AN INVESTIGATION INTO THE
HEALTH-RELATED QUALITY OF LIFE
OF REFUGEES AND ASYLUM SEEKERS
IN BRITAIN AND FRANCE

A thesis submitted to Middlesex University
in partial fulfilment of the requirements for the degree of
Doctor of Philosophy

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December 2006

ABSTRACT

This thesis is concerned with the health-related quality of life of two groups of refugees and asylum seekers from the Democratic Republic of the Congo, who are resident in Britain and France. Drawing on theories of health inequalities and psycho-social stress, the thesis argues that the health-related quality of life of refugees and asylum seekers is mediated by their immigration and citizenship status.

Introductory chapters set the scene for the study, giving consideration to patterns of immigration and the emergence of minority ethnic groups in Britain and France, thus setting the context for the arrival and reception of refugees and asylum seekers during the 1990s. Citizenship, health inequalities, and the existing knowledge concerning the health of refugees and asylum seekers are addressed.

Qualitative research, informed by phenomenology, is used to explore the health-related quality of life of these refugees and asylum seekers. The findings are presented and discussed in three chapters in the body of the thesis. Problems with psychological health dominate the findings; issues relating to physical health are presented largely within the context of seeking access to health care. A fourth chapter critically interprets the findings and locates them within wider literature.

The thesis concludes that the health-related quality of life of refugees and asylum seekers is affected by their immigration status and by their lack of citizenship in their host countries. In the absence of citizenship of either Britain or France, refugees and asylum seekers are located in hierarchical societies, characterized by civic stratification, which confers a different set of rights on citizens, refugees and asylum seekers. Asylum seekers have fewer rights than refugees, who, in turn, have fewer rights than citizens. This thesis suggests that these relative statuses contribute to psycho-social stress and thus the health-related quality of life of refugees and asylum seekers.

Acknowledgements

I would like to thank Professor Rosemary Sales, my Director of Studies, for guidance, encouragement and support, also Dr Linda Bell and Professor Eleonore Kofman for their advice.

Thanks are also due to Mike Nacey for listening and acting as a 'sounding board'; also, for his encouragement and patience.

My gratitude must also be extended to the refugees and asylum seekers, associated with Hackney Congolese Community Support Group and Le Souffle, who took the time to talk to me and share their stories.

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CHAPTER ONE

INTRODUCTION

This study arose from what I perceived to be a pressing social problem; a concern for the fate of increasing numbers of people seeking asylum in Western European countries, at a time when measures to reduce the numbers of people entering member states of the European Union (EU) were being strengthened. Difficulty in gaining entry to a safe country, compounded by insecurity of status, exacerbates the existing vulnerability of refugees and asylum seekers and can have untoward effects on their health. Much is now known about the many factors that affect health, and a range of competing and complementary theories attempt to explain the varying health and illness experiences of different groups of people. Material deprivation is widely accepted as a major contributor to health inequalities, but for this study inspiration has been drawn from the relatively recent work on the contribution of psycho-social stress (Wilkinson, 1992; 1996; 2000). While the impact of poverty on health is recognised, Wilkinson argues that people's relative status in society is now a major factor in explaining health inequalities.

Health inequalities exist in Western European countries in terms of social class, ethnicity and gender. Therefore people seeking asylum in Western Europe arrive in countries characterised by health inequalities. Refugees and asylum seekers are likely to find themselves in the lower ranges of any social stratification due to unemployment, or low-paid employment, regardless of their qualifications and occupational standing in their home countries. Refugees and asylum seekers are therefore likely to share the experiences of people in lower social classes, a situation compounded by their ethnicity; members of minority ethnic groups are more likely than the white majority population to be unemployed or employed in low-paid jobs. Added to these two factors, the health of refugees and asylum seekers will be affected by the 'refugee experience', that is by events they have experienced pre-flight, during flight, on arrival in host countries and when attempting resettlement in a host country. This experience differs from that of other migrants in that their migration is forced and not voluntary. When fleeing their home countries in search of a safe haven, people seeking asylum have to overcome a series of hurdles. As well as the traumas of exiting their home countries and travelling (sometimes perilously) to another country, they have to gain access to a safe country and be accepted as asylum seekers, and then await a decision on their application for refugee status. If granted refugee status, some degree of security may return to their lives but another hurdle has to be overcome if refugees want eventually to apply to become citizens of the host country. Thus, refugees and asylum seekers are exposed to factors that can have cumulative adverse effects on their health.

Refugees are placed at a disadvantage relative to citizens of those countries by virtue of their insecure status; those granted refugee status in a Western European country acquire the right to stay in that country, but they do not enjoy the full range of rights accorded to citizens. In turn, asylum seekers are at a further disadvantage as their futures are uncertain; asylum seekers may be granted entry to a Western European country while their applications for asylum are being considered, but they do not have the same rights as recognized refugees. This relative status may be evident in terms of civil rights, political rights and/or social rights but also in terms of an overall sense of belonging - factors encompassed and debated in theories of citizenship.

Refugees and asylum seekers have been denied human rights in their home countries, forcing them to seek safety elsewhere. International laws and treaties exist that aim to ensure the human rights of refugees and asylum seekers, to the extent that Soysal (1994) argues that these laws and treaties confer sufficient protection on migrants in general and that national citizenship is no longer the important status that it once was. Rather, post-national or trans-national citizenship is believed to derive from the range of human rights entrenched in international laws and treaties and to provide for the needs of migrants. However, in the absence of strong international institutions that can enforce the provision for human rights that is included in international laws and treaties, national governments are able to differ in their interpretations of these rights, and remain sovereign in terms of the services that are offered to refugees and asylum seekers. While refugees and asylum seekers do enjoy a range of civil and social rights in host countries, the content of these rights is subject to changes in national government policy and in some respects these rights are not as comprehensive as those conferred on the citizens of these countries.

The group of refugees and asylum seekers identified for this study come from the Democratic Republic of the Congo (DRC). The Congolese community was chosen as it comprises a group of people who had not previously been the focus of much research; other recent migrants to Britain were beginning to suffer 'focus group fatigue' and were becoming disillusioned when their contributions to research yielded few benefits for their communities. It was important, therefore, that this study involved the Congolese community and produced some benefit for it. Both Congolese communities, in Britain and France, were eager to participate in the study and were keen to tell their stories. It was possible to identify comparable groups in both Britain and France. Further, it was important to choose a group of refugees and asylum seekers who shared some similarities in terms of the 'refugee experience', and also culture. Definitions of health, beliefs about health and illness and health-related behaviours are influenced by cultural beliefs, norms and values. It is recognized that migrants from the DRC may have diverse ethnic affiliations; indeed the two groups may have supported different regimes in the DRC as they have largely left the DRC at different times in its turbulent history. Further it is acknowledged that culture is not static and is constantly changing. Nevertheless, it is believed that these two groups of informants share sufficient similarities to represent a case study of Congolese refugees and asylum seekers in Britain and France.

The thesis is that citizenship status (or the lack thereof) is an important mediating factor in health-related quality of life, and in order to investigate the impact of this status, refugees and asylum seekers have been interviewed in two countries, Britain and France. These two countries have different approaches to the integration of migrants to their societies. While sharing similarities in terms of the procedures for acquiring citizenship, Britain and France differ in their philosophical and practical approaches to citizenship. The key aim of this study is to explore the health-related quality of life of refugees and asylum seekers in order that the impact of different citizenship statuses on the health of refugees and asylum seekers as two separate groups can be identified.

Aims of the study

1. To investigate the health-related quality of life of Congolese refugees and asylum seekers in Britain and France.
2. To identify factors that have an impact on the health-related quality of life of these two groups of people who lack citizenship status and have differing civic statuses.
3. To explore the above factors in terms of their relationship to policy concerning immigration and the granting of citizenship in two countries with different approaches to citizenship and the integration of immigrants.
4. To identify the implications of the above factors for health policy and the health of refugees and asylum seekers.

Definitions of terms

Refugees and asylum seekers

It is important to define two key statuses used in this study. The term 'refugee' is defined by the United Nations Convention Relating to the Status of Refugees (1951), and its 1967 Protocol, as follows. A refugee is a person who:

> *"Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."*
> (UNHCR, 2000, p23)

The Office of the United Nations High Commissioner for Refugees (UNHCR) was created in 1950, with a three-year mandate, to help resettle European refugees who were still homeless after the Second World War (UNHCR, 2000). By the mid-1960s refugees were to be found in many countries outside Europe. The 1967 Protocol Relating to the Status of Refugees expanded the scope of the Convention and removed limitations relating to time and geography. States signing the 1951 UN Convention, or its 1967 Protocol, undertake to protect refugees and to respect the principle of *non-refoulement*, that is, not to return refugees to countries where they might be persecuted. Both the United Kingdom (UK) and France are party to the 1951 Convention and the 1967 Protocol.

In this study it is necessary to distinguish clearly between the terms refugee and asylum seeker, as their respective statuses and associated rights are different. Therefore, the term 'refugee' is reserved for someone who has been granted refugee status in his/her host country, within the terms of the above Convention, and will be referred to as a Convention refugee. An 'asylum seeker' is someone who has applied for refugee status and is awaiting a decision on his/her application. This differentiation is important as the two statuses attract different rights in Britain and France.

Citizenship

Citizenship, which forms the theoretical framework for this study, is a fundamental element of human security (UNHCR, 1997) and is central to resettlement in a country of asylum. Conceptions of citizenship vary but can be grouped under three broad headings:

- **Formal conceptions** which relate to legal status, such as formal belonging to a state;
- **Substantive conceptions** which relate to the rights attached to the status of citizenship; and
- **Citizenship as a sense of belonging** to a community or society.

Definitions of citizenship vary but most authors agree that citizenship concerns the relationship between the individual and the state. This relationship is crucial in determining an individual's formal status, associated rights and the extent to which an individual feels a sense of belonging to, or exclusion from, society. These are all factors that can affect an individual's health, and so it follows that citizenship status can have an impact on health.

A decision was made to explore the health-related quality of life of refugees and asylum seekers in Britain and France, two countries which have different approaches to citizenship and to the integration of immigrants. In France, the civic republican tradition of citizenship places emphasis on the necessity for the state and its citizens to be a community, not merely a collection of individuals, and thus is a shared activity (Heater, 1999). This approach draws on Rousseau's social contract theory which explicitly denies intermediate associations between the individual and the state (Dyke, 1995), thus there is no official recognition of minority ethnic groups. The liberal approach adopted in Britain is characterised by a shift from a "monarch-subject relationship to a state-citizenship relationship" (Heater, 1999, p4) emphasising the importance of individually held rights and freedoms. The republican model of citizenship stresses the importance of civic virtue, thus the republican citizen seeks to serve the state, while the liberal citizen seeks protection from it (Faulks, 1998). However, liberal and civic republican approaches to citizenship are 'ideal types' and thus rarely seen in a pure form.

Despite comparable colonial experiences and post war immigration patterns, Britain and France have developed different responses to the integration of migrants (Favell, 1998). Government policy on immigration and integration is informed by different philosophies of citizenship:

> *"A theory of integration for immigrants through access to a Republican social contract of citizenship in France; a social management of conflict through legal race relations mechanisms and categories, and pluralist venues of multiculturalism in Britain."*
> (Favell, 1997, p197)

These different approaches to the incorporation of migrants are further described by Silverman (1992) as individual assimilation in France, embracing the principles of universalism, assimiliation and individualism; and as recognition of differences and special provision for minorities in Britain, embodying particularism, difference and collectivity.

Soysal (1994) describes how the philosophy of citizenship in France has resulted in a 'statist' model where migrants are incorporated into society at a national level. An assumption of equality between individuals negates the necessity for the organization of minority groups. The French state places emphasis on access of individual migrants to regular services, rather than provision of designated services for migrant groups.

Assimilation requires that immigrants relinquish their cultural identity and accept that of the host country (Donà and Berry, 1999), resulting in a situation that Faist (2000, p211) describes as "*melting into the core*" of the national culture. According to the French republican tradition, immigrants will be regarded as French, provided that they espouse French cultural values and behave like a French person. The major classification of people in France is in terms of nationality, either being French or a 'foreigner' (*étranger*), that is, anyone who is not of French nationality; officially the category of ethnic minority is not recognized (Kofman, Phizacklea, Raguram and Sales, 2000). In this study the term 'foreigner' is used when referring to this category of person in France. The inverted commas are used as the term may have pejorative connotations when used in the English language.

In contrast, Soysal (1994) claims that Britain's 'liberal' approach to citizenship results in a decentralization of the incorporation of migrants into society through a proliferation of local voluntary associations. The multicultural approach adopted in Britain allows for collective identities to be retained, albeit in a context that is different from the country of origin (Faist, 2000).

Health-related quality of life

Health is a broad concept with a range of definitions, and is often measured in terms of its absence, that is, by collecting data relating to morbidity or mortality. While these measures are useful, they do not necessarily reflect more holistic views of health, for example, incorporating the ability to adapt to changing circumstances and achieve potential. When the ideas for this research were being formulated, the concept of 'health-related quality of life' was in vogue and is defined as:

> *"….. the value ascribed to a person's life, by the individual or society, as a result of her own health, and influences such as personal behaviour, medical care, health policy, or larger social forces".*
> (Lerner and Levine, 1994, p45)

This definition is more useful to this study than that of 'health' alone. It is broader in scope, moving from individual factors, through the provision and experience of medical care to wider socio-political factors. Thus the definition acknowledges the contribution of health policy to the overall health experience, for example, in the provision of health care for citizens and non-citizens, and wider social forces, such as social exclusion.

