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Life in Immigration Detention Centers

An exploration of health of immigrant detainees in Sweden and three other EU member states

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Abstract
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Governments around the world use immigration detention to detain and deport irregular immigrants, which negatively affects their health. The aim of this thesis was to explore, describe and identify factors that could mitigate the effect of immigration detention on the health of detainees. This was a mixed method study using qualitative methods (Papers I and II), quantitative methods (Paper III) and descriptive case comparison (Paper IV) comparing the Swedish system to the system in the Benelux countries (Belgium, the Netherlands and Luxembourg). The study design was strengthened by triangulation of methods and data sources.

Detainees experienced lack of control over their own lives due to lack of information in a language they can understand, inadequate responses from detention staff and restrictions within detention centers further limiting their liberty. Duration of detention was negatively associated with satisfaction of services provided in detention and the detainees' Quality of Life (QOL). Detainees had low QOL domain scores with the psychological domain having the lowest score (41.9/100). The most significant factor positively associated with the QOL of detainees was the support received from detention staff. A sense of fear was present among detainees and staff. Detainees' fear was due to their inadequate interaction with authorities, perceiving it as threatening, and due to their worry of facing repercussions of being involved in incidents caused by others. The potential for physical threat from detainees created a sense of fear among the staff. The detention staff expressed the need for more support to manage their emotional dilemma and role conflict of being a civil servant, simultaneously enabling the deportation process while providing humane care to detainees as fellow human beings. Detention centers in the Benelux countries had more categories of staff providing different services to detainees. Compared to the Benelux countries, healthcare services at the Swedish detention centers were limited. Detainees were offered no medical screening on arrival and no regular access to mental healthcare professionals.

Detaining authorities have the obligation to safeguard the health of detainees. Challenges faced by the detention staff and detainees must be addressed to create a supportive environment and fulfill that obligation.

Keywords: Immigration detention, irregular migrants, asylum-seeker, detention staff, Quality of Life, migration and health, health promotion, European Union, Common European Asylum System, Sweden, Belgium, the Netherlands, Luxembourg

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To my Parents

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I Puthoopparambil SJ, Ahlberg BM, Bjerneld M. (2015) "A prison with extra flavours". Experiences of immigrants in Swedish immigration detention centres. *International Journal of Migration, Health and Social Care*. 2015;11(2)

II Puthoopparambil SJ, Ahlberg BM, Bjerneld M. (2015) ''It is a thin line to walk on''. Challenges of staff working at Swedish immigration detention centres. *International Journal of Qualitative Studies on Health and Well-being*. 2015 Mar;10

III Puthoopparambil SJ, Bjerneld M, Källestål C. (2015) Quality of life among immigrants in Swedish immigration detention centres: a cross-sectional questionnaire study. *Glob Health Action*. 2015; 8:28321

IV Puthoopparambil SJ, Bjerneld M. (2016) Detainees, staff and healthcare services in immigration detention centers: A descriptive comparison of detention systems in Sweden and the Benelux countries. *Accepted, Glob Health Action*. 2016

Contents

Abbreviations

Benelux countries	Belgium, the Netherlands and Luxembourg
CEAS	The Common European Asylum System
CoE	The Council of Europe
CPT	Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
EC	The European Commission
EU	The European Union
IOM	International Organization for Migration
QOL	Quality of Life
SMA	The Swedish Migration Agency
UNHCR	United Nations High Commissioner for Refugees
WHO	The World Health Organization

Definitions

Asylum-seeker
An asylum-seeker is an individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee in such countries is initially an asylum-seeker. An asylum-seeker is an individual seeking international protection (1).

Forced displacement/migration
Involuntary movement, individually or collectively, of persons from their country or community, notably for reasons of armed conflict, civil unrest, or natural or man-made catastrophes (2).

Irregular migrant
A person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. These individuals are also known as clandestine or undocumented migrants or migrants in an irregular situation. The term “irregular” is preferable to “illegal” because the latter carries a criminal connotation and is seen as denying migrants their humanity (2).

Refugee
An individual owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country ; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (Article 1(A.2); 3).

Rejected asylum-seeker
An individual whose asylum application is refused by the country where they have submitted a claim.

Preface

When I moved to Sweden, I wanted to familiarize myself with Swedish society and I decided to volunteer for an NGO. It is an irony that, through my volunteering, I got to familiarize myself with immigration detention, an unfamiliar aspect of the society to most of the people living in Sweden. This increased my curiosity and interest in the area to know more and to inform others. Through my graduate and under graduate education, I learned how genes and genetic mutations, and bacteria and viruses cause diseases and the efforts to tackle them. The more I got to know about immigration detention and health in detention, the more I realized that the ill-health in detention was not caused by naturally existing pathogens, but rather by the socio-political-legal system. The newbie I was, or still I am, in the field of public health, I thought it should be easier to fix the system than killing bacteria or modifying genes to reduce ill-health. I could not have been more wrong!

However, I believe that it was my naivety which helped me to ask questions, lots of them, and in my attempts to understand the system. I was lucky enough to have the kind of collaboration I had with several stakeholders from the beginning of the doctoral project. The project has benefitted very much from this collaboration, in identifying and discussing various challenges, and while developing recommendations. In a system as complex as immigration detention, a multi-stakeholder approach is the way forward and that is exactly what I have tried to convey through this thesis.

I have tried to understand health in immigration detention from various perspectives. I believe this has contributed to a better understanding and hopefully to better plausible solutions. I hope that you, as a reader, would find my thesis interesting and become better informed on how migration management systems could become more humane and cause less suffering, if any suffering at all, to immigrants who might have already suffered a lot.

Introduction

People have been migrating since the beginning of time, mainly in search of resources such as food, water and other raw materials in order to meet their basic needs and lead a better life. This has not changed much since. People still migrate for the same reasons; to lead a better life. However, the resources or conditions that people require to live have evolved. Nowadays, people do not migrate just for food or water, but rather to save themselves and their families from war and other forms of violence. There was a mass movement of people during the two world wars (4, 5). Although there is currently no ongoing world war, the number of people who were forcibly displaced in 2014 due to various regional conflicts is the highest recorded in the post-World War II era (6). Approximately 59.5 million people were forcibly displaced in 2014 and the majority of them live within their own countries (internally displaced persons) or in the neighboring countries as refugees and asylum-seekers. Although the majority (86%) of the displaced individuals are hosted in developing countries (6), the rest make it to various developed countries as refugees, asylum-seekers and sometimes as what is commonly referred to as irregular migrants. Europe and the Americas hosted around 3.8 million refugees in 2014, with Turkey hosting the majority, at 1.6 million refugees (6). In the same year, 570,800 new asylum applications were lodged in the 28 member states of the European Union (EU), with Sweden being the second largest recipient after Germany (7). Sweden received 81,301 asylum applications in 2014 (8) and has the highest number of asylum applicants per million inhabitants in the EU (9). In 2015, that number increased and Sweden received more than double the number of applicants in 2014; 162,877 asylum applications (10). The continuing increase in number of refugees and asylum-seekers in the world is set to surpass that number in 2015 (11)[1].

All countries have policies in place to manage the flow of immigrants into their territories. These could range from granting international protection to deportation and issue of entry bans. One of the most contested migration management policies is immigration detention. Immigration detention is defined as a *non-punitive administrative measure ordered by an administrative or judicial authority(ies) in order to restrict the liberty of a person through confinement so that another procedure may be implemented*

[1] At the time of writing this thesis, compiled statistics from 2015 were not available.

(12). Generally, an immigrant can be detained on the following grounds (13-15):

- An applicant for international protection (asylum-seeker) may be detained to:
    - Protect public order and national security.
    - Verify or determine identity.
    - Determine those elements of application that cannot be carried in the absence of detention.
    - Decide an applicant's right to enter the territory (usually at border checkpoints).
- An immigrant subject to return process may be detained if:
    - There is a risk that the immigrant concerned will abscond.
    - The immigrant concerned hampers or avoids the repatriation process to his or her home country or to another EU member state responsible for examining an application for protection.

Immigration detention in the European Union

Most of the immigrant detainees in the EU are detained as part of the return process (16). They are irregularly staying in the country or have exhausted the legal process of seeking asylum/protection and are issued with a return decision. Detention is to be used as a last resort (13-15, 17), and should be as short as possible. However, governments have been criticized for systematically using detention as one of the main strategies to manage irregular migration (17-21). The European Commission (EC) has recently introduced *A European Agenda on Migration* to effectively manage migration into Europe (22). One of the main aspects discussed in the agenda was the lack of an effective system to return irregular migrants and urged the EU member states to intensify the return process. Continuing the conversation, the EC later presented an *EU Action Plan on Return* where it states that the member states 'should' use detention, still as a measure of last resort, to meet their obligation to enforce return of irregular migrants and not to end detention prematurely, as long as there is a reasonable likelihood of removal (23). Following the discussions, the Council of the European Union adopted various conclusions on the future return policy in the EU, one of which was on the use of immigration detention (24).

> All measures must be taken to ensure irregular migrants' effective return, including use of detention as a legitimate measure of last resort. In particular, Member States should reinforce their pre-removal detention capacity to ensure the physical availability of irregular migrants for return and take steps to prevent the abuse of rights and procedures *(p.5)*.

All of these developments indicate that the use of detention will continue and thus it is important to ensure humane care and mitigate the effect of detention on the health of detainees.

The Common European Asylum System (CEAS) provides all EU member states a legal framework to ensure uniform management of asylum-seekers in the EU. The CEAS consists of three directives (Asylum Procedures, Reception Conditions and Qualification directives) and two regulations (Dublin and EURODAC regulations) (25). Denmark, Ireland and the United Kingdom are not part of the CEAS and are legally bound only by certain parts of the regulations and directives (16). Immigration detention is part of CEAS and articles 8–11 of the Receptions Conditions directive (2013/33/EU) (15) lays down the minimum standards that must be maintained while detaining applicants for international protection. The Return Directive (2008/115/EC) (14) is a legally binding instrument for all EU member states to ensure minimum common standards to return irregularly staying migrants. Articles 15–17 of the Return Directive lays down the minimum requirements that must be followed while detaining irregular migrants involved in return process. These are the two main directives regulating the detention of immigrants in the EU. The conditions of detention, as stated in the two directives (14, 15), can be summarized as follows:

- Immigrants should be detained in special detention facilities and not in prisons. If detained in prisons, immigrant detainees should be kept separate from ordinary prisoners and the conditions stipulated in the directives should be applied.
- Detainees should have access to open-air spaces.
- Members of UNHCR and NGOs, legal advisors and family members of detainees should have the possibility to visit detainees and communicate with them.
- Detainees should be systematically provided with information regarding their rights and rules applicable in the detention center. The information should be provided in a language that is understandable or is reasonably supposed to be understandable by detainees.
- Arrangements for essential treatment of illness and emergency healthcare should be provided to for the detainees.

Although not legally binding, EU member states are supposed to respect the guidelines and recommendations provided by international organizations to ensure the humane treatment of detainees. The Council of Europe (CoE) (26), the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (27), the International Organization for Migration (IOM) (28) and the United Nations High Commissioner for Refugees (UNHCR) (13) have issued such guidelines. In

addition to the conditions stated in the directives, the guidelines further emphasize and add the following terms:

- The staff working at detention centers should be carefully selected and trained.
- All newly arrived detainees should be examined by qualified health professionals such as doctors and nurses, and as a minimum a qualified nurse should be present at all centers on a daily basis.
- It is commendable if detainees are allowed to keep their mobile phones or have access to them to keep allowing detainees to communicate with their relatives or other relevant parties.
- Detainees should be provided with a *document*, in a language understandable or presumed to be understandable, explaining their rights and obligations
- Detainees should have access to meaningful activities such as educational/vocational training, opportunities for physical exercise and access to reading materials.

The directives and the guidelines state additional measures to be put in place while detaining vulnerable groups such as minors, unaccompanied minors and women.

Immigration detention in Sweden

The member states are required to transpose the EU directives adopted by the Council of the European Union and the European Parliament into their national laws (29). Immigration into Sweden is regulated by the Aliens Act (30) and relevant EU directives are transposed into the act. According to the act, the decision to detain an immigrant can be taken by the Government, the Migration Court, the Migration Court of Appeals, the Swedish Migration Agency or the Swedish Police (Chap. 10, Sec.12-17; 30). The Swedish Migration Agency (SMA) is responsible for all aspects of immigration into Sweden, starting from receiving asylum applications to enforcing deportation orders. The SMA is responsible for enforcing the detention (Chap. 10 Sec. 18; 30) and deportation orders (Chap. 12, Sec. 14; 30). The SMA could seek assistance from the police authorities in enforcing these decisions, if use of force is required for executing the decision (Chap. 10 Sec. 19; Chap. 12, Sec. 14; 30). The SMA runs all of the five detention centers in Sweden with a total capacity for detaining 255 immigrants (8) and is responsible for immigrants under its custody and provides services in the centers. All the detention centers have separate sections for female detainees where male detainees are not allowed. The maximum duration allowed for detention is 12 months. In 2014, a total of 3,201 immigrants, which included 335 women and 25 children, were detained in the Swedish detention centers

and the average duration of detention was eight days (8). There has been an increase in the total number of migrants detained during the past years (16).

Two detention centers (in Märsta and Kållered) of the five centers are located in the outskirts of major cities and the remaining three (in Flen, Gävle, Åstorp) are located closer to smaller towns. The biggest detention center is located in Märsta (capacity: 80), close to the Stockholm (Arlanda) international airport. Buildings used as detention centers and physical structures therein have almost no resemblance to prisons. This could be due to the fact that no prisons are used to detain immigrants and no former prison buildings were converted for use as immigration detention centers.

Detainee

Detainees who do not have access to their own money can receive a daily subsistence allowance of 24 Swedish kronor. All detainees are provided with food and other amenities such as hygiene products. They have access to the internet and can use mobile phones, if they are not equipped with cameras. Otherwise, the SMA provides detainees with a mobile phone without camera. Amenities such as pool tables, table tennis, video games and television are available to detainees. They have limited access to the courtyards. Detainees can receive visits in private visiting rooms at the detention centers. They have the right to public counsel paid for by the SMA while being detained (Chap. 18, Sec. 130). Staff members at the centers organize weekly meetings with detainees where they are given relevant information about the upcoming week. These meetings are also used as a platform where detainees can raise their concerns.

Non-Governmental Organizations (NGOs) visit detainees mainly to provide psychosocial support. Depending on the NGOs' profile, they may also provide legal information and assistance to detainees. Depending on the location (major city versus a small town) of the detention center, the number of NGOs visiting and the frequency of their visits may vary. Centers located closer to smaller towns receive fewer visits.

Detention staff

The two main categories of detention staff who come into regular contact with detainees are supervisors (handledare) and case officers (handläggare). Supervisors are mainly responsible for the social and practical aspects related to detainees' lives in detention. They socialize with detainees, provide information and organize games and other such activities for detainees and are responsible for providing food for detainees. They are also responsible for managing visitors and visits for detainees at detention centers. The minimum educational qualification required for being a supervisor is high school education and the applicant should have 'relevant' work/life experience. Case officers are responsible for the legal aspects of detention. They process and take decisions related to detainees' case and

their accommodation in the detention centers. They are responsible for the preparation and implementation of decisions, mainly deportations. This involves communicating with detainees and motivating them to cooperate with those involved in the deportation process. They contact and coordinate communication with public counsel, other units within the SMA, the Police and other authorities related to detention cases. The minimum educational qualification required for the job is a bachelor's degree, preferably in law, social sciences or behavioral science. Along with the supervisors, case officers are responsible for maintaining the safety and security of the centers, accompany detainees during their travel to hospital, airports and embassies. The staff work in teams and teams work in shifts. Each team has two or three supervisors and one or two case officers and a team leader. The team leader plans and assigns tasks and coordinates activities between teams.

The task of detention staff is to enable and assist the execution of various decisions related to detention and deportation while providing humane services to detainees. The staff does not wear uniforms. The staff receives basic mandatory training in safety and legal aspects related to detention. They can also receive training in communication techniques such as motivational interviewing, which is client focused, where detention staff motivate detainees (clients) to cooperate with those involved in the deportation process. Detention staff can be both permanently and temporarily employed. In some cases, it could be short-term employment, as in case of summer jobs. The temporary nature of this type of employment makes it difficult for them to receive training.

Healthcare

Healthcare in the detention centers is organized and provided by the county councils in which the detention centers are located. Detainees have the same right to medical care as asylum-seekers and other categories of applicants for international protection (30, 31). They have the right to medical care which cannot be deferred, maternal care, medical care related to abortion, and contraceptive advice (Sec. 6; 31). During the registration of detainees on arrival, they are asked by detention staff about any conditions such as allergies, food preferences or medical conditions that the staff needs to be aware of.

