further escalation. In an effort to de-escalate, they sent the children toward the police with flowers. One of the officers fired a shot into the air, terrifying the children. When the group tried to protect the children, an officer pushed one of the children to the ground. One of the men protested, saying they could not treat children that way. As the respondent attempted to intervene, he said that an officer punched his 5-year-old son in the face, causing visible bleeding from the child's mouth.***

(May 2025)

*One of the officers in black unpacked the bag and gave gloves and black balaclavas to the rest of the officers, who put them on their hands and over their faces. He also handed a knife from the bag to "Ivo". All of the officers had batons. "Ivo" opened a knife and said, "who will be first to have his legs stabbed, to make sure you never try to walk here again?"*

*(August 2024)*

*According to the respondent when the police officers finished the beating they said to them: "You won't stay in Serbia, if we see you again we will shoot you"*

*(August 2024)*

*Everyone started running, the two members of the group who had started at the park ran into the forest, but the two at the bus station were surrounded by two policemen who told them to stop: "Don't run away and if you run, I will shoot."*

*(January 2024)*

*The police officer started to search first from her head and then started to take off her jacket. She still remained to plead with him, but the police officer responded, "shut up or else I will please [rape] you".  
(...)*

## **Humiliation and Dehumanization**

Many testimonies describe how border authorities psychologically abuse and humiliate PoM. One respondent ([pushed back from Croatia to Bosnia in October 2023](#)) reported that the officers laughed at one person when he asked to go to the toilet in detention. [In November 2022](#), a young girl reported that the Croatian police were laughing whi-

lst they begged for their belongings back, and she stated: “*All our suffering has made them laugh*”. **In April 2022**, during a violent pushback involving the group being transported long distances in an overcrowded vehicle, Croatian police reportedly laughed at a pregnant woman who started to feel pain. **In April 2023**, one respondent reported that the Croatian police laughed and sang along to the sounds of the drones whilst beating them. **In February 2023**, another respondent reported that the Croatian police **laughed whilst beating them** with batons, and when he begged them to stop an officer reportedly said “**Are you Moroccan? Muslim? So, I will not stop**”. In **October 2022**, a respondent described that after being beaten they were forced to sit on the ground all day, and the Croatian police tried to humiliate them by playing music from their country of origin and laughing. Such humiliating treatment enforces feelings of dehumanization: As an Afghan man who experienced an **extremely violent pushback from Croatia to Bosnia** described:

In documented cases, subjects are **forced to assume positions that physically embody submission**. People describe being **made to crawl on hands and knees** before officers:

## II

***Here, you are not a human, you are like a football, you feel very powerless like you are nothing.***

*“Several group members were beaten and ordered to take off their clothes. Most disturbingly, the sole woman in the group was targeted in a particularly degrading manner. The main respondent said that two male officers isolated the woman and ordered her to undress completely, forcing her to **stand naked in front of the entire group**. This act of humiliation was not only a gross violation of her dignity but a clear instance of gendered abuse carried out under the guise of border enforcement.”*

***June 2025***

The role of witnesses consecrates the social function of this humiliation. In this testimony, male group members are not only forced to witness the woman’s undressing but also made unable to offer protection. This **forced witness** communicates a clear message: to the woman, that her dignity can be stripped away; to the male witnesses, that they **cannot protect even members of their own group**; and to all, that **the social bonds that normally govern gender relations and communal protection have been suspended in that space**. Social norms structuring gendered relations and family protections are voided

in an instant, creating an internalized feeling of personal inadequacy despite the violence occurring under conditions of absolute constraint.

This dehumanization is then compounded also by an **utter lack of accountability**. **In one testimony**, a woman described watching children being beaten, being sexually assaulted herself, and then forced to walk back to Bosnia whilst they watched their belongings be burnt in front of them. This testimony was the basis of a **submission to the UN Special Rapporteur on Torture** in September 2024, and one of many testimonies that formed the basis of the **Burned Borders report** in October 2024. Despite receiving international press attention, including in **the Guardian**, the **Croatian government released a statement denying all accusations**, most notably claiming: (a) calling these incidents pushbacks is a “*skilled manipulation that has no basis in either national or European regulations*”, (b) that “*the Croatian police have never conducted the so-called ‘pushback’*”, (c) that it “*is completely incomprehensible that such an event [of sexual assault] would occur without immediately reporting it to the police*”, (d) that even if it did take place it was likely ‘*smuggling groups*’, and “*migrants often do not recognise who the attackers are*”.



The violence of this lack of accountability is confirmed by extensive research: the silencing of healthcare providers on issues of political violence **affects healthcare providers' ability to provide care**, and the prevention of collective recognition **hinders the recovery process and prolongs the impact of trauma**. In the words of one researcher, **Elena**

**Cherepanov**, “The experience of politically motivated victimization and abuse carries a profound psychological impact, which can reverberate across generations”. As NNK datasets show, **the absence of accountability compounds dehumanisation** by reassuring perpetrators that their brutality does not carry any consequences, and simultaneously confirming the **social and political invisibility of the victims** in line with a racial order that sustains the border regime.

## Experiencing fear and suffering

Forced to endure abandonment, humiliation, physical violence, and sub-human conditions, innumerable forms of harm compound along PoM's journeys into Europe, which leads them to experience **deep distress, fear, and suffering**. Respondents in the testimonies frequently report being terrified, whether at the sight of guns, dogs, or batons. Several spoke of feeling hopelessness or desperation after the incidents. One respondent, who was pushed back from Croatia **in December 2022**, described being pushed back multiple times at the same location. The respondent stated that in the 3 years and 7 months they had been in Bosnia, they had experienced so many pushbacks that they had stopped counting. When the respondent begged the Croatian officers to not beat his disabled brother, they beat both of them harder. He states: “*I could not speak, I cried too much. It was the first time in my life, I see people like that. They **treated me like an animal***”. They were forced to walk back to Bosnia barefoot in the snow. After the incident, he had physical injuries such as damaged ribs and problems breathing. He explained: “*I am too much sad and angry. These are black days for me*”. He stated that since that night of the pushback he cannot sleep anymore, because bad dreams are disrupting his sleep and make him wake up regularly. **He stated that he was also suffering from suicidal thoughts.**

Respondents often speak of feeling hopelessness or desperation after the incidents. A 24-year old man from Afghanistan **reported** in January 2022 that whilst walking through the Croatian forest, they reached the same river that they had found the dead body of another person in a few weeks prior. He described that seeing this again was traumatising, and he recalled that the previous time his friend had bled from his nose and mouth at the shock of seeing the body. He stated: “**To much people dead in Croatian waters and Slovenian waters**”. After 10 days walking, they reached Slovenia, but on the Italian-Slovenian border they were apprehended. Despite stating that they were trying to claim

asylum, they were driven back to Croatia and pushed back to Bosnia. Severe violence was used, and the respondent was **left with mental health problems and severe insomnia**.

