

The hidden burden of “Telefono” torture: A case series among People on the Move arriving in Agrigento, Italy.

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Introduction

Along the Central Mediterranean migration route, migrants and asylum seekers continue to report exposure to multiple forms of intentional violence before and during their journey, including forced labour, beatings, burns, stab wounds, electrocution, sexual violence, and other forms of torture or ill-treatment (IRCT, 2017; Argo et al., 2026; Bianchi et al., 2021). These abuses frequently occur in situations of unlawful detention and are often linked to extortion, with perpetrators demanding ransom payments from victims' families. Reports by humanitarian and human rights organizations have repeatedly denounced the severe conditions faced by migrants and asylum seekers in Libya, where many remain trapped in systems of exploitation, arbitrary detention, and violence involving private employers, human traffickers, armed groups, and security actors (Amnesty International, 2021; MSF, 2022; MSF, 2023; United Nations Human Rights Council, 2023; OHCHR, 2022; UNICEF, 2025; MEDU, 2024).

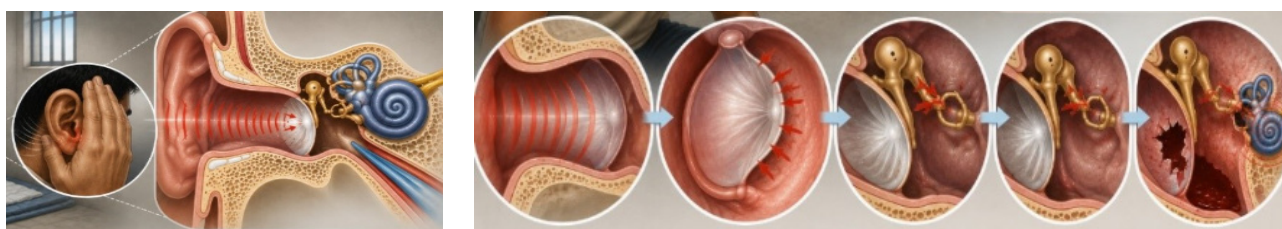
Among under-recognised forms of torture, according to Istanbul Protocol, is listed the *telefono* type of torture. It consists of hard slap of the palm over one or both ears (OHCHR, 2022, Chapter V, Physical Evidence of Torture and Ill-Treatment, paragraph 407, page 96). The mechanism involves a sudden

increase in pressure within the external auditory canal, which may produce severe pain and damage to the auditory system (Figure 1), and may also cause subdural bleeding. Reported consequences include ear pain, tinnitus, subjective hearing loss, vertigo, tympanic membrane rupture, scarring, cholesteatoma, and secondary infections such as otitis media and otitis externa (Amris et al., 2007; Graessner, 1994).

Cassone et al. (2025) described three cases of *telefono*-type auditory injuries among migrants rescued during the MSF High Seas Mission in the Mediterranean. Their report highlighted both the clinical relevance of this form of violence and the risk of under-recognition, particularly because external signs may be absent and because ship-based medical encounters are necessarily brief.

The present case series builds on that observation by describing *telefono*-type violence identified in the land-based MSF People on the Move Project in Agrigento, after disembarkation. By documenting the reported histories, otologic findings, associated symptoms, and broader context of violence, this study aims to contribute to the clinical recognition of *telefono*-type torture among recently arrived migrants and to support targeted assessment and referral pathways, as well as providing the correct documentation.

Figure 1. Graphical presentation of the damage mechanism



Methods

We conducted a retrospective descriptive case series based on anonymised clinical data collected during routine medical activities of the MSF People on the Move project in Agrigento, Sicily, from 1 October 2025 to 30 June 2026. The project provides primary medical care to people who have recently arrived in Sicily after migration, including assessment and management of migration-related health problems and reported intentional violence when clinically relevant. The project does not use a systematic screening programme for intentional violence. Clinical staff are trained to recognise and document histories and findings potentially related to intentional violence, and intercultural mediation is used during consultations. Therefore, cases emerged during ordinary clinical history-taking. When otologic complaints, previous symptoms or other elements of the history suggested possible ear trauma, MSF clinicians explored traumatic causes, including the possibility of intentional injury to the auricular region. For this case series, patients were included when the clinical record documented a reported episode of intentional ear-directed violence consistent with *telefono* mechanism described in the Istanbul Protocol. Accordingly, the numbers reported here represent cases identified during routine clinical care and must not be interpreted as population prevalence estimates.