The study

Initially, focus groups were held in London with members of the Congolese community. The discussions were audio-taped, transcribed, and analysed. Emergent themes were identified. These themes were then used to inform topic guides that were used as a basis for a series of individual interviews with Congolese refugees and asylum seekers in Britain and France. These interviews were also audio-taped, transcribed and analysed. The findings from these interviews form the basis for the argument that the health-related quality of life of refugees and asylum seekers is influenced by their citizenship status.

This study draws on several disciplines in order to investigate the health-related quality of life of Congolese refugees and asylum seekers in Britain and France. The disciplines of politics, sociology and social policy, together with wide ranging literature in the field of health, are used to advance existing knowledge that accounts for differences in health and illness experiences among different groups of people.

The context of the study

Britain and France were chosen as locations in which to investigate the health related quality of life of refugees and asylum seekers as they share similarities but also have distinct differences. The interviews took place during the year 2000, at a time when both countries had been experiencing increases in the numbers of people seeking asylum, but also a time when asylum and immigration policies were becoming increasingly restrictive in western European countries rendering it difficult for people to seek protection in these countries. The numbers of people travelling to Europe to seek asylum had been increasing during the 1980s, culminating in the tightening of immigration policy and legislation in reaction to this increase.

The following statistics are derived from the United Nations High Commission for Refugees Statistical Yearbook (2006a) and the European Council on Refugees and Exiles (ECRE, 2005). The total number of people 'of concern' to UNHCR in January 2000 was 22.3 million (UNHCR, 2006a). According to the UNHCR and ECRE, both countries experienced an increase in the numbers of new applications for asylum in the late 1990s and early 2000s. This was the period during which the informants for this study sought asylum in Britain and France, having fled the DRC. The total numbers of asylum applications were as follows:

	1999	2000	2001
France	30,833	38,588	47,263
UK	91,200	98,900	88,200

(www.ecre.org/factfile/realfacts/shtml, 2005)

Recognition rates of refugee status, as a percentage of total decisions were as follows:

	1999	2000	2001
France	19%	16%	16%
UK	23%	11%	12%

(www.ecre.org/factfile/realfacts/shtml, 2005)

There were also other humanitarian statuses recognized in the UK, but not in France. In the year 2000 there were 1.7 refugees per 1000 inhabitants in France, and 2.9 per 1000 inhabitants in the UK (www.ecre.org/factfile/realfacts/shtml, 2005).

The numbers of people seeking asylum in France have been increasing annually since 1996; individuals from the DRC formed the third largest group of people seeking asylum in France in 2003 (UNHCR, 2006a). The DRC does not feature in the top 5 countries of origin for people seeking asylum in the UK (UNHCR, 2006a).

Since the interviews for this study were conducted, the global numbers of people seeking asylum have continued to decrease, estimated at 9.2 million persons by the end of 2004. This figure represents a decrease from the beginning of 2004, when the estimated number was 9.6 million persons (UNHCR, 2005). This is the fourth consecutive year that the number of refugees has fallen. This global reduction is also reflected in numbers of people seeking asylum in Europe. The UNHCR claims that this fall is in part due to durable solutions to the refugee situation, for example, voluntary repatriation. Deterrent immigration and asylum policies by national governments must also have contributed to this reduction. While traditionally migrants have tended to be male, currently 49% of the world's refugees are female, but the proportion varies according to local circumstances. It is also estimated that Europe hosted approximately 25% of these refugees (UNHCR, 2005). The DRC forms the fourth of the ten main countries of origin of refugees in 2004 (UNHCR, 2005). Asylum applications in the European Union continued to reduce in 2005; in the United Kingdom, the number of asylum applications in 2005 was the lowest since 1993 (UNHCR, 2006b). Despite a 15% drop in asylum claims in 2005, France was the top receiving country in 2005; the United Kingdom was third (UNHCR, 2006b). Even though claims for asylum are decreasing, the situation of refugees and asylum seekers remains an important issue and the numbers of people involved are still substantial; there were an estimated 50,000 new asylum applications in France in 2005 and 30,500 in the United Kingdom (UNHCR, 2006b).

Outline of the thesis

Chapter 2 provides an overview of patterns of migration to Britain and France, setting the context in which refugees and asylum seekers arrive. Groups of migrants have become increasingly diverse resulting in the formation of minority ethnic groups. As the numbers of people seeking asylum in Britain and France have increased, the respective governments have responded by strengthening their regulation of immigration, drawing greater attention to the differences between citizens and non-citizens. The chapter then presents a critical analysis of theories relating to citizenship. This is supplemented by Morris's (1997; 2001; 2002) concept of civic stratification based on rights. This has proved particularly useful in this study, since many refugees and asylum seekers do not acquire citizenship status and the system of civic stratification encompasses people in the 'sub' or 'pre' –citizenship phase, defining the rights of refugees and asylum seekers. Different approaches to citizenship are discussed, particularly in relation to Britain and France, together with rights conferred on refugees and asylum seekers in these two countries.

Chapter 3 deals with definitions of health and factors affecting health and takes a critical stance towards the literature concerning health inequalities. Against the background of inequalities in health in relation to class and ethnicity, the refugee experience is discussed, as various factors can affect their health, such as persecution and/or disrupted services in the home country, as well as conditions experienced during flight and on arrival in their host country. It is argued that such factors, together with the psycho-social stress caused by their insecure status affect the health of refugees and asylum seekers. This argument is subsequently explored by asking members of the Congolese community about their health-related quality of life. Given the lack of an agreed definition of health and difficulties with measuring health, the decision to investigate the broader concept of health-related quality of life is justified.

Chapter 4 considers the methodology of this study. It is argued that a qualitative investigation of the health-related quality of life of this group of refugees and asylum seekers is appropriate, claiming that this approach is pertinent to the exploration of such a subjective experience. The methods of data collection, focus groups and individual interviews, are described. The process of data analysis is described. Ethical issues that relate to research with refugees and asylum seekers are discussed.

The empirical work is reported in detail in Chapters 5, 6 and 7. These results are discussed in relation to the results from other small studies, often referred to as 'grey literature'. Chapter 5 starts with some biographical information about the informants, their ages, gender and immigration status. There is also a brief account of the situation in the DRC, from which these informants have fled. The chapter then presents the results of the study in terms of the informants' psychological health and the consequences of experiences of persecution in the DRC, anxiety concerning immigration status, loss of family members and loss of financial independence. It is difficult to classify health problems in purely psychological or physical terms, but Chapter 6 concerns the physical health problems of the informants, often somatic manifestations of psychological problems. Chapter 6 also addresses the informants' experience of using health services in Britain and France and demonstrates that a lack of trust pervades all contact with health services in Britain, in contrast to complete trust in health care providers in France. These findings are discussed in relation to the differences in the provision of health care in both countries. It proved difficult to separate the various factors that impinge on the health of this group of refugees and asylum seekers, but factors that relate more to aspects of social exclusion are presented in chapter 7. While the factors identified here are known to affect health, their special relevance for refugees and asylum seekers is discussed.

Chapter 8 addresses the interpretations deriving from the data collected, and discusses the results within the context of existing theories and wider literature, and in terms of the attributes of health-related quality of life, civic stratification and the citizenship status of the informants. The chapter further demonstrates what this study has added to existing knowledge concerning the health experience of refugees and asylum seekers and the effects of psycho-social stress on health, arguing that the influence that civic stratification has on the health-related quality of life of refugees and asylum seekers is apparent in the informants in both Britain and France. The final chapter concludes that formal citizenship is the ultimate guarantor of political, civil and social rights, and also contributes to a sense of belonging in society. The implications of these findings for the assessment of the health-related quality of life of refugees and asylum seekers are discussed, together with the implications for health care professionals, health policy and immigration policy. The different approaches to the incorporation of migrants in Britain and France are considered, particularly in relation to their contribution to a sense of belonging to the respective societies.

CHAPTER TWO

IMMIGRATION AND CITIZENSHIP IN BRITAIN AND FRANCE

Introduction

This chapter considers the concept of citizenship and sets out the conceptual framework within which the research takes place, arguing that citizenship status affects the health of refugees and asylum seekers. Turner (1993) claims that citizenship forms *"a platform for interdisciplinary research on the problems of social membership in advanced societies"* (p*ix*). Consequently, this research explores citizenship, in terms of political and sociological approaches, and draws on theories of immigration, and the wide-ranging literature addressing health. The chapter commences with a brief history of migration within and into Europe, concentrating on Britain and France, together with immigration policies that have been developed in response to migratory flows. Patterns of migration have been influential in forming the multi-cultural societies into which refugees and asylum seekers currently arrive, and thus have set the context for the reception of new migrants. For example, that context is set by a society's preparedness to welcome refugees and asylum seekers at a local level, and the approaches to granting initial entry to the country, to leave to remain, and ultimately to citizenship status. This chapter then analyses asylum policy in Britain and France and describes the rights attached to the status of refugee, and that of asylum seeker, in both countries. This section thus serves as a prelude to theoretical debates relating to the concept of citizenship and its relevance for refugees and asylum seekers. The acquisition of citizenship status is becoming more elusive as states introduce increasingly arduous procedures and legislation. Even people with formal national citizenship are not always able to avail themselves of all the services normally guaranteed by this status. Three conceptions are initially considered: formal citizenship, substantive citizenship, and citizenship as a sense of belonging. Comparisons are drawn between approaches to citizenship in Britain and France. Amid criticisms of traditional approaches, which tend to focus on formal membership of nations, there have been calls for new approaches that transcend the limitations of formal citizenship, based on universal human rights and not restricted to membership of one nation. This introduces the concept of transnational citizenship.

Although those granted refugee status have security of residence, and can apply for citizenship after a determined period of residence in Britain or France, asylum seekers have a less secure status and fewer rights. The difference between the status of refugee and asylum seeker is therefore important and Morris's (1997, 2001, 2002) work on civic stratification is employed to explore these different statuses.

Patterns of migration in Europe

During the late 1800s and early 1900s migrant workers were attracted to industrialising nations in Western Europe. As the first industrial nation, Britain experienced large scale labour migration earlier than other countries (Castles and Miller, 2003), while in France, labour migration played an important role in industrial development and the formation of the working class (Castles and Miller, 2003; Vaillant, 2006). At this time, migration to both countries was usually from other European countries. In general migrants could move around Europe relatively freely before 1914; subsequently regulation and control of immigration increased (Hammar, 1990).

During the inter-war period (1918-1939) international labour migration reduced in most European countries as a consequence of economic stagnation and hostility towards immigrants. Following the Second World War in 1945 Western European countries encouraged migration from the periphery of Europe and from former colonies, often through guestworker schemes, in order to assist with post-war reconstruction (Castles and Miller, 2003; Hansen, 2003a). This pattern of labour migration continued until 1973-4, when the oil crisis heralded a period of economic recession and Western European governments ceased to actively recruit foreign and colonial workers.

While each migratory movement has its own characteristics, Castles and Miller (2003) argue that there are common characteristics. Most economic migrations start with young men seeking work. If they succeed in their new country, they send for spouses or find partners and form families, often settling permanently. The expectations of Western European governments in the 1970s, that immigrants would either return to their countries of origin when no longer required, or assimilate into the dominant culture were not fulfilled (Castles, 2003). A system of chain migration had already been set in motion by family reunion, and second and third generations of migrant families began to emerge and form communities. They tended to settle in neighbourhoods recognizable by displays of culture, for example places of worship, shops, businesses, dress and language (Castles, 2000).

The point at which migrants become members of minority ethnic groups remains contested. Castles and Miller (2003) argue that the approach of the government and people of a host country will determine whether permanent settlement is characterised by the formation of ethnic communities in a society where cultural diversity is accepted, or whether ethnic communities remain socially excluded. Minority ethnic groups are labelled as such, not only due to their relatively small numbers, but also due to their being assigned a subordinate position by the majority culture or dominant groups. The definition of minority ethnic group may thus be conferred by others, or may be an identity adopted by the group itself as a consequence of shared culture, exclusion and powerlessness (Marks and Warboys, 1997; Castles and Miller, 2003). Britain and France had thus become multi-cultural societies by the mid-1970s, when patterns of migration changed.

Against this background of migration to and within Europe, more detailed patterns of migration to Britain and France will be analysed, together with subsequent immigration policies in these two countries. The emergence of minority ethnic groups in both countries will be considered.

Immigration policy in Britain

Control of immigration to the UK barely existed prior to the Aliens Act (1905), the first piece of legislation to define and restrict the entry of immigrants, particularly the entry of Jewish people from other European countries (Dummett, 2001; Kerrigan, 2005). Following large scale labour migration during the 1950s, since the 1960s immigration policy in the UK has been progressively restrictive, aiming:

> *"to limit immigration for permanent settlement to a minimum, subject to the needs of the labour market and to obligations to dependents, genuine refugees and other exceptions."*
> (Coleman, 1996, p195)

While this intent has been consistent, the development of policy has been piecemeal. More recently, one aim of policy has moved towards better management of migration, focusing on Britain's economic interests, and reduction in the potential for seeking asylum (Flynn, 2005).

The following table summarizes important legislation relating to immigration and asylum in Britain.

