

Scott, Penelope

Article — Published Version

Black African asylum seekers' experiences of health care access in an eastern German state

International Journal of Migration, Health and Social Care

Provided in Cooperation with:
WZB Berlin Social Science Center

Suggested Citation: Scott, Penelope (2014) : Black African asylum seekers' experiences of health care access in an eastern German state, International Journal of Migration, Health and Social Care, ISSN 1747-9894, Emerald, Bingley, Vol. 10, Iss. 3, pp. 134-147, <https://doi.org/10.1108/IJMHS-11-2013-0043>

This Version is available at:
<https://hdl.handle.net/10419/190839>

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.

If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.

Black African asylum seekers' experiences of health care access in an eastern German state

Penelope Scott

Dr Penelope Scott is a Research Fellow, based at Sociology Institute, Ludwig Maximilians University, Munich, Germany.

Abstract

Purpose – *The purpose of this paper is to examine how access to health care for (rejected) asylum seekers in an eastern German state is structured and experienced and to consider the implications for their human rights.*

Design/methodology/approach – *The paper is based on 12 in-depth interviews with rejected black African asylum seekers and also draws on ethnographic research undertaken at a grassroots refugee organisation and asylum homes. The analysis of the interview data are framed by theorisations of “everyday practices” as “tactics” of resistance to an imposed order.*

Findings – *Accomplishing health care access involved a range of structural barriers and humiliating interactions with administrative and health care staff, which had adverse consequences for their health status and were injurious to their human rights and dignity. The study participants used a range of oppositional and discursive tactics in an effort to secure certain (health) outcomes, mediate social relations and resist their domination as asylum seekers.*

Research limitations/implications – *Further research should focus on the cumulative micro-level effects of asylum policies on health care access and how they create health inequities and violate asylum seekers' rights and dignity.*

Practical implications – *Policy priorities should include the provision of human rights education as well as training and support for administrative and health staff.*

Originality/value – *There is limited qualitative research on the health care experiences of asylum seekers in Germany. This paper makes policy recommendations and identifies areas for further research and human rights advocacy.*

Keywords *Germany, Asylum seekers, Black Africans, Discrimination, Health inequities, Health care, Human rights, Qualitative research*

Paper type *Research paper*

Introduction

Understanding how access to health care is experienced by asylum seekers is integral to assessing the impact of policies designed to provide this care. Yet within European countries, knowledge in this area is limited. Public health research comparing European Union country policies, however, indicates that policy provisions are based on minimum standards with the likelihood that the health needs of asylum seekers are not always met (Norredam *et al.*, 2005). The output of civil society groups has also made progress in documenting evidence of the gap between legal entitlements to care and access to these entitlements (HUMA Network, 2009). While there are some qualitative studies on asylum seekers' health needs and service barriers (Behrenson and Groß, 2004; Dupont *et al.*, 2005; Gilgen *et al.*, 2005; O'Donnell *et al.*, 2007) there is less research, particularly in Germany, exploring their experiences when interacting with the institutional framework structuring access to care and how this affects their use of services.

This is an important area of enquiry not only because of the lengthy time period asylum seekers often remain within the system and the known effects this has on physical and mental health (Watters, 2001; Laban *et al.*, 2004; Steel *et al.*, 2011). As a politically constituted societal resource, health care provision can be related to “infringements or improvements of human rights states of the people being served” (Wildner *et al.*, 2002, p. 1725). As such, it is a fruitful site to explore tensions between states’ human rights obligations and disciplinary asylum policies, which manifest in the human rights outcomes of health service provision to asylum seekers.

Access to health care is ultimately mediated by the various administrative and professional actors entrusted with translating policy provisions into practice. This occurs in socio-political environments where being an asylum seeker not only means belonging to a reified legal category. Through processes of racialisation this status has come to signify a distinctive and marginalised position in social space (Garner, 2010). Asylum seekers’ status as “rights holders” and the role of the state and its representatives as “duty bearers” have become muted in both political rhetoric and policy. Instead, the dominant discourse on asylum seekers as bogus and a threat to security have led to their stigmatisation as the “other” (Grove and Zwi, 2006). Their portrayal as “scroungers” together with migration controls, based in part on economic arguments concerning the need to protect societal goods, have cumulatively constructed asylum seekers as competitors for scarce resources (Schuster, 2003, p. 241). As a consequence, in the seemingly routine encounters and interactions as they access health care a new front of micro-politics opens up offering possibilities for strategies of domination and tactics of resistance or accommodation.

Drawing on the findings of in-depth interviews with rejected black African[1] asylum seekers and ethnographic research conducted in eastern Germany, this paper aims to explore not only how their access to health care is structured and experienced but also how, in social interactions and everyday practices alternatives to a particular regime have been found. The implications for asylum seekers’ human rights states are also considered. Theoretical insights from the work of Michel de Certeau (1984) are deployed to interpret their responses to the social encounters and institutions in which access to care is embedded. These theoretical perspectives offer frameworks for understanding asylum seekers’ behaviours and reactions to their circumstances. de Certeau’s concern is with how disciplinary regimes, such as the asylum system, are limited and the ways in which everyday mundane practices prove to be forms of resistance that challenge in an unorganised fashion, strategies of domination that render individuals powerless. Everyday practices, according to de Certeau (1984, p. 37), are “tactics” in the sense that they are manoeuvres by “the weak” in response to any imposed order. These everyday practices occur in “the space of the other” and aim to make the places, rules and discourses of institutions more “habitable”. In contrast to a “tactic”, de Certeau defines a “strategy” as the institutional embodiment of “will and power,” which include laws, authorities and administrative offices. A “strategy” is characterised by its own spatial or institutional localisation, which generates relations with the exterior. However, a “tactic” does not have its own place and instead it:

[...] insinuates itself into the other’s place, fragmentarily, without taking it over in its entirety [...] (it) is always on the watch for opportunities that must be seized “on the wing”. It must constantly manipulate events in order to turn them into “opportunities”. This is achieved in the propitious moments when (the weak) are able to combine heterogeneous elements [...] (in) the act and manner in which the opportunity is “seized” (de Certeau, 1984, p. xix).