In practice, all detention centers, except one, have a nurse visiting the centers twice a week for three to four hours. One center has a nurse visiting five days a week. Another center has a doctor visiting, once a week, for three to four hours. The same center also has the option for a counselor to visit, if the nurse finds it necessary. No other centers have arrangements in place for mental health professionals to visit detainees regularly. Referrals to other healthcare professionals, including mental healthcare professionals, could be made by the nurse visiting the centers.

Sweden is considered by some to have better standards of immigration detention. There are less places of detention (16), limited use of detention for returning immigrants (32), detention centers are run by civilian personnel not wearing uniform, and they have a good physical infrastructure (33, 34). However, a systematic evaluation of immigration detention in Sweden and its effects on the health of detainees has not yet been done. As long as immigration detention continues to exist, it is important to continuously assess and take measures to minimize the negative impact of detention on the health of detainees. The detention environment and the detainees who live therein need to be explored to identify such measures.

Health in Detention

The process of migration can negatively affect an individual's health depending on the country of origin, transit countries, final destination (host country) and type of migration (regular versus irregular) (35, 36).

Studies have shown the prevalence of mental health disorders and other non-communicable and communicable diseases among immigrants, especially among asylum-seekers and refugees, who are forcibly displaced (37-44). Although some groups of immigrants may possess desirable health characteristics (healthy migrant effect) (36, 45, 46), such as healthier lifestyles or low prevalence of chronic diseases than the native population, restrictive policies in host countries based on legal status can further exacerbate existing health conditions or create illness (35, 46). Several studies have shown the negative health impact of restrictive policies such as temporary visas for refugees, limited access to healthcare or immigration detention (37, 47-50).

The negative health impact of immigration detention has been highlighted in several studies (51-53). Studies have shown high prevalence of mental health disorders such as anxiety, depression, post-traumatic stress disorder, suicidal ideation and self-harm among detainees (50, 54-58). Detainees expressed difficulties in sleeping, frustration, hopelessness and constant stress (58, 59). Lack of access to adequate healthcare in detention have resulted in deaths of immigrant detainees (52). Increased duration of detention was positively associated with exacerbation of psychological disorders (50, 54, 55, 60). The negative mental health impact lasts even after detainees' release (54, 58, 60, 61).

Before proceeding further, it is important to understand what 'health' means in the context of immigration detention. The most commonly known definition of health is from the World Health Organization (WHO).

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (62).

This definition of health has been criticized for several reasons. The main criticism is due to the word '*complete*' in the definition. Critics argue that by defining health as a *complete state*, the WHO disregard that individuals could cope and be healthy even when there is some degree of disease or infirmity (63, 64). The WHO definition also renders most of us unhealthy because it is unrealistic to have a complete state of wellbeing on all dimensions; physical, social and mental (63-65). According to the critics, the overarching definition of health by the WHO makes it difficult to operationalize, and measure and thus has limited practical application (64, 66). Regardless of the criticisms and alternative definitions of health (63, 64, 66, 67), the WHO's definition is still the most widely known and used definition of health and has been credited for explicitly stating that health is *not the mere absence of disease or infirmity* (63, 66). It is beyond the scope of this thesis to come up with a better definition of health. However, it is important to understand 'health' in the context of immigration detention centers in order to comprehend the thesis.

Health in confinement might be different from health in an unconfined setting. Lack of control, a result of confinement, has a negative impact on health (68, 69). Moreover, different cultures might have different interpretations of health (43, 70, 71). In immigration detention, both these concerns are valid because individuals are confined and come from different cultures. Hence, the idea of a 'complete' state of physical, mental and social wellbeing might have limited relevance in detention centers. Instead of considering health as a well-defined state of complete wellbeing, the process through which health is created, as stated by the Ottawa Charter for Health Promotion, was found to be relevant to the study context. The Charter has similarities to the ecological model where individuals and systems at various levels interact, enabling individuals to create, promote or maintain their health (72).

Conceptual framework: The Ottawa Charter for Health Promotion

The Ottawa Charter came into existence in 1986. According to the Charter, *'health is created and lived by people within the settings of their everyday life; where they learn, work, play and love'(73).* Hence, in order for an individual to attain health, their everyday life setting needs to support the health-creating process. The Charter is considered as one of the most important policy documents promoting and supporting the exploration of various actions and processes through which health is created (74, 75). The Charter describes how one could attain the 'complete' health defined by the WHO:

> To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment (73).

Health promotion is defined as the *process of enabling people to increase control over, and to improve, their health* (73). In order to guide health promotion activities, the Charter suggested five action areas and three strategies. The five action areas proposed by the Ottawa Charter are *build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services*.

Build healthy public policy

Health promotion goes beyond the healthcare sector and this action area puts health on policy makers' agenda at all sectors and levels and encourages them to consider the impact of their policies on health (73).The Second International Conference on Health promotion held in Adelaide, Australia states that the aim of a healthy public policy *is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens* (76). Examples of such policies are legislation making bicycle helmets mandatory and increased taxation for tobacco products aimed at reducing tobacco use (77). Health promotion activities should also strive to make healthier choices easy for policy makers as well (73). The policies should happen at all levels, not just at national level. De Leeuw and Clavier (78) postulate that often policy making process and creating conditions for healthy public policies have been easier to achieve at local level than at national level.

Create supportive environments

A supportive environment is vital for health. Such an environment should *encompass where people live, their local community, their home, where they work and play, including people's access to resources for health, and opportunities for empowerment (79)*. This includes physical, social, spiritual, economic and political dimensions (80, 81). A supportive environment makes it easier for individuals living within a given environment to improve their health through generating conditions that are enjoyable, satisfying, stimulating and safe (73, 77). Supportive environments, as described in the Ottawa Charter, have its roots in the socio-ecological framework (72, 73).

Strengthen community action

Community action for health is defined as the *collective efforts by communities which are directed towards increasing community control over the determinants of health, and thereby improving health* (79). The core of this action area is to empower the communities to control and own their endeavors and destinies (73). The participatory approach enables individuals

and organizations to influence the decision-making process affecting their health (73, 82). Depending on the setting, a community could range from a larger setting, such as a city (83) or islands (84), to a smaller confined setting, such as prison (82).

Develop personal skills

The WHO defines life skills, the building blocks for developing personal skills, as *abilities for adaptive and positive behavior, that enable individuals to deal effectively with the demands and challenges of everyday life* (82). By acquiring such skills, an individual will be able to control factors which affect their health and make choices that are favorable for good health. Personal skills could be achieved or improved through access to information, education and by enhancing life skills. Actions to improve personal skills should be implemented on various levels, starting from the home (73).

Reorient health services

This action area aims at refocusing the services provided through the health sector from a clinical and curative focus towards a health promotion direction, one that is more focused on preventive efforts and the creation of health. As in other action areas, these efforts need to be coordinated and mediated among various sectors and not only the healthcare sector (73, 79, 85). The care provided needs to be culturally sensitive and should consider the total needs of an individual. This necessitates changes in the organization of healthcare services and the provision of training for the healthcare professionals therein (73).

The three strategies put forward by the Charter are *advocate, enable and mediate.* Several factors, ranging from environmental and economic to personal factors, are considered as determinants of health (79). Through *advocacy*, health promotion activities should strive to make such factors favorable for health (73). The *enable* strategy emphasizes the importance of enabling individuals to achieve their fullest health potential. Enabling is frequently interpreted as *empowerment* (74, 86). In order to achieve their fullest health potential, an individual should be able to control the factors that determine their health (73). A non-discriminative supportive environment and resources such as access to information is necessary for this strategy to work (73). The Charter states that peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity are pre-requisites for health. As explained under the *Building Healthy Public Policy*, the healthcare sector alone cannot ensure the conditions and prerequisites required for the creation of health. Everyone involved in various aspects of an individual's everyday life has a stake in their health and the Charter calls upon professional and social groups and health personnel to *mediate* between these various stakeholders to create conditions favorable for health (73).

The strategies and action areas are interconnected and should operate in conjunction (76). For example, the *enable* strategy is a core part of the *develop personal skills* action area. Enabling individuals to achieve their fullest health potential is strongly rooted in a *supportive environment* (73). The skills of individuals are improved as part of the *develop personal skills* action area. However, if the e*nvironment is not supportive* and does not allow the individuals to use their newly acquired skills, those skills and their impact on health will be limited. The health promotion action areas and strategies need to be implemented at different levels. Jackson et al. (77) identifies three such levels; structural level, social or group level and personal behavior level. In their review of review articles and reports they cite several examples where health promotion strategies were implemented at all levels. For example, in the case of tobacco prevention programs, there should be a supportive environment to support health at the structural level (legislations/policies), at the social/group level (prevention programs at community level) and at the personal level (education programs, support and counselling) (77). Saan and Wise (86) suggest that the strategies, advocate, enable and mediate, each operate at various levels; *advocate for macro-level policy, enable people in their microspheres and mediate among institutions and organizations at meso-level*. However, these strategies need to be applied in combination, which is the holistic approach put forward by the Ottawa Charter.

A healthy setting is a key feature of the Ottawa Charter. Settings for health is defined as *the place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing* (79). The Ottawa Charter shifted the focus of health promotion activities from individuals or groups to their everyday life settings. The focus is on a given setting and the entire population within the setting rather than just on individuals or groups at risk (74). This is known as the settings approach, which makes it a feasible approach to be applied in a variety of settings such as islands (84), cities (83), hospitals (87) and prisons (88).

Based on the results from Papers I, II, III and IV, the Ottawa Charter is used to explore the detention setting and discuss the health-promoting and health-demoting factors present therein.

Aim

The aim of the thesis was to explore and describe the lives of detainees, and identify factors that could mitigate the effect of immigration detention on the health of detainees.

The specific objectives were:

- To explore and describe the perceptions and experiences of immigrant detainees in Swedish immigration detention centers (Paper I).
- To explore and describe experiences of detention staff in Swedish detention centers in providing services to immigrant detainees (Paper II).
- To assess the Quality of Life (QOL) of immigrant detainees in Swedish detention centers and to assess its relationship with services provided in the detention centers (Paper III).
- To describe policies and practices that could affect the health of immigrant detainees in the Benelux countries and compare them to the Swedish context (Paper IV).

Methodology

Research Design

I wrote my master's thesis in 2010, where I explored the lives of immigrant detainees and staff in one of the five detention centers in Sweden. The results from the master's thesis was presented and discussed with NGOs in Sweden and the SMA which led to the doctoral project presented here. The research team consisted of Magdalena Bjerneld RN, MSc, PhD (main supervisor), Professor Beth Maina Ahlberg (co-supervisor) and me. Associate Professor Carina Källestål supervised all activities related to Paper III.

The study (Papers I, II, III, IV) used a mixed methods design where different methods were used sequentially (89, 90) to achieve the aim of the project. The project was divided into two phases. The research design was emergent, allowing us to explore health in immigration detention during the first phase which guided the second phase (*Figure 1*). During the first phase, two exploratory qualitative studies (Papers I and II) were conducted on detainee and staff experiences in the detention centers in Sweden. In the second phase, two studies were conducted. The first study was a cross-sectional survey measuring the Quality of Life (QOL) among detainees in Sweden (Paper III). Based on the factors identified from the qualitative studies, detainees' satisfaction on services provided in the centers and its relationship with their QOL was also assessed. Factors important for the health of detainees in Sweden were identified from the first three studies. The second study in phase two (Paper IV) described how these factors were addressed in the Benelux countries and were compared with the Swedish detention policies. The study design was strengthened using triangulation of methods and data sources (91). This allowed us to increase the validity of the study results.

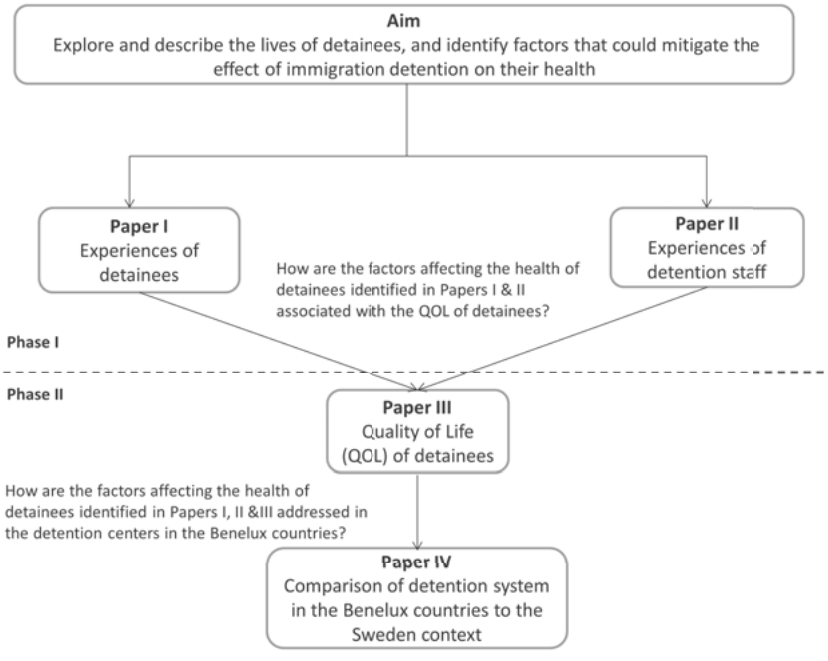

Figure 1. The emergent study design exploring the health of detainees and factors affecting it.

Project partners

The SMA, the International Organization for Migration (IOM) and two NGOs were partners in the project, each playing different roles. The SMA was a collaborating partner. Establishing trust and collaboration with the SMA was necessary to obtain access to the detention centers and to freely conduct data collection. Moreover, SMA is responsible for running detention centers in Sweden and hence it was important to have their input and thoughts throughout the project, especially while formulating recommendations to increase its feasibility.

The Migrant Health Division of International Organization for Migration (IOM), in Brussels, became a collaborating partner during the second phase. The partnership was mainly aimed at availing the IOM's expertise on reflecting the relevance of project results at EU level and to develop recommendations that are feasible. The IOM was also involved in collecting data during the fourth study (Paper IV).

NGOs play an important role in immigration detention. They mainly provide psychosocial support to detainees. The SMA and NGOs collaborate in addressing various challenges related to immigration detention and often NGOs have an advisory as well as a watchdog role. Two NGOs, Caritas Sweden and the Swedish Red Cross, were part of the reference group in the

project. These NGOs not only work with immigrant issues in Sweden, but also in other parts of the world. The reference group acted as a platform where the research team could critically reflect on the research process and findings in relation to the ever-changing migration scenario in the EU. The results and the progress of the projects were presented to the reference group regularly, at least every six months. During the second phase of the project, the Swedish Border Police also became part of the reference group.

None of the project partners made any financial contribution to the project or had any decision-making role during the research process, that is to say, the research design, participant recruitment, data collection, analysis, drafting of the articles or presentation of the results. However, the collaborative efforts and feedback received from the project partners helped us, the research team, to constantly assess and reflect on our findings and conclusions so as to ensure them to be relevant and practical in our efforts to mitigate the negative effects of detention.

This approach, involving stakeholders who are non-academic in the research process, is in line with the transdisciplinary approach (92, 93). Such an approach involves the engagement of academic disciplines and non-academic groups who have a major stake in the phenomenon being researched, providing a connection between research and the decision-making process. The research process should strive for recommendations that are feasible and should be based on perspectives from the affected groups (92, 93). The two main stakeholders in relation to immigration detention, the SMA and the NGOs, and the two affected groups, immigrant detainees and detention staff, were involved in the project. The transdisciplinary approach makes it easier to disseminate research findings among these stakeholders (92). We disseminated results from the project to the management and staff at the detention centers via several meetings and conferences. I presented the project results at four of the five detention centers. Additionally, the results were presented during two workshops where the reference group members, representatives of the IOM and the Council of Europe and the SMA staff working with various aspects of detention were present. Detention staff members were also present during these workshops. In addition to the dissemination of the results, these meetings provided us with feedback on our results and recommendations.

Study settings

Papers I, II and III

Data were collected from all the 5 detention centers in Sweden.

Paper IV

The study setting for the fourth study was detention centers in Sweden and the Benelux countries.

Participants and Data collection

Papers I and II

I collected the data through semi-structured interviews with detainees and detention staff separately in each detention center. The main supervisor and the co-supervisor took part in one detainee and staff interview, respectively. Almost two weeks prior to my visit to the detention centers, the management at the centers were informed of my arrival and received an information letter, in Swedish and English, containing information about the aim of the study, the upcoming data collection and the contact details for the research team. The information letter and an invitation to participate in the study were displayed on a notice board in the detention centers. It took me approximately one or two weeks to complete data collection at each detention center. During this period, I was present in the center from morning to evening where I invited detainees and staff, separately, to participate in the study. Data collection was carried out during the first half of 2012.