Table 1: Immigration and asylum laws and policy in Britain

Year	Brief description of legislation/policy
1905	**Aliens Act** • Targeted 'undesirable aliens', e.g. the diseased and criminal could be refused entry. • Asylum seekers were exempted.
1914	**Aliens Restriction Act** • Allowed restrictions on foreigners' entry and place of abode. • Allowed deportation.
1914	**British Nationality and Status of Aliens Act** • Acknowleged that everyone born within the British Empire was a subject of the Crown.
1919	**Aliens Act** • Repealed 1905 Act. • Introduced charges for sedition and industrial unrest by foreigners.
1948	**British Nationality Act** • Allowed all Commonwealth members to acquire British citizenship.
1962	**Commonwealth Immigrants Act** • Restricted entry into the United Kingdom for Commonwealth citizens through a system of work permits.
1968	**Commonwealth Immigrants Act** • Right of entry into the UK restricted, for those who held British passports issued by High Commissions abroad, to those people who could establish a close connection with the UK. 'Close connection' was largely defined in terms of having a British resident grandparent.
1971	**Immigration Act** • Distinguished between 'patrials'[1] and others. • Entry for non-patrials could be granted only in specified circumstances, normally the production of a work permit or on establishment of certain familial relationships.
1981	**British Nationality Act** • Intended to bring citizenship law in line with changes effected by immigration legislation. It replaced the single category of Citizen of the UK and Colonies with three separate categories: • British Citizenship • British Dependent Territories Citizenship • British Overseas Citizenship • Only the first of these had full rights of entry into Britain.
1988	**Immigration Act** • Repealed the right of unrestricted access for the wives and children of Commonwealth citizens settled in the UK prior to 1973.
1993	**Asylum and Immigration Appeals Act** • Created processes for dealing with asylum applications. • Withdrew rights to secure tenancy in social housing for asylum seekers. • Benefits for asylum seekers set at 90% of income support.
1996	**Asylum and Immigration Act** • Withdrew cash benefits for asylum seekers, followed by introduction of 'vouchers' following court judgement that local authorities should provide basic subsistence for 'destitute' people and the 1989 Children Act gave the right to support for children and families.
1999	**Immigration and Asylum Act** • Introduced vouchers for all asylum seekers. • Organisation of support for asylum seekers was placed in the hands of the National Asylum Support Service (NASS). • Subsistence was set below the level of welfare benefits; asylum seekers were ineligible for benefits, e.g. Child Benefit. • Introduced the compulsory dispersal of families and single people. • Unaccompanied minors remained the responsibility of local authorities.

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[1] The 'patriality' clause meant that Commonwealth citizens were free to enter the UK with indefinite leave to remain (which can lead to citizenship status) only if they could demonstrate that one grandparent was born in the UK (Cole, 2000).

2002	**Nationality, Immigration and Asylum Act** • Introduced new controls on entry. • Proposed induction/accommodation/removal centres for asylum seekers. • Vouchers were phased out. • Removed 'concession' allowing asylum seekers to apply for work after six months. • Detention centres were renamed 'removal centres' and targets set for removals. • Under Section 55, support was refused for individuals (but not families with children) if asylum seekers do not make a claim 'as soon as reasonably practicable'.
2004	**Asylum and Immigration Act (Treatment of Claimants, etc.)** • Introduced limited right of appeal on asylum decision. • Electronic monitoring of asylum seekers who 'appear' to be over 18 years. • Support can be refused for failed asylum-seeking families with dependent children 'deemed to be in a position to leave the UK' if they do not cooperate with removal. • Credibility of asylum applicants jeopardised if they fail to show passport on request, use false documents, change or destroy a travel document without good reason.
2005	**Controlling our borders: Making migration work for Britain (Five year strategy for asylum and immigration)** • Targets for removal of 'failed' asylum seekers. • Refugees granted temporary leave, not permanent status, to be reviewed after five years. • Detention to become 'the norm' for those whose application fails. • New processes for considering asylum claims to enable greater control over asylum seekers. • Pilot project for returning unaccompanied asylum seeking children.
2006	**Immigration, Asylum and Nationality Act** • Implements many of the measures outlined in the above plan

Sources: Cohen, 1994; Kerrigan, 2005; Sales, 2006

Britain has traditionally been a country of immigration and asylum seeking, as well as emigration. The term 'refugee' was first applied to the Huguenots, French protestants who fled religious persecution in France at the end of the 16th and beginning of the 17th centuries, seeking sanctuary in Britain and Ireland (Adelman, 1999). They were followed by refugees fleeing political upheavals in Europe, for example, Jewish people from Russia, Poland, Austria and Romania, as well as large numbers of Irish people fleeing poverty, famine and population growth and seeking work. During the 19th century British industry was expanding and the desire for labour negated the need for immigration controls (Kerrigan, 2005). The large Jewish community, particularly in the East End of London, was a ready source of labour. However, as competition from manufacturing overseas contributed to economic depression, immigrant workers were blamed for unemployment and this lead to the 1905 Act, placing restrictions on immigration to Britain.

During the 1930s refugees came to Britain from Germany, Austria and Czechoslovakia (Cohen, 1994). The atrocities and aftermath of the Second World War brought more refugees to Britain. Britain's post-war labour migrants were recruited initially from refugee camps, and from Italy, and were replaced in the 1950s and 1960s by colonial workers (Castles and Miller, 2003).

A crucial piece of immigration legislation was the British Nationality Act (1948), which allowed commonwealth members to acquire British citizenship and the associated civil, political and social rights. These workers, largely from the Caribbean, India and Pakistan, took jobs in foundries in the Midlands, textile mills in the North of England, in transport industries in the cities, and also in the National Health Service (Wrench and Solomos, 1993). These new arrivals received a mixed welcome and many experienced exploitation, discrimination and marginalisation in their economic and social lives (Wrench and Solomos, 1993; Bleich, 2003). After the Second World War, successive governments failed to satisfy demands for housing, and immigrants became scapegoats, in the public eye, for the housing shortage (Mason, 2000). In 1958 riots occurred in Notting Hill and Nottingham, when white youths attacked immigrants from the Caribbean. By the 1960s, many immigrants were employed in the least desirable jobs and lived in poor housing (Mason, 2000). Since 1965 a series of Race Relations Acts have made it unlawful to discriminate on grounds of colour, race or ethnic origin in public places, employment and housing.

Migration from the Caribbean, the Indian sub-continent and Africa increased during the 1950s, then reduced after 1962, following the restrictions imposed by the Commonwealth Immigrants Act of that year. Two further pieces of legislation in 1968 and 1971 required immigrants to have close family connections in Britain. These successive Acts thus sought to establish control over the opportunities that had been created by the 1948 Act. British Asians arrived in Britain following expulsion from Kenya in the 1960s and Uganda in the 1970s (Cohen, 1994). During the 1970s Greek Cypriots fled to Britain following the invasion of Cyprus by Turkey and its subsequent division, and refugees arrived from Chile and Vietnam (Cohen, 1994).

In 1968 political concern surrounding immigration was expressed in Enoch Powell's apocalyptic and controversial 'river of blood' speech, which gave dire warnings of the possible consequences of the numbers of immigrants and geographical concentration in Britain (Layton-Henry, 1992). While such sentiments were embraced by few politicians, it supplied the National Front with a campaigning issue; racist violence became a problem for Asian and Afro-Caribbean people. The 1980s thus marked a period of racial tension, as immigrants were blamed for a disproportionate amount of crime and for 'sponging' off the welfare state (Layton-Henry, 1992). Urban riots occurred in the 1980s, triggered by heavy-handed policing of black youths (Castles and Davidson, 2000). Such problems resulted in government measures related to the more general problems of poverty, decaying urban areas and the maintenance of public order, rather than the central issues of rights and integration (Jones, 2000). The formal equality supposedly enjoyed by minority ethnic groups in Britain continues to contrast with the reality of their experience of discrimination and social exclusion (Castles and Miller, 2003). Members of minority ethnic groups experience higher unemployment that the white majority and are also over-represented in low-paid occupations, with poor working conditions (Smaje, 1995a).

Subsequently legislation relating to immigration became more restrictive, as the British Nationality Act (1981) heralded a hierarchy of citizenship statuses. Further, in the 1980s, asylum policy became conflated with immigration policy, when an increasing proportion of asylum seekers were black and thus more visible (Pirouet, 2001). Asylum policy will be considered later in this chapter.

Immigration policy in France

In spite of a tradition of immigration since the 13th Century, a respect for the 'rights of man' and welcoming asylum seekers, Weil (2004) contends that France does not have a coherent strategy for immigration. Like Britain, France has reacted to waves of immigration which was not seen as a problem until the 19th century, when progressive state intervention began. Nevertheless, immigration has an important place in French history, as at various times France has needed to recruit foreign labour to compensate for losses of its population due to war and a falling birth rate and has thus been essential to the construction of the modern French nation (Forbes, Hewlett, Nectoux and Reymond, 1994; Noiriel, 1996; Weil, 2004).

Immigration policy in France has traditionally been informed by debate around the contradictory views of whether immigration poses a threat to public order and to the national French community, or represents the founding values of the Republic, based on the 'rights of man', i.e. liberty, equality and fraternity (Khamès and Paoletti,1993; Weil, 2004). The maintenance of national identity has featured prominently in immigration and asylum policy, to the extent that during the inter-war and post-war years a process of 'francisation' encouraged immigrants who became naturalised to change their names in order to sound more French (Noiriel, 1996).

The following table outlines key legislation and policy in relation to immigration to France.

Table 2: Immigration and asylum laws and policy in France

Year	Brief description of legislation/policy
1917	**Decree** • Required identification cards to be held by all foreigners residing in France.
1926	**Law** • Formally incorporated identification card for foreigners, renewable every 2 – 3 years. • Formed a distinction between the French and foreigners.
1934	**Law** • Excluded foreigners from all government-paid jobs.
1938	• A naturalised citizen had to wait 5 years before obtaining the right to vote, and a mandatory French language exam was added to the requirements for naturalisation. • The desire was expressed to distinguish between "good foreigners and undesirables" (Noiriel, 1996, p65)
1945	**Regulation** • Concerned the status of foreigners and entry and residence in France. (Institution of the 'Card' - residence.) • The National Code defines people without French nationality as 'foreigners'. (*Institution of the 'Code' – nationality.)* • The French State re-established its control over immigration. • National Immigration Office (ONI, *L'Office National d'Immigration)* was established to deal with all recruitment of foreign labour.
1952	**Asylum Act** • Created the French Office for the Protection of Refugees and Stateless Persons (OFPRA, *L'Office français de protection des réfugiés et apatrides*). This institution is responsible for examining requests for asylum.
1960	**Agreement** • Citizens of former French colonies of Africa offered total freedom of movement and complete assimilation with the French.
1972	• Immigration of non-qualified workers dependent on having employment. Loss of employment meant loss of right to stay.
1973	• Introduction of opportunity for 'regularisation' of clandestine 'foreign' workers.
1974	• Immigration of workers and their families restricted to nationals of the member states of the European Economic Community. Family reunion was re-instated in 1975. The suspension of immigration by non-European workers was lifted in 1977.
1980	**Bonnet Law** • Made it easier to deport undocumented immigrants. • Entry requirements increased for immigrants.
1986	**Pasqua Law** • Modified the conditions under which foreigners could enter and reside in France: increase in documentation required. • Introduced visas for all non-EC citizens.
1989	**Joxe Law** • Provided protection from expulsion for people with families in France. • Some restrictions placed on the decisions that Prefects could make.
1989	• National Council for Integration (*Haut Conseil de l'Intégration*) created. Recognition of discrimination against 'foreigners'.
1991	**Law** • Restricted the entry, stay and work by undocumented immigrants.
1993	**Pasqua Law** • Tightened immigration and nationality rules. • Conditions for entry and family reunion became stricter. • Deportation was facilitated • Rules on citizenship for children of immigrants tightened. • Asylum seekers' right to work abolished
1997	**Debré Law** • Reduced immigration. • Restrictions placed on family reunion and visits.

	• Abolished appeals by asylum seekers and imposed greater controls on immigrants. • Reform of nationality law for second generation migrants.
1998	**Law on Entry and Residence of Aliens and Right to Asylum** • Rapid procedure created for making quick decisions for genuine refugees and deterring unfounded asylum seeking.
2003	**Law** • New powers given to mayors concerning residence cards. • 'Subsidiary asylum' replaced 'territorial asylum'. • Created lists of 'safe' countries to which asylum seekers could be returned. • Allowed for asylum seekers who make applications at port of entry to be taken to a detention zone and to risk immediate deportation if refused asylum at the frontier. • Rejection of application possible without opportunity to explain reasons for seeking asylum.
2006	**Sarkozy Law** • 'Choice' of immigrants to become more selective, focusing on needs of the economy. • Further restrictions placed on rules of entry and stay

Sources: Delouvin, 2000; Barats-Malbrel, 1999; Noiriel, 1996; Weil, 2004 ; GISTI, 2004; Vie-publique.fr, 2005

Before 1851 immigration into France was primarily from neighbouring countries, for example, Belgium, Italy, Spain (Moigne and Lebon, 1999), and until 1946 largely took the form of labour migration. During this period France also received refugees from other European countries, for example from Russia and Armenia. Until 1917 immigrants to France were required only to present themselves to the local mayor in order to be able to reside and work (Vaillant, 2006); in 1917 a decree required identification cards to be held by all 'foreigners'. State involvement in the regulation of immigration commenced in 1926, when the government set up a private company to control the recruitment of foreign workers (Barats-Malbrel,1999; Weil, 2004). Agreements with sending countries imposed limits. By 1930 France had one of the highest immigration rates in the world, but economic problems and unemployment provoked anti-immigrant feeling (Barats-Malbrel, 1999) and in 1931 immigration was restricted to selected countries (Khamès and Paoletti, 1993; Moigne and Lebon, 1999; Vaillant, 2006).

During the Second World War, the Vichy regime in France actively discriminated against 'foreigners', notably Jewish people (Barats-Malbrel, 1999). The requirement that Jewish people wore yellow stars promoted their identification and stigmatisation. This arguably contributes to the ongoing reluctance on the part of the French state to identify members of minority ethnic groups as such.