Enacting discipline through German asylum law and the policy context of health care

Asylum seekers, including those who have been rejected and are living with a “temporary stay of deportation” (*a Duldung*), are objects of dividing practices employed by the state that include welfare measures and restrictions which do not apply to other groups of nationals and legally resident non-nationals. The asylum laws prescribe living conditions characterised by the payment of benefits in kind or vouchers, inadequate housing, restrictive access to employment and unequal access to health care. These measures coalesce into a truth regime regarding their material needs and have effectively reduced the validity of the international human rights framework to minimum standards (Liedtke, 2002, p. 493; UNCESCR, 2011).

Access to health care for both asylum seekers and those awaiting deportation is regulated by the Asylum Seekers' Benefits Act (ASBA), as well as administrative structures at municipal level in each federal state. A defining feature of this access for the first four years of their residence is the existence of specific access barriers which include first, limitations on the medical care available to cases of "serious illness or acute pain" (ASBA, §4.1). Second, in many regions access is contingent on following certain administrative procedures. Specifically, asylum seekers must first request a medical voucher, in most instances from the local Social Welfare Office or in some cases, from the asylum home staff. Significantly, these legal measures violate Germany's human rights obligations to respect individuals' right to health by refraining from limiting or denying equal access for all persons including asylum seekers (United Nations Committee on Economic, Social and Cultural Rights, 2000, §34). At the end of this four-year period they become eligible to use the health system like all legally resident persons and possess a health insurance card. The lifting of restrictions, however, does not guarantee equity in access (Riesberg and Wörz, 2008, pp. 77-79; Norredam *et al.*, 2005, pp. 278-288; Pross, 1998).

Further dividing practices codified into law which impact upon access to care include their location in specified accommodation facilities, many of which, particularly in eastern German states, are in former military barracks situated in rural woods. As Behrenson and Groß (2004, p. 13) argue, these accommodation centres exhibit many of the characteristics present in Goffman's (1961) analytical construction of the "total institution". The spatial containment and confinement of asylum seekers in these remote locations is achieved through the disciplinary force of the "residence obligation" set out in the Asylum Procedure Act §56. It severely restricts their freedom of movement by prohibiting them from leaving their assigned district without first applying for a "leave of absence" (§58). Observation, as well as the ever present threat of being observed constitute a surveillant gaze that is central to the operation of the asylum laws bringing together power, knowledge and control (Foucault, 1977). Their geographic location is of heightened significance due to the double jeopardy of being both an "asylum seeker" and a "black African" in eastern Germany. Right wing racially motivated attacks are statistically speaking more likely to happen in eastern states and among the groups most targeted are asylum seekers, particularly Africans (Federal Ministry of the Interior, 2010, p. 32; United Nations Committee on the Elimination of Racial Discrimination, 2008, p. 4). This inhibits their readiness to be in public spaces or transport, even to seek medical attention (Riesberg and Wörz, 2008).

Their subordinated position raises questions concerning their capacities to act independently. However, Goffman's (1961, p. 320) observations on personalised responses to structured vulnerabilities are pertinent here:

Our sense of being a person can come from being drawn into a wider social unit; our sense of selfhood can arise through the little ways in which we resist the pull. Our status is backed by the solid buildings of the world while our personal identity often resides in the cracks.

One line of enquiry this opens up is how asylum seekers exercise agency in negotiating the institutions and encounters structuring access to health care. In addressing this question, this study aims to investigate not only accommodating behaviours. A primary focus are those actions and postures which "resist the pull" of power and domination, those everyday practices and taken for granted acts in social interaction that assert selfhood. It will be shown that rather than being "docile bodies", the research participants were resourceful and savvy as well as knowledgeable about their rights. In negotiating access to health care they displayed a repertoire of oppositional and discursive tactics, which mediated social relations, secured certain outcomes and in the process resisted domination.

Methods

Ethnographic research was conducted between summer 2007 and winter 2010/11 and included 12 in-depth interviews, two of which were follow up interviews with participants who had specific health issues at the time of their first interview.

The topics ranged from their illness experiences, living conditions and interactions with health staff and administrators. The ten study participants, purposively selected on the basis of an existing or pre-existing health condition, were recruited at meetings held at a black African

refugee activist organisation. The group's organisers, who were former asylum seekers, facilitated contact to potential participants. This assistance was particularly advantageous given the known difficulties in recruiting asylum seekers for research (Gilgen *et al.*, 2005, p. 263). Success in gaining access to the organisation and participants' consent was contingent on several factors. The first was the perceived convergence between the issues of the research and an aim of the organisation to raise awareness of the social injustices generated by Germany's asylum politics. Another was an unsolicited commitment to respect certain ethical boundaries by protecting participants' identities and refraining from asking prying questions about their asylum claims. In keeping with this former pledge, their names and other identifying personal details have been changed and pseudonyms used. All participants were living or had lived in asylum homes in the particular state where the fieldwork was conducted.

The study participants comprised six women and four men all of whom were living or had lived on a *Duldung* after the rejection of their asylum claim for periods ranging from two to seven years. Half of the women were mothers and had given birth to at least one of their children while on a *Duldung*. Three of the participants had recently married and had started the complicated and potentially lengthy process to regularise their residence status. One of the female participants had already obtained her residence permit through marriage and had statutory health insurance. As a result, she had the dual experience of negotiating the health system both with and without the status as a beneficiary under the ASBA.

Most of the interviews were conducted on the premises where the organisation held its meeting and these interviews were recorded and later transcribed. Three were held at the remotely located asylum home where the respective participant lived. Two of these participants preferred the interview not to be taped. Detailed notes and verbatim quotations, derived from a personal shorthand system, were taken during these interviews. Six of the participants were native English speakers whereas among the remaining four, French was the dominant language. For the interviews with this latter group, the researcher opted to accept the offer of interpreting support from one of the organisation's leaders who was bi-lingual and whose command of the French language therefore, exceeded her own. These interviews, which were all recorded, were thus bounded by "triple subjectivity" (Temple and Edwards, 2002, p. 6; Temple, 2002, p. 846).

The interview data as well as the ethnographic notes, comprising thick descriptions of visits to the refugee organisation and four remotely located asylum homes, were analysed with a two-step data coding process described by Charmaz (2002). The qualitative software programme HyperResearch facilitated the coding.

Findings

Organising access to health care

None of the participants had been provided with information on the health services available and how to access them. It was usually from other asylum seekers that they learned the first step involved getting the medical voucher. Their accounts of the process provoked strong emotions and the causes of their frustration centred on the logistical difficulties involved as well as their treatment by administrative personnel.