**In August 2022**, a father from Cuba described how his family was pushed back to Bosnia. They were driven for around 2 hours. **The 4-year old daughter was not permitted to leave the van to go to the toilet**, and eventually wet herself inside the van. The father repeated several times during the interview that it broke his heart to see his daughter wet herself like this. At the time of the interview, two weeks after the incident, the father explained that his daughter was **still very affected by the incident, and was afraid of leaving the camp in the evening**.

Another respondent **in January 2022** described being **ignored for hours whilst he tried to claim asylum**. The respondent describes this form of ignoring him as inhumane and hurtful. He was eventually forced to walk 3-4 hours back to Bosnia, to the same place he had been before the ordeal began. He felt as if they simply did not care for him as an individual, as a human being with rights and needs. He described that **the form of violence in this incident was not physical, but more of a mental kind**. Ignoring a human being for several hours and in doing that depriving a person of rights such as the right to claim asylum is a form of violence, the respondent feels.

### ONGOING EXPOSURE TO TERROR

*It has a profoundly harmful effect on mental health. Nevertheless, even in long-lasting situations of fear, a considerable proportion of individuals with elevated post-traumatic symptoms tend to recover gradually over time. Moreover, **prolonged exposure may intensify existing symptoms, and it can also contribute to the development of new cases of PTSD.***

**Source study**

## Symptoms of Mental Illness: Case Studies

**Repeated exposure to violence, fear, and trauma** can lock neuronal

pathways into patterns that exponentially increase the likelihood of people developing mental illnesses. Given the enormous amounts of suffering PoM endure at the hands of the border regime, it is not surprising that NNK psycho-social support teams often encounter individuals with **severe symptoms of mental illness**. In the field, we do not have the capacity to medically diagnose the PoM that we support with projects, especially given that individuals tend to spend short periods of time in one place. But overall, the repeated behavioral symptoms that we see across individuals are **consistent with serious mental health disorders**, such as Major Depressive Disorder, Borderline Personality Disorder, and PTSD. In the rest of this section, we will focus on a few individual case studies and link case notes from the field teams to specific mental health diagnoses and the general context of the border regime. We do this **not to provide definitive diagnoses**, but to show how specific behavioral patterns are consistent with both established diagnostic categories—most of which have already been linked to refugee populations’ structural conditions by [previous research](#)—as well as the broader violent context of the border regime.

## 2 PSYCHOLOGICAL RESPONSES TO BORDER VIOLENCE

- 01  
**Collapse pathway**  
Withdrawal  
Hopelessness  
Depression
- 02  
**Dysregulation pathway**  
Hypervigilance  
Aggression  
Substance use

Feelings of hopelessness, a lack of future prospects, and **losing the will to live** are common symptoms amongst PoM, and they are directly tied to the border regime's impact on people's lives. Case notes from one of NNK's psychologists (March, 2025) illustrate this point. A Syrian man in his thirties, residing in Harmanli camp in Bulgaria, was referred to the project by peers who had grown concerned about his wellbeing. From the outset of contact, he expressed a desire to disengage from life, stating that "**there was not much to talk about, he just sees no point to keep on living.**" His behavior was **consistent with Major Depressive Episode**: he had stopped leaving the camp, and when contacted would report that he would "*just stay in his room doing nothing,*" adding that he was "*not so interested in having interactions because he doesn't know anymore what to talk about.*" This behavior is consistent with **anhedonia, the loss of pleasure in social interactions** and other elements of daily life, which is a key characteristic of depression. Also present in the man's behavior was another core aspect of depression: hopelessness due to a perceived lack of future prospects. The notes record that "**he sees no future for him,**" a statement reflecting the complete foreclosure of forward orientation that characterises depressive hopelessness and is a **significant predictor of suicidal ideation**. Features consistent with **Prolonged Grief Disorder** were also present, most visibly in the moment he shared photographs of himself "*when he was younger and happy and full of ideas,*" a behavior that signals mourning of a former self and a rupture in identity continuity.

What is particularly relevant for this report is the degree to which his mental state was **shaped by the structural conditions produced by the European border regime** rather than any single traumatic event. Having fled Syria and accumulated approximately €40,000 in debt to fund his journey, he found himself **legally trapped in Bulgaria** following an asylum rejection at a time when applications from Syrian nationals had been suspended across much of Europe. The case notes describe a **condition of total entrapment: "he can't go on with his trip because nothing will change or his documents and the debt will increase; he can't go back neither to Syria or Turkey."** This removal of all viable options maps onto the psychological concept of **learned helplessness**, a well-documented cognitive pathway toward depressive disorders and suicidality. Even his living conditions compounded his mental deterioration; he described Harmanli camp as "*terrible and not even good for animals*," a characterization that points to the psychological toll of dehumanizing environments. **Research** indicates that **conditions which systematically deny dignity and agency** reinforce the perception that one's circumstances are permanent and uncontrollable, deepening the cognitive patterns associated with learned helplessness and depressive disorder. This case demonstrates how the structural conditions directly manufactured by the border regime--legal immobilization combined with materially and symbolically degrading living environments--can systematically erode a person's mental health, **stripping them of agency, dignity, and any meaningful orientation toward the future.**

Not all behavioral profiles follow the type of depressive collapse discussed above. Some people's response to the structural violence of the border regime go in the opposite direction: **hypervigilance, paranoid ideation, extreme mood swings, explosive aggression, and substance use** that both mediates and intensifies these symptoms. One case from Sjenica camp, documented between February and April 2025, presents a clinical picture consistent with Emotionally Unstable Personality Disorder, paranoid ideation, and Substance Use Disorder. According to the case notes, his person formed intense attachments to female-read volunteers, referring to them as sisters, mothers, or wives, and on one occasion carving a volunteer's name into his own arm. These behaviors, alongside his frequent references to his sick mother, must be read against the backdrop of forced migration and the border regime, which **systematically ruptures family bonds**, strips individuals of their attachment figures, and **traps people in limbo**, leaving them unable to either go back to their families or move forward to places where they can earn enough money to provide for them. The notes also document a recurrent paranoid response to being photographed. On one occa-

sion, a volunteer taking a selfie nearby was immediately interpreted as a deliberate attempt to capture his image for the "scientific police," triggering an escalating aggressive episode that ended in a physical altercation. In the context of the hypersecuritized border regime, where identification and surveillance carry very real consequences for PoM, this **hypervigilance around cameras could very likely have emerged as a survival response.**

Another set of case notes from activists at one of community centers in the Balkan route follows a PoM for more than half of 2025. "A long-time figure in the Balkan route," this person's behavioral profile is consistent with Emotionally Unstable Personality Disorder and Substance Abuse Disorder, operating in a mutually reinforcing manner. The most clinically distinctive feature of this case is a **recurrent cycle of violent outburst followed by immediate remorse and apology**, which becomes particularly pronounced when this individual uses alcohol. This pattern was documented across multiple incidents, with "**feelings of rejection and injustices**" being noted as major triggers for outbursts.