In 1945, regulations determined the rules of entry into France (the 'card'), and access to French nationality (the 'code') (Weil, 2004), and have been regularly amended as governments have changed (Barats-Malbrel, 1999; Delouvin, 2000). Concerns for the need for labour, set against concerns about the social composition of the French nation, resulted in the creation of the identity card for 'foreigners' (Barats-Malbrel, 1999; Vaillant, 2006). Access to nationality concerned the 'code', and this legislation defines people without French nationality as 'foreigners' (Gliber, 1997; Weil, 2004). It is only by 'the card' (French identity card) and by 'the code' (French civil code) that the distinction between 'nationals' and 'non-nationals' is made and the legal category of 'foreigner' defined (Barats-Malbrel, 1999).

Following the Second World War, refugees and immigrant workers were welcome in France and many came from other European countries (Khamès and Paoletti, 1993; Moigne and Lebon, 1999). Like Britain, during the 1950s and 1960s, France recruited workers, and attracted spontaneous immigration, from its former colonies in North and West Africa (Khamès and Paoletti, 1993; Moigne and Lebon, 1999). Those who arrived in France prior to the independence of their home countries were French citizens, with full civil, political and social rights. French citizens also arrived from the Overseas Departments of Gaudeloupe, Martinique and Réunion.

The period 1945-1974 was one of uncertainty; authorities did not know whether immigrants would stay in France, but for those who did stay a policy of assimilation was assumed (Weil, 2004). During the 1960s Algerians formed the most visible minority ethnic group in France and were subject to racial violence (Dummett, 2001; Bleich, 2003), to the extent that in 1973 the Algerian government stopped its citizens migrating to France (Vaillant, 2006).

Immigrant workers who were neither qualified nor European had limited prospects for settlement in France; they were given jobs at lower levels of the labour market than French people, and often lived in poor quality housing that was segregated, overcrowded, or destined for demolition (Castles and Miller, 2003; Weil, 2004). Thus, by the late 1960s non-European migrants were experiencing increasing social exclusion and living in 'shanty towns' (*bidonvilles*). In an attempt to make public housing more accessible to migrants and prevent the formation of 'ghettoes', the French government introduced the notion of a 'threshold of tolerance' (*seuil de tolérance*) by which small numbers of 'foreigners', what Weil (2004, p383) describes as "*a homeopathic dose*", were dispersed to various parts of France with the expectation that assimilation would take place and they would 'disappear' into French society (Weil, 2004). In line with this threshold, subsidies to public housing associations (HLMs, *Habitations à loyer modérés)* were coupled with quotas for immigrants (Castles and Miller, 2003). The reality was that as new housing was built, poorer housing was still reserved for 'foreigners', resulting in the very concentration of minority ethnic groups that the policy had aimed to avoid (Castles and Miller, 2003; Weil, 2004).

The 1970s saw steps to reverse the traditional French welcome to immigrants (Forbes et al, 1994; Dummett, 2001). Immigration controls successfully reduced the numbers of immigrants, but failed to encourage immigrants to return to their countries of origin. At the end of the 1970s immigrants mobilised to protest against racism, unemployment, housing conditions and deportation (Lloyd, 1998; Weil, 2004). By the mid-1970s there was a realisation in France that immigrants would stay and policy turned towards improving their situation. Nevertheless, France accepted that maintaining cultural links with the country of origin was important in facilitating return to the home country, and the Government promoted language classes in various mother tongues in schools, and the practice of Islam in factories and hostels (Weil, 2004).

Thus, French policy moved from assimilation of immigrants to insertion in the 1970s, and integration in the 1980s (Noiriel, 1996; Nyer-Malbet, 1996; Barats-Malbrel, 1999; Weil, 2004). Favell (1997) and Brubaker (2001), however, argue that such moves, together with the socialist government's assertion of the 'right to difference', were stronger in rhetoric than reality. In practice, the 1980s saw the resurgence of the assimilationist republican tradition (Favell, 1997).

In 1980 the Bonnet Law made the first major modification to the 1945 legislation (Barats-Malbrel, 1999), requiring individuals wishing to enter France to provide documents guaranteeing the possibility of repatriation, for example, a return ticket or the means to purchase one. It also became easier to deport undocumented immigrants, although the incoming socialist government passed a law during the following year (1981) repealing some aspects of the Bonnet Law, improved the residence rights for 'foreigners' and introduced an amnesty for undocumented immigrants.

In spite of attempts to improve conditions and housing, by 1982 11.9% of 'foreigners' were living in overcrowded accommodation, compared with 1.8% of French people (Weil, 2004). Poor socio-economic living conditions, together with rising unemployment, of migrant populations resulted in continuing social tension. The National Front (FN, *Front National*) capitalized on these tensions and achieved success in municipal elections in 1983 (Forbes et al, 1994; Noiriel, 1996). This forced immigration up the political agenda and resulted in a change of approach by the government in 1984. Barats-Malbrel (1999) argues that 'immigrants' problems' came to be viewed not as problems faced by immigrants, but as problems generated by immigrants. Thus, immigration became problematised, aided by media reporting. As a consequence, and with a change in government, the Pasqua Law (1986) further revised the 1945 legislation and increased the requirements for entry into France. Charles Pasqua, Minister of the Interior, declared 'zero immigration' to be his objective.

In 1989 the National Council for Integration (*Haut Conseil à l'Intégration)* was created; discrimination against 'foreigners' had been recognised and it was acknowledged that many of the problems faced by 'foreigners' had their origins in French society (Weil, 2004). Nevertheless, restrictions continued on immigration and in 1993 a further Pasqua Law deprived many longstanding African immigrants of their residence rights in France, leading to protest by undocumented migrants, known as the *sans papiers*[2]. This law also fundamentally changed the rules on children's acquisition of citizenship, removing the automatic right to citizenship at the age of 18 years. Children of non-citizens had to apply to become French between the ages of 16 and 20 years (Favell, 1998), though this was reversed in 1998 (Moigne and Lebon, 1999). In 1995 the Debré Law targeted immigration from non-EU countries. French asylum policy is discussed later in the chapter.

Minority ethnic groups in Britain and France

By the time Britain and France experienced their first large-scale flows of non-European asylum seekers from Chile and Vietnam in 1973 (Kumin, 1998; Westin, 1999), both countries were host to established minority ethnic groups. Migrant workers had been joined by spouses, had raised families, and settled alongside other members of their communities. They tended to have low-paid jobs and reside in poor and overcrowded housing concentrated in the major cities. Racism and discrimination had resulted in racial tension and in general government policies restricted further immigration.

Britain and France have similar numbers of members of minority ethnic groups who form a visible and integral part of life in the metropolitan areas (Bleich, 2003). Both countries

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[2] Many *sans papiers* had entered France with temporary visas in the 1980s while the French state deliberated on their right to remain in France. At the time the French state did not intervene when their visas or work permits expired; they remained in an 'irregular' situation in France (Davidson, 2000).

were colonial powers, experienced de-colonization at similar times and received large numbers of immigrants following the Second World War (Bleich, 2003). However, Britain and France differ in their approaches to managing the settlement of immigrants, Britain adopting a 'race relations' approach and France favouring 'antiracism'.

Racism, in terms of access to employment, housing, and goods and services, is punished by civil law in Britain and by criminal law in France. This has resulted in more convictions in Britain than in France, because criminal standards of proof are higher (Bleich, 2003). Bleich (2003) argues that the approach taken by France is essentially 'colour-blind' and individualist, while Britain's approach has been 'race conscious' and works by categorizing, protecting and assisting minorities defined by group. The French Revolution proclaimed that the nation was 'One and Indivisible' and the French constitution recognizes no intermediary bodies, such as minority ethnic groups, that might fragment the political community (Body-Gendrot, 1995). Thus, the policy in France is to assimilate and transform immigrants individually into French citizens (Favell, 1998). In contrast, Britain's multi-culturalist approach recognizes the existence of diverse minority ethnic groups and aims to manage public order and relations between majority and minority ethnic populations, allowing ethnic cultures and practices to mediate the process (Favell, 1998). Britain has proved capable of accommodating different ways of being British (Bryant, 1997), though it has been argued that diverse cultures are accepted only on unequal terms (Rex, 1992), and Britain has not achieved the multi-cultural citizenship espoused by Kymlicka (1995). Problems have often been seen in terms of socio-economic issues, housing, unemployment and urban concentration, rather than citizenship in broader cultural terms (Favell, 1997).

Britain's approach was influenced by the civil rights movement in the United States, since it was believed necessary to eliminate discrimination and promote successful integration in order to avoid the problems experienced in North America (Bleich, 2003). In contrast, France has espoused a human rights approach framed by anti-semitic experiences during the war (Bleich, 2003). Britain has created a quasigovernmental organization to encourage good race relations, whereas France uses non-governmental associations which, arguably, have less power. Positive action is permitted in Britain, for example, actively recruiting minority job applicants; this is strictly forbidden in France (Bleich, 2003).

Refugees and asylum seekers in Britain and France

This section will describe asylum policies in Britain and France, and demonstrate how national policies have been influenced by the harmonisation policies of the European Union (EU). An analysis is provided of the policies that determined the rights of Congolese refugees and asylum seekers in Britain and France during the time the interviews for this research were conducted, thus setting the context in which the data were collected. Subsequent asylum policy is addressed and the implications of policy changes will be discussed further in Chapter 8, in the light of the findings of this study.

While Western European countries had been familiar with people seeking asylum from other European countries following the Second World War, in the 1970s asylum seekers from developing nations started to appear in Europe and over the ensuing years such patterns of migration increased dramatically. Europe's first large-scale experience of non-European asylum seekers was the resettlement of Ugandan Asians in Britain in 1972, followed by asylum seekers from Chile and Vietnam in 1973 in both Britain and France (Kumin, 1998; Westin, 1999). By the mid 1980s, both countries were also receiving asylum seekers from Africa, Asia and the Middle East (Kumin, 1998; Bloch, 1999a; Bloch and Schuster, 2002).

The 'ideal-typical' liberal and statist models of state membership (Soysal, 1994), described in Chapter 1, have informed patterns of reception of refugees and asylum seekers in Britain and France. Joly (1996) compares approaches to the reception and settlement of refugees in Britain and France, by studying the experience of Chilean and Vietnamese refugees in both countries in the 1970s. There were no structures in either country for their reception and resettlement when Chilean refugees arrived in Britain and France. France therefore devised a permanent centralized resettlement programme, whereas in Britain resettlement programmes consisted of short term measures for specific groups of refugees (Joly, 1996; Duke, Sales and Gregory, 1999). In both countries dispersal policies were in place. In spite of evidence that previous experiences of dispersal were not generally successful (Joly, 1996; Duke et al, 1999; Bloch, 2004), Britain continues to disperse asylum seekers to diverse parts of the country where they may not have contact with their own communities, which is essential for successful resettlement.

The philosophy was in France, that refugees were to feel part of the national community, strongly supported by central government, but much of the day to day work was conducted by non-governmental organizations (Joly, 1996). In contrast, the British central government provided some funding, but relied on non-governmental organizations and sympathetic groups (Joly, 1996). Crucially, central government funds covered initial reception but not after-care, which became the responsibility of local authorities, with a large burden of resettlement falling on local volunteers (Joly, 1996). The absence of a national strategy resulted in poor co-ordination between central and local government and the voluntary sector (McFarland and Walsh, 1989). Joly (1996) describes how refugees need advice on their entitlements and welfare systems: at the same time many experience psychological problems, some of which do not become apparent for months or years. Joly thus concludes that many of the features of resettlement programmes in Britain and France failed to recognize the distinct needs of refugees and asylum seekers. During the 1990s these resettlement programmes were curtailed (Duke et al, 1999), although France has retained reception centres for some asylum seekers.

Refugees and asylum seekers from the Democratic Republic of Congo started arriving in Britain and France in 1989. Refugees from sub-Saharan Africa had fled from ethnic and political conflict, initially between liberation movements and colonial powers and thereafter between different ethnic or political factions within the boundaries of given states (Westin, 1999). In the former Belgian Congo, the shift to independence was particularly chaotic.

The arrival of these earlier asylum seekers coincided with the oil crisis of the early 1970s and economic stagnation, and they were viewed as the *"physical embodiment of external threats to jobs, living standards and welfare"* (Castles, 2003, p20), and portrayed as welfare scroungers (Bloch and Schuster, 2002). The numbers of asylum seekers in western Europe increased from under 70,000 in 1983 to over 200,000 in 1989 (UNHCR, 2000) and by the end of the 1980s all European governments had tightened their asylum procedures (Kumin, 1998; Westin, 1999), migration became politicised and asylum policies became conflated with immigration policies (Castles, 2003). By the time the number of asylum seekers in Europe peaked at 696,500 in 1992, governments were applying a 'zero immigration' policy, reducing applications for asylum in Europe by 1997. The emphasis had shifted from one of protecting refugees to one of exclusion and control (Kumin, 1998), leading Kumin to claim that "*Today, Europe's doors to asylum seekers are, at best, ajar*" (p6).

Asylum policy in Britain

Following the arrival of quotas of refugees in Britain in the 1970s, immigration policy became increasingly restrictive and deterrent towards asylum seekers who, since 1990, have been 'spontaneous', making individual claims for asylum under the Geneva Convention (Sales, 2002a). The British government has been reluctant, until recently, to formulate an integrated approach to asylum, instead it has continued to react to different flows of asylum seekers (Zetter, Griffiths, Feretti et al, 2003).

- ***Claiming asylum in Britain***

In Britain, asylum applications are currently considered within the Immigration and Nationality Directorate of the Home Office. Applications can be made at a port of entry or 'in-country', though asylum seekers are expected to claim asylum at the port of entry into Britain, where they may receive assistance from the Refugee Arrivals Project and/or the Refugee Council, but many depend on community networks (Sales, 2002a). Free legal advice and interpreting are available. Asylum seekers participate in a short interview to establish their identity and immigration status. They are then issued with an identity document and a form to complete to return to the Home Office; this document forms the basis of their application for asylum. A port applicant may be detained pending interview with an immigration officer, or a decision by the Home Office, concerning their application. Asylum seekers whose claims are rejected can appeal to the Immigration Appellate Authority.