For each included case, the following variables were extracted from the anonymised clinical record: age, time elapsed between the reported episode and clinical evaluation, current otologic and related symptoms, otoscopic findings, and other reported forms of intentional violence. Routine management, including analgesic treatment or first-line antibiotic therapy when clinically indicated, was also recorded. All patients reporting telefono-type violence were referred to the Italian National Health Service for specialist otorhinolaryngological assessment and comprehensive audiometric evaluation. Specialist test results were not systematically available to the MSF project and are therefore not included in this series. Photographic documentation of otoscopic findings was not routinely collected in the mobile clinic setting due to technical constraints and ethical considerations regarding photographing patients in a vulnerable context.

Ethical consideration

This manuscript reports a retrospective descriptive analysis of fully anonymised data that had been collected during routine clinical care. No additional examinations, procedures, or data were obtained for research purposes, and no identifiable patient information is reported.

Results

During a period of nine months, from the 1st of October 2025 to the 30th of June 2026, in the context of the MSF People on the Move Project in Agrigento, medical staff identified and documented 230 cases (29,5%) of intentional violence among the 779 people who had access to the project services.

Among these 230, 13 cases of patients (5,6%) reporting *telefono* type of torture were identified. All patients were Bangladeshi men who reported that the ear-directed violence had occurred during transit through Libya. Their median age was 28 years (range 17–41 years). These cases are described in Table 1.

Five patients were evaluated less than one month after the reported episode, four between one and three months, one between three and six months, and three between six and twelve months.

Otoscopic hyperaemia was documented in nine patients, including bilateral hyperaemia in two. Tympanic membrane rupture was documented in two patients. Ear pain was reported in seven patients, tinnitus in five, subjective hearing loss in three, vertigo in three, otorrhoea in two and masseteric pain in three. One patient had no current otologic symptoms and no objective ear findings at the time of evaluation. Twelve of the 13 patients also reported beatings; three reported falanga, two reported nail avulsion, one reported positional torture, one reported burn and one reported sexual violence.

During the consultations, pain relief or first-line antibiotic treatment was prescribed in cases where the medical staff deemed it necessary.

All patients evaluated were referred by medical staff to the Italian national health system for global audiometry and otorhinolaryngologist assessment.

Discussion

This small clinical-forensic case series describes 13 Bangladeshi male migrants who reported *telefono*-type violence during transit through Libya and were subsequently evaluated in a land-based humanitarian medical setting in Agrigento. Although the limited sample size does not allow any estimate of prevalence or generalisation to the broader population of migrants crossing the Central Mediterranean route, the cases provide useful observations on the clinical presentation of an under-recognised form of violence. This series should be read in continuity with the previous ship-based report by Cassone et al., who described three cases of *telefono*-type auditory injuries among migrants rescued by Geo Barents during the MSF High Seas Mission in the Mediterranean. That report highlighted the clinical relevance of this form of violence, but also the risk of under-recognition in search-and-rescue settings, where medical encounters

Table 1. Description of the 13 telefono cases with their age, time passed between torture and clinical examination, signs and symptoms, and other kinds of violence reported.

	Age	Time between <i>telefono</i> and clinical evaluation	Signs and symptoms	Other types of torture reported
Case 1	21 yo	< 1 month	Unilateral ear pain, unilateral tympanic hyperaemia, unilateral masseteric pain	beatings and falanga
Case 2	41 yo	Between 1 and 3 months	No otologic symptoms or objective ear findings	falanga
Case 3	31 yo	< 1 month	Unilateral ear pain, vertigo, and unilateral tympanic hyperaemia	beatings, falanga, positional torture, nail avulsion
Case 4	17 yo	< 1 month	Unilateral tympanic hyperaemia	beatings
Case 5	22 yo	Between 6 and 12 months	Bilateral ear pain, bilateral tympanic hyperaemia, unilateral tympanic membrane rupture, and otorrhoea	beatings, burns, nail avulsion
Case 6	31 yo	Between 6 and 12 months	Vertigo and unilateral masseteric pain	Beatings
Case 7	36 yo	Between 6 and 12 months	Vertigo, bilateral tympanic hyperaemia, subjective hearing loss, and otorrhoea.	Beatings
Case 8	39 yo	Between 1 and 3 months	Unilateral ear pain, tinnitus, and unilateral tympanic hyperaemia	Beatings
Case 9	21 yo	Between 1 and 3 months	Unilateral ear pain, tinnitus, unilateral tympanic hyperaemia, and unilateral masseteric pain	Beatings
Case 10	28 yo	< 1 month	Unilateral ear pain, tinnitus, unilateral tympanic hyperaemia, and subjective hearing loss	Beatings
Case 11	28 yo	Between 1 and 3 months	Unilateral ear pain	Beatings
Case 12	22 yo	Between 3 and 6 months	Tinnitus and unilateral tympanic membrane rupture	Beatings
Case 13	38 yo	< 1 month	Tinnitus, unilateral tympanic hyperaemia, and subjective hearing loss	Beatings, sexual violence