A total of 22 detainees (three women, 19 men) were interviewed. The inclusion criterion to participate in the study was a minimum duration of detention of two weeks and older than 18 years of age. Some detainees expressed their interest to participate in the study via detention staff, while some others expressed their interest to participate directly to me. During the visit I was present in the common areas such as the dining room, game room, television room and courtyard, where I invited detainees to participate in the study. Other detainees who participated were recruited through this method. In order to avoid invading detainees' privacy I refrained from knocking on the doors of their rooms and inviting them to participate. Once a detainee agreed to participate, a time convenient to them was agreed upon for the interview. Female detainees could choose to be interviewed by a female, the main thesis supervisor, if they preferred. None availed this option. Interviews were carried out in a private room at the centers and only the detainee and I were present. The interviews were conducted by me in Swedish or English. If required, authorized telephone interpreters from private companies were used during the interviews. The detainees were familiar with this method because public agencies in Sweden, such as the

SMA and healthcare centers use this method. All interpreters used in the study were briefed upon the nature of the study and type of questions that were going to be asked during the interview. Before starting the interviews, the participants were verbally informed about the study, the confidentiality of the collected data, the voluntary nature of their participation, and the absence of any benefits such as legal or financial assistance as a result of their participation. They also received an information sheet containing the abovementioned information and contact details for the research team. An interview guide consisting of questions on detainees' perceptions about the care received at detention center, their experiences of interacting with detention staff, lawyers, police and volunteers, their health in detention and general information about their stay in Sweden and detention was used to guide the interviews.

The inclusion criterion for detention staff to participate in the study was being employed for at least six months in any of the five detention centers in Sweden. Fifteen detention staff members (six females, nine males) participated in the study. Similar to detainees, interviews with detention staff were conducted in a private room. All interviews were conducted by me in Swedish or English. All participants were informed about the study, the voluntary nature of their participation, the absence of any benefits for their participation and that the data collected would be treated with confidentiality, before starting the interviews. The interview guide for detention staff consisted of questions on their opinion of the current detention systems, challenges (if any) in performing their jobs, what was good and bad about their job and their experience of the training and support provided to them by the SMA.

Paper III

Data were collected from all of the five detention centers in Sweden to assess detainees' Quality of Life (QOL) during September to November, 2014. The WHO defines QOL as *individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns* (94). It is a subjective assessment, assessed by individuals themselves, of their overall sense of wellbeing, physical and psychological health, personal beliefs, social relationships and their relationship to the environment they live in (95, 96). Data were collected using the Swedish and English versions of the WHOQOL–BREF questionnaire (94, 95). We used only Swedish and English questionnaires and availed the services of authorized telephone translators when participants could not understand either of those languages. Although the questionnaire was available in some of the other languages spoken by detainees, it was not available in all languages spoken by them. Moreover, I administered the questionnaire and because I could only understand English and Swedish, it would be difficult for me to explain to

the interpreters a questionnaire written in any other language. In addition to the information about the study, all interpreters were briefed on the importance of translating the questionnaire and the participant's response word by word (as closely as possible) before starting the questionnaire administration. This approach was discussed and approved by the WHO office in Geneva. In addition to the WHOQOL–BREF questions, four questions on the detainees' satisfaction in relation to the services provided in the centers were asked (*Table 1*, column 1). The additional questions and response options were phrased in a similar style as that of the WHOQOL–BREF questions. These questions were developed based on the results from Papers I and II. Additionally, participants were asked questions on their socio-demographic characteristics. The questionnaire (WHOQOL–BREF and the additional questions) and the use of telephone interpreters were pilot-tested in one of the detention centers and were found to be feasible. The questionnaire had high internal consistency (Cronbach's alpha = 0.90).

All detainees, except those who were under 18 years of age, present in the detention centers during my visit were invited to participate in the study, which resulted in 127 (out of 193 invited) participating in the study. Detainees who declined their participation cited reasons such as lack of any benefits due to participation, too stressed to participate or, in certain instances, telephone interpreters in certain languages were not available. Detainees who could understand Swedish or English were encouraged to complete the questionnaire by themselves. However, only 16 (out of 50) chose to do so.

Paper IV

The aim of this study was to describe and compare how factors which were found to be important for the health of detainees (based on results from Papers I, II and III) were addressed in the Benelux countries and Sweden. Data were collected in two stages using a questionnaire (*Appendix I)* developed by the research team based on international guidelines, monitoring tools (13-15, 26-28, 97, 98) and results from Papers I, II and III.

During the first stage, the questionnaire was sent to representatives of the authorities responsible for immigration detention in the Benelux countries. The questionnaires were completed and returned to me prior to the second stage. During the second stage, a team consisting of researchers (myself and my main supervisor), a representative from IOM and a representative from the SMA visited the detention centers in the Benelux countries. All detention centers in the Netherlands and Luxembourg and two out five detention centers in Belgium were visited. The aim of the visit was to corroborate and triangulate the information provided by the Benelux authorities through our observations and discussions. During the visit, the team was briefed by the manager at each center on its policies and practices at the national as well as at the local level (at each detention center). The team received a guided tour

of the centers. After each visit the team members answered the same questionnaire, separately, based on the information they obtained during the visits and their observations, enabling triangulation based on multiple data sources and observers (91).

From the Swedish side, the SMA representative completed the questionnaire. No separate visits were made to the Swedish detention centers during the study as the required information was available from data collected for Papers I, II and III.

The representatives from the IOM and the SMA did not play any role in choosing the countries or centers to visit and in the planning or analyzing phase of the study. In addition to their contribution to the triangulation process, they contributed with their respective stakeholder perspectives during the discussions held with the authorities and through their observations.

Field notes

Field notes were taken by me during all my visits to various detention centers for data collection and other discussions. These notes contained my observations, reflections and a summary of events that occurred during each visit. The notes were not systematically analyzed as a dataset. However, they brought me back to the interview settings and provided a better understanding of the context during data analysis (91). Some of the observations became part of the results. For example, the heightened security reported in some of the detention centers explained in Paper I came from observations and not directly from the interviews.

Data analysis

Papers I and II

Thematic analysis, as described by Braun and Clarke (99) was used to analyze the interview transcripts of the detainee and staff interviews. The analysis process was inductive, that is to say, it was data driven. Conducting and transcribing the interviews helped me to familiarize myself with the data set. The research team read all the interview transcripts to gain a general understanding of detainee and staff experiences. After the initial reading, I analyzed the interviews following the steps of thematic analysis. I re-read the interviews to develop initial codes, as extensively as possible. Depending on their relevance to the unit of analysis, a couple of words or a line or a set of lines were coded to maintain the context surrounding the code (99). During the next phase the codes related to each other and describing similar experiences were organized to form themes. In the next phase, the themes developed during the previous phase were refined and revised so that codes within each individual theme were connected and coherently elucidated a

theme. This meant that some themes from the previous phase were collated to form an overarching theme consisting of sub-themes or were divided to form separate homogenous themes. Later during this phase, the themes were reviewed in relation to the dataset and the ideas drawn from the initial reading.

At this stage, the research team discussed the analysis process, codes, sub-themes and themes multiple times. The sub-themes and themes were re-evaluated to ensure consistency and validity within each theme and in relation to the whole dataset to describe the experiences of detainees and staff. This involved the constant comparison between the unit of analysis and the codes, codes with the sub-themes and sub-themes with the themes to ensure that the final themes reflected the dataset. Memos were written during the analysis process which helped me to understand my own analytical progression during the constant comparing and reviewing process.

The data management software, NVivo 10, was used to organize the dataset (100).

Paper III

According to the instructions in the WHOQOL–BREF manual (95) the last 24 questions (out of 26 questions) were divided up into four domains, namely; environmental (eight questions), physical (seven questions), psychological (six questions), and social (three questions) domains. The raw domain scores were calculated by adding up the scores and were then converted to a 0 to100 scale to be comparable with WHOQOL-100. The remaining two questions from the WHOQOL–BREF measured the general QOL and health of the detainees on a Likert scale. These two questions and the four questions on service satisfaction were given a score on a range of 1 to 5.

The main outcome variables were the four domain scores (continuous variables), general QOL (categorical variables), general health (categorical variables) and the four service satisfaction scores (categorical variables).

Associations among categorical variables were assessed using Chi-square test. Simple linear regression analysis was performed to assess the association between the service satisfaction scores and the four domain scores. Multiple linear regression analysis was performed to assess the same association while adjusting for potential confounders such as age, educational status, gender, children living in Sweden, partner living in Sweden, detention center and duration of detention. Spearman's rank correlation coefficient was calculated to assess the association between duration of detention (not normally distributed) and the categorical variables, and duration of stay in Sweden before being detained (not normally distributed). Duration of detention and psychological score was visualized using a plot with a smooth curve fitted using locally weighted scatterplot smoothing (Figure 2).

A significance value of, p, <0.05 was considered to be statistically significant. The software package R was used to perform all analysis (101).

Paper IV

The study and the analysis was guided by the Case Study Research method recommended by Yin (102) and the policy review and comparison methods outlined by the WHO (89). The three main aspects chosen to be described and compared, based on the results from Papers I, II and III, were living conditions of detainees, categories of staff working in detention centers and training provided to them, and the healthcare available to detainees at the centers. Parts relevant to the aspects were chosen from international monitoring tools (16, 97, 98) and included in the questionnaire. Based on the responses to the questionnaire, the three aspects in the four countries were described. The use of same the data collection tool, the questionnaire, in all the settings enabled comparison of the systems.

Participant check

Participant check (also known as member check or respondent validation) can be used as a method to avoid misinterpretation and ensure the validity of qualitative and case studies (103, 104). It is the process in which research participants (all of them or a selected few) are provided with the interview transcripts or analyzed/interpreted material to receive feedback and validate the researchers' interpretation of the interviews (103, 105, 106). However, getting back to the same participants might be problematic because of challenges such as finding and getting a response from all participants (103), it might be a labor-intensive process for the participant to read and reflect on the transcript (107), participants might not be able to recognize their complete story in the abstracted results based on systematic analysis of a set of interviews looking for a wider explanation of the phenomenon being studied (104-106) or a participant could experience the phenomenon under study differently during the interview and later during the participant check (103). The latter becomes a valid concern when there is a considerable time gap between the first interview and the participant check. Due to these concerns, it is usually recommended to avoid participant check (103, 104, 107).

However, Morse (105) puts forward an alternative way of performing participant check. She suggests that themes emerging from previous interviews could be verified during interview with other participants. We adopted this approach for Papers I and II. The first set of data was collected from three (out of five) detention centers in Sweden. They were analyzed and the manuscripts were written. After one-and-a-half years, we wanted to see if the experiences described by detainees in the first three centers were similar to the experiences of detainees in the remaining two centers. There

were no significant changes in the detention system during this period. I visited the remaining two detention centers and conducted interviews (5 interviews with detainees and 6 interviews with staff) using the same method and the same interview guide described in Papers I and II. The participants described experiences similar to the experiences present in the first set of data collected (Papers I and II). If the participants did not discuss some of the themes developed from the first set of data, I presented the themes to the participants and asked their thoughts on them. Initial analysis of the second set of interviews conformed to the themes generated from the first set of interviews. Data from the second set of interviews were not included in Papers I and II. Some of the quotes presented in the results section of this thesis are from the second set of interviews. Such quotes will be marked as 'participant check interview'.

For Paper IV, the descriptive case study, the results were sent to the representatives who initially answered the questionnaire via email and these were validated.

Ethical considerations

Studies forming the basis for Papers I, II and III had ethical approval from the Regional Ethical Review Board (EPN) in Uppsala (Dnr 2011/463). The fourth study (Paper IV) did not seek ethical approval as no data based on research or experiment conducted on human beings were reported. The study reported practices and polices followed in immigration detention centers in four countries.

Conducting interviews in settings such as detention is challenging because detainees are in a disadvantaged situation and are looking for help to get out of detention. It was important to explain, multiple times, that I was a researcher and was not working for any authorities. Prior to and during the interviews with the detainees, the first five to ten minutes was spent on explaining the study, the voluntary nature of their participation and especially, the absence of any direct benefits due to their participation. I believe I was able to get this message across because some detainees decided not to participate in the study once I explained that there were no benefits. For detainees who did not understand English or Swedish, the information sheet was interpreted using a telephone interpreter. I obtained only verbal informed consent from the detainees because, based on my experience, I suspected detainees to be skeptical of signing any document. In detention, they are usually asked to sign documents related to their deportation case. If any detainee was found to be in need of medical care, mental or physical, during the interviews, I had the option to inform the nurse at the center. If the nurse was not available, I could notify the staff to inform the nurse. However, the need for such measures never came up during the interviews.

Written informed consent was obtained from all of the staff members who participated in the study. Similar to detainees, the staff was also informed about the voluntary nature of their participation, lack of benefits and that their identity would never be revealed in any way. All participants received an information sheet containing the abovementioned information and contact details for the research team.

Results

Paper I explored the daily life of detainees and their experiences of being detained. They felt being controlled by the system, which made them passive, and compared detention centers to prisons. Paper II explored the experiences of detention staff in providing services to detainees. They found it emotionally challenging and wished for more training and support. Paper III estimated the QOL among detainees and found it to be low. The support received from detention staff was significantly positively associated with the QOL domain scores of detainees. Paper IV compared the Swedish detention system to the system in the Benelux countries. Detainees were offered more healthcare services and staff was offered more training in the Benelux countries. However, there were lesser restrictions placed on detainees within the Swedish detention centers, such as unrestricted access to activities, internet access, mobile phone and not locking detainees in during the night.

Presented here are the highlights of the main results from the four studies, organized into four factors that are important for the health of detainees.

Lack of control and adequate support

The main stressor, which the detainees found most difficult to manage, was their experience of lack of control over their lives. They experienced this through their interaction with detention staff, but also through the various restrictions within the detention centers. The non-responsiveness, where detention staff failed to adequately respond to queries from detainees, was a major reason for their experience of lack of control. The detention staff attributed several reasons to this. One of the most important and common query for detainees was related to the progress of their case, an issue for which the detention staff members were not always able to provide a proper response. The detention staff said that if the deportation or detention case was handled by the police, the SMA staff often had limited information to respond to queries from detainees. The detainees also reported to having experienced a lack of response from their lawyers and the police. Another reason for the suboptimal response received by detainees was inadequate communication between staff members, resulting in staff not providing a response to queries from detainees. Because detention staff works in teams

and shifts, there might be miscommunication between teams which leaves the detainees waiting for a response.

> . . . he [detainee] was trying to ask for help yesterday and he asked somebody [staff] but that staff member went home. And then he asked somebody [else] during the night, and that staff member said, ‘‘I don’t know, maybe.’’ Then he came to me in the morning and said, ‘‘I have been asking two three people. Everybody was saying maybe later’’ . . . what lots of people [staff] do is that they are listening to the detainee and then they go away and forget it. (Staff member)

Lack of information, presented in a language the detainees can understand, was also a reason for them to experience the lack of control. This affected their interaction with detention staff and their ability to understand legal decisions which were written in Swedish. Although interpreters are used while providing information to detainees about their legal cases, the detainees expressed their inability to understand the information.

> They will just give you papers [to] sign and they read the paper to you. But, what they are reading to you, is it correct? You don’t know […] they ask me to sign […] I sign […] sometimes you sign for something you don’t know and it is crazy. How can you sign for something you don’t understand? (Detainee).

The detainees’ ability to understand information had an influence on their health. Their ability to understand (speak and/or write) Swedish or English was significantly positively associated with the general health score in the WHOQOL–BREF ($\chi^2 = 16.5$, p=0.002). Detainees in the Benelux countries are provided with information related to the internal rules and regulations at the centers in a language understood or reasonably assumed to be understood by them.

The detainees also experienced a lack of control through various restrictions present in detention centers. Limited access to the courtyards within the centers was cited as an example. However, there were differences among the centers. One of the centers allowed detainees to access courtyards whenever there was a staff member available to accompany them, whereas other centers mostly adhered to the 3 hours of access to courtyard per day as per guidelines. The restrictions were not just limited to the detainees’ freedom of movement. For example, the detainees reported that, irrespective of the type of illness, they were mainly given pain killers by nurses visiting the centers. This prompted them to suggest that they were not able to seek adequate solutions such as consulting a doctor for their illness. There were also other experiences contributing to the feeling of lack of control. A participant in the study reported being not able to get food if he missed the meal serving schedule. Another detainee from the same center had a similar

experience, but said he was able to get food once he asked the staff. In comparison to the Swedish detention centers, daily routines in the detention centers in the Benelux countries were more restricted. Luxembourg and the Netherlands locked detainees in their rooms during the night. Access to internet, library, gym and other activities at the detention centers were restricted to a couple of hours per day in the Benelux countries while access to these activities was mostly unrestricted in Sweden.