Contending with time, distance and place. Since in most cases participants had to apply in person at the Social Office for the voucher, they had to overcome the physical distances separating the office and the asylum home. The distances were daunting, particularly in winter, for participants living in remote, forested areas. They had to walk a considerable way to reach the first bus stop or train station from where they could start the journey to the office. They also had to have the cash available to pay for the trip, an expense they could hardly budget for given their meagre allowance. This money could be reclaimed from the Social Office, but as they noted, unless an asylum seeker knew this was their right, none of the staff would voluntarily disclose the information.

Going to the Social Office had to be timed carefully to coincide with its restricted opening hours. Several participants recounted experiences where the Social Office's limited opening hours had

resulted in delays to accessing medical assistance and the prolonging of physical suffering. Visibly upset, Barbara related:

I discovered I had an abscess in between my buttocks. I had to go to the hospital but I had to wait until the Social Office is working so that I can take the voucher. So I was very sick on the Friday and unfortunately I had to wait Friday, Saturday, Sunday, Monday until Tuesday before going to the hospital because the Social Office works (in District A) on Tuesdays and Thursdays. I was in very severe pain, very, very severe.

Arriving outside of the designated office opening times would result in them being turned away by the staff as Lorraine had experienced. Her attempts to reason with the office administrators were of no avail:

When I go there, they tell me I must only come on appointment. And I say but my sickness does not come on appointment and they say that is not the point, I must only come there on appointment. At times if I go there on Monday, they tell me to come on Thursday to get the voucher.

Participants had to learn not only their respective legal entitlements to care and the explicit rules governing the functioning of the office such as the opening times. They also had to learn the attitudes of the staff, how the staff would act towards them and then respond accordingly. In this way, the disciplinary framework regulating access to health care also achieves social control. However, this does not mean that the power of this institutional framework is unlimited. Social control is dependent upon reenactment in order to achieve success. This need for social control, and thus power, to assert itself repeatedly opens up opportunities for resistance, which ultimately subvert its influence (Foucault, 1978). de Certeau's (1984) distinction between regime strategy and daily tactics reveals ways in which subversion is effected. If the Social Office as a constitutive element of the asylum regime strategy functions without any symbolic acts of defiance then the regime is legitimised. However, through the use of oppositional tactics such as arriving outside of office hours and questioning the logic of the opening hours, the legitimacy of the regime strategy is subverted in daily practices.

Negotiating the voucher with the gate-keepers: enduring humiliation and administrative intransigence. Given the legal specification that asylum seekers are eligible for emergency care only, it was not a foregone conclusion that they would be given the voucher. It was the job of medically untrained administrative staff to make enquiries about their health complaints and then assess their "eligibility" for care. This was, without exception, a humiliating experience for all participants. As Stephen and Karl said, they were often made to feel as if their claims to be ill and the nature of their symptoms were being doubted. Worst of all was the shame induced by this invasion of their privacy and their fear of the consequences of what they disclosed:

At times you don't know even what you are suffering from because of shame or anything you don't want to tell the Social Office which kind of illness you are suffering from. At times you are afraid of the scandals in case they discover you have a certain type of illness because if they see you have HIV, the Social Office will call the asylum home and all the people in the home will tell the other refugees and you will be mocked. So many refugees have been suffering this kind of a problem, because they are afraid, frightened, ashamed. No privacy, no nothing so many wait until they can have an insurance card before they start visiting the doctor – and by then it is too late, your health has deteriorated. It is really sad (Barbara).

Kenneth stated he had been refused a medical voucher and this seemed to have been related to the number of requests he made within a specific period of time:

It is really complicated because you may go one or two times in a month and the third time you go and ask for a voucher you are being refused from having one. It is really, very difficult, at times you have to go through serious torment before you can get this voucher.

This fits a general pattern of legalism and inflexibility regarding the disbursement of vouchers. Stephen noted that if the asylum home administrators realised his *Duldung* would soon expire, they would insist that he first go to the Foreigner's Office, which was almost an hour's distance away by train, to renew his status. This inevitably meant a delay in seeking medical attention.

Bureaucratic subjugation: prioritising "paperwork" over patient need. The pivotal importance of the voucher in accessing health care was clearly demonstrated in times of sudden illness at night when both the Social Office and doctors' surgeries were closed. This could result in the

emergency doctor refusing to treat them unless they possessed an insurance card. Similar obstacles faced new mothers. They could find themselves trapped in a bureaucratic maze as they tried to sort out the paperwork necessary for their babies to access care. Erica's experiences illustrate how the complexity of the work involved and the lack of alignment between prerequisites for access and participants' circumstances create specific vulnerabilities for women with detrimental consequences for their children. Erica's requests for vouchers so her baby could have the developmental checks and vaccinations to which all infants are entitled were refused with the explanation that the father of the child was financially responsible for the baby's health care. Within the health system, paying the costs of a child's health care is possible through the father's insurance although this is dependent on the submission of the child's birth certificate. Before her baby could be registered and a birth certificate issued, however, the authorities insisted that Erica's birth certificate had to be sent back to her home country for verification. This bureaucratic process could take three months. In the interim Erica's baby became "undocumented" with no official papers certifying its identity. The baby not only missed its developmental checks but also became sick. In desperation, Erica again appealed for assistance at the Social Office where an administrator used spurious arguments based on the child's invisibility in the law, due to its undocumented status, to justify the lack of a legal obligation to help. As Erica explained:

The lady in the Social Office told me that the child is not a person, the child is not registered in Germany so it is not officially recognised.

But seizing this opportunity "on the wing", Erica countered this syllogistic argument equating documented proof of her child's identity with the facts of its recognition in law and consequently its very existence, by referring to the infant's hospital card:

I told the lady she cannot say that the child does not exist because the child has been born here, the child has a hospital card so she cannot consider that the child is not existing in Germany.

The power of such rhetorical tactics, expressed in the language of "documents" and "proof", lies in its ability to "make the weaker position seem the stronger" by "turning the tables on the powerful" (de Certeau, 1984, p. xix). These tactics enabled Erica to insinuate herself into the bureaucratic space of the Social Office and achieve a small victory. The administrator then explained that her baby could be "recognised" and consequently eligible to access care if she made an asylum claim on the infant's behalf.