This sharp back-and-forth between **aggression and shame** indicates that violent behavior is not pre-meditated but rather stems from impulsivity and **emotional dysregulation**. These types of aggressive outbursts are consistent with Dr. Gilligan's, a psychiatrist that spent decades working in prisons, influential account of violence as a maladaptive coping mechanism. According to Gilligan, violent behavior often emerges as a type of last resort, when individuals have exhausted all other options of preserving a sense of dignity and agency in the face of chronic humiliation and violence. The fact that the person in question here also verbalized the will to commit suicide reinforces the suspicion that this person has experienced extreme forms of humiliation and violence. A border regime that routinely subjects PoM to arbitrary detention, psychological abuse, and dehumanizing conditions continuously produces precisely the type of shame that can lead to this behavior, making dysregulated violence a predictable structural outcome.

The clinical literature on trauma assumes an event that ends. What the border regime produces is something categorically different: not a wound that heals, but a condition that compounds. When someone survives a fire or a tsunami, the ambulance arrives with psychologists and social workers. Protection alternatives are mapped. The state mobilises because it recognises a catastrophe worthy of response. A person beaten, robbed, and pushed into a river at the Croatian border receives nothing of the sort. No psychological support. No pro-

tection assessment. No recognition that something irreversible may have just happened. The violence is treated as routine – and because it is treated as routine, it becomes routine, repeated, compounded, absorbed into the body as a permanent state of emergency. **Border violence functions as a mechanism of reconfiguration of the social order: subjects experience themselves as existing outside of a recognized category of persons whose rights, dignity and suffer matter.** The outcome is a landscape of **continuous trauma: manufactured by national and international policy and enacted by racist and violent border forces.**



**CH.06**

# **THE AMBULANCE THAT NEVER CAME**

**When life-saving infrastructure  
becomes a tool of migration control**

**Access to healthcare, particularly in cases of emergency, is not a privilege but a fundamental right under human rights and national legal frameworks.** Despite these obligations, in practice PoM across the EU, Balkans, and Mediterranean routes **are frequently denied urgent medical assistance.** Authorities refuse to call ambulances for people in critical condition, lifesaving medication is withheld, people are rejected from hospitals, and patients face discrimination in triage systems. In many cases, **healthcare providers collaborate with border forces to exacerbate violence.**

# 13 %

*of all testimonies report denial of healthcare, neglect, or mistreatment*

In the period of analysis, from January 2022 to June 2025, **these practices of neglect and mistreatment appeared in 13% of all testimonies.** We note, once again, that NNK's border violence monitoring has a survival bias: **The denial of professional intervention, particularly to those in critical conditions, can and does cost lives,** and often those stories are absent from reporting mechanisms.

What emerges from the following testimonies is not a gap in provision, but **a systematic practice that is embedded in border enforcement.** Denying medical intervention, and mistreating migrant patients, seems to serve as a feature of deterrence doctrines: the refusal to intervene leaves people trapped in a handicapped state, and traps the lives of PoM in the threshold of death.

## Ambulance denials

Access to ambulances is one of the most basic forms of emergency healthcare. **Yet, even in life-threatening situations, authorities on the Balkan and Mediterranean routes have refused to call ambulances or even blocked the efforts of others to call ambulances.** This occurs most frequently in the context of pushbacks, but also during search and rescue operations, when people fall ill in police custody or detention, and for people in reception centres. For example, on January 30, 2025, a man swam to the coast of Ceuta and collapsed from exhaustion upon arrival. **NNK activists witnessed** that the man was hit with batons by police and denied medical intervention. No ambulance was called, despite his evident medical emergency and risk of severe hypothermia. The NNK team in Ceuta inquired about him at the CETI (Reception Centre), but he had not been seen since, raising concerns that he had been pushed back to Morocco.

Similarly, a 39-year-old man from Kurdistan reported issues accessing healthcare during his deportation from Germany to Bulgaria. He recalls an ambulance being called only when he was in acute respi-

ratory distress due to asthma. Until that point, the police ignored his condition. Incidents such as this have become commonplace in deportations, with authorities prioritising the time constraints of the deportation over the person's health, to the point of serious injuries. **In one case of a deportation from the Netherlands**, the respondent had an infection so serious he needed to be taken to the hospital, but the IND (Immigration Department) refused in case it delayed the deportation. The airline crew then found him unfit to travel. Similarly, activists with **MiGreat in the Netherlands witnessed** a person being deported in May 2024 being suffocated to the point of passing out. Although an ambulance was eventually called, this was done so far too late in an attempt to ensure the deportation was carried out.

These cases illustrate a pattern in which ambulance intervention is not a neutral safeguard, but rather, is mediated by discriminatory - punitive logic. In these cases, **medical urgency is subordinated to control and deportation imperatives**. A key example of the deadly impact of this practice was reported on in the **Frozen Lives report**, as explored in Chapter 1: in January 2025. Bulgarian authorities not only refused to trigger ambulance responses for the three children at risk, but blocked the rescue efforts of activists, subjecting them to heavy criminalisation and degrading treatment. As a result, the three children died. In this instance, not only was the refusal to call an ambulance used as a punitive measure against the children in critical conditions, it also seemed to be used as a punitive measure against the activists who had attempted the search and rescue mission.

## **Discriminatory triage systems**

Even when ambulances are called, this does not ensure adequate treatment. Several testimonies reveal how, even when somebody received access to professional medical care, that medical care was rationed along racialized and exclusionary lines, transforming triage into a discriminatory tool rather than a protective one.

As previously mentioned, in November 2024, **NNK Activists met a seriously ill person on the move in Sid**. He had been ill for several days: his skin was yellowish, he had constant dizziness, chest pain, and a headache. The team decided to book an appointment with a private doctor, but the person passed out on the way there. An ambulance was called. EMTs immediately asked for his ID and did not do a proper assessment (did not take all his vitals). They forced the person to stand up on his own, even preventing the team from helping. The team was not allowed into the ER examination room. No hospital staff spoke

English to the person and the person was let go quickly after an IV of saline solution and a medication which, from the description, did not seem related to his symptoms - although neither the respondent himself nor NNK received any medical record. Then the police took the person into custody and transferred him to Presevo (an open camp in the south of Serbia, 6 hours drive from Sid), where he was allowed to see a doctor only thanks to another association which we contacted to put pressure on the camp staff. He was transferred to different hospitals over a few days before ending up in intensive care for a week.