The service satisfaction scores, part of the QOL survey, showed that the detainees were not 'Unsatisfied' with the services provided, rather they were 'Neither satisfied nor dissatisfied' (*Table 1*). However, there was a negative correlation between duration of detention and all service satisfaction scores, but one, and the general QOL score (*Table 2*). The average duration of stay in detention for the detainees who participated in the QOL survey was 37.8 days (SD=57.3). Around 39% of them were detained for more than four weeks. Although not statistically significant, a similar negative correlation was observed between duration of detention and all the QOL domain scores and the general health score in WHOQOL–BREF. Figure 2 shows such a trend between the duration of detention and WHOQOL–BREF psychological domain score.

There were different support mechanisms available at the detention centers. These included activities such as playing billiards, table tennis and other games, visiting gyms at the centers and visits by NGOs. However, the detainees still reported being stressed. The support from detention staff affected their QOL the most. After adjusting for socio-demographic characteristics and other factors present in detention, such as the duration of detention, it was the support received from staff that was significantly positively associated with the WHOQOL domains. The level of support received from detention staff was positively associated with the physical ($\beta_{adjusted}$ 3.93, [CI] 0.06 – 7.80), psychological ($\beta_{adjusted}$ 5.72, [CI] 1.77 – 9.66) and social ($\beta_{adjusted}$ 4.59, [CI] 0.64 – 8.54) domain scores. The level of satisfaction on the care received from the staff was positively associated to the physical ($\beta_{adjusted}$ 6.69, [CI] 2.02 – 11.36), psychological ($\beta_{adjusted}$ 5.76, [CI] 0.69 – 10.83) and environmental ($\beta_{adjusted}$ 4.20, [CI] 0.29 – 8.17) domain scores. The detainees who have been detained in different centers compared the centers and considered some centers to be better than the others due to staff behavior.

The absence of adequate support and their experience of lack of control in detention centers resulted in detainees considering detention centers as a prison with extra flavors, although some considered it as worse than prison because they were detained without having committed any crime and did not know the duration of their detention. According to the detainees, the various restrictions in the centers meant they could influence neither their daily life in detention nor their life in general. This forced them to conclude that it was futile to seek help, which made them passive.

Table 1. *WHOQOL–BREF and Service satisfaction scoring scale and scores*

WHOQOL–BREF score (Scoring scale)	**Mean score (SD)**
Environmental domain (0–100)	47.0 (16.3)
Physical domain (0–100)	57.5 (18.4)
Psychological domain (0–100)	41.9 (19.3)
Social domain (0–100)	60.5 (19.9)
	Median Score (IQR)
General QOL in detention (1–5)	
1: Very poor	
5: Very good	2 (1–3)
General health (1–5)	
1: Very dissatisfied	
5: Very satisfied	2 (2–4)
Service satisfaction scores (scale)[a]	**Median Score (IQR)**
Level of support received from detention staff (1–5)	
1: Not at all	
5: Completely	3 (2–4)
Ability to understand information provided by authorities (1–5)	
1: Not at all	
5: Completely	3 (2–4)
Satisfaction with care provided by detention staff (1–5)	
1: Very dissatisfied	
5: Very satisfied	4 (3–4)
Satisfaction with food provided (1–5)	
1: Very dissatisfied	3 (2–4)
5: Very satisfied	

Source: Adapted from Paper III

IQR: Interquartile range; SD: standard deviation

a:These were additional variables added to the WHOQOL–BREF questionnaire to collect information on detainee satisfaction with service provided in the detention centers

Table 2. *Duration of detention and its relationship with QOL and services provided in detention*

	Level of support received from detention staff	Ability to understand information provided by authorities	Satisfaction with care provided by detention staff	Satisfaction with food provided		
Duration of detention	ρ_s = -0.32, p= 0.0003*	ρ_s = -0.03, p= 0.71	ρ_s = -0.29, p= 0.001*	ρ_s = -0.38, p < .0001*		
	General QOL	General Health	Physical Domain	Psychological Domain	Social Domain	Environmental Domain
	ρ_s = -0.19, p< .05*	ρ_s = -0.14, p > .05	ρ_s = -0.11, p > .05	ρ_s =-0.11 p > .05	ρ_s = -0.03 p > .05	ρ_s = -0.1 p > .05

*****p<.05 is considered to be statistically significant

ρ_s : Spearman's rank correlation coefficient

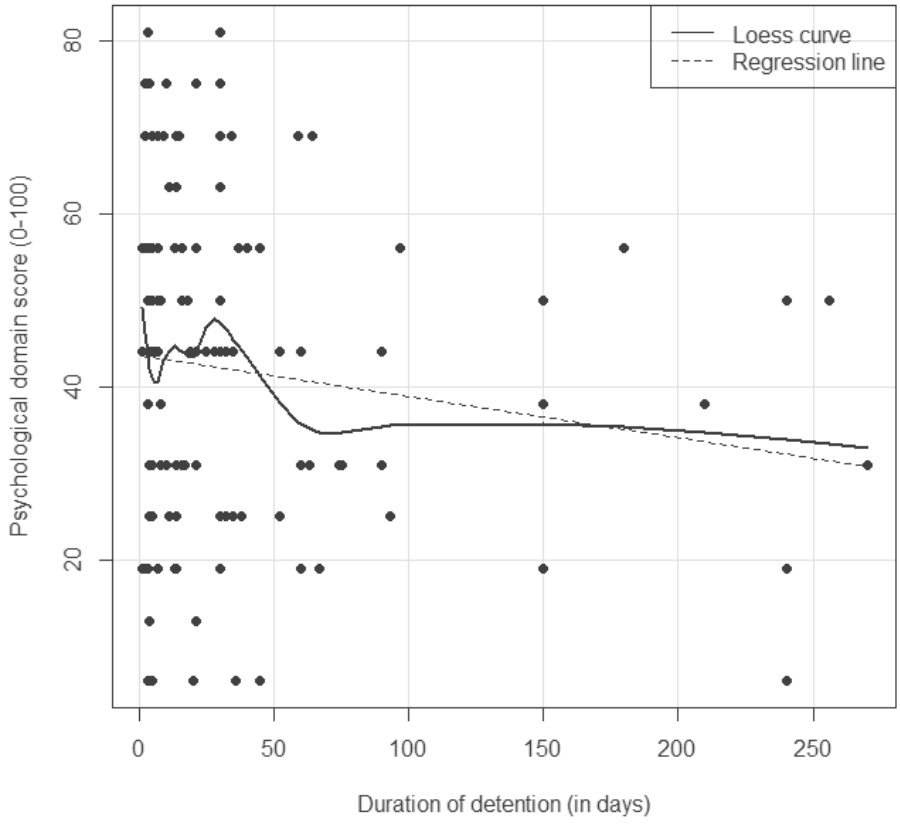

Figure 2: A scatter plot showing the relationship between WHOQOL psychological domain score and duration of detention. Source: Paper III

A sense of fear

A sense of fear was present among the staff members and the detainees. The detainees felt threatened through their interaction with detention staff and other officials, such as the police and lawyers. The detainees indicated that they were threatened with facing long-term detention or other negative consequences if they did not cooperate with those involved in the deportation process. The manner in which such conversations were carried out was perceived by the detainees as threatening. The detention staff, too, recognized this issue and argued that detainees would accept a negative decision or response, as long as it was communicated properly. The detainees reported not feeling safe in the centers. This was partially due to a lack of privacy, where in some of the centers doors to the sleeping rooms could not be locked by the detainees so that other detainees, but not detention staff, could access the rooms. There were detainees who said they did not feel safe because any dispute among them could result in both

individuals involved in the dispute, the wrongdoer and the victim, being considered guilty by detention staff.

> One day a boy [detainee] from [country X] … had been watching porno [pornographic content]. He turned [to me] and I said, "What?" He said "Come [and see this]." I said, "Hey man! You can't speak to me like that. It is like you are cursing me [watching porno is like cursing someone]. You want me to look at it? You don't know me. I don't watch porno, man. I wasn't raised like that. But I respect you are watching, I respect that. I didn't tell you anything. But, don't call me for that. Don't call me for that anymore". He said, "You crazy, Stop it." I just smiled and left him alone because that is his level of mentality. I can stand up and beat him up. But the staff is not going to see that he offended me, they are not going to see that. They are just going to see that I beat him up and I am going to have another charge. I avoid all that confrontation and asked myself why? Even if there is something I don't like and … I just keep myself quiet. (Detainee, participant check interview)

The presence of detainees who, after serving their prison sentence, were transferred from prison to detention centers to be deported was mentioned as another reason for their fear. The concern for the detainees was that if those detainees (ex-prisoners) caused any problems in detention, others could also face negative consequences. As in Sweden, the Benelux countries also detain immigrants who have served their prison sentence and are waiting to be deported in immigration detention centers.

The detention staff's sense of fear came from the awareness that the majority of the detainees are confined against their will, and there is always a chance that something unpleasant could happen. They had concerns about their safety due to the perceived fear of physical aggression from detainees, although such incidents were reportedly uncommon. None of the detention staff who participated in the study had experienced such an act, but they knew of or had heard of colleagues who had experienced physical aggression from detainees. The staff considered it important to know the environment they work in and the people they work with in order to feel secure, known as dynamic security. However, they were not always able to spend enough time with detainees due to lack of time.

Being a young female staff member was reported to be challenging by both male and female detention staff members. The majority of the detainees are men belonging to the age group 20 – 40 years. Young female staff members who participated in the study said that detainees might comment on how they conduct themselves or on their physical appearances. Hence, they found it important to portray themselves as a civil servant and not as a 'female' civil servant. Meanwhile, they also said that it could be advantageous to be a female staff member because it might be easier for them than their male colleagues to resolve conflicts among detainees as some detainees respect women more than men. Older female staff members

reported that the male detainees respected them considering them as 'Mama'. Male participants did not discuss their gender being advantageous or disadvantageous. Although the detention staff received some support from the SMA, it was not considered to be adequate.

> *Staff:* There is a macho culture in detention, which I think is quite well known … When you are a female working in this confined environment… you become a female object ... everything from offers to marry us, to compliments for our looks etc. It can also be that … people could be condescending and they could say that I don't want to talk to you or that I don't think you are capable of doing this because you are a woman.
> *Interviewer:* As a female staff, do you get any special help or support or training?
> *Staff:* No
> *Interviewer:* Have you discussed that in your supervision sessions?
> *Staff:* Yes, I have done that. We will see what happens. I have heard that this question has been raised before as well (Female detention staff, participant check interview)

Detention staff: limited support received, limited support to offer

The detention staff had challenges in performing their duties. They considered the current detention system to be acceptable, given the migration situation in Europe. However, they found it difficult to agree with the current system when immigrants who are suspected, based on the staff's experience, to be detained for longer periods are detained. They considered such instances as misuse of detention. One such group of immigrants could be the ones who have been staying in Sweden for a longer period of time. The detainees who participated in the QOL survey lived in Sweden for an average of 31 months before being detained. The detainees' duration of stay in Sweden before being detained was significantly positively correlated to their duration of stay in detention (ρ_s 0.42, p<0.0001).

Although the detention staff wanted to offer more help to the detainees to manage their stress in detention, they were not able to do so due to restrictions present in the centers. They partially attributed restrictions and lack of activities for detainees to the increased focus on security and regulations. According to them, some of the rules could be relaxed creating a less stressful environment both for detainees and staff. They cited an example where one of the detention centers allowed female detainees to bring and use hair colors while in detention, whereas some other detention centers considered hair color as a 'dangerous' item and prevented the detainees from bringing it in. According to the detention staff, small things, such as coloring their hair, might help the detainees to alleviate their stress.

They considered these restrictions to be excessively restrictive, making the detention environment stressful.

> I think we should not consider everything dangerous. We should really look, is this dangerous or is this something good to make them [detainees] feel better? And if they feel better, everything is going to be better. It is a better workplace, it is a safer workplace, because the better they feel, the less violence, and the less hospital visits and medication (Detention staff).

As a member of the detention staff, they considered it important to be a fellow human being in order to provide humane services to detainees. Simultaneously, they considered it important to be a migration officer to perform their duty to assist in executing deportation decisions. However, they found it challenging to perform the 'balancing act' of executing both roles simultaneously, especially when detainees belonged to vulnerable groups such as the elderly or children. They tried to manage this dilemma by not thinking about the bigger picture, the detainees' stories, or by believing that the SMA has made the right decision by detaining the individual. However, it became complex when children were detained or when the detention staff considered some detention decisions unjustifiable. In such cases, they blamed the SMA for making wrong decisions, but still continued to perform their duties. Irrespective of these management strategies, the staff still experienced the dilemma and found it challenging to manage it.

> I am expected to perform various roles simultaneously while these roles are in conflict with each other … On one hand we are service staff, I assist the police, repatriation case officer, decision-maker, I assist the detainees on judicial and administrative aspects, and simultaneously I assist people hands-on. I can serve people coffee, I have helped them [detainees] with their hygiene needs and other things such as helping them to carry their bags. It is everything at the same time. And simultaneously I am expected to carry out motivational interviews [talk] to motivate people [detainees] to repatriate meanwhile console them while they cry. So there is a big conflict between the roles.
>
> It is emotionally difficult to see detainees feeling bad and to think what they are going to eat when they return … the questions we have to take care of are emotionally challenging, but at same time I should be a civil servant and a professional and ignore a major part of my political and personal opinions ... otherwise I wouldn't be able to perform my job … This is something I think a lot about and discuss with my colleagues quite a lot (Detention staff, participant check interview).

The detention staff expressed a need for better support and training, especially in managing their dilemma, communication strategies and in conflict management. They considered the ability to communicate properly with detainees to be one of the most important skills required to carry out their duties.

Compared to Sweden, the Benelux countries offer more timely and customized training programs. For example, in the Netherlands, all newly employed detention staff is expected to receive training within six months of their employment. They are given training in areas, such as intercultural communication, self-defense and non-violent communication. Although not to the same extent, similar training programs are offered to the Swedish detention staff. However, these are not mandatory and it might take up to 2 years or more before they actually attend the training. In the Benelux countries, they also have different categories of staff that are specialized in working with various aspects of detention such as social, health, practical, legal and security aspects.

Healthcare services in detention centers

Immigrant detainees in Sweden have low QOL (*Table 1*). Among the four WHOQOL–BREF domain scores, the psychological domain had the lowest mean score (41.9, SD = 19.3). More than half of the detainees (53.4%) who participated in the QOL survey considered themselves ill and requiring medical care. The healthcare services provided in the detention centers were not considered adequate by the detainees. It was difficult for them to consult a doctor.

> I am in this place [detention] for 5 months now. I am here and I am sick and I go to the … nurse here. I go there [and] they tell me to take some medicine. I trusted that medicine, but it is not helping me … One week later again I go back [and] she tells me to take other medicine again and I take that medicine … I get pain in my stomach [again] … I said I want to, if they can't help me, to go to hospital. They tell me it is not easy to go to the hospital (Detainee).

None of the Swedish detention centers, but one, have a doctor visiting the centers regularly. One center has a doctor visiting the center once a week for half a day. None of the Swedish detention centers have mental healthcare professionals working at the centers. The possibility for detainees to receive mental healthcare at the detention centers is very limited. In one of the centers, if the nurse found it necessary, a counselor can come to the center once a week for two-to-three hours. Otherwise, the nurse can refer detainees for medical care outside the centers. If it is not an emergency, the waiting period can be quite long. The detention staff was bewildered by the absence of a mental health professional, such as a counselor, at the detention centers. According to them, it was necessary to have such services in the centers because the detainees considered talking as a way of managing their stress. The staff found it difficult to cater to this need due to the lack of time and most of them were not educated for that task. There were staff members who

were educated to be social workers. However, their job as a supervisor was not similar to the role of a social worker or counselor.

> It might be odd with the staff because they [detainees] can think that we have created the problem, that we are part of the problem. We work for an authority [SMA] they don't necessarily like. Maybe they [detainees] should have access to a counselor. Of course, if a detainee comes to us and requests to see a counselor, they get to see one. But, they don't come forward always. We [staff] should be active. "You saw this happen; do you want to talk to someone?" [You can talk to] me or somebody from outside… It will be good if they can get professional help because I am not trained as a counselor or a social worker and I don't have the right things to say (Detention staff, participant check interview)

Compared to the Benelux countries, Swedish detention centers have limited healthcare services available at the detention centers themselves (*Table 3*). The absence of mental health professionals and an entry and/or exit medical screening is noteworthy. All detention centers in the Benelux countries had a mental healthcare professional visiting the centers regularly, or in some centers, they were employed at the centers.