An asylum seeker who is granted refugee status loses support from the National Asylum Support Service (NASS) within 14 days, and as a refugee then becomes entitled to state support in the same way as a British citizen. There is no support available for anyone whose claim for asylum has been rejected.

At times the British government has accepted quotas of refugees, but otherwise successful asylum seekers are accepted as Convention Refugees. Refugees have the same rights as British nationals, except the right to vote. Convention refugees are granted Indefinite Leave to Remain (ILR) and can apply for British citizenship five years after obtaining ILR. People who do not qualify for refugee status according to the Geneva Convention, yet can demonstrate that they may be harmed if returned to their country of origin, have in the past been awarded an individual humanitarian status, which was renewable, for example Exceptional Leave to Remain (ELR) in Britain. This is a weaker position than refugee status, for example, there was no right to family reunion attached to this status (Sales, 2002b). Like refugee status, ELR can lead to ILR. Since April 2003 grants of Exceptional Leave to Remain have been replaced by grants of either Humanitarian Protection or Discretionary Leave (Refugee Council, 2003a). Both grants are for three years initially, followed by review of the case. After three years, individuals granted Humanitarian Protection can apply for ILR. People in both categories enjoy welfare benefits and the right to work, and can apply for family reunion after three years.

- ***Asylum policy***

While the 1971 Immigration Act gave immigration officers powers to detain asylum seekers, it was not until the Immigration and Asylum Acts of 1993 and 1996 that the social rights of asylum seekers were restricted (Sales, 2002b). In the 1990s they could claim cash benefits, income support at 90% of the standard rate, and local authority accommodation (Sales, 2002a). In 1993 restrictions were placed on access to housing, and finger printing was introduced. 'Fast-track' procedures for assessing applications were created. The Act of 1996 removed the right to benefits from in-country applicants and appellants, rendering many destitute. Consequently, the National Assistance Act (1948) was invoked which required local Social Service Departments to provide food and accommodation to destitute people, including asylum seekers. This resulted in adults being housed and provided with subsistence in the form of vouchers. Until 2000 port applicants to the UK with no capital or income could claim means-tested income support at 90% of the rate available to UK claimants; in-country applicants were supported by local authorities which issued vouchers and cash. Subsequently, the Immigration and Asylum Act (1999) extended the use of vouchers to all asylum seekers. Social Service Departments' responsibility for asylum seekers was transferred to a centralised agency, the NASS. Following this legislation, support became 'cashless', taking the form of accommodation (if needed) and vouchers that could be exchanged for food at certain supermarkets. The level of provision was reduced to the equivalent of 70% of income support. A small cash element was also provided (£10 per person per week) to meet other essential living needs. The Act also introduced dispersal to different parts of the UK in order to "relieve pressure on local authorities in London and the Southeast", the areas in which asylum seekers have traditionally attempted to settle, and where they are more likely to find members of their own communities. Refusal of allocated accommodation resulted in the withdrawal of vouchers and cash and no offer of alternative accommodation.

It was at this stage in the development of asylum policy that the interviews for this study took place.

Table 3: Rights of refugees and asylum seekers in Britain in 2000

Status	**Rights**
Convention Refugee	Right to reside in Britain. Right to work. Right to income support and benefits as any British citizen. Right to health care as any British citizen. Right to family reunion.
Asylum seeker	Right to reside in Britain while the application is processed. Right to apply for work after six months. Reduced right to income support, equivalent to 70% of that provided to British citizens and refugees. Right to health care as any British citizen. No right to family reunion.

Asylum policy in France

The right to asylum has rarely been the subject of great debate in France, since policy has usually been addressed within the framework of general immigration controls (Delouvin, 2000).

- ***Claiming asylum in France***

In France, asylum seekers who submit their claim at a port of entry may be detained in waiting zones in ports, airports and railway stations for up to 20 days (Danish Refugee Council, 2000). They are entitled to interpreting and medical assistance. They may also seek advice from a lawyer, but no free legal assistance is available. An asylum seeker who is admitted to France is given a 'safe conduct' pass which is valid for eight days and allows him/her to apply for asylum with the Prefecture (local authority) in the area of proposed residence. Asylum seekers who apply 'in-country' must also present themselves to the Prefecture. Following an initial assessment, the Prefecture will issue an asylum seeker with a document granting leave to remain valid for one month. The asylum seeker will also be provided with documents that must be completed and sent to the French Office for the Protection of Refugees and Stateless Persons (OFPRA, *Office Français de Protection des Réfugiés et Apatrides*), the organization which decides on applications for asylum in France. This is an independent body, supervised by the Ministry of Foreign Affairs (GISTI, 1997a; Danish Refugee Council, 2000). Once OFPRA has received the application, a certificate is issued confirming registration (Danish Refugee Council, 2000). This certificate is then presented to the Prefecture, who issues a provisional residence permit (*carte de séjour*), for three months, renewable every three months until a final decision is made.

Individuals whose applications are rejected can appeal to the Appeal Board for Refugees (*Commission des Recours des Réfugiés).* Following unsuccessful appeal, a final negative decision is accompanied by a request to leave France voluntarily within one month. After one month, an expulsion order is issued and can be implemented immediately (Danish Refugee Council, 2000). Rejected asylum seekers are left without any kind of documentation or residence permit and become one of the groups of undocumented immigrants known as the *sans papiers.* However, it is rare to deport an asylum seeker who has been in France for some time and who is working (Weil, 2004).

Reception centres exist for asylum seekers (CADA, *Centres d'accueil pour demandeurs d'asile*), however, most asylum seekers live outside of these centres (Gliber, 1997), since there are never enough spaces (Kofman, 2002). While the French government has no explicit policy of dispersal, provision of these hostels was decentralised in the 1970s to a large number of departments, and the effect is therefore one of dispersal (Kofman, 2002).

Asylum seekers are not allowed to work, but presentation of a residence permit at the National Employment Agency (ANPE, *Agence Nationale pour l'Emploi*) entitles them to income support (*allocation d'insertion*) for one year, for those who do not stay in Reception Centres (GISTI, 1997b; Refugee Council, 1998). Asylum seekers are entitled to free health care. As individuals in France are obliged to present their residence papers when seeking health care, undocumented immigrants are not entitled to free health care in France. Voluntary organizations like *Médecins due Monde, Médecins sans Frontières, Croix Rouge Française* and COMEDE offer free health care to excluded groups without the need for 'papers' (Moigne and Lebon, 1999).

If an asylum claim is successful OFPRA issues a document (*Certificat de Réfugié*) which is presented to the Prefecture, who issues a residence permit. Once granted refugee status, individuals have the same rights as French nationals except the right to vote.

Refugee status is privileged in France, for example, a refugee, in contrast to a resident 'foreigner', cannot be deported to his/her country of origin (Weil, 2004). France interpreted the Geneva Convention differently from Britain and until 1998 only state persecution warranted protection, whereas Britain accepted fear of persecution by other groups as a criterion for affording protection (Dyer, 2001). Individuals who are granted Convention status are issued with a residence permit valid for ten years, and it is renewable.

- ***Asylum policy***

Since the late 1980s the increase in numbers of requests for asylum prompted two policy strands. Firstly there were moves to prevent access to the asylum system, by being selective concerning the countries of origin of the applicants, with preference being given to those from Asia, Europe and South America (Weil, 2004). In 1992 transit zones were created in ports and airports for the detention of unauthorised immigrants. In 1993 the French government abolished the need to examine requests for asylum that had been previously presented in countries included in the Schengen[3] agreement.

The second policy strand made seeking asylum in France less desirable than previously. The Pasqua Law of 1993 ended asylum seekers' right to work, and tightened immigration and nationality rules; conditions for entry and family reunion became stricter and deportation was facilitated. A law in 1998 introduced a rapid procedure for assessing applications for asylum, aiming to make quick decisions for genuine refugees and deter 'unfounded' asylum seekers (Weil, 2004).

In 1998 legislation made entry into France easier for certain categories of immigrant. It broadened the criteria for issuing residence permits and created a new category of visitor for the purpose of family and private life (Kofman, 2002). However, Delouvin (2000) contrasts the Socialist Party's (1997) pre-election proposals relating to asylum with its post-election measures in government, and he finds the latter lacking. While the former recognized the right to asylum as distinct from immigration, and rejected the labelling of asylum seekers as economic migrants, the government chose not to implement the recommendation of UNHCR, that refugee status should be awarded in the case of non-state persecution as well as persecution by governments or their agents. Instead the category of territorial asylum was introduced for those persecuted by non-state agents (Kofman, 2002). Territorial asylum, which had been exercised on a discretionary basis for Algerians, became enshrined in law as a discretionary emergency humanitarian measure, for exceptional cases (Delouvin, 2000; Kofman, 2002). Territorial asylum attracts fewer rights than refugee status: a residence permit for one year, which can be renewed twice, each time for another year. Individuals may then be granted a ten year residence permit and afforded the same rights as migrant workers (Danish Refugee Council, 2000).

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[3] The Schengen agreement was founded in 1985, by France, Germany, and the Benelux countries, but in 1997 was joined by all EU states except the UK and Ireland. This agreement dismantled internal border controls, and external borders were controlled more strictly. Ease of movement within these countries necessitated co-ordination and integration of migration policies.

Another status, Constitutional Asylum, was introduced by the law of 1998 and attracts the same rights as Convention Refugee status, but has limited application (Danish Refugee Council, 2000). This did not alter asylum seekers' access to French territory, their detention in holding areas, or the process of applying for asylum. In spite of promises to the contrary, fewer asylum seekers are allowed to attend an interview in person in order to explain the factors that prompted their forced migration (Delouvin, 2000). In spite of a reaffirmation of France's commitment to human rights, OFPRA and the Appeal Board were rejecting 90% of claims for recognition as a refugee in the late 1990s (Delouvin, 2000). Those who are rejected are required to leave French territory. If they do not comply, they may be escorted back to their countries of origin. Aware of the risks that many of these people would face on return, in spite of the rejection of their claims, the administration removes very few nationals of countries like the DRC. Instead these people are tolerated in an 'irregular' situation, without any rights (Delouvin, 2000). The law also allowed for an annual quota of undocumented immigrants to become legal, if they had been in France for ten years (Vaillant, 2006). This policy is currently being re-appraised.

At the time the interviews for this study were being conducted refugees and asylum seekers had the following rights:

Table 4: Rights of refugees and asylum seekers in France in 2000

Status	**Rights**
Convention Refugee	Right to reside in France. Right to work. Right to income support and benefits as any French citizen. Right to health care as any French citizen. Right to family reunion.
Asylum seeker	Right to reside in France while the application is processed. No right to work. Right to accommodation in a hostel OR income support for one year. Right to health care as any French citizen. No right to family reunion.

(Danish Refugee Council, 2000; GISTI, 1997b)

Subsequent asylum policy in Britain and France

Since the interviews took place, asylum policy in both Britain and France has followed a similar path. In Britain, the main theme of the Nationality, Immigration and Asylum Act (2002) was the control and removal of refused asylum seekers. Pilot accommodation centres were planned to house asylum seekers awaiting decisions and were to include education and health facilities on site. The voucher system was replaced with cash, as the system was opposed by a range of organisations, including statutory and voluntary service providers (Sales, 2002b). This legislation has also paved the way for a resettlement programme for quotas of refugees. Citizenship policy is also introduced in this legislation. Destitute asylum seekers are only eligible for NASS support if they can prove that they have applied for asylum as soon as is reasonably practicable. Crucially, the 2002 Act also removed the opportunity for asylum seekers to apply for work after six months. These policies had the effect of increasingly marginalising asylum seekers while at the same time increasing their dependence on the state.

In France a law was passed in 2003 which incorporated some of the directives from the EU. This law rendered asylum seeking less attractive by 'nationalizing' OFPRA and the Appeal Board, thus reducing their independence, and giving greater power to the Minister of the Interior (GISTI, 2004). The law allowed port applicants to be taken to a detention zone with the risk of immediate deportation if they are refused asylum at the frontier (Weil, 2004). Prefects were given the power to reject applications from asylum seekers if they had arrived in France via another EU country or from a country deemed 'safe' (Weil, 2004). During the same year, the Minister for the Interior put pressure on prefects to increase the number of asylum seekers they deport (Schuster, 2005). Territorial asylum was replaced by subsidiary protection, which is granted for one year, and renewable, but may be refused if the authorities estimate that the beneficiary might threaten security or public order, or has committed a crime (Gas, 2003). Subsidiary protection is also a lesser status than territorial asylum because it does not include the threat to an individual's freedom (Gas, 2003).

The changes introduced by this law have lead Delouvin (2004) to claim that the predominant worry is the focus on the control of migration flows and not the protection of people seeking asylum. Following this legislation more applications for asylum will be rejected without a thorough examination and without the opportunity for applicants to present their cases. Measures in place in originating countries and at borders will control access to French territory without the guarantee of access to asylum procedures (Delouvin, 2004).

The Asylum and Immigration Act (2004) rendered it a criminal offence to enter the UK without documents demonstrating identity and nationality without a good reason. This makes it harder for asylum seekers to reach the UK. The Immigration, Asylum and Nationality Act (Home Office, 2006) presents a five year strategy for immigration. Strict controls on entry to Britain are outlined, including the prevention of illegal entry, reductions in illegal working, enhanced deportation procedures and strict criteria for economic migration. New asylum processes will be introduced, detaining more people and using other means of contact like tagging to prevent people absconding when they are ready to be removed. The intention to remove more asylum seekers is stated and arrangements with other countries will facilitate more removals. While it is stated that Britain will continue to welcome genuine refugees, this White Paper proposes a crucial change to the status of refugee. Refugees admitted according to the 1951 Convention will be granted temporary, rather than permanent, status, while the situation in the refugee's home country is assessed. If the situation improves, refugees will be expected to return home; if it does not improve, they will be allowed to stay. Permanent settlement will be dependent on the economic benefit to Britain and social integration, thus threatening the security and settlement of refugees. Those applying for citizenship will have to pass a residence test, and tests in English language and knowledge of the UK. These proposals have huge implications for the civil, social and human rights of refugees and asylum seekers in Britain.