In Bulgarian camps, **respondents reported** that police officers and guards mediated access to doctors and routinely dismissed or mocked requests from PoM while prioritizing others. A man from Syria who suffered seizures due to a medical condition **described** how one officer recommended medical attention, only for another to insist that no medical care was required and instead physically assaulted him during an episode. Even when medical professionals were present, decisions about who was "worthy" of care reflected broader logics of exclusion. Broken bones, asthma crises, and head injuries were systematically deprioritized.

# 35 %

longer wait times for  
Black patients (US study)

This discrimination is not unique to migrants, but is compounded by the intersection of race, precarious legal statuses, and a lack of access to national healthcare or health insurance structures. **A study in the US has revealed** that "patients identifying as Black, Hispanic, and Other tend to have less acute triage scores than their White peers". **Black patients with substance abuse disorders are likely to wait 35% longer in emergency care than white patients with the same disorders.** In the UK, a study has found black patients wait longer for all forms of care. For undocumented and illegalised people, a general doctrine of "**no papers, no treatment**" places hostile immigration policies above the lives of PoM.

These accounts demonstrate how triage itself became an instrument of violence — not a neutral process based on urgency, but one shaped by racism, securitization, and the erasure of the suffering of PoM.

## Medication withheld

In addition to withholding ambulance services, **confiscation or withholding of medication is a further practice that compounds the weaponisation of health in border violence.** Denying medication has emerged as a recurring form of institutional violence.

For example, a 37-year old Egyptian man **described to NNK reporters** that he was apprehended by police on the Bosnian-Croatian border in November 2024. The police took all their belongings and clothes, leaving them naked, and threw them all into a fire. Although the respondent had medication for his heart condition, which he had proof of, the police burned both his documents and his belongings, leaving him exposed to potentially fatal risks.



Other testimonies also demonstrate the systemic neglect of chronic illness. **For example**, a Kurdish man with asthma who needed inhaler therapy was denied medication during his deportation from Germany and after his arrival in Bulgaria, where **camp staff refused to help him access life-saving treatment**. On the French-Italian border, **in October 2024** local activists met a man with diabetes who was readmitted from France to Italy, despite having a valid residence permit. He described that when he asked to call somebody to get them to bring his medication, the French authorities

## II

### ***Did not listen and did not care.***

Access to medication is also commonly reported as restricted within formal reception facilities: In Lipa camp medication is limited to painkillers, iron tablets, and occasional antibiotics and in Busmantsi Detention Center in Bulgaria, medical care is limited to painkillers only. In case of chronic disease such as diabetes or heart related conditions and even cancer, access to these vital medicines (which are confiscated or destroyed by border police during pushback) is not granted nor

facilitated by the staff in the centers. In one instance reported to the NNK team in Bosnia, a patient with dependence on benzodiazepines and pregabalins was not prescribed anything to help them titrate the dosage down, leaving them at increased risk of seizures.

In all these cases, the denial of medication was not a passive oversight, but rather an active mechanism of control that exacerbates vulnerability and serves as a coercive tool within migration governance.



### Neglect of police-inflicted injuries

Many respondents described being beaten, kicked, or tortured, only to have their injuries ignored by medical staff or authorities. Broken bones, lost teeth, and bruising were dismissed without treatment.

In one case, [a 24-year-old Tunisian woman](#) broke her foot after being pushed violently by Croatian police. **Officers refused to take her to the hospital and mocked her cries for help.** She finally received treatment once she returned to Bosnia. [Another account from Bulgaria](#) describes a Syrian man in need of urgent care after a police assault. Officials refused to transfer him to hospital, leaving his injuries untreated until he was pushed back across the border. [In another case](#), a 21-year old Algerian man suffered a car crash, and then beating and electric shocks from the Bulgarian border police. Two of his teeth were broken and his wrist and ankle damaged, but the doctor in Harmanli camp (where he was taken to) **refused to examine him and instead insulted him.** A 27-year-old man from Morocco [was beaten](#)

**up so severely** by Serbian police that his leg was broken, but when he was examined by a doctor this doctor said that he was fine. He stated: Perhaps deriving from an willingness to face the consequences of their

||

***They did not beat us up to beat us up, but to kill us.***

own violence, police brutality is compounded by a refusal to acknowledge injuries.

This neglect can also happen within healthcare facilities: a 30-year-old man from Syria **suffered a skull fracture from police violence in Serbia**. The respondent was denied admission to a Belgrade hospital due to a lack of insurance. These examples demonstrate **how state actors and medical institutions collude to erase responsibility for violence and normalize police-inflicted injuries as unworthy of care.**

## **Collaboration with border forces**

Testimonies also reveal how medical encounters became sites of humiliation, neglect, and further violence, as healthcare providers collaborate with border police. In Bulgaria, a 31-year-old from Syria reported that the camp doctor only gave out painkillers without examining patients, while police controlled access to care. Other respondents described visible bruises, broken teeth, and fractures that doctors in camps or detention centers refused to examine. **This refusal effecti-**



vely normalized violence by omission. **In one particularly brutal case in Serbia**, officers mocked a Syrian man while beating him, saying:

||

***We are doctors. We will treat you.***

before inflicting electric shocks on his body. Police forces, whilst supposedly entirely separate from healthcare structures for the main population, mediate migrants' access to essential healthcare.

Multiple respondents report being pushed back from hospitals. For example, a 35-year old man from Afghanistan described that he fell unconscious during a pushback, and woke up inside a hospital. Two officers told him to get up, made him get dressed, and stole his phone and money. He was taken to the police station, and only given one biscuit and a small cup of juice over the course of 5 hours. He was given a piece of paper to sign, the officers demanded that he did not read it but just signed it, and he was pushed back to Bosnia.

Language barriers compounded this violence. In Croatia, for example, **an Iranian man who suffered a heart attack** in detention was taken to the hospital, returned to his cell, and denied a translator while being pressured to sign documents he did not fully understand. **These practices transform medical intervention into another form of coercion**, where the denial of examinations and the lack of interpreters serve to perpetuate violence under the guise of healthcare.

## Repatriation of Bodies

When tragedies do occur and people become injured or even die, those around them also suffer psychologically. Death, for most people, is followed by ritual. A body washed and prepared. A community gathered. Words spoken over a grave or a pyre. The specific form varies across cultures and traditions – but the shared function is constant: **to mark the end of a life with dignity**, and to allow those who loved the person to grieve.

For people who die in transit, in reception centres, in detention facilities, or in hospital rooms where no one knows their name, **that ritual is almost always denied**. Repatriating a body across international borders is **slow, expensive, and bureaucratically complex** under the best of circumstances, and often an institutionalization of the inci-

dent takes place - where various different involved agencies, embassies, healthcare providers, and government actors **pass the case from pillar to post**. For families of people who died without documents, in contexts where authorities are reluctant to acknowledge the circumstances of the death, the barriers are categorically different. Deaths go unreported for days. Official causes of death are recorded in ways that obscure what actually happened. Consulates of origin countries may lack the capacity or the will to advocate for families without resources. And those families may have **no legal mechanism to compel action, no lawyer, no money**, and no one in the country of death formally obligated to represent their interests.