Table 3. *Access to medical care for detainees in the detention centers in the Benelux countries and Sweden*

	Belgium	The Netherlands	Luxembourg	Sweden
Access to medical care	As required	Same as citizens	As required[a]	Access to care which cannot be deferred[b]
Daily access (5 days/ week) to a nurse	Yes	Yes	Yes	No[c]
Regular access to a doctor	Yes	Yes	Yes	No[d]
Regular access to a mental healthcare professional	Yes	Yes	Yes	No[e]
Do healthcare professionals receive training to work in immigration detention centers?	Yes	No[f]	No	No
Entry/Exit medical screening	Yes/Yes	Yes/Yes	Yes/No	No/No

Source: Paper IV

a: Dental care: only emergencies are treated and paid by the center.

b: Detainees have the right to contraceptive advice, care related to abortion and maternal care

c: One Swedish detention center has a nurse visiting the center Monday–Friday.

d: One Swedish detention center has a doctor visiting the center once a week.

e: In one of the Swedish detention centers, if the nurse finds it necessary, a counsellor can visit the center to provide services.

f: Nurses receive training to be a judicial nurse, a training given to nurses working in prisons.

Discussion

The immigration detention environment and the factors that are important for the health of detainees will be discussed here using the five action areas of the Ottawa Charter for Health Promotion (*Figure 3*) (73). The three strategies for health promotion, *advocate, enable and mediate,* will not be discussed separately as they are deeply embedded in the five action areas. Although different aspects of various health promotion strategies such as healthy cities, universities and hospitals could be used to aid the discussion, I have chosen examples and attributes from health-promoting prison initiatives to aid us in the discussion. There are many similarities between a prison and immigration detention environment. Both are confined environments, one group (prison/detention staff) has substantially more control over the daily life of another (prisoners/detainees), prisoners and detainees have limited autonomy, detainees and prisoners are heavily dependent on staff to get access to resources and both environments have negative effects on the health of inmates. However, there are also differences between the two environments. Prison sentence is a punishment for a committed crime whereas immigration detention is an administrative measure. Prison services focus on rehabilitation and the main aim is to prevent recidivism. The purpose of immigration detention is to make an immigrant available during an administrative process such as the verification of identity or the execution of a deportation order. The majority of prisoners are released back into their home communities whereas most of the detainees are sent back to the countries from which they fled. Notwithstanding the differences, due to the aforementioned similarities and the detainees' own comparison of immigration detention to prison (Paper I), results from studies conducted in prisons and other confined settings, such as hospital inpatient care wards, if comparable, will be used to discuss the results.

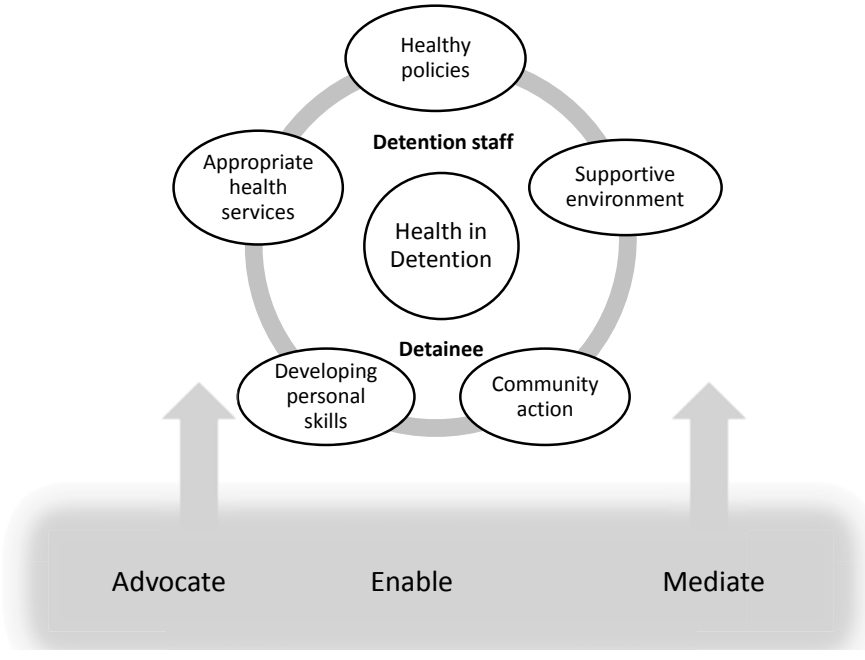

Figure 3. Health in immigration detention: An interpretation by Puthoopparambil using the Ottawa Charter for Health Promotion (73)

Unhealthy policies in detention

Identifying obstacles for making healthier choices makes it easier for policy makers to develop healthy public policies to address those obstacles (73). The results from the project have identified such obstacles. Detaining immigrants who have not committed or who are not suspected of any crime might not be considered as a healthy public policy and some have argued that it is arbitrary and attributes to the criminalization of migration (108, 109). This is why the international guidelines (13, 97) and the EU directives (14, 15) recommend detention to be used as a last resort. There exist several alternatives to detention (32, 110). Compared to other EU member states, alternatives to detention are not used to the fullest possible extent in Sweden (32). The only available alternative in Sweden is supervision (Uppsikt) (Chap. 10, Sec. 6-8; 30) and 359 supervision decisions were made in 2014 compared to 405 decisions in 2013 (8). This trend was opposite to the total number of detainees in Swedish detention centers. It increased from 1,735 detainees in 2007 to 3,750 in 2015 (*Table 4*). It should also be noted that the total number of asylum applications rose from 36,207 in 2007 to 162,877 in 2015 (10, 111). Supervision and other alternatives could be used much more effectively in order to prevent the use or misuse (as defined by the detention staff) of detention. A recently conducted study in Sweden highlighted the

plight of immigrants who were once detained, but who were later released because the Swedish authorities were unable to deport them (34). The statistically significant positive association between duration of stay in Sweden with duration of stay in detention points to another group of immigrants whose detention could be considered as misuse of detention. Detention of such individuals could be avoided to a certain extent if alternatives to detention are implemented effectively, thus preventing the misuse of detention. Notwithstanding that immigration detention is not a healthy public policy, immigration detention exists and according to the available information on future policy planning to manage migration to the EU (22-24), detention will continue to exist. Thus, it is important to explore the policies that are in effect within detention centers and their impact on the health of detainees.

Table 4. *Total number of detainees and average duration of detention in Swedish detention 2007-2015*[1]

Year	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**[2]
Total number of detainees	1,735	1,645	1,761	1,801	2,244	2,550	2,864	3,201	3,750
Avg. duration (in days)	16.7	20.8	21	18.2	15.6	11.2	7.58	7.92	20.7

[1]Data were compiled from the Annual Reports of the Swedish Migration Agency [8, 111-117].
[2]Statistics for the year 2015 were obtained from the Swedish Migration Agency and are preliminary. The compiled final version will be presented in the Agency's Annual Report later in 2016.

Guidelines and directives discourage the use of prisons to detain immigrants and not to mix prisoners and immigrants in order to emphasize the non-criminalization of immigration detention (13-15). The Swedish detention centers follow the recommendation. This was evident in the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) report of 2009 (33). Although the physical standards of Swedish detention centers are considerably good (33) and no prisons were used for detention, the detainees still compared detention centers to prisons highlighting the importance of policies and practices in detention centers and how they contribute to the feeling of imprisonment. It was the restrictive policies within the detention centers, which led the detainees to consider detention centers as 'prisons with extra flavors'. The presence of these restrictions could be attributed to the absence of policies that were promoting health.

As highlighted in the results, language barriers prevented detainees from accessing and understanding available information. Access to relevant information is important in order to have control of one's life (118). Detainees' access to information was limited due to language barriers and suboptimal interaction with detention staff and other personnel. For asylum-

seekers, information about the asylum seeking process is available in numerous languages. Article 9.2 in the Receptions Conditions directive (15) and the guidelines (26, 27), directs the authorities to provide detainees with information in a language that they understand or are reasonably assumed to understand. However, in detention, most of the information exists in Swedish. As shown in the results, detainees in the Benelux countries have access to the rules of the detention centers in several languages. This practice could be extended to legal decisions regarding their detention or deportation. It might not be feasible to translate every decision into a language understood by detainees, but a general document containing information about the legal decision and steps to be followed could be made available in languages common among detainees, similar to the document explaining the internal rules of detention centers.

Another 'unhealthy' policy which has a direct impact on the health of detainees is the law limiting their access to healthcare services while in detention (31). The law grants detainees *access to medical care which cannot be deferred*. Article 12.1 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) (119) explicitly states *the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. General comment No. 20 (para. 30) to the Covenant clearly states that the rights in the Covenant are applicable to everyone, irrespective of their legal status or documentation (120). International guidelines (13, 26-28) and resolutions (17) call on states to provide appropriate treatment, periodic health assessments and to safeguard the health of detainees. As shown in the results, healthcare provisions at the Swedish detention centers could be improved substantially. As highlighted in *Table 3*, healthcare services can vary from center to center depending on the county councils in which the detention centers are located. This shows how local policies could differ from national policies (78). It also shows the possibility of adapting national policies to the local context (detention centers) to improve the healthcare services at detention centers. However, in order to mitigate the negative impact of detention on the health of detainees, the current law in Sweden should be modified so as to offer better access to healthcare. As discussed in the Introduction, forcibly displaced immigrants, even before being detained, have higher prevalence of diseases and have a higher risk of being sick due to their legal status resulting in limited access to healthcare (121, 122), fear of negative consequences such as asylum application being rejected and deportation as a result of seeking healthcare (123-126), and suboptimal living conditions often combined with long waiting periods during the asylum seeking process which are stressful (34, 42, 47, 123, 126, 127). Sweden is one of the EU member states which has the most restrictive healthcare policies for irregular migrants and asylum-seekers (121, 122), and most of the detainees in the Swedish detention centers belong to this category of immigrants. In addition to the negative effect of detention on

detainees' health, the aforementioned pre-detention condition makes it even more important to change the healthcare access policy for detainees, if not for all vulnerable immigrants. Not just the detainees, but healthcare staff working with other groups of migrants, such as undocumented migrants and newly arrived asylum-seekers, also faced challenges in interpreting the law while providing services because interpretation of the law varied between providers and cases. The term 'medical care which cannot be deferred' was considered vague creating confusion among healthcare providers and resulting in ethical dilemmas, and arbitrary assessments and treatments (123, 124). A recently concluded inquiry by the National Board of Health and Welfare (*Socialstyrelsen*) on the application of the law concluded that it is not in line with medical ethics and is not appropriate for providing healthcare to vulnerable groups of migrants, putting patient safety at risk (128).

Detention staff is detainees' daily point of contact and the main service provider. It is important to provide them with timely and adequate support because the wellbeing of staff and inmates in confined environments is interdependent (129-131). This is very important considering the diverse educational and professional backgrounds of staff working in Swedish detention centers. The absence of policies ensuring systematic training is highlighted in the results. Another aspect negatively impacting on detention staff is role ambiguity and conflict. Unclear role expectations and role conflicts, such as providing humane care while enabling or executing deportation process, are predictive factors of job stress, emotional exhaustion, burnout and the decision to quit a job (132-137). Lesser role ambiguity and conflict was associated with higher levels of job satisfaction among nurses (135) and prison officers (138). Clearer role description, role division and recruitment policies can mitigate the effects of role ambiguity and conflicts (134, 138). Although the EU directives do not address the issue of detention staff recruitment, the Council of Europe (26), the CPT (27) and UNHCR (13) identifies it as an important aspect to ensure the humane treatment of immigrant detainees and recommends that authorities carefully select and train the detention staff.

Unsupportive environment

The Ottawa Charter states that a supportive environment should be enjoyable, stimulating, satisfying and safe (73). According to the results, none of these conditions are achieved in the detention centers. Detention leads to incapacitation of detainees and does not allow the use of their coping skills (51). Being detained might never be enjoyable or satisfying, however, detention environments could be made more supportive for its inhabitants, the staff and detainees. Supportive environments should allow an individual to have control of aspects that are important to their health,

making it easier to be healthy (139). Additional restrictions in an already controlled environment are not healthy as shown in the results. It is important to allow detainees to have as much control as possible on their lives in detention. Reducing restrictions within confined environments such as prisons or psychiatric inpatient hospitals have shown positive effects on the health and overall quality of life of inmates (131, 140-142). Flexibility in allowing inmates to borrow more books from library, more access to courtyards and allowing inmates to make extra phone calls to families, and increasing the availability of meaningful activities are some examples of reduced restrictions. Increasing restrictions and removing control from detainees is contrary to the *enable/empower* strategy in the Charter, preventing the creation of health. Reduced restrictions increases the sense of autonomy and reduces the boredom of confined individuals (142) and, according to the WHO, autonomy is one of the factors required to maintain mental health in confined settings such as prisons (143). The relaxing of restrictions and increased flexibility has been shown to have positive effects on staff as well. Reducing restrictions within confined settings such as prisons and hospitals have shown to reduce stress and fear among staff and to lower the chances of incidents of aggression (132, 141). As the results indicate, there are possibilities to reduce restrictions within the detention centers. Increased access to courtyards and allowing the use of hair color in detention centers are such examples. Reducing language barriers, as discussed earlier, also contributes to increased autonomy because, under such circumstances, detainees would have access to information that they can understand.

Fear creates insecurity and unsafe environments that are not supportive. Both the staff and detainees expressed a sense of fear. Detainees' sense of fear was attributed to the lack of privacy and suboptimal interaction with authorities, both of which were perceived as threatening. The latter could be addressed by supporting staff to improve their interaction with detainees. Inpatients at hospitals identified poor communication between nurses and patients as the main precursor of fear and aggression in the wards (141, 144). The former, fear arising from lack of privacy, is a much more complicated issue to be managed. On the one hand, the detainees reported not having enough privacy and not being able to lock doors to their sleeping rooms, and on the other hand, they reported being afraid of getting involved in conflicts initiated by someone else and facing negative consequences, if these were not witnessed by detention staff. This indicates a lack of surveillance in detention centers. Introducing more surveillance measures could make detention centers more similar to prisons and a further encroachment on detainees' privacy and liberty. However, it is important to ensure the safety of detainees and staff in the centers while ensuring limited intrusion into their daily lives. As discussed below, improving the communication skills of detention staff through training might be a key aspect in solving this issue.

It is important for detention staff to have a supportive work environment for their own health as well as the health of detainees. Fear of violence is cited as a major stressor for staff working in confined environments (130, 134, 145-147). Nurses working with psychiatric inpatients (147), residential care staff (148) and detention officers in immigration detention centers (146) attributed their fear to the 'unknown' aspect of inmates. These staff members wish to know their inmates in order to better predict events in their work environment. This is similar to the idea of dynamic security followed by detention staff in Swedish detention centers. The Swedish prison and probation services describe dynamic security as an overall view of safety in prisons where prison staff have good knowledge in developing a good interpersonal relationship and approach towards inmates, they are present where the inmates are present, follow instructions and routines, creating a safe and secure environment (149). They emphasize not only the importance of training prison staff in the above aspects, but also in following up and providing refresher training at regular intervals in order to create and maintain a safe living and working environment. Leggett and Hirons (150) describe dynamic security in prisons as *'knowing what is going on'* through building trust and engaging in effective communication and relationships with inmates. At the same time, they warn of the danger of officers becoming too friendly with inmates, a situation which might compromise their role as prison officers, making them vulnerable. Similar to the detention staff in our study, this dilemma is expressed by other staff categories, such as prison officers, police officers, debt collectors, flight attendants and nurses, that interact with their clients extensively (133, 148, 151, 152). A study conducted among prison officers in local jails in the United States found that fear of victimization (fear of aggression) from inmates was significantly negatively correlated with organizational support and training, and positively correlated to role ambiguity (138). As discussed above, proper communication between staff and inmates is a major tool to manage violence in confined settings. If properly trained, communication skills can be used to calm down an aggressive inmate, but if used timely and appropriately can prevent incidents of aggression from happening in the first place (141). This shows the importance of providing detention staff with the necessary training and support, especially to communicate properly and prevent violence. This is important to manage and alleviate perceptions of fear among detention staff as well as among detainees.

Female officers in workplaces dominated by males, such as prisons, seem to perceive various aspects of work differently. The young female staff in our study faced challenges in working with detainees and both male and female staff perceived their role to be more challenging for females. This was similar to the experience of uniformed female immigration detention officers in one of the detention centers in the United Kingdom (153). Most of the female officers in the study were ex-prison officers at the same facility

which was a prison until early 2012. A study conducted among prison officers found that members of both sexes were similarly satisfied or unsatisfied on work aspects such as supervision, job satisfaction, personal efficacy, job-related stress and workplace safety refuting the idea that female officers might have more negative experiences (154). However, the same study shows that officers of both sexes perceived female officers to be more vulnerable. Other studies from prison settings also draw similar conclusions (136, 138). These results might indicate that being a male or a female officer does not make the work environment safe or unsafe for prison officers, rather it is the work environment that contributes to the difference in perceptions of fear between the sexes. For example, in a study conducted to explore the effect of the prison environment on the mental health of prison staff (male and female), the participants reported that the 'macho' culture in prisons prevented them from opening up, causing more stress in their jobs (130). In another study conducted among prison officers, female prison officers expressed their fear of falling short in performing their duties because they were judged differently from their male counter parts (136). As explained in the results of this study, being a female staff member can be advantageous as well. In order to capitalize on the advantages and minimize the disadvantages, in addition to providing the necessary support for female officers, efforts must be undertaken to improve the work environment to be mutually understanding and supportive for both sexes. In order to further understand gender dynamics in detention, more research is required.

