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'I don't think there's anything I can do which can keep me healthy': how the UK immigration and asylum system shapes the health & wellbeing of refugees and asylum seekers in Scotland

Anna Isaacs , Nicola Burns , Sara Macdonald and Catherine A. O'Donnell

General Practice and Primary Care, Institute of Health & Wellbeing, University of Glasgow, Glasgow, UK

ABSTRACT

Many migrant groups, particularly those that are politically and economically marginalised, such as asylum seekers and refugees (ASRs), face inequities in access to health care as well as poorer physical and mental health outcomes. The role of post-arrival experiences in contributing to these inequities is increasingly being explored, and it is suggested that being a migrant is itself a determinant of health outcomes. Drawing on the theoretical concept of structural vulnerability, this paper explores ASRs' experiences of health, wellbeing, and health practices in the context of their lived realities in Scotland. 24 semi-structured interviews were conducted with ASRs from Sub-Saharan Africa between January and December 2015. Data were explored using thematic analysis. Experience of the UK asylum system, both alone and in conjunction with other sources of vulnerability including racism, poverty, and language barriers had a negative and ongoing impact on the physical and mental health of ASRs. These impacts continued, even once refugee status was obtained. Efforts to engage ASRs in preventive health programmes and practices must take into account the ways in which the asylum system acts as a determinant of health, affecting both what it means to be healthy and what capacity individuals have to engage with their health. Political choices in how the asylum process is enacted have far-reaching implications for individual and population health.

Background

Many migrant groups, particularly those that are politically and economically marginalised, such as asylum seekers and refugees (ASRs), face inequities in access to health care and poorer physical and mental health outcomes compared to the majority population (Gill- Gonzalez et al., 2015; Medecins du Monde & University College London, 2017; O'Donnell et al., 2016). While the focus of much research on migrant health has been on infectious diseases and mental health, increasing attention is being paid to why marginalised migrant groups face disproportionate risk of developing non-communicable diseases (NCDs) and what could be done to address this (Agyemang et al., 2012). Various factors have been considered as potential contributors to these health disparities. These include biological determinants, behavioural factors related to cultural norms, pre-migration experiences, and the social and structural factors that shape migrants' lives once they have moved to a new country (Abubakar et al., 2018; Agyemang, 2019). Not only are certain migrant groups exposed to many of the structural determinants of poor health (Chaufan et al., 2011), but migration-related factors can intersect with these determinants to intensify chronic disease risk (Castañeda et al., 2015).

Migration-related factors, including migration status, are increasingly argued to be determinants of health in their own right, (e.g., Castañeda et al., 2015; Fleischman et al., 2015; Ingleby, 2012). Scholarship has sought to link specific policies related to migrant status to the risk of poorer health outcomes (Cassidy, 2018). For example, Page-Reeves et al describe how fear of immigration enforcement is reflected in the ways undocumented Latinx immigrants in the US respond to diabetes risk (2013). In the UK, Hostile Environment policies which have seen the UK Border Agency (UKBA) extend its reach into an increasing range of everyday spaces including the health service, have been found to create barriers to healthcare access amongst asylum seekers and undocumented migrants (Equality and Human Rights Commission, 2018; Feldman et al., 2019) Additionally, the experience of navigating the asylum system has been documented to have as significant, if not a greater, effect on mental health than the experiences that led to a forced migration in the first place (Carswell et al, 2011; Martinez et al, 2015). It remains less clear, however, whether and how the experience of holding a particular migrant status may affect ongoing physical health at a more fundamental level, nor the processes by which this might happen.

Glasgow currently hosts the largest number of dispersed asylum seekers outside of London, with 3,741 in receipt of section 95 support, which provides accommodation and financial assistance, at the end of 2018 (Sturge, 2020). It is unclear exactly how many refugees live in Glasgow since there is a lot of movement once leave to remain is granted (Mulvey, 2009). However, recent reports suggest around 20,000 recognised refugees live in the city (Strang & Quinn, 2014). There are also unknown numbers of migrants in an irregular situation along with destitute asylum seekers, following failed asylum applications.