Accessing care

Finding a doctor was not necessarily straightforward since some medical practices had turned them away on the grounds that "they did not accept vouchers". They reported having to wait in the practice "from morning to night" to see the doctor since German patients appeared to have priority. Their accounts of the consultation revealed it as a site where their domination was enacted through collaboration between doctors and the Social Office and where their social identity as black African asylum seekers often overtly structured interactions.

Cost, collaboration and collusion in limiting access to treatment. Participants quickly realised that cost played a central role in the level of access they had to diagnostic tests, medicines and specialist medical attention. As a direct consequence, their expectations regarding the medical consultation and its outcomes were usually low, as Kenneth commented:

They don't really carry out a serious diagnosis for you. What they do is they just look at you and then they tell you it's nothing serious and they will just try to give you some tablets and mostly it's just pain killers.

Several participants reported health complaints that remained unresolved or even worsened after treatment. Frustrations with doctors' limited interventions could boil over into angry confrontations. Errol admitted he had shouted at a doctor when he presented with a painful, swollen knee and was prescribed the same tablets he had been previously given for headaches. Participants often recounted that during medical consultations the doctor called the Social Office for guidelines on the drugs or tests that would be covered. This collaboration undermined

participants' trust in health service provision in several ways. First, it not only reaffirmed their experience of having limited access to health care; the ultimate power of the Social Office over decisions regarding their entitlements led to the belief that the quality of the care provided was compromised. As Kenneth added, their care was "being determined by the people at the Social Office who have no adequate knowledge of the medical field". Secondly, this collaboration was perceived as collusion with the result that doctors were not considered neutral providers of care acting in their interest. As a consequence, fears that the rules of doctor-patient confidentiality did not apply to them were frequently expressed.

Even more distressing for some participants was the experience that limitations in medical attention also extended in some instances, to the withholding of care to which they were entitled. In this regard, the accounts of female participants who had given birth in Germany illustrated just how discrimination intersected with gender to create particular vulnerabilities for women leading to failures in care provision. While the ASBA (§4.2) stipulates that pregnant and post-partum women are entitled to ante natal as well as post natal care, standard provisions in pre-natal care include investigative blood tests to establish for example, the haemoglobin level and blood group of all pregnant women (Gemeinsamer Bundesausschuss, 2011). However, from Erica's account these standards were not always followed:

When I visited the doctor they were supposed to test my blood but they didn't do that. Nothing was done for me. I saw the doctor once per month and close to birth I saw him twice a month. The attention that other women had in the hospital I did not get, I could see that.

Participants' experiences led to a general violation of trust in the medical profession, which was often articulated in anxieties about seeking medical attention. Stephen, who was eligible for a health insurance card, actively avoided going to the doctor:

I have never had a positive reaction from any doctor. The negative experiences I've lived have discouraged me. I don't want to go to the doctor. Since three years now, I haven't been despite the fact I've been sick.

Several of the female participants had in the course of time, however, managed to find doctors they claimed to trust. This trust was constructed from a set of professional behaviours exhibited by the doctor. These included taking their complaints seriously and not dismissing them with instructions "to take this drug and everything will be okay". It was also created through attitudes displayed by doctors that affirmed their personhood rather than their social identity as "Blacks" and "foreigners":

Some of the doctors, especially when you are black and a foreigner, they don't care. When I went to this doctor, the way that she welcomed me, the way that she talked with me, I really felt good with her, that she is not racist (Angela).

This parallel existence of trust in specific doctors and distrust in the health service and its providers is consistent with other studies pointing to patients' high levels of trust in individual clinicians and their lower levels of trust in doctors in general (Calnan and Rowe, 2007, p. 288). However, what is significant for asylum seekers is their structured subordination to the health system. By choosing either tactics of avoidance or consumerist tactics of "shopping around" for a trustworthy clinician, participants demonstrated that their subordination to the system did not mean submission to it.

The doctor-patient interaction as a site for the reproduction and resistance of identities. Participants' encounters with health professionals were accompanied by stressful anticipation of how they would be received and not only because of the challenges posed by language differences. They reported that during the consultation they were often spoken to in a "rude" or condescending manner and experienced rejecting behaviours. Kenneth was told after one consultation that he "was not to come back there again". Several participants complained that doctors' had asked "prying questions" about their asylum claim:

When I entered the doctor's office the first thing she asked me was why did you come to Germany. I said why and she said why didn't you go to England. I asked why and she said it would better if I had gone to England and when I asked again why, she didn't say anything (Barbara).

One time I was at a medical doctor and I had chest pain and he asked why you didn't go to France to seek for asylum but you came to Germany. I pleaded with the doctor that I am sick, let us forget about the other issue and concentrate on my treatment (Stephen).

These enquiries and comments about their asylum status were experienced as intrusive and out of place in the context of a medical consultation. As Barbara added, such questions were also "racist": they appeared rooted in prejudiced assumptions about asylum seekers and served to reproduce their devalued social identity. The doctors' inquisitiveness signalled a deviation from the ceremonial order of the consultation (Strong, 1979), creating one of those institutional vulnerabilities, those "cracks" that Goffman (1961, p. 320) describes. However, through counter questioning tactics and re-directing attention to the purpose of the consultation, the participants asserted selfhood and achieved certain ends. Aside from signalling individualised efforts to manage their structured vulnerabilities, they were also able to exercise control over how they were perceived by doctors. This is on one level, a form of image management (Goffman, 1959, 1963). On another, by deflecting attention away from their status as asylum seekers, they also engaged in a symbolic struggle over perceptions of the social world by managing the image of their position in social space (Bourdieu, 1989, p. 20).

Discursive articulations of resistance. Tactics of resistance to their treatment were not solely situational designed to achieve certain outcomes at the Social Office or in medical consultations. Discursive tactics were employed that served to transform their racially stigmatised identities into a site of resistance. Contact with authorities and daily life experiences had led participants to internalise a sense of their "place" relative to others and their triple disadvantage as asylum seekers, foreigners and black Africans. This was reinforced by a consciousness of being at the bottom of an ethno-racial hierarchy of asylum seekers. Their lighter skinned and eastern Europeans counterparts were described as benefiting from certain privileges and exemptions whereas "everything that is black is bad and criminal". Participants understood that the asylum system did not support their health and well-being or enabled their efforts to find protection. As a consequence, their discursive tactics were grounded in constructions of society and strategic institutional practices as inhumane, racist and disrespecting of their rights:

Because I am an asylum seeker they treat me like shit [...] they do this to frustrate you (Angela).