In July 2025, **NNK wrote an open letter to the European Commission, D.G. for Enlargement and Eastern Neighbourhood, and the EU Delegation in Serbia**. Within a period of just seven months, **four young people had died** as a result of the gross negligence by camp authorities. All four men, well known to members of our organisation and to those who come to the community centre in Sjenica each day, died **preventable deaths** at the hands of an institution that claims to offer protection. These deaths have raised urgent questions about medical oversight and potential human rights abuses taking place in Sjenica AC. It is also apparent that these deaths have had a serious psychological toll on other residents of the camp: multiple residents have reported to us (NNK field teams) that they are **afraid they will be next**. These fears are not unfounded: Sjenica AC is **grossly unsanitary** to the point that its conditions are degrading, access to services are virtually non-existent, and **healthcare provisions are entirely inadequate**. Suspicious circumstances surround all these deaths, in particular the professional misconduct of the General Practitioner employed by the AC, such as the administration of medication without informing residents what they are being given, lack of access to appointments for residents and no clear schedule of the doctor's working hours, and extended periods of absence with no doctor present at all.

As the introduction of this report also shows with the case of Mukter - a 41 years old who was pushed back from Croatia to Bosnia and died of his injuries - these conditions kill. **At 17:15 on 23 November 2025, Mukter died in his bed. There was no funeral, no repatriation of the body.**

This abandonment is, in general, the norm for those that die on Europe's borders. Bodies are buried in local cemeteries, sometimes in **graves marked only with a number**. Families are notified late, if at all, and the psychological consequences are profound. Grief research consistently identifies the presence of a body, the performance of funeral

rites, and communal mourning as critical to what clinicians call adaptive grieving. When those elements are absent, the result is frequently prolonged grief disorder: an inability to process the loss, a persistent sense of unreality, and lasting psychological impairment.



*An unmarked grave near Patras, January 2022.*

The impossibility of these rites is experienced not only as loss, but as desecration. **This violence continues after death**, visited on the living who cannot grieve. It is almost entirely absent from policy discussions. Deaths are counted, sometimes, in aggregate figures. But the cascading consequences for families left **without a body, without a grave, without a funeral**, are rarely documented and almost never addressed. They are the invisible wound left by a system that treats people as problems to be managed and, when they die, as incidents to be contained.

## **Rotten borders and rotten institutions**

What the testimonies in this chapter reveal is not a healthcare system failing to reach PoM. It is **a healthcare system that has been repositioned** – through policy, through institutional culture, and through the daily choices of those who operate it – **to function as an extension of the border**. The triage room that applies a racial logic. The camp doctor who withholds treatment pending paperwork. The officer who mocks a dying man from the doorway. **The ambulance that doesn't come**. Then, when death is the final outcome, an administrative structure so complex it is impossible for the grieving to navigate, and **proper burial does not take place**.

A retired national who has never paid into the system receives emergency care without question. A Western tourist — Canadian, German, Belgian — who collapses on a beach gets an ambulance before anyone asks for their insurance card. Nobody imagines otherwise. Some institutions claim that healthcare is a finite resource, or that the systems are too under pressure; but the variable is not contribution, not legal status, not fiscal legitimacy. **The variable is race and origin.** What is withheld from PoMis not rationed by scarcity. It is rationed by a racial order that has decided, in advance, whose life is worth saving.

**None of this is a malfunction.** It is the border regime operating beyond the fence, **using the denial of care as a final instrument of deterrence.** If a person survives the forest, the river, the beating, and the camp — **they will still have to survive the doctor.**

# CONCLUSIONS

Between 2014 and the end of 2025, IOM's Missing Migrants Project recorded 45,096 people dead or missing on migration routes to Europe — an average of 3,758 each year. Expressed as a mortality rate, this amounts to roughly 0.84 deaths per 100,000 people annually: comparable in scale to tuberculosis mortality in the EU and EEA in 2023.

Across the six chapters of this report, we have traced how this deterrence regime manifests itself on Europe's borders. The comparison is not epidemiologically equivalent — but it reveals something politically precise: border enforcement functions as a powerful determinant of health, and the healthcare system itself can play a key role in exacerbating border violence.

Europe already knows how to respond when preventable deaths are treated as politically intolerable. It mobilises research, funds treatment, and directs enforcement against perpetrators instead of those at risk. The death toll on migration routes has not produced the same response because it has not been treated as the same kind of problem. It has been treated, largely, as a feature.

The documentation in this report confirms the central hypothesis: that being blocked from care is not a peripheral failure of Europe's border regime, but one of the mechanisms through which it operates. Three main findings support this conclusion:



## **Finding 1:**

**Border violence is systematic, pervasive, and deliberately injurious.**

64% of NNK's pushback testimonies document heavy beatings — fractures, head trauma, permanent eye injuries, blows to the throat and chest. Based on an estimated average of 221 pushbacks per day in 2025, the real number of people affected by police beatings may exceed 50,000 annually. 44% of testimonies record authorities aban-

doning people in rivers, forests, and remote locations. 36% document denial of food and water in custody.

The violence described in this report is expressed not only through immediate injuries but through a broader system that produces illness en masse, exacerbates chronic conditions and vulnerabilities, and generates widespread psychological trauma. The public health crisis along Europe's migration routes are therefore inseparable from the political and institutional policies of the European border regime. It is a pattern that predictably produces injury, and then relies on the denial of care to complete the harm.

### **Finding 2:**

#### **The denial of healthcare is not a gap — it is a tool.**

Healthcare denial appeared in 13% of all testimonies analysed, a figure that almost certainly undercounts reality given the survival bias inherent in documentation. 54% of first aid treatments provided by NNK in 2025 involved walking-related injuries sustained on routes that only exist because safe alternatives have been shut down. Medication is burned alongside phones and documents. Ambulances are refused. Triage systems consistently deprioritise PoM. A doctrine of "*no papers, no treatment*" places hostile immigration policy above the right to life.

This report documents, chapter after chapter, a coherent regime of harm. Border violence damages the body, mind and soul; degrading living conditions deepen that damage; denial of care ensures it endures. The border does not end at the fence. It reaches into the triage room that looks the other way, the camp doctor who refuses new arrivals, the ambulance that doesn't come.