In a similar vein, the recent Sarkozy Law (2006) in France focuses on the economic needs of the country, greater 'choice' and selection of immigrants, limiting the opportunities for non-qualified workers and families, in favour of workers 'useful to the economy', and the capacity of the country to absorb migrants (Vaillant, 2006). Against the background of an increase in applications for asylum, but a reduction in acceptances (since 2003), further restrictions are being placed on the rules of entry and stay in France (Raizon, 2006). Opposition to undocumented immigration continues and the prospect of deportation has created a climate of fear, prompting protests in France (Raizon, 2006).

Harmonization of EU asylum policy

European states' policies on asylum depend increasingly on EU harmonisation (Delouvin, 2004). During the early stages of the Cold War, Western Europe generally welcomed small numbers of refugees, who tended to be absorbed within the labour migration framework (Westin, 1999). By the end of the 1980s all European governments had begun to tighten asylum procedures (Kumin, 1998; Westin, 1999). Since the late 1990s European states have increasingly restricted the flow of asylum seekers (Schuster, 2005).

Increasing numbers of asylum seekers in Europe coincided with the development of the EU and the formulation of policies to restrict the entry of third-country (non-EU) nationals

(Sales, 2002b). A series of legal reforms have been in progress across the EU since the early 1990s, popularly referred to as 'Fortress Europe' (Marfleet, 1999). The Dublin Convention came into force in 1997 and represents the first step taken by Europe to coordinate national policies on asylum (Telöken, 1998). In 1997 the Treaty of Amsterdam (which came into force in 1999) established community competence in asylum and immigration and committed the EU to a comprehensive asylum and immigration strategy (Castles and Miller, 2003). A further regulation, Dublin II, established the criteria and mechanisms for determining the Member State responsible for examining an asylum application, namely the country which has allowed the asylum seeker to enter the EU. This made one member state responsible for dealing with a claim for asylum, aiming to avoid one state appearing more attractive than another (Telöken, 1998; Düvell and Jordan, 2002). This means in practice that asylum seekers who arrive in an EU member state without visas are required to apply for asylum in the first country reached, and may be returned to the country which first allowed them to enter the EU (Watt, 2001). This regulation thus allows states to return asylum seekers to other EU states where they may have fewer chances of being offered asylum (Kerrigan, 2005).

The main elements of a common EU asylum and immigration policy were agreed at a meeting of the European Council in Tampere in 1999. This policy aimed to integrate refugees into EU societies, while stopping illegal immigration (Düvell and Jordan, 2002). The intention was to establish a common asylum system, with procedures for determining which state was responsible for assessing an asylum application, common procedures, and minimum standards of reception, and consistency in the determination of refugee status (Düvell and Jordan, 2002). In 2004 member states agreed shared procedures for processing asylum claims, as well as a series of regulations and directives, for example, conditional subsistence benefits and shelter for destitute asylum seekers (Dwyer, 2005).

Most EU countries produced 'safe third country' rules that allow applicants to be returned to their country of origin. Many require applications for asylum to be made at the port of entry to the country, and have also reduced welfare rights. Applications at the port of entry present problems, because asylum seekers may not speak the local language adequately, may not be in possession of the necessary documents, and thus might not be prepared to present their case. Both Britain and France have responded, at various times, by imposing visa requirements, for example, following the rise in numbers of applications in 1985 visa controls were introduced for travel to Britain for principal groups claiming asylum, that is, people from Sri Lanka, India, Bangladesh, Ghana, Nigeria and Pakistan (Zetter, et al, 2003). Presentation at a foreign embassy in an attempt to acquire visas may be dangerous for people who have been targeted by a regime (Harding, 2000). Carrier sanctions have also been applied in both countries. The British government first began to fine airlines which brought passengers into the UK without valid travel documents in 1987, and this was extended to cross-Channel Eurostar trains. France, in 1990, and several other European countries, have followed suit.

In summary, since the early 1990s a series of legal reforms across the EU have served to exclude asylum seekers and raise questions about the legality of applications for asylum. The terms '*clandestin*' and 'bogus' have increasingly appeared in French and British documents, respectively (Marfleet, 1999). The general trend has been towards portraying asylum seekers as undesirable and undeserving (Delouvin, 2000; Sales, 2002a). Consequently, the human rights of asylum seekers do not appear to be the focus of EU asylum policy, and the notion of social rights has been replaced by that of conditional entitlement (Dwyer, 2005).

A report on the rise of far right political parties in Europe describes the exploitation of fears about immigration (Hooper and Osborne, 2002). These authors describe one German state planning to offer African countries more than £5000 a head to accept rejected black asylum seekers, regardless of nationality. The long-standing success of Le Pen in the French presidential elections is telling; the centre-right coalition in Denmark has drafted tough new asylum policies; a Far Right party in Belgium campaigned to repatriate all non-European foreigners, and in Norway an administration supported by the far right wanted immigration capped at 1000 people a year (Hooper and Osborne, 2002). Thus European countries are becoming increasingly hostile places for refugees and asylum seekers.

Citizenship

This section briefly describes developments in the conceptualization of citizenship, and identifies three conceptions of citizenship. Firstly, the concept of formal citizenship is considered, and the acquisition of British, French, and European citizenship is addressed. Secondly, substantive citizenship is explored in terms of the rights conferred by this formal status. Thirdly, citizenship is considered as a sense of belonging. Formal citizenship remains important in terms of the rights attached to the status, and for refugees and asylum seekers, who do not acquire the same rights as citizens, civic stratification is evident (Morris, 1997; 2001; 2002; 2003). Morris' work is thus used to argue that formal citizenship has limitations and that a transnational approach (Bauböck, 1991; 1994) may have greater currency in modern multi-cultural societies.

Developments in the concept of citizenship

According to Turner (1993) the concept of citizenship has featured prominently in Western political thinking since the formation of classical Greek political culture. This concept, understood as active membership of and participation in a body politic, features in the development of the city-state in the classical Greek and Roman world (Turner, 1990; Clarke, 1994). The city-state provided the public arena in which rational, free men participated in the polity. However, the status of citizen was accorded to a privileged few, based on economic freedom (Clarke, 1994) and women and slaves were excluded. Those able to participate took their status seriously and political activity was seen as an important aspect of being human (Clarke, 1994).

Changes during the 17th and 18th centuries gave rise to an expanded notion of political participation and membership. Ideas of contemporary citizenship and democracy have their origins in the French Revolution and its aftermath (Turner, 1986; 1993). Turner (1986) describes how notions of liberty, equality and fraternity linked citizenship rights with human equality and community. Also, the French Revolution developed the idea of national citizenship, for the Declaration of the Rights of Man and the Citizen located sovereignty in the nation (Turner, 1986; Sliverman, 1992) and thus invented the modern version of republican citizenship in France (Rees, 1996).

The last ten to fifteen years have seen a revival of interest in citizenship (Vogel and Moran, 1991; Turner, 1993; Oliver and Heater, 1994; Lister, 1997). This is attributed to various factors, including the re-shaping of national boundaries (Turner, 1993), the emergence of citizenship of the EU (Lister, 1997), the emergence of multi-ethnic societies (Lister, 1997), and the increase in migration and asylum seekers (Vogel and Moran, 1991; Turner, 1993).

Other contributing factors include issues of democracy (Lister, 1997), a legacy of the exclusion of women from the political construction of citizenship (Lister, 1997), and concern for the future of social citizenship against a background of economic crisis (Vogel and Moran, 1991; Lister, 1997). Lister refers to the prominence of debates about citizenship in the UK.

Citizenship has become a contentious concept over the last two decades and has attracted various definitions, but many authors agree that the concept concerns the relationship between the individual and the state (Vogel and Moran, 1991; Oliver and Heater, 1994; Steenbergen, 1994; Lister, 1997).

Conceptions of citizenship

Conceptions of citizenship fall into three broad categories: those relating to nationality and formal citizenship or membership of a state (Hammar, 1990); those concerning substantive citizenship, or the possession of rights and duties in a state (Hammar, 1990); and those relating to a sense of belonging to a society.

- ***Formal citizenship***

Faulks (1998, p2) provides an example of a legal or formal definition of citizenship:

> *"Citizenship is a status that denotes membership of a nation-state and which carries with it certain rights and duties associated with that membership".*

The nineteenth century saw the emergence of the nation-state as the basic political and economic unit of the modern world (Lister, 1997). Most modern nation-states are formally defined by a constitution and laws, according to which power derives from the people (Castles and Miller, 2003). Turner (1986) explains how the nation-state boundary allows the definition of insiders and outsiders. Membership is marked by the status of citizenship, which lays down rights and duties. Non-citizens are excluded from at least some of these. Citizenship is the essential link between state and nation, and obtaining citizenship is of central importance for newcomers to a country (Castles and Miller, 2003).

Ideal types of formal citizenship

Within Europe there are differences in how citizenship (in a formal sense) is constructed. Castles and Miller (2003) suggest a typology of ideal types of citizenship, including:

- ***The imperial model***

This model concerns the definition of belonging to the nation in terms of being a subject of the same power or ruler. Prior to 1948 people in the British Isles and the British Empire were indeed formally subjects of the Crown. British citizenship was invented when the Nationality Act (1948) created the status of 'Citizen of the United Kingdom and Colonies', defining who has right of entry and residence in Britain (Cohen, 1994; Cole, 2000). Britain thus has an uneasy relationship with the concept of citizenship as it has developed in a passive form, being granted from above, rather than being achieved by struggle (Cesarani, 1996; Dummett, 2001). Definitions of British citizenship have changed with patterns of migration and the piecemeal development of immigration policy (Spencer, 1994). British citizenship as national citizenship, exclusively for England, Scotland and Wales, was defined in the British Nationality Act of 1981 (Hansen, 2003b).

- ***The republican model***

This model embraces the traditional Republican formula of assimilation and civic incorporation (Castles, 1997; Stolcke, 1999) and defines the nation as a political community which welcomes newcomers, provided that they adopt the national culture. Republican citizenship, invented in France in the late 18th century, derives from the Revolution, when people ceased to be subjects of the sovereign and became instead common citizens of a national entity. In France, citizenship developed in an active form, from below (Turner, 1990).

Castles and Miller (2003) argue that the main concern for immigrants is how they obtain citizenship rather than its benefits. In Britain, citizenship has traditionally been easy to acquire because of the emphasis on *ius soli*, but recent trends made the acquisition of citizenship more difficult. A more restrictive form of citizenship was introduced in the British Nationality Act of 1981 (Hammar, 1990; Layton-Henry, 1991), which ended the practice of automatic *ius soli* for children born on British soil of non-British parents (Favell, 1998; Cole, 2000). A child born in the UK is a British citizen only if a parent is a British citizen or has permanent right of residence (Dummett, 1994). People migrating to Britain can apply for citizenship after four years of work and one year of residence (Hansen, 2003b).

Access to citizenship in France is governed by the desire to protect French nationality. In keeping with the principles of *ius soli*[4], children born in France of two 'foreign' parents (not

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[4] Citizenship can be acquired in two ways: by birth and by residence. Citizenship by birth can, in turn, be acquired in two ways; by being born within the territory of the state, independent of the parents' citizenship (*ius soli*) or being born to parents, at least one of whom is a citizen of the state (*ius sanguinis*). Citizenship by residence can be acquired either by marrying a citizen of the state, or by application following length of residence in the state (Cole, 2000; Faist, 2000).

born in France) automatically acquire French nationality on reaching the age of 18, providing they have lived in France for five years since the age of 11. They can decline citizenship between the ages of 17 and 19 (Weil, 2004). Young people aged between 13 and 16 can apply for citizenship as long as their parents agree and they have lived in France for five years since the age of 8. Between the ages of 16 and 18 young people can apply for citizenship without their parents' agreement, if they have been resident in France for five years since the age of 11 (Weil, 2004). These regulations require evidence of education in France and some degree of integration into French society. Applicants for citizenship must have spent a minimum of five years in France, have a working knowledge of the French language, have stable financial resources and have current residence in France.

'Foreigners' can become 'French by acquisition', in contrast to those who are 'French by birth' (Gliber, 1997), although in practice no distinction is made in official statistics between these two categories (INSEE, 1997). The key issue is that one is either French (and therefore a citizen) or a 'foreigner' (not a citizen); as 'foreigners' are people resident in France who are not French (INSEE, 1997), this category includes diverse groups but by its nature it is homogenizing (Barats-Malbrel, 1999). The official category of 'foreigner' excludes immigrants who have gained nationality through naturalisation, but includes a considerable number of non-immigrants, for example, children born in France to immigrant parents who have not yet acquired French nationality.

- ***European citizenship***

A third form of citizenship emerged in 1993 when European citizenship formally came into being via Article 8 of the Maastricht Treaty of Union. European citizens are citizens of member states of the EU. As such, European citizenship remains exclusionary by denying access to the many non-European citizens who are legally resident in EU member states, including refugees and asylum seekers. European citizenship allows freedom of movement and residence within the member states, the right to vote and to stand as a candidate at municipal elections in the member state in which the citizen is residing, the right to vote and to stand as a candidate in elections to the European Parliament in the state in which he/she resides, the right to protection by the diplomatic or consular authorities of any member state and finally the right to petition the European Parliament (Martiniello, 1994; Meehan, 1997). While European citizenship has already begun to undermine national citizenship, via the provision of structures of representation and appeal beyond the nation state, non-EU citizens remain excluded (Tambini, 2001).