For them (Germans) any asylum seeker or foreigners, you don't have a place in this society [...] This inhuman policy of exclusion goes a long way to make people feel psychologically frustrated. They put you in a forest, they put you in a camp. You come from different countries, you would be speaking French and your neighbour is speaking English and you are not able to understand. They ask you what language you speak but they (the authorities) keep on writing letters to you in German and when these letters come, you don't know where to go. It depreciates people psychologically (Kenneth).

The discrimination is terrible. You think you are going to be protected but your rights are not respected. You face discrimination just because you are an asylum seeker (Marjorie).

Participants' characterisation of their racialised subject position in relation to institutional practices and norms resonate with de Certeau's claims of the existence of alternative scripts on social organisation that serve to challenge the status quo. These alternatives, de Certeau argues, are the "remains of different hypotheses for that society" (de Certeau, 1984, p. 48). This he notes, are as much a constitutive element of society as the "foregrounded practices organising its normative institutions" (de Certeau, 1984). Participants' critique of German society and the asylum system fundamentally questioned social and political integrity. By invoking the notion of rights, they acknowledged the law as a source of their capital but were aware of how discrimination and social injustice structured the gap between "law on the books and law in action, abstract formal equality and substantive, concrete material inequality" (Silbey, 2008, p. 326). Drawing attention to these discreditable aspects of social organisation subverted the process of stigmatisation; instead society's image as safe, just, and non-discriminatory had become "spoiled". Significantly, the power of engaging in social critique and defining their subject position in these terms was the possibilities this opened up for participants to construct emancipatory responses to their situation.

Managing health by finding a way through the “cracks”

The challenges imposed by their material conditions and the limited health care they received meant that participants' experience of sickness was accompanied by a sense of vulnerability. This was further heightened by the scarcity or total absence of social support. Calling the ambulance in times of need was the only recourse for Patricia and Lorraine who experienced numerous health crises due respectively to a complicated pregnancy and uncontrolled high blood pressure.

Seeking assistance in the voluntary sector. Others such as Kenneth and Angela, whose health conditions had not improved with the treatment they received, sought alternative assistance in the non-profit voluntary sector. Here, charitable clinics staffed by professionals committed to providing health care to the uninsured, offer low cost or free treatment, mainly to undocumented migrants (Castañeda, 2011). The attending physician acted as an advocate by helping them claim their legal entitlements to health care. In Kenneth's case, the doctor called both the Social Office in his jurisdiction as well as his general practitioner and according to Kenneth, “threatened them”. As a result of this intervention he was able to access treatment from an internal medicine specialist that finally brought relief to the pain he had been experiencing for three years.

By seeking help in the non-profit sector the participants' efforts are as much tactical as they are acts of self-preservation in the face of physical suffering and distress. Their discovery of this parallel universe of health care, an institutional “crack” in a seemingly monolithic health system, also signalled a “victory of the weak over the strong” (de Certeau, 1984, p. xix). By combining heterogeneous elements of their social identity as asylum seekers, foreigners and members of a racialised group, they were able to “vigilantly make use of the cracks” and insinuate themselves into the space of the law regulating access to health care, making it more “habitable”(de Certeau, 1984, p. 37).

Seeking refuge from the asylum system. Flight from the asylum home into a precarious underground existence was another tactic employed by participants to secure healthier outcomes. The restrictions of the residence obligation prohibited Patricia from living legally in Berlin with the father of her child. Struggling with the difficulties of looking after a sick baby on her own in a cockroach infested asylum home, she left her administrative district to live in a neighbouring urban area. Whenever her baby needed medical attention, she travelled back to the district to see the doctor:

Because of the colostomy William always cried, sometimes he cried for twenty-four hours. I couldn't cook; I was living only on bread. Of course you see where the home is, so you see how difficult it is to do shopping. Shopping for me was hell [...] and I was living in that home with cockroaches in my room. I complained but nobody bothered. [...] I would see cockroaches on my food; they would be in William's clothes and even in his cot. I had to sleep without taking a shower because when William is crying I need time with him and when I am ready to take a shower then the warm water was already gone. I would lock myself in my room and shed tears.

Lorraine, who had lived in the same asylum home but at a different time, could not cope either with the cockroaches and the home's remote location. In her first interview, Lorraine was tense and upset as she described her living conditions and how vulnerable she felt being sick in such an isolated place. By the time of the second interview six months later, she had left her administrative district to live in an urban area only travelling back to collect her monthly allowance or to see the doctor. She was visibly more relaxed and related freely how she organised her new life to avoid detection by the authorities. She noted her health had improved in spite of the great risks she was taking:

I feel better in City A, here I am happy [...] I have my friends. Here at the meetings I can see my brothers and sisters and we can discuss what we are doing, we can laugh together. I felt really, really bad in District B.

The significance of social support during times of illness and in the lives of migrant groups has been established by numerous studies (Vassilev *et al.*, 2011; Jasinskaja-Lahti *et al.*, 2006; Stewart *et al.*, 2008; Hernández-Plaza *et al.*, 2006). However, participants' reorganisation of their lives in order to access the social support needed is embedded in oppositional tactics that

undermine the disciplinary system regulating their existence. The tactics employed are those “clever tricks” knowing how to get away with things and “hunter’s cunning”, that de Certeau (1984, p. xix) identifies as constituting opportunistic challenges to an imposed order. The calculated success of these tactics was grounded in participants’ legal consciousness: those meanings of law circulating in social relations, which refer to what people do as well as say about law (Silbey, 2008). Despite, or because of their knowledge of the law governing their freedom of movement, participants sought refuge and support in circumstances more conducive to their physical and mental health. In pursuit of this sanctuary, their “clever tricks” and “cunning” were guided by their knowledge of which laws and regulations had to be accommodated so that others could be effectively resisted.