As indicated in various guidelines and directives, Sweden does not detain immigrant detainees with prisoners. However, there are no clear guidelines when it comes to detaining prisoners who have served their prison sentence and are waiting to be deported. This was a concern for the detainees. As indicated in the results, this phenomenon is not unique to Sweden. Although this was not cited as a reason for the perceived fear among the Swedish detention staff, a study conducted in a British immigration detention center indicates that the suspicion that detainees might have criminal background was a reason for the fear present among the British detention center staff (146). This issue needs to be addressed in efforts to create a safe supportive environment.

Community action in detention centers

Community action in a detention context could be interpreted in two ways. One is to consider detention as being part of the general community, such as a city (83) or an island (84), and thus community action would mean the involvement of members or groups from communities in activities related to detention. The other way is to interpret detention itself as a community, similar to prisons (129, 155) and hospitals (87), with its main inhabitants as detention staff and detainees.

In the Swedish detention context, the only group from the general community having regular contact with detainees is the NGOs and they mainly provide psychosocial support through visiting, talking and listening to detainees. Their participation in creating a better detention environment could be improved and increased (85). In the United Kingdom, Bail for Immigration Detainees is an organization providing legal services and information to detainees and assisting them in their efforts to be released from detention (156). The Jesuit Refuge Service (JRS) in Malta provides legal and psychosocial support to immigrants detained in Maltese detention centers (157). The Red Cross in Luxembourg visits detainees and conducts leisure activities (painting), provides material help and help with contacts in the detainee's country of origin (158). These are some examples of what NGOs are doing in detention centers across Europe. The type of activities NGOs could provide or assist with varies depending on the NGO's profile and the country in which they are operating. Academic institutions and academics, as part of the general community, are also getting involved in studying various aspects of immigration detention (20, 34). The current project is such an endeavor. Collaboration with several stakeholders in the general community is important because it may not be realistic to expect SMA to implement sustainable health promotion strategies on its own. Moreover, by definition, health promotion is a multisector endeavor (73).

Regardless of the engagement from the general community, it is important to analyze and understand detention centers as communities in themselves. The two main groups encompassed within this community, detention centers, are its detainees and detention staff. From the perspective of *Strengthening community action* (73, 79), both of these groups should be able to participate in and influence conditions that matter to their health. According to Frohlich and Potvin (159), participatory processes create a social space where individuals or groups of individuals whose voices are usually repressed by dominant structures are heard. Neither the detention staff nor the detainees who participated in the study gave an indication of being part of a participatory process. In the case of detainees, this is mainly due to the controlling nature of the detention. Access to information is a necessary element in the *enable* strategy of the Ottawa Charter (73). Whenever detainees tried to seek information or help and gain autonomy and control of their life, they were unsuccessful due to language barriers and other restrictions in detention. In prisons, prison councils offer inmates the opportunity to raise their concerns and offer their views on prison policies (82). Detention centers in Sweden have a similar system where, during weekly meetings, detention staff informs detainees about activities and other major issues during the upcoming week. It is also an opportunity for detainees to raise their concerns. This could be described as a participatory approach. However, the effectiveness of such meetings in empowering detainees is yet to be studied. Peer-based schemes in prisons where inmates

support each other have been found to be part of a participatory approach and were found to have a positive effect on their health (155, 160, 161). However, language barriers, diverse cultural backgrounds and comparatively shorter duration of confinement might pose challenges if such a system is to be put in place in an immigration detention setting.

Even though the staff have great control over detainees' daily lives, they might not be able to influence the detention environment and the policies affecting their work. The detention staff not being able to offer the support they wished to, due to lack of time and restrictions, is such an example. In prisons, staff wanted to feel part of the decision-making process (145). Employees being part of decision making makes programs or interventions sustainable and effective because they are the ones who deliver services to clients and maintain regular contact (155). Increased participation in decision-making has been shown to have a positive effect in reducing role conflict and increasing perceived influence, which in turn was positively related to job satisfaction (162).

Based on the results and the discussion above, it seems that the two main groups in a detention environment, detainees and staff, do not have any major influence over the environment in which they live and work. Clark refers to such groups as *implicated actors* (163). These are actors (individuals or group of individuals) who are ignored or are invisible to other actors who make decisions and form the environment where *implicated actors* operate. This finding is not surprising because the purpose of detention is for the state to exert control over irregular immigrants and to deport them (20, 108, 164). There might be less room here for any participatory processes. *Creating a supportive environment* where detainees can exercise some control might aid participatory processes, if any can exist. It is important for the SMA to listen to staff and provide the necessary assistance, such as training and support, creating a sense of influence.

Developing personal skills of detainees and staff

Based on the results, detainees need support in managing their stress, overcoming their passivity and belief that seeking help is futile, overcoming language barriers and other factors that are relevant to their situation in detention. Assisting them in acquiring skills that could help them to address the above mentioned factors will probably have the most impact on their time spent in detention. If the personal skills that an individual has developed have limited applicability in the environment where they live, those skills will have a very limited effect on their health (77). While taking measures to tackle these issues, the average time spent in detention by a detainee should be considered. The average duration of eight days might not be sufficient to learn a language and to overcome the language barrier. Such barriers should be addressed through other measures, as discussed earlier.

However, acquiring skills to manage their stress and passivity might be more relevant to detainees. Due to their mental ill-health and stress, immigrant detainees might have self-harming and suicidal ideation. There are incidents where immigrant detainees have committed suicide (56, 165, 166). Measures assisting detainees to develop skills to address issues such as these might be more feasible during this short period of time. Although the average duration of detention is short, as per the statistics from the SMA (8), there are immigrants who are detained for more than four weeks. For such detainees, measures such as language or computer lessons might be feasible. However, if the detention environment continues to be *unsupportive,* restricting detainees in having a sense of control, acquiring new skills might have a very limited impact on their health. This emphasizes the need for action areas to operate in conjunction; in this instance, absence of a supportive environment undermines effect of developing personal skills.

It might be more important to focus on developing the skills of detention staff because they are the services providers and long-term training strategies could be implemented. This will have an impact on them as well as on the detainees for whom they provide services. As highlighted in the results, it was the support received from detention staff that affected detainees' QOL the most. One of the main skills they found necessary to improve was their communication skills. Detainees perceived some of their interaction with detention staff as threatening. This indicates suboptimal interaction. Studies have shown the positive effect of good interaction between staff and patients or inmates in confined environments (131, 132, 144, 147, 150). This allowed staff to be observant and support inmates' wellbeing through talking to them when they are stressed or engaging in group activities, such as cooking or playing games with inmates. Reinforcing negative relationships and interaction between staff and inmates affects the stress levels of both of the groups (130, 131, 153). Detention staff (153) and staff in prisons (33, 132, 152) use their communication skills to maintain a distant, but not too distant, and a close, but not too close, relationship with detainees. Similar to the staff in the aforementioned studies, the detention staff in our study found this balancing act challenging. Detention staff needs support and training in managing their emotional dilemma and performing the balancing act. A relationship that is too distant causes alienation and increases fear, while a relationship that is too close can cause emotional exhaustion and burnouts (Paper II). Staff working in other professional settings found discussing challenges with their peers helpful (132, 167, 168). Providing training for staff to improve their interpersonal skills can also help to address the emotional strain (169). As recommended by the guidelines (26, 27), detention staff should be provided with training to recognize stress symptoms and other major illnesses as detainees are known to have poor health status. In addition to training and other forms of support, preventing role conflict and role ambiguity through clear role description and

recruitment strategies, as described earlier, will aid in reducing the occurrence of emotional dilemmas.

Similar to detainees, the skills acquired by detention staff through training should be applicable in the immediate environment in order to have a healthy effect on the environment (77). If detention staff is trained in communication skills but have less time to interact with detainees, the training will have limited impact.

Inadequate health services at detention centers

The Ottawa Charter suggests shifting the focus of healthcare services from curative to preventive. In detention, the health services available are curative and are limited. The curative aspect of healthcare services in the detention centers needs to be improved substantially while adding the preventive care aspect.

The results from our studies and other studies show the mental ill-health present among immigrant detainees, highlighting the need for mental healthcare services (44, 51, 53). A study conducted among families detained in an Australian detention center comparing psychiatric disorders prior to and during detention showed that there was an increase in the number of individuals diagnosed for post-traumatic stress disorder (PTSD) and suicidal ideation during detention (55). Another study from Australia showed that previously detained refugees, now living in community, had lesser self-destructive thoughts such as self-harm and committing suicide, and higher life satisfaction while living in community than in detention (57). A study conducted by Keller et al (54) among immigrant detainees in the United States of America found that detainees who were continued to be detained had increased symptomatic scores for PTSD, depression and anxiety than the immigrants who were detained, but released later. A Swedish register-based study showed that asylum-seekers in Sweden reported more symptoms of mental ill-health compared to other group of immigrants such as quota refugees and individuals who migrated due to family ties (42). Another study on immigrants living in Sweden found that refugees had a higher likelihood of poor mental health than non-refugees from the same country of origin (37). As shown in the results, detainees in Sweden scored the lowest in the psychological domain of all the four QOL domains. The SMA was criticized by CPT in 2009 for the lack of arrangements for regular visits by mental health professionals in the detention centers (33). In spite of the evidence and criticisms, as highlighted in the results, mental health services remain almost absent in Swedish detention centers.

In addition to the absence of adequate healthcare services, Swedish detention centers do not offer any medical screening for detainees on arrival. Screening and providing care for identified diseases, especially communicable diseases, protects fellow detainees, staff and others who come

in contact with a detainee who might have an infectious disease. Absence of screening presents a health risk for detainees and staff. The county councils in Sweden should, if it is not clearly unnecessary (*om det inte är uppenbart obehövligt*), offer medical screening to all asylum-seekers on arrival in Sweden (Sec. 7; 31). However, a recent report from the Swedish Association of municipalities and county councils (SKL) stated that the county councils were not able to contact all newly arrived asylum-seekers and offer them medical screening (170). Only 44% of the newly arrived asylum-seekers were screened in 2014, a 1% increase compared to those arriving in 2013 (170). One of the reasons for this low rate could be that the invitation letter to attend medical screening is written in Swedish (124, 126). In addition to the inability of the county councils' health authorities' to reach all immigrant detainees, and along with the language barrier, immigrants' fear of negative consequences, such as deportation if diagnosed with a disease, may limit their willingness to be screened or share information about their health status to healthcare providers (125, 126, 171). Recent statements from the European Centre for Disease Prevention and Control (ECDC) and others suggest the presence of infectious diseases among newly arrived migrants (mainly asylum-seekers) (44, 172, 173). The threat of such infectious diseases to public health in the host countries is considered to be low (173, 174), but this does not remove the need for screening. As shown in the results, prior to being detained, detainees stayed in Sweden for an average of 31 months and their health status may have worsened during this period due to difficult living circumstances and stress related to the asylum process, and limited access to healthcare due to their legal status (42, 121-123, 127). Absence of medical screening for all asylum-seekers on arrival, prevalence of infectious disease among immigrants and difficult pre-detention living circumstances underscore the need to provide appropriate medical care for detainees, if necessary. The purpose of medical screening is to prevent the spread of infectious diseases, if there are any and to provide appropriate medical care for identified health issues (170, 175). Detainees in Swedish detention centers do not come in contact with nurses at the centers unless they themselves find it necessary to seek care. Detention staff can also refer detainees to the nurses, however, detention staff are not trained to recognize the symptoms of various diseases. Hence, in order to find out if medical care is necessary, a medical screening for all detainees on arrival is necessary. Such a screening should not only check for infectious diseases, but also for mental illness. Moreover, medical screenings should be culturally appropriate and healthcare system should be able to provide necessary treatment for any identified diseases (126). This allows the authorities to safeguard the health of detainees as they are supposed to (13, 17). However, if the law remains the same, that is to say, detainees only have the right to medical care that cannot be deferred (which is interpreted differently by individual healthcare providers), screening may cause more harm than good.

Identifying a disease and not providing treatment can create professional and ethical dilemmas for healthcare providers and increased stress for detainees. Hence, *Reorienting health services* must go hand-in-hand with *Healthy public policy*.

Prevention of illness or health promotion is not just about medical screening on arrival or the provision of other medical services in detention centers. It includes measures such as raising health awareness, the training of personnel to know the importance of health promotion and to participate in it (88), organizing meaningful activities for detainees to reduce frustration and boredom (130, 141, 143), and other measures, including reducing restrictions and granting more freedom within the confined environment. It is not feasible for the healthcare providers in detention centers or the SMA to implement all these measures by themselves. Collaborating with other sectors, as discussed under *community action*, such as civil societies might be a way to address this concern (85). Existing collaboration with NGOs could be improved and cooperation with other stakeholders should be established in order to cater to these needs.

In order to provide culturally appropriate curative and preventative care for detained immigrants, healthcare staff should be provided with appropriate training. Culturally appropriate and migrant-friendly care is more than overcoming language barriers (43). It involves healthcare providers having an understanding of effect of migration on health, migrant patients' health beliefs, and migrants' attitudes towards the healthcare system based on their past experiences and their understanding of illness (43, 124, 126, 176). For healthcare staff working in immigration detention centers, one additional aspect should be included in such training programs; the effect of immigration detention on immigrants who are not convicted of any crime, yet who are detained. A recent study conducted among healthcare providers in the Swedish detention centers highlighted their ethical and emotional dilemmas of providing healthcare to immigrants living in a 'not so' healthy setting; the detention centers (177). They highlight instances where they wanted the deportation to be delayed or stopped so that detainees could receive the necessary treatments. However, those detainees were deported.

Methodological considerations

The biggest strength of the study was the use of triangulation by employing multiple methods and data sources (91), and the transdisciplinary approach (92). I would like to consider the biggest achievement of the study to be getting access to the detention centers and allowing the unheard voices of detention staff and detainees (implicated actors) to be heard.

All the data were collected and analyzed by me, which increased consistency throughout the study. However, this could also lead to systematic bias. Hence it is important to explain how I might have influenced the study and the measures that I put in place to counteract such bias.

Reflexivity: Who am I and what impact did I have on the project?

According to Mays and Pope:

> Reflexivity means sensitivity to the ways in which the researcher and the research process have shaped the collected data, including the role of prior assumptions and experience, which can influence even the most avowedly inductive inquiries (104).

How have I influenced the research process and the data collected and analyzed as part of it? I don't think I have a complete answer to this question because, as any other researcher, I have influenced the research process knowingly and unknowingly. Here, I explain the 'knowingly' part.

A researcher's background and other characteristics will affect the research (178). I will start by describing who I am and discuss how I positioned myself as a researcher while designing the study, collecting and analyzing data and writing the articles. In 2009, I moved to Sweden from India, at the age of 24, to pursue my Master's degree in International Health at Uppsala University. I have a Bachelor's degree in Bioinformatics and was working with clinical drug trials in India. Once I moved to Sweden, I wanted to understand, explore and familiarize myself with Swedish society and I started volunteering for an NGO. The volunteering task was to visit immigrants in a Swedish detention center and provide psychosocial support to them, mainly by listening to them. I continued the assignment until I started the PhD project.

Researchers' preconceptions can influence research (104, 178). As is evident from the description above, I had almost no prior experience and preconceptions about immigration detention and research in public health. However, prior to the PhD project, my master's education gave me an understanding of research and my volunteering experience introduced me to immigration detention in Sweden. However, this understanding also created preconceptions. For example, in the beginning the research team thought an explorative approach using qualitative methods would have been enough to answer our research question. However, after collecting data for Papers I and II, we found the need to use other methods to complement the results in Papers I and II to answer the research questions. Thus, Papers III and IV became part of the project. Based on my volunteering experiences, I was

more focused on detainee experiences and how staff could assist in alleviating the suffering of detainees. My understanding of staff challenges and their health was limited. Paper II helped me to further expand this understanding and I tried to explore these aspects further in Papers III and IV. However, the papers explored the influence of detention staff on detainees' quality of life and the support and training for detention staff. The focus on the health and wellbeing of detention staff was very limited. In phase II of the project, a questionnaire survey to estimate detention staff's health and wellbeing at work was planned. However, due to a lack of resources, the survey was not carried out. This is an area which needs further research. Most of the existing literature is on the legal and political aspects of detention, and the health of immigrant detainees. In addition to the practical aspects of bias, there might be theoretical bias as well. My style of writing, choice of theoretical frameworks in the thesis and in the Papers, and the aspects I chose to discuss are influenced by the research training provided at the Faculty of Medicine at Uppsala University. However, I believe that the influence of my supervisors, who have different profiles, my main supervisor is trained as a nurse and my co-supervisor is a sociologist, combined with my profile might have reduced such biases. However, as Malterud says "an elephant looks very different when seen from above or below" (178). I hope I have been able to look at 'the elephant' from various viewpoints through the use of triangulation techniques, the transdisciplinary approach and through our multidisciplinary team.