Clearly there is a democratic deficit within this arrangement for people who are legally resident but not citizens.

Definitions of citizenship refer to its 'formal' aspects, for example, who can become a citizen, the legality of becoming a citizen, notions of nationality, but also more substantive aspects such as social rights. Steenbergen (1994) claims that social rights are meant to give the formal status of citizenship a material foundation, since a certain level of material well-being is necessary before citizens can exercise their rights to full participation in any community.

Substantive citizenship

Substantive citizenship concerns the extent to which those who enjoy formal citizen status may, or may not, enjoy the rights attached to that status.

> *"The issue of who can practise citizenship and on what terms is not only a matter of the legal scope of citizenship and the formal nature of rights entailed in it. It is also a matter of the non-political capacities of citizens which derive from the social resources they command and to which they have access".*
> (Barbalet, 1988, p1)

Substantive citizenship, with full and equal rights and opportunities, does not always automatically follow from formal citizenship (Hammar, 1990; Lister, 1997).

- ***Marshall's three elements of citizenship: civil, political and social rights***

Marshall's (1964) influential discussion addresses the substantive aspects of citizenship by describing the evolution of civil, political and social elements; that is the set of rights that give substance to formal citizenship. Current debates often take Marshall's seminal essay 'Citizenship and Social Class', written in 1949, as a starting point. The essay addresses Marshall's conceptualisation of society's move towards equality that he believed to be the latest phase of an evolution of citizenship going back some 250 years, culminating in the egalitarian policies of 20th century Britain. During this period, characterised by the development of capitalism and the social class structure, Marshall (1964) detected a shift of emphasis from duties to rights and poses the question:

> *"Is this an inevitable feature of modern citizenship - inevitable and irreversible?"(p73)*

Marshall (1964) describes three elements of citizenship which, he argues, have developed historically, in a linear fashion and which culminate in social rights.

The civil element, an eighteenth century development, involves the rights necessary for individual freedom, for example, freedom of speech, religion, the right to justice and equal justice in law. The political element was a nineteenth century development and concerns the right to participate in the exercise of political power, either by exercising the right to vote or to stand for political office. However, women did not acquire the right to vote until 1918 in Britain, and 1944 in France (Castles and Davidson, 2000).

Marshall accorded primacy to social rights, assured by the welfare state, which aimed to ensure a certain level of material well being that would enable citizens to participate in society. The social element of citizenship involves:

> *"the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilised being according to the standards prevailing in the society."*
> (Marshall, 1964, p74)

Oliver and Heater (1994) argue that the welfare state strengthened a sense of community and made it possible for all individuals to feel that they were fully respected members of society. Citizenship could be taken for granted. Marshall claims that such policy developments reduced risk and insecurity; an equalisation not so much between classes as between individuals. Citizenship alters the pattern of social inequality and, for Marshall, equality of status is more important than equality of income. For Marshall, social citizenship was the final stage in the development of citizenship. However, it is claimed, for example (Turner, 1986), that the world Marshall described no longer exists and Steenbergen (1994) argues that it is now necessary to develop new concepts of citizenship, or extensions of old concepts, that represent present day society. Steenbergen (1994) refutes the idea that social citizenship is the final stage, supporting his argument with the example of European citizenship, and the need for new types of citizenship, for example, that are race-neutral and gender-neutral.

Marshall's work has been criticised from a number of perspectives. For example, Mann (1987) and Turner (1990) claim that Marshall's work is evolutionary and ethnocentric, indeed a very British approach, conceptualised in terms of values and interests of the majority population (Castles and Miller 2003). Marshall's whole approach to citizenship has limited universal application (Dwyer, 2004) and is predicated on a 'male bread winner' model of families, prompting Oliver and Heater (1994) to argue that women form the largest group of 'second-class' citizens. For example, Ungerson (1993) discusses how citizenship concerns rights located in the public domain, yet caring occurs in the private and domestic domain, where it is difficult to enforce rights. Many women, as a result of their long-term caring roles, may find themselves excluded from society due to poverty in later life (Ginn and Arber, 1992). Consequently, Twine (1994) stresses that a social right of citizenship must recognize the contribution to society of the unpaid labour of women.

Soysal (1994) claims that for migrants, social and civil rights typically precede political rights, in contrast to the Marshallian evolutionary model in which social rights represent the final struggle. Similarly, Dwyer (2004) claims that for women, political and social rights preceded some civil rights, for example, married women in Britain only gained the right to a tax status independent of their husbands in 1990. Marshall's relative neglect of the struggle to achieve the three sets of rights has been raised (Giddens, 1986; Turner, 1986; Barbalet, 1988; Bottomore, 1993). Turner (1986) claims that the extension of rights can be likened to a series of circles that expand and contract, for example, rights can be undermined by economic recession, inflation, and the redefinition of social participation through law. Examples of contraction can be found in the increasingly restrictive immigration policies of some western European countries, reductions in the welfare rights for asylum seekers and the increasingly elusive nature of formal citizenship in Britain and France.

Lister (1997) further claims that the concept of citizenship is associated with the nation state at a time when the latter is less important economically and politically. Tension exists between the autonomy of nation-states and international human rights law. A common cultural standard is implicit in traditional ideas of citizenship and Marshall's idea of having a share in the "social heritage" of society is not commensurate with contemporary multi-cultural societies (Lister, 1997). Cultural homogeneity can no longer be a foundation for citizenship (Oliver and Heater, 1994). However, tensions in the notion of a sense of belonging in multicultural and stratified societies have spawned further approaches to citizenship (Bauböck, 1991, 1994; Soysal, 1994).

Barbalet (1988) claims that citizenship can be characterised as both a status, and a set of rights which arise as a consequence of this status. Status determines what one can do and refugees and asylum-seekers, with diminished status relative to the majority population, may as a consequence have diminished rights, which affect what they can do. In other words, this is what Prior, Stewart and Walsh (1995) refer to as a concept of '*being*' and '*doing*'; citizenship being a status which people possess and a practice in which people engage.

- ***Citizenship as a sense of belonging***

Citizenship, in the sense of social contract theory, refers to the

> *".. ability of an individual member of a given national community to partake – albeit indirectly – in the elaboration of laws that he or she must then obey."*
> (Noiriel, 1996, pxvi)

Steenbergen (1994) points out that citizenship represents a participation in public life which is broader than political life, emphasising that Marshall's definition of the ideal of citizenship - participation in the community - represents a shift from a political definition, concerning the relationship with the state, to a sociological definition, emphasising the relationship of the citizen with society as a whole. Sense of belonging may relate to Marshall's notion of sharing a social heritage, something which poses challenges in large multi-cultural societies with diverse cultural heritages. Something else is required to foster a sense of belonging that can be shared across disparate communities. The goals of republican citizenship do infer belonging to society; the British government has identified citizenship as means of promoting a sense of belonging in Britain; individuals are now prepared for citizenship through the means of language training and education about British society, culminating in ceremonies to celebrate the acquisition of citizenship (Sales, 2005). However, according to Lewis (2004), citizenship also entails how we identify ourselves and associate with others. As such citizenship binds people together through common interests, or excludes those whose values are different from those of the majority population. This raises issues concerning 'first class citizens' and 'second class citizens'; while both categories may share formal citizenship, the latter often feel that they do not 'belong' as a consequence of social exclusion (Dummett, 2001). Citizenship thus serves to include and exclude members of society.

Dahrendorf (1994) claims that exclusion is the enemy of citizenship. The portrayal of citizenship by nation-states is often through popular feelings of national identity and through restrictions on immigration and naturalisation processes. Twine (1994) claims that social rights entail establishing the material and cultural conditions necessary for social inclusion and participation, in order that the 'social self' may develop. While social exclusion may encompass poverty, it also refers to a condition where people may be poor in terms of power or influence in those policy-making spheres which materially affect their lives (Meehan, 1997). This is particularly evident in the case of refugees and asylum-seekers, at a time when many western countries are increasingly excluding asylum seekers by restricting their rights to welfare pending resolution of their applications for asylum (Lister, 1997).

Civic stratification

Formal citizenship remains the status that determines rights in any given nation. However, the distinction between citizens and non-citizens is becoming less clear: immigrants who are legally resident in a country can often acquire a 'quasi-citizenship' status, for example Convention refugees (Castles and Miller, 2003). This may confer such rights as: secure residence status, rights to work, seek employment and run a business; entitlements to social security benefits and health services; access to education and training; and limited political rights, such as the rights of association and of assembly, to the extent that Soysal (1994) argues that national citizenship is no longer a crucial determinant of security for immigrants. According to Soysal, post-national belonging is based on universal personhood rather than national belonging, and derives from universal human rights laid down in supra-national institutions like the United Nations. While many immigrants with the right to permanent residence in Britain or France do share many rights with citizens of these countries, they are still denied political rights with the resultant lack of 'voice'. Indeed, as Kofman (2002) argues, the existence of different status for migrants challenges the idea of attainment of post national citizenship based on universal human rights.

It is clear that the legal status is central in deciding eligibility for rights, but Sales (2002b, p154) states that *"among those without citizenship status, there is an increasing civic stratification"*, in terms of the increasing differentiation between different groups of migrants. As a consequence of these tiers of entitlement, Heater (1999) suggests a hierarchy of expressions or experiences of citizenship which place strains on the ideal of citizenship.

The close relationship between rights and citizenship has been demonstrated (Morris, 1997; 2001; 2002). Morris argues that, in the absence of a sociological theory of rights, citizenship has served as a substitute. Morris draws on Lockwood's (1996) work and proposes a framework of civic stratification based on a system of stratified rights which is described as:

> *"a nascent structure of inequality built upon the differing rights conceded by the state ..."*
>
> (Morris, 1997, p243)

which:

> *"can serve as both a statement of rights and an apparatus of surveillance or control."*
>
> (Morris, 2002, p410)

This structure includes the following:

- Inclusion and exclusion: a structure of legal statuses that governs eligibility for rights. This refers to the rules governing entry to the territory of a state, definitions of different statuses and access to formal citizenship.
- Gains and deficits: the actual realisation of those rights, often by informal processes. This includes the ability to realise the rights that are attached to any given legal status, and thus concerns substantive rights.
- Expansion and contraction: the dynamic nature of the whole domain of providing and withdrawing rights. In other words, the capacity of governments to change policies according to prevailing circumstances.

(Morris, 2002)

This stratification system described by Morris reflects increasing degrees of security if individuals progress through it (Morris, 2001). However, such upward mobility is not guaranteed. Gains and deficits occur when health professionals interpret policy; an example of deficit arose in Britain when asylum seekers have been denied health care by health professionals who are unaware of their entitlement. Kabeer (2000) notes that the social actors in institutions interpret the rules, and thus contribute to patterns of inclusion and exclusion. This example raises questions about the extent to which those charged with the implementation of rights make them available to those who are formally entitled to them, but also questions can be raised concerning whether or not people have access to the resources that permit them to operationalize these rights (Mason, 2000). Again, in relation to health care in Britain, an example might arise from the lack of availability of interpreters. Expansion and contraction occur in response to economic cycles and public opinion; contraction has occurred in Britain and France when rights have been withdrawn from asylum seekers.

Dependence on formal citizenship status, as a determinant of rights, has resulted in modern societies that are stratified, as Morris describes. Reflecting the concept of stratification, Bauböck (1991) points out that national citizens are in a privileged position relative to immigrants, who are stratified in a hierarchy ranging from "illegal", or undocumented, through "alien", "denizen" to citizen. Bauböck argues that the inequalities that are generated by the different rights attached to stratifications are actually legitimized by national citizenship. In the absence of any guarantee that individuals will ascend through the hierarchy, those who do not acquire citizenship status remain without a full range of rights, as below the level of citizenship there are "divisive internal boundaries" between the different statuses (Bauböck, 1991). These divisions confer different political, civil and social rights, but also the relative statuses have a psycho-social impact on people. While civic stratification is exclusionary, Bauböck's (1991) inclusionary solution is either to adjust and equalise rights between the different statuses, or to promote ease of upward mobility through the hierarchy of statuses, that is, change the structure or individual position.

Transnational citizenship

Like Soysal (1994), Tambini (2001) predicts the demise of national citizenship as nations become less important as political and social units, as a consequence of economic globalization, the receipt of welfare being increasingly tied to residence or human rights, cultural pluralism in contrast to assimilation, and the existence of trans-national institutions.

Amid calls for a different type of citizenship a fourth conception, that of transnational citizenship, has emerged (Bauböck, 1991; 1994). National citizenship, through the perception of common belonging to a state, represents an institutionalized form of solidarity (Faist, 2000). In Britain, this has been fostered through the provision of universal welfare benefits representing some sort of 'common possession'. However, once welfare benefits are no longer provided universally, but targeted selectively at certain groups, solidarity may disintegrate. Faist (2000) notes that transnational citizenship may further entail loyalty to multiple states, as migrants retain attachments to the 'social heritage' of their countries of origin. While national citizenship requires acculturation, and multicultural citizenship involves cultural retention, Faist (2000) refers to transnational syncretism, where syncretism entails to an attempt to reconcile different systems of belief. Bauböck (1991) presents a compelling argument for transnational citizenship, which transcends national citizenship, and is located in universal human rights. If rights are available to individuals, regardless of national citizenship status, they cease to be citizen rights, with their location in the world of nation-states, and thus become human rights (Mason, 2000). However, in the absence of strong international institutions that can enforce the provisions of international laws and declarations, nation states are able to differ in their interpretations of these documents, rendering national citizenship the most important guarantor of a full range of rights and security.