Following devolution in the UK, ASRs in Scotland exist at the intersection of two conflicting political paradigms (Mulvey, 2009; Scottish Government, 2013). On one hand they are subject to UK immigration rules, guided by the aforementioned hostile environment policy, which controls housing and income support, excludes them from work, and ultimately judges their claim to refugee status (Mulvey, 2009). However, in other sectors, including health and education, the Scottish government is responsible for service provision (Mulvey, 2009; Scottish Government, 2013). It has stated a commitment to the health, wellbeing, and social inclusion of ASRs in Scotland (Strang & Quinn, 2014), investing in ASR integration through its 'New Scots' strategy (Scottish Government, 2018).

However, research suggests that despite these positive approaches in Scotland, the asylum system, along with other structural factors, continues to adversely affect ASR health and wellbeing (Kearns et al., 2017; Strang & Quinn, 2014).

This paper explores ASR's experiences of health, wellbeing and health practices in the context of their lived realities in Glasgow. Drawing on the theory of structural vulnerability (Quesada et al., 2011) we consider the ways in which the asylum process, and other intersecting macro-level structures, translates at the individual level to put ASRs at risk of poor long-term health.

Our focus on ASRs from Sub-Saharan Africa was a pragmatic decision, based on community links and experience of working with individuals from this region (Cooper et al., 2012). We acknowledge that Africa is a vast continent with a huge diversity of cultures, languages, and experiences and that there is a long history of African migration to Scotland. African ASRs were not chosen on the assumption that they represented a homogenous group, but because of our aforementioned links to these communities in Glasgow and the shared experience of navigating the asylum system as a racialized group.

Theoretical insights into migrant health

Critiques of migrant health research point to a historical overemphasis on 'culture' in explaining barriers to healthcare access and differences in health outcomes (Viruell-Fuentes et al., 2012). While culture is an important factor (Baumann, 1996), this focus risks obscuring the impacts of 'up-stream' determinants of health such as poverty, discrimination, exclusion, and migration itself (Castañeda, 2010; Fleischman et al., 2015; Page-Reeves et al., 2013; Zhou et al., 2016). An approach that focuses

on the social determinants of health (SDH) may thus provide a helpful corrective. However, SDH approaches can often be too abstract, with insufficient attention paid to how factors at the macro-level express themselves at the individual level and how macro-level factors intersect with various aspects of identity beyond socioeconomic status (Kapilashrami et al., 2015). Responding to this critique, Popay (2012) calls for research that examines the pathways between inequality at the macro-level and poor health at the individual level, because although inequality might be structurally determined, the way in which it manifests in individuals' lives is equally important.

To develop a more dynamic understanding of the health of marginalised groups, a growing body of work engages with critical theories that consider how structural constraints and unequal power relations interact to influence personal experiences of health and wellbeing. 'Structural violence' describes the indirect harm inflicted on individuals due to political and economic inequity (Farmer, 2004; Galtung, 1969), and has been used as a lens to explore factors undermining the health of marginalised migrant groups (e.g., Holmes, 2006; Larchanché, 2012; Page-Reeves et al., 2013). Importantly the obscuring of these determinants can also be a form of violence. Sargent and Larchanché demonstrate how the political determinants of the health of undocumented migrants in Paris are obscured when psychiatric solutions are sought for migrants' problems, rather than there being any attention paid to their 'political and economic precarity' (2009).

A related term, 'structural vulnerability', refers to a positionality resulting from the way in which 'socioeconomic, political, cultural/normative and psychodynamic "insults" mutually reinforce an individual's or population's risk of negative health outcomes' (Bourgois et al., 2017; Quesada et al., 2011). With a focus that spans many potential sources of (intersecting) inequality, structural vulnerability provides a nuanced means to explore how certain groups might be placed in vulnerable positions, and to demonstrate how individual health outcomes are linked to politics and power (Bourgois et al., 2017; Quesada et al., 2011). Analyses that engage with concerns around structural violence and vulnerability focus on micro-level lived experiences in order to explain how macro-level structures are embodied (Quesada et al., 2011; Rhodes et al., 2011).