Discussion

Participants’ experiences in accessing medical care demonstrate the complexity of this task and its consequences for their health status. The physical efforts and social interactions involved, whether these interactions were anchored in accommodating behaviours or resistive tactics, placed a unique burden on participants, one not experienced by nationals or other immigrants. The stratification in access and the inequality in outcomes this produces run counter to social arrangements which should allow for the realisation of human rights and enhance the dignity of all individuals (Raworth, 2005, p. 397).

Yet participants’ assertion of selfhood in accomplishing access was also constituted through efforts to claim their rights. Agency was shaped by a legal consciousness in which human rights and entitlements often formed an explicit source of capital. More specifically, it was in the interpretative space between “law on the books and law in practice” that hegemonic legal norms governing access were contested and reworked showing that although the law may be durable, its meanings are in fact malleable. For the participants who were “caught in the nets of discipline”, these meanings became stabilised into patterned responses, the tactics and “modes of operation” which de Certeau (1984, pp. xiv-xv) describes. These “unmappable” forms of subversion enabled participants to manoeuvre through institutional cracks, challenge and circumvent the dominant order in efforts to secure better health outcomes and protect dignity. Crucial to the accomplishment of these tactics was how participants exerted agency in the shifting constructions of their identities as black Africans, foreigners and asylum seekers. However, the vigilance and prolonged, high effort coping required in accomplishing access and enacting tactics of resistance may be a factor affecting their health (Syme, 1979; James, 1994).

Arguably, one of the principal inequities surrounding health care access is the discriminatory practice of making this contingent on the acquisition of a voucher. Not only does this implicate time, distance and place as a constellation of factors leading to the construction of health risks. The uncertainties surrounding the disbursement of the voucher give the administrators power to enact governmentality (Foucault, 1997). As an inherent feature of German federalism, the localised execution of national laws and policies through municipal level agencies and their personnel has already been critiqued as challenging the transformation of international human rights commitments into concrete actions at the local level (United Nations, 2009, p. 5). With the power of implementation residing mainly at the local rather than federal level, the current structure assumes that agencies are fixed and stable entities working purposefully to execute policies. However, this ignores the link between organisational culture, the social order and the ways individuals’ pathways to completing tasks are influenced by their “culturally inscribed dispositions and toolkits” (Hallett, 2003, p. 131). Understanding how this recursive relationship shapes work performance and ethics among those brokering access to rights and entitlements, particularly in contexts with specific migration histories, is central to understanding the micro-politics of accessing care. Integral to such an analysis is the range of settings in which access is negotiated and interactive encounters occur.

Participants’ anxieties about accessing health care are consistent with studies, which show how perceptions of discriminatory treatment by health services can discourage members of a socially excluded minority group from accessing such services with detrimental effects for their health status (McLean *et al.*, 2003, p. 667). The implications of this for health inequalities have to be

weighed together with the health effects likely to be experienced by asylum seekers as a consequence of their racialised status. Individual experiences of discrimination as well as belonging to a group that is stigmatised and discriminated against have been linked in several studies to poorer physical and mental health (Veling *et al.*, 2007, p. 765).

The specific features of the participants' social position together with the negative and stressful nature of interactive encounters in different health related settings are significant for their health and human rights states. The psychosocial stress of asymmetric, humiliating and burdensome interaction and the known association this has with biological immune functioning are also linked to violations of human dignity (Wildner *et al.*, 2002, p. 1727). A likely consequence for health service use is the avoidance of individuals or sites, which users know to be "dangerous to their dignity" (Jacobson, 2009, p. 1545). Given the lack of assessment tools for empirical research on human rights and health, particularly those sensitive to the more subjective dimensions of violations such as dignity (Raworth, 2005), the likelihood is that demeaning experiences and the ensuing health effects are overlooked. This is a fertile field for further exploration.

The study's findings must be viewed in the context of certain limitations. They are based on the experiences of a highly visible racialised group in a specific geographical region with a relatively low concentration of immigrants and a particular post-war history. As such the results cannot be generalised. All participants were recruited from the same organisation thus excluding the views of other black Africans who either by choice or for practical reasons had no contact with the group. Only a minority of participants knew each other personally and they each had varying degrees of connectedness to the ideological space of the refugee organisation. This contact to each other and to the organisation, however minimal it may have been for some, should be considered as implicit in the shaping of their views and actions.

Conclusion

This qualitative study aimed to examine how access to health care is experienced by (rejected) asylum seekers and how they exercise agency in seeking to access this care. Participants' responses to their experiences were examined from the perspective of de Certeau's theorisation of everyday practices as a form of resistance to an imposed order. The study shows how onerous it is for asylum seekers to access health care as well as the range of oppositional and discursive tactics they use in trying to do so. Granting asylum seekers equal access to health care as well as providing them with information, in a relevant language, on available services is integral to redressing health inequities and respecting their rights.

This paper has shown the oppressiveness of the bureaucracy surrounding access to health care and how the gate-keeping role of the Social Office staff creates opportunities for the articulation of power. The data suggest this is achieved through administrative intransigence and practices leading to humiliation and the invasion of privacy. On one level, such practices are potentially injurious to human rights and dignity and should become a focus of human rights action. On another level, these practices and the attitudes of administrators and health professionals contribute to the racialisation of asylum seekers. This draws attention to the necessity of examining the micro level effects of asylum policies and by extension, how these policies manifest as forms of structural racism producing health inequities (Gee and Ford, 2011; Schuster, 2003). Human rights education as well as training and support for administrative and health staff in how to engage with and provide for asylum seekers should also be a policy priority.

Writing about the need for ethnographers to consider the political implications of their research among migrants, Hirsch (2005, p. 236) argues that such research carries with it an inherent commitment to advocacy. This commitment intersects with a goal of human rights accountability mechanisms, of which advocacy is one form, to changing relationships of power and promoting social justice in health (Yamin, 2008a, p. 12; Yamin, 2008b, p. 50). Ethnographic research can contribute to this process by making visible in the domain of advocacy, those interactions with the potential to injure dignity and infringe rights which otherwise could go unnoticed. When located within intersectional paradigms, such accounts can uncover ways in which identity categories such as gender, "race", sexuality and disability status interact, often simultaneously, to produce different experiences of discrimination. An analysis at this micro level

of interaction is an imperative because rights are constructed through the “mutually constitutive relationship between the individual and the social” (Woodiwiss, 2009, p. 104). Such analyses require active engagement with marginalised groups such as asylum seekers. This is an empowering process that reaffirms their human status (Bloom, 2010) and importantly, their human right to participate in policy decisions affecting them.