I believe I had elements of 'insider' and 'outsider' perspectives while conducting research. Often when detainees saw me for the first time with my laptop bag on my shoulder, they asked me "When are you going (to be deported)?" This was mainly due to my physical characteristics of being an individual from India. This preconception of detainees helped me to 'break the ice' and build a rapport with them. My Indian background led some of the detainees to consider that I have an understanding of their lives in their home countries. They often said "Brother, you know how it is in our countries", although I have never visited most of the countries where the detainees came from. This might have led them to assume that I might have a better understanding of their experiences, which might have prevented them from describing their experiences in detail. During the interviews, I probed and asked for clarification, as much as possible, to counteract the chance of the detainees not describing their experience in detail. The detention staff considered it important that somebody from 'outside' observed and reviewed immigration detention because the detention system and the staff themselves might be ignorant of the challenges within the system.

It was challenging to conduct interviews in the detention centers, especially with detainees. Although I had no power over detainees, I was privileged. I was not detained! Spending time in detention centers helped me

to see 'freedom' in a completely new perspective. It was challenging when the detainees asked me question such as "How can you help me (detainee)?" or "What is the point of conducting the study since it is not going to help me (detainee)?" However, some of the detainees, after the interviews, said that describing their experiences to me made them feel calmer.

Like any other researcher, I have influenced the research process. I tried to minimize my influence in causing bias in several ways through the participant check interviews, triangulation, the presentation and discussion of results at various international conferences and with detention staff and other stakeholders during multiple meetings, peer debriefings with my supervisors, and reviewing the study results alongside other academic literature. Regardless of my efforts, there were some shortcomings, which are discussed below.

Qualitative studies (Papers I and II)

While conducting interviews, especially in a situation such as detention where participants are in a disadvantaged position and might seek help, interview responses could be exaggerated. As explained under *Ethical Considerations*, all possible efforts were made to inform the detainees about the non-beneficiary nature of participation. However, the possibility of exaggeration cannot be completely ruled out. It was not possible to directly verify the claims made by the detainees, especially those related to staff behavior and the services provided at the detention centers, with detention staff because it might have breached confidentiality. However, as shown in the results, some of these claims were similarly discussed during the staff interviews, suggesting that exaggeration by the detainees might have been minimal.

There is a chance that I might have missed opportunities to invite detainees with extreme cases, such as those who are depressed or vulnerable, to participate. In the case of detainees, as explained earlier, I decided not to encroach upon their privacy by knocking on the doors to their sleeping rooms. Otherwise, I invited every detainee present in the common areas of the detention centers to participate in the study. For Paper II, I invited all detention staff members present at the centers during my visit.

Only a few female detainees participated in the study, reflecting the limited discussion on gender aspects of detainees. This might be a reflection of the detainee population, where females make up only 10% of the total detainee population. Moreover, male and female detainees who participated in the study did not discuss aspects related to gender when discussing their lives in detention. It could be that being detained and the various restrictions and stress therein might have been more compelling for them to discuss than the gender aspects. However, in order to create a supportive environment for

all and to promote health, the influence of gender on the lives of detainees should be studied further.

The use of telephone interpreters in the study might have affected the results. However, efforts were made to minimize such effects. Authorized interpreters were used in the study. The authorization is approved and recognized by governmental agencies in Sweden. Interpreters in the study acted as an 'interpreting device', where I asked a question in Swedish which would be then interpreted for the detainees. Then, the detainees' answer to the question was interpreted for me in Swedish. This allowed me to have a 'direct conversation' with the detainees. This approach also helped me to seek clarifications directly with the detainees, which would not have been possible if the interpreters interpreted or translated the entire interview, once it was over. This minimized the chances of misinterpretations or mistranslations.

In order to increase the rigor (trustworthiness) of the qualitative studies, measures to ensure validity and reliability were put in place (105). Researchers have suggested measures such as prolonged engagement in the field and observation, thick description, triangulation, reflexivity, peer debriefing and participant checking (104, 105, 107). As discussed above and in the *Methodology* and *Discussion* sections of this thesis, these measures were employed throughout the project to increase its rigor. In addition to all these measures, it is important for any study to have a detailed description of the research process, the research context and the researchers' preconceptions to let the readers judge the quality and transferability or generalizability of the study results (104, 178, 179). I believe I have provided such descriptions.

Quantitative study (Paper III)

No causal inference can be drawn due to the cross-sectional design. Although the WHOQOL–BREF was available in other languages, we decided to use only the English and Swedish versions. This was due to two reasons. Firstly, I could only speak English and Swedish and hence using questionnaires in other languages could have made it difficult for me to answer questions from the detainees about the words and concepts used in a foreign language. Using the questionnaire in Swedish and English helped the researcher to explain the questions directly to the participants, using an interpreter, and helped to maintain a direct conversation (as explained previously) with the participants and identify issues such as difficulty in answering the questions or any other emotional issues which may have arisen. The alternative was to use the questionnaires in the other languages and allow interpreters, who might not be trained in questionnaire administration, unaware of the situation in immigration detention or not familiar with the QOL concept, to be in charge of the questionnaire

administration. I do not consider this type of questionnaire administration to be ideal in a sensitive situation such as detention. We found it practical and ethical to use questionnaires in languages familiar to me because I administered the questionnaire. This methodology was discussed and approved by the WHO in Geneva.

Despite other studies showing a significant negative association between increasing duration detention and mental illness (50, 51), the negative association between duration of detention and QOL was not statistically significant. This could be due to the small sample size. Moreover, by definition (94), QOL is a broader concept, encompassing several aspects of health and not just mental health. Hence, duration of detention might have a different effect on mental health than QOL. Regardless of the statistical significance and the differences in the definitions, increasing duration of detention is associated with negative outcomes for detainees (*Table 2*).

Only 67% of the detainees detained during the study period participated in the study. Under normal circumstances, this might be considered as lower participation rate. However, considering the stressful and unfortunate situation of detainees, in addition to language barriers, I argue that the participation rate in the study was reasonably high.

Descriptive case comparison (Paper IV)

The study was a comparative description of the detention systems in four EU member states based on observations and information provided by the authorities. This does not offer the same detailed understanding as offered in Papers I, II and III. However, the aim of the study was not to perform an in-depth analysis, but rather to describe how factors identified in previous Papers (I, II and III) were addressed in other member states belonging to the same Common European Asylum System (CEAS) system. The seemingly better healthcare services and staff training procedures in the Benelux countries and the lesser restrictions in the Swedish detention centers cannot be concluded as health-promoting factors because such conclusions should be based on studies assessing causal relationships. However, the study showed how various aspects of immigration detention could be addressed differently, allowing member states to identify and adapt approaches best suited to their detention context.

A way forward

This thesis explored the life of immigrant detainees in Swedish detention centers. The exploration was mainly based on data collected from detainees and detention staff, and observations on the detention systems in Sweden and the Benelux countries. The aim of the project was to identify factors that could mitigate the negative effects of detention on the health of immigrant detainees and thus develop feasible recommendations. In order to develop recommendations that were more practical than theoretical or technical, we had to explore how the factors, which were found to be important for detainees' health in Sweden, were addressed in other similar systems. This was the idea behind Paper IV. I am not claiming that all of our recommendations are feasible. Feasibility depends on the political, social and economic context, which is constantly evolving. This thesis presents only a glimpse of an under-researched area, at least in Sweden, and a lot remains to be explored. Hence, claiming that all of our recommendations are feasible will be nothing short of being ignorant of the complexity of immigration detention where multiple dimensions such as legal, social, spiritual, health and economic aspects interact. However, we tried to challenge our, the researchers', understanding of the feasibility and practicality of the recommendations with that of other stakeholders working with immigration detention. The recommendations below were presented and discussed, during various meetings and workshops, to staff from all detention centers in Sweden, senior management and experts from the Swedish Migration Agency, researchers, and with representatives of the public agencies responsible for running immigration detention centers in the Benelux countries, NGOs in Sweden, the Swedish Border Police, IOM and the Council of Europe. Hence the recommendations to mitigate the negative health effects of detention presented below are not only based on the four papers but also on the discussions with the major stakeholders.

1. *Recommendations directly impacting detainees:*

    a. Develop an adequate support system for detainees to cope with their lives in detention:
        i. Increase psychosocial support through measures such as employing social workers/counselors at detention centers and through targeted and meaningful activities to avoid passivity.

ii. Enhance the collaboration with Non-governmental organizations at all centers to assist in creating a support system.

b. Take measures to address the sense of fear for detainees:
   i. Provide detention staff with customized and regular trainings to improve their communication and interpersonal skills.
   ii. Avoid detaining ex-prisoners along with other detainees.

c. Minimize language barriers and ensure easier access to information:
   i. Provide legal and practical information relevant to detainees' situation written in a language reasonably understood by them.
   ii. Continue and enhance the use of professional interpreters when needed, even during all medical consultations.
   iii. Provide training and support for detention staff to be more receptive and responsive to queries from detainees.

2. *Recommendations for improving healthcare services at detention centers*

   a. Introduce medical screening on arrival for detainees to safeguard the health of detainees and others:
      i. Mental health screening should be an essential part of screening.
   b. Ensure appropriate healthcare services are provided at detention centers, based on needs identified through medical screening:
      i. Regular mental healthcare services need to be established at the centers.
   c. Adequate training for healthcare staff to provide culturally appropriate and migrant-friendly care.

3. *Recommendations directly impacting detention staff*

   a. Clearer role definitions and division of work to minimize role ambiguity and conflict.
   b. Provide customized and timely training for detention staff:
      i. Include aspects such as intercultural communication, emotional management and recognition of stress symptoms in the mandatory introductory training.
      ii. Same as 1.b.i, 1.c.iii.
   c. Provide better support and supervision for detention staff:
      i. Provide opportunities for staff to discuss and to receive support for their emotional and professional conflicts.

4. Recommendations to be considered at policy/system level

a. Pursue alternatives to detention much more efficiently:
    i. Use detention as a last resort.
b. Enhance efforts to take quickly executable decisions preventing detainees from spending months in detention and thus reducing duration of detention.
c. Grant freedom to detainees to the largest possible extent within detention centers.
d. Develop a long-term strategy to recruit staff appropriate for the roles and to provide them with ongoing training and support:
    i. Same as recommendations 3.a,b and c.

Ongoing process improvements in Swedish detention centers

As stated earlier, I have been regularly interacting with the SMA throughout the project. All results were communicated and discussed regularly with them. During 2015, the immigration detention department at the SMA has started several process improvements aimed at improving the conditions at the detention centers. I was not involved in the process, however, the officials at the immigration detention department indicated that the project and its results have enabled them to identify various aspects of immigration detention that needed to be improved. The following improvements have been implemented so far:

- Employment of a national officer for coordinating health services at all detention centers
- Employment of a conflict management officer responsible for conducting training programs for detention staff
- Employment of supervisors at all detention centers specifically aimed organizing meaningful activities for detainees and minimizing their passivity
- Clearer role description for case officers and supervisors to minimize overlapping of tasks.
- Clearer instructions on how to respond to various incidents such as emergency health conditions, violent behavior from detainees, isolation in case of violent behavior, managing visits for detainees, fire outbreak, death, suicide attempts and activities for detainees

The following improvements are in the process of being implemented:

- A ten-day compulsory introductory training program for all newly employed staff. The program will include training on aspects such as conflict management, suicide prevention, safety and security, and communication with detainees

- Negotiations are ongoing to ensure that a qualified nurse is present at every center, at least for half a day during the weekdays
- Information/brochures will be made available to detainees explaining their rights and obligations, and rules to be followed in detention. The brochures will be available in common languages spoken by detainees. This will be in addition to the verbal information provided to detainees on arrival
- On arrival, all detainees will be screened for suicide risk using a questionnaire.
- Establishing standards to offer similar services across all detention centers.

Conclusions

Immigration detention is a complex administrative system where immigrants who are not suspected of or who have not committed any crime are detained for the execution of an administrative measure, mainly deportation. It has negative effects on the health of detainees. Detaining immigrants for administrative purposes should be avoided to the largest possible extent. However, if immigrants are detained, the detaining authority has to explore and implement measures to mitigate the impact on their health. The efforts to mitigate negative health effects in detention are a multisector approach involving stakeholders ranging from law-makers to NGOs and researchers. During such an endeavor, the voice of detainees and detention staff are to be heard and taken into consideration, which is often not the case. This thesis presents their voice and has identified factors that have the potential to mitigate the negative impact of detention on the health of detainees.

The detention environment should be supportive for its inhabitants. This thesis highlighted factors which are important for the health of detainees. Staying true to the definition of detention, restrictions in detention should not go beyond the restriction on movement or liberty. Detainees had limited access to information they could understand, healthcare services at the detention centers were not adequate, especially mental healthcare services, and psychosocial support to manage the stressful situation in detention was suboptimal. Detention staff faced emotional and professional challenges, mainly arising from role conflict and ambiguity, and lack of timely support and training appropriate to address their challenges. Addressing these factors could contribute to the creation of a detention environment which is supportive for detainees and staff.

Summary in English

Every country has systems in place to manage the flow of immigrants into and out of the country. One such system is immigration detention where immigrants who are residing in the country without a permit (irregular migrants) are detained to be deported. Immigration detention has negative effects on the health of detainees. Sweden has five detention centers with a total capacity of 255 places. The total number of detainees has increased during the past years.

The aim of this study was to explore and describe the lives of immigrants in Swedish immigration detention centers, and to identify factors that could mitigate the negative effects of detention on their health. The study consists of four papers and the study design was emergent and was strengthened through triangulation of methods and data sources. Papers I and II were qualitative studies exploring the perspectives of detainees and staff on life in immigration detention centers. Paper III was a cross-sectional survey to estimate the Quality of Life (QOL) of detainees and assess its relationship with the services provided in detention. In Paper IV, the Swedish detention system was compared to the system in the Benelux countries (Belgium, the Netherlands and Luxembourg) following the principles of descriptive case comparative study design. Benelux countries were chosen for the comparison because all EU member states have similar detention systems under the Common European Asylum System (CEAS). The results from the papers are summarized here as *four factors* that are important for the health of detainees: *lack of control and adequate support, a sense of fear, Detention staff: limited support received, limited support to offer* and *healthcare services in the detention centers*.

Detainees experienced *lack of control and adequate support* to cope with their situation at the Swedish detention centers. This was mainly due to the language barriers, inadequate responses from detention staff and restriction in the detention centers which made it difficult for them to help themselves. Language barriers made it challenging for them to understand the legal decisions and to be informed about their case and plan their lives accordingly. This was further hindered by the inadequate responses, delayed response or no response, from detention staff. The detention staff attributed this to miscommunication between staff members and between the Swedish Migration Agency (SMA) and other authorities such as the police involved in the deportation process. Restrictions within the detention centers, such as

limited access to courtyards and opportunities to seek appropriate healthcare, created a sense of lack of control among detainees. The restrictions varied slightly between the Swedish detention centers with some centers being more lenient than others. Due to these experiences, the detainees considered it futile to seek help, which made them passive. Although the detainees were not 'unsatisfied' with the services provided in detention, increasing duration of detention was significantly negatively associated with the service satisfaction of the services provided and the general QOL score. The duration of detention was further negatively associated, but not statistically significant, with the environmental, physical, psychological and social domain scores of the QOL construct. The average duration of detention was 38 days. After adjusting for socio-demographic characteristics and other factors present in detention, such as gender, educational level, duration of stay in Sweden and duration of detention, it was the support received from staff that was significantly positively associated with the QOL domain scores.

The second factor that was important in affecting the detainees and staff was *a sense of fear*. The detainees experienced fear through their interaction with detention staff and the police involved in various aspects of the deportation process, where they were threatened with prolonged detention if they were not cooperative with those involved in the deportation process. Detainees were also afraid that they could face negative repercussions of being involved in a fight or any other incidents in which they were involved, but not initiated by them, as detention staff might not have witnessed the fight and thus made it difficult for them to judge who had provoked the fight. Detention of immigrants who were imprisoned prior to immigration detention, and are now waiting to be deported, added to the detainees' fear. The sense of fear for the detention staff came from their awareness of the potential physical threat from detainees as detainees were confined against their will. Being a young female staff member was mentioned as challenging by male and female staff members. This was due to the attitude of male detainees towards the female staff members where male detainees commented on how young female staff conducted themselves or on their physical appearances or, in some instances, where detainees considered female staff to be inferior to their male counterparts. However, being a female staff member also has its positive aspects, as they might be able to resolve a conflict more easily than their male counterparts because detainees have greater respect for female staff, especially the older female staff.