Both concepts draw on Bourdieu's notion of symbolic violence, arguing that the structural context (historical, social, political, and/or economic) in which individuals find themselves is reflected in their sense of agency and how they understand their own health, wellbeing, and entitlement to healthcare (Quesada et al., 2011). For migrants, factors might include the healthcare system in their country of origin, their migration journey, attitudes towards migrants in settlement countries (on the part of the media, political establishment and general population), the ways in which rights and entitlements are constructed, and experiences of racism at an individual, institutional, or structural level (Castañeda et al., 2015; O'Donnell et al., 2007; Zimmerman et al., 2011).

Structural violence and structural vulnerability have been used to examine the health experiences of a variety of migrant groups, including migrant workers in the US and migrant sex workers in Germany, but to date have been under-explored in the UK context. This paper thus engages with this theoretical lens to elucidate how one particular structure – the asylum system – shapes the individual level physical health and wellbeing experiences of asylum seekers and refugees in Glasgow, Scotland. Throughout, we consider the asylum system as a singular structure in so far as it determines the rights and entitlements of all ASRs in the UK.

Methods

The findings presented in this paper are based on 24 ethnographically informed, semi-structured interviews with refugees and asylum seekers from Sub-Saharan Africa, conducted in Glasgow, Scotland between January and December 2015. These interviews were conducted within the context of Als PhD research: a 'focused ethnography' that explored understandings of health, wellbeing, and access to care amongst ASRs in Glasgow. In addition to the interviews presented here, this focused ethnography included community engagement, focus groups that incorporated participatory learning and action approaches, walk-along interviews, and interviews with public

health and primary care professionals. Ethical approval was obtained from the University of Glasgow College of MVLS ethics committee; Research and Development approval from NHS Greater Glasgow and Clyde.

Sampling and recruitment

The sampling strategy took a purposive approach with participants chosen because they matched specific characteristics that would enable the aims of the study to be met (Ormston et al., 2014). Initially male and female ASRs from Sub-Saharan African living in Glasgow were the focus of recruitment, however as the research progressed, the focus shifted towards interviewing young, single men due to a concern that they are often overlooked (Strang, 2015). Participants were initially recruited through three organisations; one health charity, and two migrant social groups, and subsequently through a process of snowball sampling. AI attended events at the organisations where she spoke about the project aims. Potential participants were invited to ask questions and sign up if interested. Thirteen participants agreed to an interview after taking part in a participatory focus group (not reported here), and 11 were recruited straight to an interview.

Research process

The interviews followed a semi-structured approach with a series of topics to cover, but were guided by the participant's perspectives as far as possible. The topic guide covered the experience of being a migrant in Scotland, understandings and experiences of health and wellbeing, attitudes towards healthcare, and experiences of accessing care.

Research materials were produced in English and Tigrinya, to accommodate the large number of Eritrean ASRs newly arrived in Glasgow. Interviews took place either in English, or with an English-Tigrinya interpreter. All focus groups and interviews were digitally recorded and transcribed verbatim, following informed consent. All participants received a £15 shopping voucher as a thank you for taking part.

Analysis

Analysis followed a two-stage process: first, organising, indexing, and categorising the data into themes; second, abstraction and analysis (Ormston et al., 2014; Ziebland & McPherson, 2006). The formal analytic process commenced once approximately half of the fieldwork was complete. Transcripts were read and reread in a process of data 'familiarisation' and immersion (Ormston et al., 2014); initial observations on the data, together with organisational categories and sub-categories were noted. After an initial coding framework was developed, all transcripts were uploaded to the qualitative research software Nvivo11 and coded. Coding was iterative, with more codes added as the analysis progressed. Analysis was conducted primarily by AI, with coding clinics involving COD, NB, and SM to ensure that the process was robust. In the second stage of analysis the 'One Sheet of Paper' (OSOP) method of analysis was used (Ziebland & McPherson, 2006). Here, a sheet of A4 paper was assigned to each category and the higher level themes in each category were mapped out. For this paper, categories related to perceptions of health and health promoting practices were considered with reference to the concept of structural vulnerability. Specifically, potential forms of vulnerability (e.g., racialisation, migration status, poverty) were considered in terms of how they shaped perceptions of, and practices surrounding, health and wellbeing.