Note

1. Black African’ is a translation of the term “Schwarzafrikaner”, which is one of the identity labels ascribed to Africans in Germany who have origins in sub-Saharan Africa. It is an identity which the research participants also asserted in the interviews.

References

- Behrenson, B. and Groß, V. (2004), *Auf dem Weg in ein normales Leben’? Eine Analyse der gesundheitlichen Situation von Asylsuchenden in der Region Osnabrück*, Universität Osnabrück, Deutschland.
- Bloom, T. (2010), “Asylum seekers: subjects or objects of research?”, *The American Journal of Bioethics*, Vol. 10 No. 2, pp. 59-60.
- Bourdieu, P. (1989), “Social space and symbolic power”, *Sociological Theory*, Vol. 7 No. 1, pp. 14-25.
- Calnan, M. and Rowe, R. (2007), “Trust and health care”, *Sociology Compass*, Vol. 1 No. 1, pp. 283-308.
- Castañeda, H. (2011), “Medical humanitarianism and physicians’ organized efforts to provide aid to unauthorized migrants in Germany”, *Human Organization*, Vol. 70 No. 1, pp. 1-10.
- Charmaz, K. (2002), “Qualitative interviewing and grounded theory analysis”, in Gubrium, J. and Holstein, J. (Eds), *Handbook of Interview Research: Context and Method*, Thousand Oaks, Sage, pp. 675-94.
- de Certeau, M. (1984), *The Practice of Everyday Life*, University of California Press, Berkeley, CA.
- Dupont, H., Kaplan, C., Hans, T., Verbraeck, H., Braam, R. and van de Wijngaart, G. (2005), “Killing time: drug and alcohol problems among asylum seekers in the Netherlands”, *International Journal of Drug Policy*, Vol. 16 No. 1, pp. 27-36.
- Federal Ministry of the Interior (2010), “Annual report on the protection of the constitution”, available at: www.verfassungsschutz.de/en/index_en.html (accessed 18 March 2011).
- Foucault, M. (1977), *Discipline and Punish: The Birth of the Modern Prison*, Vintage Press, New York, NY.
- Foucault, M. (1978), *History of Sexuality: An Introduction Volume I*, Vintage Press, New York, NY.
- Foucault, M. (1997), “Security, territory, and population”, in Rabinow, P. (Ed.), *Michel Foucault, Ethics: Subjectivity and Truth*, The New Press, New York, NY, pp. 67-71.
- Garner, S. (2010), *Racisms: An Introduction*, Sage, London, CA, New Delhi and Singapore.
- Gee, G. and Ford, C. (2011), “Structural racism and health inequities: old issues, new directions”, *Du Bois Review*, Vol. 8 No. 1, pp. 115-32.
- Gemeinsamer Bundesausschuss (2011), “Richtlinien über die ärztliche Betreuung während der Schwangerschaft und nach der Entbindung (Mutterschafts-Richtlinien)”, available at: www.g-ba.de/downloads/62-492-550/Mu-RL_2011-05-19.pdf (accessed 10 June 2011).
- Gilgen, D., Maeusezahl, D., Salis Gross, C., Battegay, E., Flubacher, P., Tanner, M., Weiss, M. and Hatz, C. (2005), “Impact of migration on illness experience and help-seeking strategies of patients from Turkey and Bosnia in primary health care in Basel”, *Health & Place*, Vol. 11 No. 3, pp. 261-73.
- Goffman, E. (1959), *The Presentation of Self in Everyday Life*, Pelican, Harmondsworth.
- Goffman, E. (1961), *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Doubleday Anchor Books, New York, NY.
- Goffman, E. (1963), *Stigma: Notes on the Management of Spoiled Identity*, Prentice Hall, Upper Saddle River, NJ.
- Grove, N. and Zwi, A. (2006), “Our health and theirs: forced migration, othering and public health”, *Social Science and Medicine*, Vol. 62 No. 8, pp. 1931-42.

- Hallett, T. (2003), "Symbolic power and organizational culture", *Sociological Theory*, Vol. 21 No. 2, pp. 128-49.
- Hernández-Plaza, S., Alonso-Morillejo, E. and Pozo-Muñoz, C. (2006), "Social support interventions in migrant populations", *British Journal of Social Work*, Vol. 36 No. 7, pp. 1151-69.
- Hirsch, J. (2003), "Anthropologists, migrants, and health research. Confronting cultural appropriateness", in Foner, N. (Ed.), *American Arrivals. Anthropology Engages the New Immigration*, Santa Fe and Oxford, School of American Research Press, James Currey, pp. 229-57.
- HUMA Network (2009), "Access to health care for undocumented migrants and asylum seekers in 10 EU countries", available at: http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf (accessed 15 March 2011).
- Jacobson, N. (2009), "Dignity violations in health care", *Qualitative Health Research*, Vol. 19 No. 11, pp. 1536-47.
- James, S. (1994), "John Henryism and the health of African Americans", *Culture, Medicine and Psychiatry*, Vol. 18 No. 2, pp. 163-82.
- Jasinskaja-Lahti, I., Liebkind, K., Jaakkola, M. and Reuter, A. (2006), "Perceived discrimination, social support networks, and psychological well-being among three immigrant groups", *Journal of Cross-Cultural Psychology*, Vol. 37 No. 3, pp. 293-311.
- Laban, C., Gemaat, H. and Komprou, I. (2004), "Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands", *Journal of Nervous and Mental Diseases*, Vol. 192 No. 12, pp. 843-51.
- Liedtke, M. (2002), "National welfare and asylum in Germany", *Critical Social Policy*, Vol. 22 No. 3, pp. 478-97.
- McClean, C., Campbell, C. and Cornish, F. (2003), "African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (Re)Productive of health inequalities", *Social Science & Medicine*, Vol. 56 No. 3, pp. 657-69.
- Norredam, M., Mygind, A. and Krasnik, A. (2005), "Access to health care for asylum seekers in the European Union – a comparative study of country policies", *European Journal of Public Health*, Vol. 16 No. 3, pp. 285-9.
- O'Donnell, C., Higgins, M., Chauhan, R. and Mullen, K. (2007), "They think we're OK and we know we're not", *A qualitative study of asylum seekers' access, knowledge and views to health care in the UK*, *BMC Health Services Research*, Vol 7 No. 75, pp. 1-11, available at: www.biomedcentral.com/content/pdf/1472-6963-7-75.pdf (accessed 5 February 2012).
- Pross, C. (1998), "Third class medicine: health care for refugees in Germany", *Health and Human Rights*, Vol. 3 No. 2, pp. 41-53.
- Raworth, K. (2005), "Measuring human rights", in Guskin, S., Groding, M., Annas, G. and Marks, S. (Eds), *Perspectives on Health and Human Rights*, Routledge, New York, NY and London, pp. 370-86.
- Riesberg, A. and Wörz, M. (2008), "Quality in and equality of access to healthcare services: country report for Germany", available at: http://ec.europa.eu/employment_social/spsi/studies_en.htm (accessed 30 March 2011).
- Schuster, L. (2003), "Common sense or racism? The treatment of asylum-seekers in Europe", *Patterns of Prejudice*, Vol. 37 No. 3, pp. 233-56.
- Silbey, S. (2008), "Legal Consciousness", *New Oxford Companion to Law*, Oxford University Press.
- Steel, Z., Momartin, S., Silove, D., Coello, M., Aroche, J. and Tay, K. (2011), "Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies", *Social Science & Medicine*, Vol. 72 No. 7, pp. 1149-56.
- Stewart, M., Anderson, J., Beiser, M., Mwakarimba, E., Neufeld, A., Simich, L. and Spitzer, D. (2008), "Multicultural meanings of social support among immigrants and refugees", *International Migration*, Vol. 46 No. 3, pp. 123-59.
- Strong, P.M. (1979), *The Ceremonial Order of the Clinic: Parents, Doctors and Medical Bureaucracies*, Routledge and Kegan Paul, London.