The detention staff members expressed the need for more appropriate and timely training and support to perform their duties through the *Detention staff: limited support received, limited support to offer* factor. The main challenge they found difficult to manage was their emotional dilemma arising from being a civil servant with a duty to enable the deportation process and simultaneously provide humane care to fellow human beings,

the detainees. They experienced role conflict while performing their duties. The detention staff wanted to offer more support to the detainees to manage their stress. However, they indicated that restrictions within detention centers were preventing them from doing so. They stated there was a need to reduce restrictions so that the detention environment can become less stressful. The detention staff expressed their wish to have better training and support to improve their communication skills and to manage their emotional dilemma. Compared to Sweden, the Benelux countries offer more customized and timely training to their detention staff, especially in cross-cultural communication and non-violent conflict resolution. Compared to the two categories of staff in Swedish detention centers, the centers in the Benelux countries have more staff categories assigned to different roles.

Healthcare services in the detention centers were found to be inadequate by the detainees and the staff. This was especially true in the case of mental health services where none of the detention centers, but one, had the possibility for a counsellor to visit the centers. Healthcare services at the Swedish detention centers are the responsibility of the county council in which the center is located. Healthcare professionals are employed by the county councils and not by the SMA. Among the four QOL domains, the detainees had the least mean score in the psychological domain. They scored 47.0, 57.5, 41.9, and 60.5 (out of 100) for the environmental, physical, psychological, and social domains, respectively. There were no arrangements in place for doctors to visit any of the centers, except one. All the centers, but one, have nurses visiting twice a week. One center has a nurse visiting five days a week. No medical screening of detainees on arrival is performed at the Swedish detention centers. Healthcare services at detention centers in the Benelux countries offered more services to their detainees. Healthcare professionals such as doctors, nurses and mental health professionals were employed by the authority responsible for immigration detention and they offered regular services to detainees, at least 5 days a week. They also performed medical screening of detainees on arrival. Neither Sweden, nor the Benelux countries, except Belgium, offered special training for healthcare professionals to work with immigrant detainees. Healthcare staff in Belgium was offered training similar to the non-healthcare staff.

If governments decide to continue the use of immigration detention, efforts to minimize its impact on the health of detainees should be explored and implemented. The needs of detainees as well as staff should be addressed in order to create a supportive environment in detention centers, mitigating the impact of detention on the health of detainees. Factors highlighted in this thesis could assist in such endeavors.

Sammanfattning på svenska/Summary in Swedish

Alla länder har olika system för att styra flödet av människor in och ut ur landet (migration). Förvar är ett av de system där immigranter som saknar tillstånd att stanna i ett land (irreguljära migranter) tas i förvar för att bli utvisade eller avvisade. Förvarsvistelse har negativa effekter på förvarstagnas hälsa. Det finns fem förvar i Sverige med en kapacitet om 255 platser. Antal förvarstagna i svenska förvaren har ökat under senaste åren.

Syftet med den här studien var att utforska och beskriva immigranters liv i de svenska förvaren, och att hitta faktorer som kan lindra effekter av förvar på förvarstagnas hälsa. Studien består av fyra delarbeten som presenteras i artiklarna I - IV. Studiens design var "emergent", det vill säga den var flexibel och anpassades efter resultaten från delarbetena under studiens gång. Designen förstärktes genom triangulering av metoder och datakällor. I delarbete 1-2, som presenteras i artiklarna I och II tillämpades kvalitativ forskningspraxis för att utforska förvarstagnas och förvarspersonals perspektiv på att leva i förvar. Delarbete III (artikel III) bestod av en enkätundersökning med en tvärsnittsdesign i syfte att uppskatta livskvaliteten hos förvarstagna och bedöma dess samband med servicen på förvaren. I delarbete IV (artikel IV) jämfördes det svenska förvarssystemet med systemen i Beneluxländerna (Belgien, Nederländerna och Luxemburg), enligt principerna för så kallad "deskriptiv case komparativ studiedesign". Alla Europeiska Unionens medlemsländer ingår i det gemensamma europeiska asylsystemet (CEAS – Common European Asylum System) och har därför liknande förvarssystem. Således valdes Beneluxländera ut som lämpliga för jämförelsen. Resultatet från delarbetena är summerat i avhandlingen som fyra faktorer som är viktiga för förvarstagnas hälsa: brist på kontroll och stödsystem, rädsla i förvaren, förvarspersonal: får mindre stöd men vill erbjuda mer stöd, sjukvård i förvaren.

Förvarstagna upplevde brist på kontroll över sina liv och brist på stödsystem att hantera situationen på förvaren. Orsakerna var språkbarriärer, otillräcklig respons från förvarspersonal och restriktioner inom förvaren som gjorde det svårt för förvarstagna att hjälpa sig själva. Språkbarriären skapade stora utmaningar för förvarstagna att förstå beslut från svenska myndigheter, som är skriven på svenska, och att hålla sig informerade och planera sina liv. Det försvårades ytterligare genom otillräcklig, fördröjd eller ingen respons

från förvarspersonalen. Personalen ansåg att detta berodde på att det är en brist på ordentliga informationsutbyten mellan olika aktörer som är involverade i förvarsärenden, till exempel mellan olika personer i personalen eller mellan myndigheter såsom Migrationsverket och polisen. Restriktioner inom förvaren, såsom begränsad tillgång till utegård eller trädgård och möjlighet att söka lämplig sjukvård, skapade en känsla av brist på kontroll över sina egna liv bland hos de förvarstagna. Restriktionerna varierade mellan enheterna. Vissa enheter visade mer överseende när det gäller restriktionerna. Utifrån dessa upplevelser konstaterade de förvarstagna att det var meningslöst att söka hjälp och det gjorde dem passiva. Även om förvarstagna inte var "missnöjda" med servicen på förvaren påverkades deras övergripande livskvalitet och belåtenhet av servicen de får på förvaren negativt av ökad förvarsvistelse. Ökad förvarsvistelse tenderade att vara negativt korrelerad (inte statistik signifikant) med miljön och de fysiska, psykiska och sociala domänerna i livskvalitetskonceptet Quality of Life (QOL) som användes i det tredje delarbetet. De förvarstagna, som deltog i enkätundersökningen (delarbete III), hade suttit i förvaren i genomsnitt 38 dagar. Stödet som förvarstagna får från personalen var positivit korrelerat med de domänernas poängtal efter justering för potentiella "confounders" (faktorer som kan påverka korrelationen) såsom kön, utbildningsnivå, längden av vistelsen i Sverige och längden av vistelsen i förvar.

Både förvarspersonal och förvarstagna upplevde rädsla på förvaren. Förvarstagna upplevde rädsla i sina kontakter med förvarspersonal och polis eftersom de kände sig vara hotade med förlängd förvarsvistelse om de inte ville samarbeta och bli utvisade. De var också rädda för negativa konsekvenser om de var involverade i incidenter (någon form av våldshandling) orsakad av någon annan förvarstagen eftersom personalen kanske inte kan bevittna alla incidenter och därmed har svårt att bedöma vem som provocerade fram incidenten. Förvarsplacering av ex-fångar, som har avtjänat sitt straff och väntar utvisning, bland andra förvarstagna var en annan faktor som orsakade rädsla bland förvarstagna.

Förvarspersonalens rädsla kom av att de visste att det fanns en risk för fysiska attacker från förvarstagna eftersom de är frihetsberövade mot sin vilja. Både den kvinnliga och manliga personalen konstaterade att det kan vara en utmananing för ung kvinnlig personal att arbeta på förvaren på grund av manliga förvarstagnas attityd mot kvinnlig personal. Det kunde handla om kommenterar om kvinnlig personals utseende eller, i vissa fall, att de ansåg att kvinnliga tjänstemän var underlägsna manlig personal. Men, att vara kvinnlig personal hade också sina fördelar. Den kvinnliga personalen sa att det var lättare för dem än för deras manliga kollegor att lösa en konflikt eftersom förvarstagna respekterar kvinnor mer än män, särskild äldre kvinnor.

Förvarspersonalen uttryckte behov av mer anpassad och tidig utbildning i sin anställning. Den största utmaningen de hade var att hantera sitt

emotionella dilemma av att samtidigt vara tjänstemän, det vill säga att verkställa utvisningsbeslut, och att vara en medmänniska, det vill säga att sörja för god omvårdnad av förvarstagna. De upplevde en konflikt mellan dessa roller. Förvarspersonalen ville erbjuda mer stöd till de förvarstagna för att minska deras stress men, kunde inte det på grund av restriktioner inom förvaren. De konstaterade att färre restriktioner skulle kunna göra förvarsmiljön mindre stressig. Personalen önskade bättre stöd och fortbildning i att hantera detta dilemma och i att bättre kommunicera med förvarstagna. Beneluxländerna erbjuder en mer anpassad fortbildning tidigt i anställningen för sin personal, särskild i interkulturell kommunikation och konflikthantering. Beneluxländerna har fler personalkategorier med olika roller i jämförelse med två personalkategorier i Sverige.

Varken de förvarstagna eller personalen ansåg att sjukvården på förvaren (som landstinget där förvaret är belägen ansvarar för) är tillräcklig. Bara på ett av de svenska förvaren finns möjlighet till ett besök av en kurator eller någon annan personal, specialiserad i psykiskt omhändertagande. Sjukvårdspersonal är anställd av respektive landsting. Bland de fyra livskvalitetsdomänerna i delarbete III hade förvarstagna lägsta genomsnittliga poängtal inom den psykiska domänen. Förvarstagna fick 47.0, 57.5, 41.9, respektive 60.5 (av 100), på miljön, och de fysiska, psykiska respektive den sociala domänen. Bara på ett av förvaren har förvarstagna möjlighet att träffa läkare på plats. På de andra förvaren kan de eventuellt träffa en läkare på en närliggande vårdcentral. Alla förvaren, utom ett, får besök av en sjuksköterska två gånger i veckan. Ett förvar har en sjuksköterska på besök fem dagar i veckan. Ingen hälsoundersökning av förvarstagna utförs på de svenska förvaren. Förvarstagna i Beneluxländera får mer sjukvård, inklusive hälsoundersökning vid ankomsten till förvaret. Sjukvårdspersonal såsom läkare, sjuksköterskor och psykiatriskt specialiserad sjukvårdspersonal erbjuder vård för förvarstagna många dagar i veckan och är anställda av myndigheten som har ansvaret för förvaren. Varken Beneluxländerna, utom Belgien, eller Sverige erbjuder specialutbildning för vårdpersonal som jobbar i förvar. Belgien ger vårdpersonal och förvarspersonal samma utbildning.

Om länder fortsätter att använda förvar, som ett verktyg att kontrollera migration bör de införa åtgärder för att lindra effekten på förvarstagnas hälsa. De behov de förvarstagna och personalen har för att skapa en stödjande miljö i förvar bör tillgodoses och kan därmed bidra till att lindra effekterna av att vara förvarstagen och till att underlätta att arbeta där. De förhållanden och upplevelser som identifierats i denna avhandling och de förslag på åtgärder som givits kan förhoppningsvis bidra till ett förbättringsarbete.

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Appendix

UPPSALA UNIVERSITET

EUROPEAN UNION
European Refugee Func

Questionnaire used for data collection in Paper IV

Daily life and wellbeing of irregular immigrants detained in Sweden & other EU member states

Country:

General	
1.	Please state the national and EU laws relevant to detention of irregular immigrants?
2.	What are the various legal grounds for detention of an immigrant?
3.	Which agency/authority is responsible for running/overseeing the centers?
4.	How many detention centers exist in the country?
	a. Type and capacity
5.	Are private companies allowed to run centers?
	a. If yes, how many of the above mentioned centers are run by private companies?
6.	What is the maximum duration of detention?
	a. How does duration of detention vary depending on detainees' legal status (asylum seeker, detainees subjected to Dublin regulation, irregular migrant etc.)?
7.	Is re-detention (releasing an immigrant from detention and detaining him/her again) possible?
	a. If yes, how is the maximum duration calculated? (i.e. duration of all instances together or each instance has its own maximum duration)
8.	Are children detained?
	a. If so, what is the maximum duration?
	b. What special measures are put in place while detaining children?
9.	Are families detained?
	a. If so what is the maximum duration?
	b. What special measures are put in place while detaining families?
10.	Are immigrants with criminal background (individuals who have finished serving their prison sentences/punishment and are waiting to be deported) detained together with other immigrant detainees?
11.	Please provide data for past 5 years on detention duration and legal status of detainees. Please refer to the annex (Table 1 & 2) for table formats.
12.	Please provide the top 5 detainee nationalities during the last 5 years.
13.	Please describe 'vulnerability' according to the country's legal framework and kindly provide data on type of vulnerability and number of vulnerable individuals detained during

	the last 5 years
14.	What kind of daily/weekly allowances do detainees receive?
	a. If these entitlements vary based on detainees' legal status, please provide details.
15.	Do detainees have access to lawyer provided and paid by the state?
	a. How does it vary according to detainees' legal status?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
16.	What is the average cost for detaining an immigrant a day?
17.	What was the total cost incurred for detention and related services during 2014 (or the latest year for which the figures are available)?
Communication	
18.	How are detainees informed about decisions/process/procedures (including internal rules at centers) by authorities?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
19.	If detainees do not understand the local language, how is information translated for detainees?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
20.	What options are available for a detainee who does not speak one of the common languages in detention (local language and/or English) to communicate with staff at detention centers?
	Please state whether the above mentioned measures are part or a **legal regulation** or **guideline** or an **ad hoc** measure:
21.	What options are available for detainees to raise complaints about their living conditions in detention and legal proceedings?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
Living conditions in detention centers	
22.	To what extent are detainees allowed to freely move within detention centers (including access to common areas such as dining rooms, library, computer room etc.)?
23.	To what extent have detainees access to courtyard or other possibilities to be outdoor?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
24.	Are there any educational/social activities such as English lessons or sports competitions available for detainees?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
25.	What kinds of leisure activities are available for detainees?

	a. Do they have unrestricted access to these facilities?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
26.	Are detainees allowed to cook or bake?
	a. If allowed, who provides food items to cook/bake?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
27.	How often do detainees have access to shower, toilets and laundry?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
28.	Are they provided with free toiletries and clothes?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
29.	What is the average size of a detainee cell/room and how many detainees live in such a room?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
30.	What facilities do detainees have in their rooms (TV, toilet, microwave)?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
31.	How often do detainees have access to telephone, internet and other communication channels?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
32.	How often and how long can detainees receive visits from family and friends?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
Detention staff	
33.	What are the various staff categories (who regularly interact with detainees) present in detention centers and their tasks?
34.	What are specific requirements such as professional, ethnic, linguistic background are in place while recruiting new personnel?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
35.	Please state the staff to detainee ratio?
36.	Does staff wear uniforms?
37.	What are the different training/educational programs offered for detention staff? Please mention which of these programs are mandatory/optional.
Health care	
38.	What kinds of heath care services are available at detention centers?

	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
39.	What are the different categories of medical professionals working at detention centers?
	a. What is their employment agreement? (employed by the center, private contractor, part of the public health service offered in the country)
	b. What is the consultation schedule?
	c. Do they receive any special training to work with detainees?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
40.	Is there an entry/exit medical checkup/screening for detainees?
	a. What happens if a detainee is identified with a disease during this process?
	i. On entry check up
	ii. On exit check up
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
41.	What kind of health care entitlements do detainees have?
	b. Does it include dental care?
	c. Does it include mental health care (counsellor/psychologist)?
	d. Do they have to pay for their medical visits within the centers?
	e. Who pays for medicines?
	f. If they have to access health care services outside detention centers, what transportation arrangements are in place?
	g. Who pays for medical visits outside of detention centers and for medicines prescribed during these visits?
	Please state whether the above mentioned measures are part of a **legal regulation** or **guideline** or an **ad hoc** measure:
NGOs/ international organizations	
42.	How are various international organizations (UNHCR, IOM etc.) involved in detention?
43.	How are NGOs involved in detention?

Annex

Table 1: Statistics on immigrant detainees during 2010-14

	2010		2011		2012		2013		2014	
	Total	**Average duration**	**Total**	**Average duration**	**Total**	**Average duration**	**Total**	**Average duration**	**Total**	**Average duration**
Boys (<18 yrs)										
Girls (<18 yrs)										
Men										
Women										

Table 2: Statistics on immigrant detainees based on legal status

Legal status	**Total**				
	2010	**2011**	**2012**	**2013**	**2014**
Asylum-seekers					
Rejected asylum seekers					
Immigrants subject to Dublin procedures					
Immigrants who have finished their prison sentences and are waiting to be deported					
Irregular migrants (detainees who do not belong to the above 4 categories)					

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