Findings

Twenty four ASRs (10 men and 14 women) participated in semi-structured interviews. Eighteen interviews were conducted in English and six with an English-Tigrinya interpreter. Nine participants had refugee status, one was destitute, and 13 were waiting on the outcome of an asylum application. Nine participants originated from Zimbabwe, eight from Eritrea, two from Ghana, two from Malawi, and one each from South Africa, Sudan, and Zambia. Reflecting their different statuses, the participants varied in terms of financial security, social marginalisation, language capacity, and migration status, but all shared the experience of the asylum system and of being a racialized minority. The findings presented here demonstrate how the UK immigration and asylum process shapes the risk of poor health amongst ASRs. We consider a) how the nature of the asylum process shaped individual understandings of health and capacity for health practices, b) how it intersected with and amplified other sources of vulnerability such as race and poverty, c) processes of coping through extreme constraint, and d) ongoing impacts after an asylum decision.

The asylum process shapes perceptions of health

The experience of navigating the UK asylum system was described as all-encompassing and highly stressful, while simultaneously removing participants' agency. The stress of awaiting an asylum application decision severely undermined capacity to prioritise health even if individuals wanted to. This was reflected in narratives of what health meant, and through what health-promoting activities were considered to be accessible.

Health was described as having various causes, from biological to behavioural to structural. However, for those in the most precarious positions: undecided asylum applications, unable to speak English, and engaged with limited community support services, the question of what it means to live a healthy life elicited entirely instrumental responses such as to 'have your papers sorted' (Tadesse, Eritrea, AS). Any other practice or experience that might be desired remained on hold until refugee status could grant security, the right to employment, and a route out of poverty. Robel, a destitute asylum seeker from Eritrea who spent his nights at a homeless shelter mentioned first his immigration status, and then isolation from his family.

> The most important thing is for my papers to be sorted to get status, but I don't have any issues apart from that (…) it's been more than 12 years without paper so I would love to see my family which is a very important thing and to get a job, I mean to get peace basically.

While further discussion elicited that Robel did, in fact, have physical health concerns, these were not considered a priority in terms of living a healthy life. By preventing individuals from thinking about health now, the asylum system puts them at risk of more serious problems later on.

The all-consuming nature of the process also shaped what participants felt they *could* do to maintain their health. Priscilla's (Mozambique, AS), capacity to engage in health practices was constrained not only by time challenges associated with raising her three children, but also the Home Office in creating stress that curtailed her activities.

> We go through maybe like a lot of stress with the Home Office and stuff and I end up not prioritising [our health] because of that. Because I'm trying to focus on that [health] and then when I start focussing on Home Office issues everything else just falls to the side.

Waiting for a response to their asylum claim, asylum seekers were kept in perpetual limbo. Participants could not develop strong ties, or think seriously about a future in any one place. Many of the asylum-seeking participants described how this lack of agency and sense of uncertainty became embodied, particularly for those who had been waiting for several years. Participants described 'sitting', 'waiting', and 'doing nothing' for years on end. For Mufaro (Zimbabwe, AS), the unending nature of the process sapped her energy to such an extent that

she did not feel she could do much else, leading her to say 'there is nothing I can do which can keep me healthy'. There is already considerable evidence to show that this has a profound impact on the mental health of asylum seekers (Bradby et al 2015:10; Carswell et al 2011:108), but participant narratives suggested that it extends considerably further in the way that it limited activities and created exhaustion.

> It's like all the time I will be tired, I'll just be feeling, now I was sleeping but I don't wake, I don't do anything. I'll just eat, bath, then go wherever I want to go but I was just too tired, like I've worked so, so much, but I don't work.

Intersections with race and poverty

Fleishman et al. suggest that there are determinants of migrant heath that are directly related to being a migrant, and those that are exacerbated by it (2015). Narratives about health and health-promoting practices demonstrated how additional structural factors – namely (but not exclusively) poverty and otherness – interacted to further entrench the positions of participants as structurally vulnerable in relation to maintenance of physical health.