Mukter Hossain died in Lipa because guards were eating dinner. Ahmed Samra, Ahmed Elawdan, and Seifalla Elbeltagy — seventeen, sixteen, and fifteen years old — froze to death in a Bulgarian forest while authorities blocked the people trying to reach them. A 27-year-old Syrian man died of a heart attack in Sjenica while staff waited for him to formally request care he was no longer capable of requesting. These deaths were not failures of a broken system, but of a system working as designed.

**Finding 3:****This violence follows a racial order.**

The targeting of the most vulnerable, such as people with pre-existing conditions, unaccompanied minors, pregnant women, people with disabilities, is foreseeable, documented, and in many cases explicit. The EU has for years incentivised and institutionalised pushbacks, funding accession states willing to display extreme shows of force, while Frontex has curated an institutional culture of under-reporting. Certain bodies are deemed less worthy of protection. The denial of an ambulance, the withholding of insulin, and the burning of prescription medication are all expressions of the border regime.

For healthcare providers, these findings carry significant ethical and professional implications. Medical practitioners are often amongst the first to encounter the physical and psychological consequences of border violence. Treating these injuries is essential, but clinical care alone cannot address the conditions that produce them – particularly when that clinical care is not contextualised within a need for accountability and community action to reduce trauma. As well as delivering harm, that harm must be documented, professionals must advocate for true medical neutrality and ensure that access to healthcare is not conditional on migratory status. Healthcare professionals must play a more proactive role in tackling this healthcare crisis at its core: the violent and racist policies of the European border regime.

That regime can be unmade. But unmaking it requires first calling it what it is: not a crisis, not a failure, not a gap, but a policy. A policy with authors, with budgets, with institutional defenders, and with victims whose names we all are still learning. Healthcare denial at Europe's borders is one of the instruments through which a deterrence architecture reproduces itself: engineered, funded, and defended by institutions that have chosen securitisation and xenophobia over the right to health.

Blocked from care is not an accident at the edge of the system. It is one of the system's methods.

**Recognising that is not the end of the work. It is the beginning.**

# POLICY RECOMMENDATIONS

## POLICY RECOMMENDATIONS: FROM EVIDENCE TO ACCOUNTABILITY

The evidence presented in this report is the result of **4 years of documented and cross-verified data collection**, grounded in even more years of field presence. As this report has traced, the deaths, injuries, and suffering described here are the foreseeable consequences of political decisions – made in Brussels, in national parliaments, in ministry offices, and in the daily choices of those paid to provide care and protection. Accountability must reach every level of that chain.

The following recommendations are addressed to specific actors, with specific obligations, and specific mechanisms for enforcement. General calls for “*more attention*” to migrant health are insufficient. What is needed, **legally, morally, and politically**, is action.

### I. EUROPEAN INSTITUTIONS

#### European Commission – DG SANTE & DG HOME

- Establish a binding legal framework making emergency healthcare access for all people on EU territory an enforceable right, with sanctions for member states that systematically deny it. Fully operationalise the ‘*health in all policies*’ approach mandated by Article 168 of the Treaty on the Functioning of the European Union (TFEU), ensuring that all migration policy proposals are subject to systematic health impact assessment before adoption. In this regard, the Commission must also include a specific and urgent review of the forthcoming deportation law, negotiations for which are advancing rapidly and whose expected health impacts require pre-legislative scrutiny.
- Affirm the primacy of the EU Charter of Fundamental Rights over migration law, with specific reference not only to the

right to health, but to access to justice, the rights of the child, and the rights of persons with disabilities. Those who have experienced the violence documented in this report are victims with enforceable rights under EU law, notably the Victims' Rights Directive and the Violence against Women Directive. The EU's ratification of the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) further strengthens the legal basis for action, given the strong findings in this report on sexual violence at borders.

- Commission an independent audit of healthcare provision in all EU-funded facilities – Lipa TRC, CARA di Gradisca, Harmanli, Busmantsi, Krnjača, Sjenica, Šid, Sombor, and Preševo.
- Require **healthcare impact assessments** for all new migration policy proposals, including the **EU Pact on Migration and Asylum** and the Returns Regulation, with specific attention to the health consequences of the “fiction of non-entry” doctrine.
- Condition all EU migration management funding – including IPA funds, AMIF contributions, and Frontex operational budgets – on verifiable compliance with minimum health standards, with suspension for non-compliance.
- Mandate that IOM and other implementing partners include healthcare monitoring and death reporting in all operational agreements, with publicly reported quarterly health indicators.

### European Parliament – LIBE & DROI Committees

- Open a formal parliamentary inquiry into the systematic denial of healthcare at Europe's borders – beginning with the **death of Mukter Hossain at Lipa TRC on 23 November 2025** and the **deaths of three Egyptian minors in Bulgaria in January 2025**.
- Invite NNK and partner organisations to provide formal testimony to **LIBE** and **DROI**, establishing a regular mechanism for civil society evidence to feed into parliamentary oversight.
- Legislate mandatory independent healthcare monitoring in all EU-funded migration facilities, with real-time public reporting on ambulance response rates, medication availability, and doctor-patient ratios.
- Initiate infringement procedures against Croatia, Bulgaria, and Greece where documented evidence of systematic pushbacks and denial of care reaches the threshold of state-level human rights violations.
- Pass a resolution formally recognising border violence as a public health crisis, triggering obligations under the EU's health security framework.

### European Ombudsman

- Accept complaints from civil society on behalf of individuals denied healthcare in EU-funded facilities, regardless of their documented status. See: [European Ombudsman](#).
- Investigate IOM and other implementing partners in facilities where deaths have occurred following documented denial of care – beginning with Lipa TRC and Sjenica Asylum Centre, where a 27-year-old Syrian man died of a heart attack in May 2025 after staff refused to act without his explicit request, despite clear signs of incapacity.

### Council of Europe – Commissioner for Human Rights, CPT & PACE

- Conduct emergency visits to Lipa TRC, Harmanli, Busmantsi, Krnjača, and Sjenica with immediate publication of findings and binding recommendations to the respective states. See: [Commissioner for Human Rights | CPT](#).
- Allow civil society organisations to formally trigger CPT visits based on documented evidence of systematic medical neglect, without requiring individual victims to file complaints.
- Issue a formal legal opinion on whether the [“fiction of non-entry”](#) under the EU Pact is compatible with Article 3 of the ECHR.
- Publicly caution Croatia, Bulgaria, and Serbia for systematic denial of healthcare without accountability measures.
- Ensure that the ongoing [PACE report on Migrants’ and Refugees’ Access to Healthcare](#) (Rapporteur: Pelin Yilik, mandate 2025–2027) draws directly on field-based evidence from civil society. NNK formally requests to be heard as part of the consultation process, and calls on the Rapporteur to include Lipa TRC, Sjenica, and Harmanli in the fact-finding mission planned for 2026.