are necessarily brief and follow-up after disembarkation is often not possible. Indeed, the land-based ‘People on the Move’ project identified, on average, more cases of intentional violence than the GeoBarents SAR project (29,5% vs 5%). Among these, also *telefono* cases are identified proportionally more frequently (5,6% vs 2,5%). This could be attributed not to the characteristics of the population (migrants from the same migratory backgrounds), but to the specific characteristics of a land-based project: post-disembarkation services may provide an additional opportunity for disclosure, otologic assessment and referral. However, a direct quantitative comparison between the two settings would be inappropriate because case ascertainment, patient selection, timing after the traumatic event, consultation duration, disclosure patterns, staffing and documentation practices differ. Greater opportunity for follow-up in a land-based setting is therefore a plausible hypothesis, not an explanation demonstrated by these data.

In line with international literature, in our series *telefono*-type violence was associated with both objective otoscopic abnormalities and persistent subjective symptoms. Tympanic hyperaemia was documented in nine cases, while tympanic membrane rupture was observed in two. Ear pain was the most frequently reported symptom, followed by tinnitus, subjective hearing loss, vertigo, and otorrhoea. These findings are consistent with a mechanism involving a sudden increase in pressure within the external auditory canal, which may damage the tympanic membrane and, in some cases, affect middle-ear function. However, these signs and symptoms are not specific to *telefono* and may also be influenced by prior infections, poor hygiene during migration, delayed access to care, or other traumatic events.

Although the Istanbul Protocol states that it is necessary to identify ruptures of the eardrum at an early stage because they can heal within 10 days, a relevant aspect emerging from this series is the persistence of symptoms over time (OHCHR, 2022, Chapter V, Physical Evidence of Torture and Ill-Treatment, paragraph 407, page 96). Several individuals were evaluated months after the reported violence, including three cases assessed between six and twelve months after the episode. The presence of symptoms such as tinnitus, hearing loss, vertigo, otorrhoea, or ear pain beyond the acute phase suggests that *telefono*-type violence may have consequences that persist when not identified and managed promptly. This is particularly relevant in mobile populations, where access to specialist assessment or follow-up is often not possible.

The cases also show that *telefono* rarely occurred in isolation. All individuals reported additional forms of violence or torture, most commonly beatings, but also falanga, positional

torture, burns, sexual violence, and nail avulsion. This supports the interpretation of *telefono* as part of a broader pattern of coercive and detention-related violence rather than as an isolated assault.

Previous ship-based observations have highlighted that *telefono*-type injuries may be under-recognised during search-and-rescue operations because medical encounters are necessarily brief and survivors may be reluctant or unable to disclose violence immediately after rescue. A project based after disembarkation may offer an additional opportunity for disclosure, clinical evaluation, documentation, referral, and continuity of care. In this sense, land-based mobile clinics may represent a crucial bridge between emergency rescue and longer-term clinical, rehabilitative and eventually medico-legal pathways.

This case series has some limitations. The number of cases is small; the data relies partly on self-reported histories; no control group was available; and specialist otolaryngological assessment or audiometric testing was not systematically performed. The time elapsed between the reported violence and clinical evaluation varied considerably, which may have influenced both the persistence and the detectability of clinical findings. Despite these limitations, the findings suggest that *telefono*-type violence should be actively considered in recently disembarked migrants reporting detention-related abuse, especially when they describe ear pain, tinnitus, hearing loss, vertigo, otorrhoea, or facial pain. Targeted otologic examination and early referral pathways may help identify complications and vulnerabilities that could otherwise remain untreated and undocumented.

Conclusions & recommendations

Reported *telefono*-type violence should be considered when recently arrived migrants describe ear pain, tinnitus, hearing loss, vertigo, otorrhoea or a history of blows directed to the ears. In routine humanitarian care, targeted questioning prompted by otologic symptoms or relevant history, careful otoscopy and timely referral for specialist otorhinolaryngological and audiometric assessment can improve detection of treatable complications.

Future prospective work should use standardised otologic assessment, document the timing of exposure and symptoms, obtain audiometric data whenever feasible, and incorporate structured follow-up. Where technically feasible, ethically appropriate, and supported by specific informed consent, clinical imaging could strengthen documentation. Larger studies with systematic ascertainment and denominator data are needed before the frequency of *telefono*-type violence or differences between demographic groups and care settings can be estimated.

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