Poverty is a formalised feature of the UK asylum process, with asylum seekers entitled to £39.63 (€44.01; 51.27 USD) a week (UK Government, 2020). The experience of poverty took participants yet further from the practices required to maintain health. The many participants who raised healthy eating as important immediately referenced their financial situation as a barrier: 'If you have money you eat healthy' (Brenda, Malawi, AS). Indeed, a number of participants noted that they came to understand health-promoting practices as important on moving to the UK, at exactly the time their situation forbid them from engaging in such practices. This continued to be experienced by many of the refugees who struggled to find meaningful employment.

> Yeah when I moved here, yes. That's when I realised you can eat whatever you want as long as you can afford [it]. –(Melissa, Zimbabwe, refugee)

Walking was one of the few health-promoting practices that was considered financially accessible. However, an additional structural constraint – a sense of othering, reinforced by awareness of being audibly foreign, and visibly black, led to restrictions in terms of what ASR participants felt they could engage in outside of their home. Participants recounted racist experiences in their everyday interactions such as going to the local shops and travelling on buses. These encounters then shaped their willingness to partake in ostensibly free, healthy activities such as walking in their local area. Female participants in particular, sought to minimise time outside lest others became suspicious about them. Thus, racism and discrimination in local communities had a dual negative impact on health. It contributed to poor well-being due to insults on personhood, and it led to vulnerability to poor health through limiting capacity to engage in health practices.

> If you go out, is maybe difficult, I am scared to disturb people. And still now not doing any exercise. Just some walking for a little bit then come back. (Asmeret, Eritrea, AS).

> Because we are migrants, we do create some noise with other people, but me, I don't have that time. I'll go to the city and just come straight away my house. (Elizabeth, Zimbabwe, AS)

Coping through constraint

In the context of the stress of the asylum process and extreme financial marginalisation the only coping strategies that ASRs can employ further entrench health vulnerabilities. When Audrey (Zimbabwe, AS) had her first asylum claim rejected she became destitute, forced in her late 50s to

sleep on a series of acquaintances' floors. In the time that she was destitute, she was diagnosed with both depression and type 2 diabetes. She attributed her diabetes diagnosis to one of the few pleasures available to her during that time – sweet foods.

> Friends they say 'oh you are losing, you can have this chocolate'. I was eating chocolates. I think that's where I get the diabetes. And I was starting putting sugar, little bit here, little bit until I was three teaspoons in a cup of tea. It was too much. I started to like the sweetness, I didn't know the sweetness was going to kill me.

Thus, the structure of the asylum system places individuals in a position of vulnerability for both poor physical and mental health. Audrey's depression came about as the result of a very concrete situation and one of her coping mechanisms – changes in her diet – had potentially impacted on her physical health profoundly.

Ongoing impacts

Participants who had their refugee status confirmed were able to think about the next stages of their lives with an element of control. However, this alone did not prevent them from being structurally vulnerable to poor health. This was partly due to health challenges that occurred during the asylum process, and because other risk factors – poverty, racialisation, and isolation did not disappear on receipt of a positive decision or with positive approaches to integration, and continued to shape how participants lived their lives. On receipt of refugee status, an additional source of stress, the pressure to find a job quickly, was also added to the equation.

As well as still experiencing racism, Melissa (Zimbabwe, refugee) described her struggle to control her type 2 diabetes while unable to find a job and under pressure to continue paying rent.

> If you've got such a massive pressure on you, you end up not eating properly, you end up not sleeping enough, all the worry is making me anxious, sleepless nights. My glucose was all over, and that made me even lose my concentration, lose confidence. I almost became withdrawn until [...] I was deferred because I couldn't continue going to uni.