## II. NATIONAL GOVERNMENTS

### Ministries of Interior and Migration

- Immediately cease all pushback practices that leave people unable to access medical care – including Croatia’s documented practice of pushing people back barefoot into rivers in sub-zero temperatures and [burning their medication and documents](#).
- Establish legally binding minimum healthcare standards in all reception and detention facilities, with independent monitoring, public reporting, and criminal liability for facility directors who knowingly deny emergency care.
- Repeal legislation restricting undocumented people’s healthcare access, including [Italy’s Meloni-era decrees](#) and [France’s budget](#)

- cuts** to undocumented health access.
- Explicitly prohibit laws requiring healthcare providers to report undocumented patients. Reporting obligations are not new: in Germany, they have existed since the 1990s under the Residence Act (see [PICUM factsheet on reporting obligations and firewalls](#)); in Sweden, a [legislative proposal introduced in March 2026](#) would extend similar obligations (see also [researchers' analysis of racial profiling risks](#)). Such obligations are incompatible with the Council of Europe's [ECRI General Policy Recommendation No. 16](#) on safeguarding irregularly present migrants from discrimination, and must be repealed.

### **Regional Health Authorities**

- Issue binding guidance to all healthcare facilities that undocumented status is never grounds for denial of emergency care, in line with [CESCR General Comment No. 14](#).
- Establish confidential reporting channels for healthcare workers pressured to deny care, with whistleblower protections and formal investigation obligations.
- Create dedicated training programmes for emergency medical staff on the health needs of PoM in all regions with significant transit or reception populations.

## **III. DONOR STATES**

The facilities documented in this report are not self-funded. They exist because European states wrote cheques. That financial relationship creates legal and moral obligations that do not disappear once the wire transfer is complete. Funding a facility where a man dies because guards were eating dinner is not a neutral act of humanitarian generosity. It is co-responsibility – and it must be treated as such.

[Lipa TRC, Bosnia and Herzegovina](#) was built and operated with funding from the European Union (€1.7 million, principal donor), Germany (THW), Austria (Federal Ministry of Interior and Austrian Development Agency), Switzerland, Italy (Ministry of Foreign Affairs), and the Council of Europe Development Bank. Mukter Hossain died in a facility their money paid for.

[Serbia's asylum and reception centres – Krnjača, Sjenica, Šid, Sombor, and Preševo](#), where NNK has documented starvation, denial of medication, ambulance refusals, and at least one preventable death – have been funded primarily by the European Union (over €40 mi-

llion since 2015), with Germany and Austria contributing bilaterally, and IOM, UNHCR, UNICEF, and the Danish Refugee Council as implementing partners.

**Harmanli and Busmantsi, Bulgaria** — where NNK has documented denial of medication to a cancer patient, refusal to treat seizures, and conditions described by residents as comparable to Saydnaya prison — receive funding through AMIF and bilateral contributions from Switzerland (SEM), with operational support from UNICEF and IOM.

### European Union

- Suspend operational funding to Lipa TRC and Sjenica immediately, pending independent investigation into the deaths that occurred there.
- Make all future migration management funding conditional on binding health standards and enforceable conditionality, as required under the **EU's human rights conditionality framework**.

### Germany

- Commission an independent audit of all facilities receiving German bilateral contributions in the Western Balkans, including through THW's contribution to Lipa and AMIF co-financing in Serbia and Bulgaria, with public reporting of findings to the Bundestag.
- Review Dublin return practices: deporting people to Bulgaria while co-funding facilities where they face **conditions described as torture** is an inescapable contradiction that requires immediate policy review.

### Austria

- Suspend Dublin transfers to Bosnia and Bulgaria until healthcare standards in receiving facilities can be independently verified.
- Review all Austrian Development Agency contributions to migration facilities in the Western Balkans, with public reporting of findings.
- Make all future funding conditional on binding health standards with independent verification.

### Switzerland

- Conduct an immediate review of all **SEM-funded migration facilities** in the Balkans.

- Require IOM to report quarterly on health outcomes — including deaths — in all facilities receiving Swiss contributions.
- Attach enforceable health standards to all future funding agreements.

### Italy

- Acknowledge dual accountability: as a donor to Lipa TRC and as the operator of [CARA di Gradisca](#), where NNK's own investigation found hundreds of people living in overcrowded tents without adequate healthcare.
- Commission an independent audit of healthcare provision in all Italian-managed reception facilities, with public reporting.

### Holy See

- Publicly demand an independent investigation into Mukter Hossain's death.
- Make any future contributions to migration facilities conditional on verifiable healthcare standards and independent monitoring.

### Council of Europe Development Bank

- Require rights compliance audits and healthcare impact assessments as conditions of all future migration-related grants.
- Publicly report on any investigation into facilities it has funded where deaths have occurred, beginning with [Lipa TRC](#).

### UNICEF and Danish Refugee Council

- Formally document and report healthcare failures in [Serbian reception facilities](#) where both organisations operate, to relevant national and international authorities.
- Publicly advocate for minimum healthcare standards for all residents — not only children.

## IV. SPECIAL RAPORTEURS

### UN Special Rapporteur on the Human Rights of Migrants

- Request urgent country visits to Bosnia and Herzegovina, Bulgaria, Croatia, Serbia, and Greece with a specific mandate to investigate denial of healthcare as a component of border enforcement. See: [SR on Migrants](#).

- Issue formal communications to the governments of Bosnia and Herzegovina, Bulgaria, Croatia, and Serbia requesting information on the deaths of [Mukter Hossain](#) (Lipa, November 2025), the Syrian man who died at Sjenica (May 2025), and [the three Egyptian minors in Bulgaria](#) (January 2025).
- Produce a thematic report on the weaponisation of health as a migration control tool for presentation to the UN General Assembly.

### UN Special Rapporteur on the Right to Health

- Issue a formal statement recognising the systematic denial of healthcare to PoM at Europe's borders as a violation of the [right to health under the ICESCR](#). See: [SR on Health](#).
- Investigate the legal compatibility of the EU Pact – specifically the “fiction of non-entry” and the Instrumentalisation Regulation – with states' right to health obligations.
- Formally engage the European Commission on the health impact of deterrence policies, calling for mandatory health impact assessments as a precondition for new border enforcement legislation.

## V. HEALTHCARE WORKERS AND MEDICAL INSTITUTIONS

- Healthcare workers occupy a morally critical position in this system. Some are complicit in denial of care. Many others are prevented from doing their jobs by institutional pressure or the absence of protocols for treating undocumented people. All of them have obligations under [medical ethics](#) that precede and supersede immigration law.
- Medical associations across Europe must issue binding ethical guidance stating that no immigration law can override the obligation to provide emergency care, and that compliance with reporting obligations that put patients at risk is incompatible with medical ethics.
- Emergency medical services must adopt explicit protocols for calls from reception centres and border areas, with mandatory response times and accountability mechanisms for refusals.
- Hospital emergency departments in border regions must establish liaison roles with civil society organisations to ensure documentation requirements do not become de facto denials of care.
- Healthcare workers pressured to deny care must be legally and institutionally supported in refusing to comply.
- Medical faculties must integrate recognition of [torture injuries](#) and trauma-informed care into core curricula.