Syme, S. (1979), "Psychosocial determinants of hypertension", in Oresti, E. and Klint, C. (Eds), *Hypertension, Determinants, Complications and Intermention*, Grune and Stratton, New York, NY, pp. 95-8.

Temple, B. (2002), "Crossed wires: translators, interpreters and bilingual workers in cross-language research", *Qualitative Health Research*, Vol. 12 No. 6, pp. 844-54.

Temple, B. and Edwards, R. (2002), "Interpreters/translators and cross-language research: reflexivity and border crossings", *International Journal of Qualitative Methods*, Vol. 1 No. 2, pp. 1-12.

United Nations (2009), "UN expert of racism concludes mission to Germany", available at: www2.ohchr.org/english/issues/racism/rapporteur/docs/PRelease_end_mission010709.pdf (accessed 5 April 2011).

United Nations Committee on Economic, Social and Cultural Rights (2000), "The right to the highest attainable standard of health. General comment 14 E/C.12/2000/4", available at: www.unhcr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En (accessed 5 April 2011).

United Nations Committee on Economic, Social and Cultural Rights (2011), "Concluding observations of the committee on economic, social and cultural rights: Germany E/C.12/DEU/CO/5", available at: www2.ohchr.org/english/bodies/cescr/docs/E.C.12.DEU.CO.5-ENG.doc (accessed 5 April 2011).

United Nations Committee on the Elimination of Racial Discrimination (2008), "Concluding observations of the committee on the elimination of racial discrimination: Germany CERD/C/DEU/CO/18", available at: www2.ohchr.org/english/bodies/cerd/docs/co/CERD.C.DEU.CO.18.pdf (accessed 5 April 2011).

Vassilev, I., Rogers, A., Sanders, C., Kennedy, A., Blickem, C., Protheroe, J., Bower, P., Kirk, S., Chew-Graham, C. and Morris, R. (2011), "Social networks, social capital and chronic illness self-management: a realist review", *Chronic Illness*, Vol. 7 No. 1, pp. 60-86.

Veling, W., Selten, J.-P., Susser, E., Winfried, L., Mackenbach, J. and Hoek, H. (2007), "Discrimination and the incidence of psychotic disorders among ethnic minorities in The Netherlands", *International Journal of Epidemiology*, Vol. 36 No. 4, pp. 761-8.

Watters, C. (2001), "Emerging paradigms in the mental health care of refugees", *Social Science & Medicine*, Vol. 52 No. 11, pp. 1709-18.

Wildner, M., Fischer, R. and Brunner, A. (2001), "Development of a questionnaire for quantitative assessment in the field of health and human rights", *Social Science & Medicine*, Vol. 55 No. 10, pp. 1725-44.

Woodiwiss, A. (2009), "What could it mean to take human rights seriously?", in Morgan, R. and Turner B. (Eds), *Interpreting Human Rights: Social Science Perspectives*, Routledge, London, pp. 104-20.

Yamin, A. (2008a), "Beyond compassion: the central role of accountability in applying a human rights framework to health", *Health and Human Rights*, Vol. 10 No. 2, pp. 1-20.

Yamin, A. (2008b), "Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care", *Health and Human Rights*, Vol. 10 No. 1, pp. 45-63.

Further reading

Mann, J. (1998), "Dignity and health: the UDHR's revolutionary first amendment", *Health and Human Rights*, Vol. 3 No. 2, pp. 298-305.

Corresponding author

Dr Penelope Scott can be contacted at: penelope.scott@wzb.eu

To purchase reprints of this article please e-mail: reprints@emeraldinsight.com
Or visit our web site for further details: www.emeraldinsight.com/reprints

This article has been cited by:

1. Penelope Scott. 2018. "It's Like Fighting for Survival": How Rejected Black African Asylum Seekers Experience Living Conditions in an Eastern German State. *Journal of Immigrant & Refugee Studies* 16:4, 372-390. [[Crossref](#)]
2. Eric Nwachukwu Agbata, Paulina Fuentes Padilla, Ifeoma Nwando Agbata, Laura Hidalgo Armas, Ivan Solà, Kevin Pottie, Pablo Alonso-Coello. 2018. Migrant Healthcare Guidelines: A Systematic Quality Assessment. *Journal of Immigrant and Minority Health* 15. . [[Crossref](#)]
3. Naama Kiat, Rafael Youngmann, Ido Lurie. 2017. The emotional distress of asylum seekers in Israel and the characteristics of those seeking psychiatric versus medical help. *Transcultural Psychiatry* 54:5-6, 575-594. [[Crossref](#)]