Discussion

Asylum seekers and refugees often face traumatic journeys to reach countries of destination, with consequences for their physical and mental health. Here, we demonstrate that the way in which the UK asylum system operates, with long-drawn out legal procedures, no rights to employment, and enforced poverty, also renders ASRs vulnerable to poor long-term physical and mental health. Using the lens of structural vulnerability we highlight the multiple intersections of poverty, uncertainty, racism and 'otherness', which negatively impact on capacity to maintain health practices. Neither the attainment of refugee status – which brings rights and entitlements to work and benefits – nor living in a country with (arguably) a more positive approach to integration could overcome these multiple insults to health and wellbeing. In research with irregular migrants in San Francisco, Marrow (2012) similarly noted, that supportive city-level policies were not sufficient to overcome a punitive national context.

Recent work has highlighted the impacts of non-health-related migration policies on migrant health, suggesting that restrictive policies have a negative impact on mental health, self-rated health, access to care, and all-cause mortality (Juárez et al., 2019). In the UK the establishment of a 'hostile environment' as government policy is an explicit example of structural violence operating to make life uncomfortable for both waiting and failed asylum seekers (Mulvey, 2015; O'Donnell et al., 2019). Thus, the asylum process acts as an upstream determinant of health, shaping individuals' capacity to respond to health-care messages, their views of themselves and their perceptions of society's view of them. Both individually and collectively this has the effect of not only challenging health and wellbeing but shaping the

extent to which they are willing and/or able to enact health supporting practices. This degree of structural vulnerability has similarly been described for hepatitis C risk amongst sex workers and injecting drug users, where the 'political processes of everyday violence cross over from public space to traumatize personal space and then cross back as collective experience' (Rhodes et al., 2011). This may also explain the observation of Kearns et al that while the majority of migrants to Glasgow experienced better health than their Scottish neighbours, this was not the case for asylum seekers, with this disadvantage remaining, even after an asylum application had been approved (Kearns et al., 2017).

The findings here demonstrate how the experience of the asylum system shaped not only feelings about health, but also approaches to health practices more broadly. In high-income countries, the dominant health discourses assert that, to be healthy requires individuals to take an active role in their health. Asylum seekers, however, have no control over their futures (Stewart, 2005). This leads to a tension between health promotion, which emphasises individual agency, and a legal status that diminishes that agency. The result is an existence where individuals have limited control of their personal circumstances, little idea of what may happen to them and when, severely constrained access to resources, and where they are the subject of suspicion and racial discrimination. These structural factors intersect, so that refugees and asylum seekers are unable to access the resources that would afford them the opportunity to live a healthy life and maximise their chances of preventing chronic illness.

Thus, ASRS can be understood as being put in risky spaces, in a manner similar to that discussed in relation to HIV risk amongst marginalised populations (Rhodes et al., 2011).

Limitations

Both the qualitative design of the study and the approach to sampling mean that the findings present an account of the perspectives and experiences of ASRs from a particular range of countries and backgrounds and do not necessarily represent the experiences of the wider ASR population in Glasgow. In addition, because recruitment was carried out through community groups, those ASRs who were most marginalised were effectively excluded from the study.

Conclusions

This paper presents an analysis of the ways in which the UK asylum and immigration system places ASRs in spaces of risk for poor long-term health and chronic illness. The asylum system had a profound impact, both directly, and by compounding other structural influences to diminish agency at a psychological level (e.g., through placing individuals in limbo, casting them as the subject of suspicion), and also at a resource level (e.g., through enforced poverty). Even seemingly cost neutral health-promoting activities, such as walking, carry a burden of visibility which can lead to experiences of racism and discrimination. In placing ASRs in positions where they are less able to engage in preventive care, the asylum system enacts a form of violence with long-term implications on those who must engage with it. Such a position is the result of political choices in the enactment of the asylum process. The cost of the long-term health outcomes is, however, borne by the individuals and the health system. Improving population health needs to recognise, and address, the inequalities enshrined in this and other government-level policies.

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ORCID

Anna Isaacs 🔟 http://orcid.org/0000-0001-5135-232X
Nicola Burns 🔟 http://orcid.org/0000-0003-4764-9731
Sara Macdonald 🔟 http://orcid.org/0000-0002-5380-6943
Catherine A. O'Donnell 🔟 http://orcid.org/0000-0002-5368-3779

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