## VI. HUMANITARIAN AGENCIES

- **IOM** must publicly clarify its accountability framework for facilities where deaths have occurred following documented denial of care. Technical support without accountability for outcomes is not a morally or legally defensible position.
- **UNHCR** must formally review the Sjenica case – where its representatives declined to intervene on behalf of a man visibly alternating between consciousness and unconsciousness – and revise its protocols for medical emergencies in facilities where it operates.
- Both agencies must establish independent, multilingual, anonymous complaints mechanisms in all facilities, with mandatory follow-up, allowing residents to report denial of care without fear of retaliation.
- All humanitarian agencies present at borders and in facilities must develop shared, standardised protocols for documenting ambulance denials and medication refusals, creating an evidentiary record usable in legal proceedings and advocacy.

## VII. NATIONAL COURTS, PROSECUTORS AND OMBUDSPERSONS

- In **Bosnia and Herzegovina**, the prosecutor's office must open a criminal investigation into the death of Mukter Hossain, examining whether the conduct of Lipa TRC staff on 23 November 2025 constitutes criminal negligence or unlawful homicide under Bosnian law.
- In **Serbia**, the death at Sjenica in May 2025 must be formally investigated by the **Commissioner for the Protection of Equality** and the relevant prosecutor's office.
- In **Bulgaria**, the **deaths of three Egyptian minors in January 2025** – subsequently confirmed by **Frontex's own Fundamental Rights Office** to involve obstruction of rescue efforts – must result in criminal charges against those responsible.
- Individual accountability must reach all levels of the chain of command – from the camp guard who refused to call an ambulance while eating dinner, to the ministry official who approved staffing models that left medical emergencies without qualified personnel, to the state councils that funded facilities without monitoring compliance with basic rights standards.
- The ombudspersons of **Croatia, Bulgaria, Bosnia and Herzegovina, Serbia, and Greece** must open formal investigations into healthcare conditions in reception and detention facilities, transmitting findings to the European Commission and the Council of Europe for follow-up. **NNK's UPR submission on Bulgaria** provides a detailed evidential basis for the Bulgarian ombudsperson to act on immediately.

# CALL TO ACTION

## Journalists and media

- **Follow the money.** Request public funding data for all EU-financed migration facilities and report on the gap between donors' stated commitments to human rights and the conditions documented on the ground.
- **Investigate the financial flows** between European donor states, IOM, and facility operators — mapping who knew what, when, and what accountability mechanisms, if any, were triggered when people died.
- **Name those responsible.** Institutional violence thrives on anonymity. Where individuals — camp directors, guards, ambulance operators, hospital administrators — make decisions that result in preventable harm, journalism has both the capacity and the obligation to put names to decisions.
- **Cover deaths at borders as what they are** — not tragedies, not accidents, but the foreseeable outcomes of funded, documented, and accountable policy choices.
- **Platform survivors and witnesses.** The people with the most direct knowledge of what happens in these facilities are rarely heard in mainstream coverage. Seek them out, protect their identities where necessary, and let their accounts anchor the story.

## Civil society

- **Accompany people, always.** Be present at borders, in camps, in hospitals, and in courts. Presence is documentation. Presence is protection.
- **Document relentlessly.** Every ambulance denial. Every medication withheld. Every door closed in someone's face. Use standardised forms, secure platforms, and networks to ensure evidence reaches those who can act on it.
- **Assert rights in healthcare settings.** When accompanying people to healthcare facilities, assert their right to care in writing. Request written refusals. The right to emergency care applies regardless of status in virtually every European jurisdiction. Use it.

- **Support strategic litigation.** Cases before the **ECtHR**, national courts, and UN treaty bodies are among the most powerful tools available. Provide testimonies. Fund legal aid. Name those responsible.
- **Ask your representatives** what conditions are attached to bilateral migration funding. The money that funds Lipa TRC, Sjenica, and Harmanli is public money — and the people who pay it have the right, and the responsibility, to know what it is paying for.
- **Build coalitions.** The siloing of “*migrant health*” from “*border violence*” from “*human rights*” is itself a political choice that makes accountability harder. Bridge those silos across medical professionals, activists, lawyers, journalists, and communities — the work must continue.

# ACRONYMS

**AMIF** – Asylum, Migration and Integration Fund

**BVMN** – Border Violence Monitoring Network

**CARA** – Centro di Accoglienza per Richiedenti Asilo (Reception Centre for Asylum Seekers, Italy)

**CAT** – Convention Against Torture

**CEB** – Council of Europe Development Bank

**CESCR** – Committee on Economic, Social and Cultural Rights

**CPT** – Committee for the Prevention of Torture

**CRM** – Commissariat for Refugees and Migration (Serbia)

**CRPD** – Convention on the Rights of Persons with Disabilities

**DRC** – Danish Refugee Council

**ECHR** – European Convention on Human Rights

**ECRE** – European Council on Refugees and Exiles

**ECtHR** – European Court of Human Rights

**EMT** – Emergency Medical Technicians

**ER** – Emergency Room

**EU** – European Union

**EURODAC** – European Asylum Dactyloscopy Database

**EUROSUR** – European Border Surveillance System

**FRA** – European Union Agency for Fundamental Rights

**Frontex** – European Border and Coast Guard Agency

**GCM** – Global Compact for Safe, Orderly and Regular Migration

**ICESCR** – International Covenant on Economic, Social and Cultural Rights

**IOM** – International Organization for Migration

**MEP** – Member of the European Parliament

**MSF** – Médecins Sans Frontières /  
Doctors Without Borders

**NGO** – Non-Governmental  
Organisation

**NNK** – No Name Kitchen

**OHCHR** – Office of the United  
Nations High Commissioner for  
Human Rights

**PoM** – People on the Move

**SEM** – Swiss State Secretariat for  
Migration

**SFA** – Service for Foreigners'  
Affairs (Bosnia and Herzegovina)

**THW** – Technisches Hilfswerk  
(German Federal Agency for  
Technical Relief)

**TRC** – Temporary Reception  
Centre

**UN** – United Nations

**UNHCR** – United Nations High  
Commissioner for Refugees

**UNICEF** – United Nations  
Children's Fund

**UPR** – Universal Periodic Review

**WHO** – World Health Organization



**No Name Kitchen** (NNK) is a grassroots movement determined to transform Europe's racist and violent borders into safer and non-discriminatory pathways.

[www.nonamekitchen.org](http://www.nonamekitchen.org)

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