Indeed, in relation to refugees and asylum seekers, Dahrendorf (1994, p17) states:

> *"The refugee, that characteristic social figure of our time, is the victim of intolerant homogeneity, and is therefore the greatest and saddest expression of the need for real citizenship".*

Conclusion

While both Britain and France had traditionally welcomed refugees and asylum seekers, from the late 1970s onwards efforts were made to reduce the numbers of immigrants. Asylum policies became amalgamated with immigration policies, to the relative neglect of the needs of refugees and asylum seekers. Seeking asylum in Britain and France has become increasingly difficult. By the time asylum seekers started to arrive from the DRC in Britain and France in the late 1980s, both countries were host to substantial numbers of minority ethnic groups, who were experiencing varying degrees of social exclusion.

The nature of asylum policies has served to distinguish clearly between the status of refugee and asylum seeker in terms of security and rights attached to the different statuses. In turn the bestowal, or not, of citizenship status makes a distinction between who belongs and who does not in the eyes of the British or French public, but also in the subjective experience of refugees and asylum seekers. This 'outsider' experience arises from the lack of political rights for both refugees and asylum seekers, and thus the ability to participate in the production of the policies that shape their everyday lives, and from reduced social rights for asylum seekers. A lesser range of civil rights, and identification with established minority ethnic groups, many of whom possess formal citizenship status yet perceive themselves as 'second class' citizens, serves to set refugees and more so asylum seekers on the margins of British and French societies. These tiers of entitlements have resulted in civic stratification in both an objective sense, since different rights attach to the statuses of citizen, refugee and asylum seeker, and in a subjective sense in terms of the psycho-social effects of living in societies characterised by such hierarchies.

Ahmad (1993) argues that health and ill health are socially produced and are mediated by citizenship status. The civic stratification that results from citizenship approaches that serve to include and exclude has resonance with the hierarchies that result in psycho-social stress, and thus produces the health inequalities described by Wilkinson (1992; 1996). This thesis draws on Wilkinson's work to explore the health related quality of life of refugees and asylum seekers.

CHAPTER THREE

HEALTH AND REFUGEES AND ASYLUM SEEKERS

Introduction

The civic stratification described in the previous chapter has implications for health. The health of refugees and asylum seekers can be affected by many factors relating to their experience before flight, during flight and after arrival in a host country. However, on arrival in a Western European country, including Britain or France, refugees and asylum seekers are situated in a society that is characterised by health inequalities. These inequalities have many contributing factors but poverty and social status have been found to be important. In this situation any existing health problems that refugees and asylum seekers face may be compounded by their location and experience in the social hierarchy in the host country.

'Health' is a term that lacks an agreed definition, a fact that has implications for any attempts to measure it. Consequently there has been a tendency to measure health in terms of its absence, that is, by measuring morbidity and mortality. This chapter examines the concept of health and the existing health inequalities in relation to social class and ethnicity that pertain in Britain and France, before addressing the health of refugees and asylum seekers. Various threats to the health of refugees and asylum seekers will be identified: these can occur at all stages of the 'refugee experience' and will serve to demonstrate the particularly vulnerable situation of refugees and asylum seekers. Through this examination of the refugee experience, and by drawing on relevant literature concerning documented experiences of refugees and asylum seekers, it is suggested that refugees and asylum seekers share the untoward effects of relative deprivation with people of low socio-economic status and members of minority ethnic groups as a consequence of civic stratification.

Most of the data that provides the evidence for health inequalities is derived from morbidity and mortality statistics. This chapter further discusses the limitations of current measurements of health, particularly when exploring health issues related to minority ethnic groups. Health-related quality of life is identified as a more appropriate concept for the investigation of the health experience of refugees and asylum seekers.

Health

There are various definitions of the term 'health'. Most definitions assume that health is a valued state, for example *"a state of being to which most of us aspire ....."* (Aggleton, 1990, p1). Health can be defined in positive terms, for example, as a state of well-being, or in negative terms, for example, the absence of disease[1]. Blaxter (2004) argues that the idea that health is something normal, and that illness is a deviation from normal, leads to negative definitions. Recently there has been a tendency to favour more positive definitions, for example, in 1984 the World Health Organisation (WHO) defined health as:

> "......... *the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not an object of living; it is a positive concept emphasising social and personal resources, as well as physical capacities".*
> (WHO, 1984, p3)

Existing theories view health variously as an ideal state, or as an ability to carry out activities of daily living; health may be viewed as a commodity, the ability to adapt to changing circumstances or as a personal strength. Seedhouse (1986; 2001) has undertaken a synthesis of various theories of health and, while noting the differences, identifies a common factor; all theories of health, and all approaches designed to increase health, are concerned with the achievement of human potential. Hence health is currently viewed in a holistic sense, incorporating notions of adaptation and self fulfilment.

Health beliefs

As important as definitions of terms are the beliefs people hold concerning health and illness, which also vary from place to place as well as at different times in history (Aggleton, 1990; Guillemin, Bombardier and Beaton, 1993; Clarke, 2001). These can also hamper consistent measurement and comparison across time and between groups of people. While health, illness and disease are influenced by biological factors, they can also be influenced by social, economic and cultural characteristics of the society in which people live (Helman, 2000; Clarke, 2001). Culture provides a framework within which individuals view and make sense of the world and a set of guidelines which inform ideas, beliefs, values and behaviours (Helman, 2000). Culture is transmitted from one

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[1] The term 'disease' refers to the objective signs and symptoms, while the term 'illness' refers to the subjective experience of feeling unwell.

generation to the next, but it is not fixed and involves a process of adaptation and change, rendering generalisations unhelpful if not damaging (Helman, 2000). For example, the formation of fixed ideas about the health beliefs of any particular ethnic group might not be useful if false assumptions are made. As a consequence of acculturation, long-held cultural beliefs may give way to those of the host society. Lay definitions of health, illness and disease are thus embedded in wider socio-cultural contexts and as such are influenced by prevailing social norms and values (Kleinman, 1986; Stacey, 1986; Clarke, 2001; Blaxter, 2004). As such, people in different social classes and members of different cultures may hold differing views concerning the nature of health and illness.

Many lay beliefs about health and illness adopt a holistic approach and consequently may be at odds with professional notions of health, illness and disease, which have tended to adhere to the bio-medical model often associated with western medicine. Some people have been found to use both 'private accounts', reflecting lay views of health, in informal settings and 'public accounts', employing medical terminology, when engaged with professionals (Cornwell, 1984; Donovan, 1986). When investigating the health of different groups it is important to be aware of this as different research methods may elicit different types of response.

- ***Health inequalities and social class***

In both the UK and other European countries health policies are placing greater emphasis on tackling inequalities in health (Graham, 2004). Health inequalities, in relation to social class, exist in all western European countries, though the causes of death differ between countries (Fox, 1989; Power, 1994; Macintyre, 1997; Kunst, Groenhof, Mackenbach et al 1998; Mackenbach, Bakker, Kunst et al, 2002; Menke, Streich, Rössler et al, 2003). Difficulties exist when attempting a systematic comparison of socio-economic differences in mortality across countries as each country has tended to use its own classification of socioeconomic position and these are not directly comparable (Kunst et al 1998; Leon, 1998). Consequently some researchers (Kunst et al, 1998) have attempted to overcome this difficulty by considering manual and non-manual classes. Kunst et al (1998) found higher mortality in manual classes than non-manual classes in 11 Western European countries and while the causes of mortality differ among the countries, the lower mortality rates of people in higher occupational classes is independent of the specific diseases and risk factors involved. Moreover, other authors (Power, 1994; Levine, 1995; Brunner and Marmot, 1999) have drawn attention to research that demonstrates the absence of a clear distinction between 'privileged' and 'underprivileged' people in terms of health status and the presence of a gradient with increasing morbidity and mortality with declining socio-economic status.

- ***Health inequalities in Britain and France***

In this study comparisons are drawn between the health experience of refugees and asylum seekers in Britain and France. In order to place this experience in context, inequalities in health in relation to social class will be explored in both countries. Researchers usually refer to people's location in an occupation or social class classification when describing and analysing inequalities in health. The classifications used in official statistics in Britain and France are as follows:

BRITAIN	
I	Professional
II	Intermediate occupations
IIInm	Skilled non-manual occupations
IIIm	Skilled manual occupations
IV	Partly skilled occupations
V	Unskilled occupations

FRANCE
Upper Executives
Farmers
Middle Executives
Craftworkers
Employees
Workers (*Ouvriers*)

The classification identified for Britain is used by the Registrar-General and is an occupational classification. It is one of many classifications, but is frequently cited in health-related research. This classification has been much criticised and was revised in 1998 in order to be more representative of modern British society. All the studies referred to in this work have used the older classification outlined above.

The system identified for France is used by the National Institute for Economic Studies and Statistics (*INSEE*) (Lang, Fassin, Grandjean et al, 2002); it is also based on occupation. While there are differences in these two classifications, there are similarities at the two extremes of the classifications to allow for some degree of comparison between the two countries.

Much of the early interest and research into health inequalities has come from Britain (Power, 1994). Lang et al (2002) acknowledge that, in comparison with the UK, data on inequalities in health in France is relatively sparse and France has also been absent from international conferences on the subject. Although awareness of health inequalities in

Britain existed since the 1850s (Macintyre, 1997), the defining point in Britain was probably the publication of the Black Report in 1980 (Townsend, Davidson and Whitehead, 1992). A Working Group was set up by the then Secretary of State for Health to investigate variations in the health and illness experience of different groups of people following his recognition that:

> *"the crude differences in mortality rates between the various social classes are worrying. ..... in 1971 the death rate for adult men in social class V (unskilled workers) was nearly twice that of adult men in social class I (professional workers) ...."*
> (Townsend, Davidson and Whitehead, 1992, p1)

Particularly worrying at the time was the fact that this awareness of differences in mortality rates existed against the background of a National Health Service that was set up with a specific aim of treating people equitably. The Working Group completed its review of evidence in 1980 and concluded that the poorer health experience of the lower occupational group, previously identified in relation to adult men, applied at all stages of life (Townsend, Davidson and Whitehead, 1992).

At the time the Working Group did acknowledge difficulty in identifying exactly how poverty and the class structure cause ill-health and death, but argued strongly that a key concept linking higher mortality rates with social class was material deprivation. These inequalities in mortality rates were not necessarily a function of the National Health Service (NHS), though it did appear that middle-class people made more use of preventive services than did those in lower social classes. There was also some evidence, from the 1970s, that middle-class patients had longer consultations with their doctors than did working-class patients and that they were able to make better use of that consultation time (Townsend, Davidson and Whitehead, 1992). This situation does not appear to exist any longer as a more recent review of relevant literature (Goddard and Smith, 2001) identified that higher rates of General Practitioner (GP) consultation are associated with greater deprivation and with lower socio-economic group. Goddard and Smith report that this finding is supported by studies which have attempted to control for need. However, manual groups continue to be less likely to consult GPs for preventative care than those in higher social classes.

While socio-economic inequalities had been apparent in France for many years, it was not until 1994 that the first report on public health was published, announcing conclusions that were similar to those found in Britain, i.e. differences in the health experiences of different social classes were identified, in spite of a reduction in inequalities in utilization of health care services (Lang et al, 2002). In 1998 a further report confirmed the persistence of inequalities in health in France (Lang et al, 2002). As in Britain, the French health service was not believed to be responsible for these inequalities, but rather than looking at wider social causes in France as the British government has done (Department of Health, 1999), health was viewed very much as an individual concern (Lang et al, 2002).

In Britain the findings of the Black Report aroused interest in inequalities in health and prompted further research, and while the main focus of the Black Report was mortality data, subsequently social inequalities in a number of dimensions of health have been reported. In 1987 Whitehead (Townsend, Davidson and Whitehead, 1992) found that inequalities in health between different social groups continued to exist on a substantial scale, with most of the 'killer' diseases affecting the poorest occupational classes more than the rich. In 1995 Benzeval, Judge and Whitehead claimed that the life expectancy of people living in the least privileged circumstances was 8 years less than that of those who are more affluent, a trend that has continued into the late 1990s, with reports of 9.5 years difference in life expectancy for men in social classes I and V and 6.4 years for women (Shaw, Dorling and Smith, 1999). Similarly, life expectancy of working class people in France is also lower than that of professional classes (Aïach, 1997; Fassin, 1999; Lang et al, 2002); Lang et al (2002) report 6.5 years difference in life expectancy for men at the top and bottom of the social scale and 3.5 years for women.

Crucially, whereas in 1971 the death rate for adult men in Britain in social class V (unskilled workers) was nearly twice that of adult men in social class I (professional workers) (Townsend, Davidson and Whitehead, 1992), by 1996, the death rates for men in social class V were nearly 3 times higher than those for men in social class I (Drever, Whitehead and Roden, 1996). Again, this is a trend that has continued as Davey Smith, Dorling, Mitchell et al (2002) have identified increasing inequalities in terms of mortality differentials between the social classes that reflect trends in income inequality up to 1998-99.

France has also experienced increasing inequalities in mortality between the upper and lower classes (Lang et al, 2002), to the extent that since 1997 there has been a heightened interest, prompting the National Health Research Institute (INSERM) to promote research in the area, along with 'state of the art' critiques (Lang et al, 2002). One such critique (Leclerc, Fassin, Grandjean et al, 2000) concludes that in order to reduce inequalities in health it is necessary to reduce social inequalities.

Refugees and asylum seekers arriving in Britain and France will enter societies that are characterised by inequalities in relation to social class but their potential to find themselves in a similar position to people in the lower social classes, as a consequence of social stratification, is compounded by the possible effects of migration and ethnicity on health.

Migration and health

Following migration to Europe and North America after the second world war, there has been an assumption that immigrants are always at a health disadvantage (Marks and Warboys, 1997). There has traditionally been much concern in both Britain and France about immigrants as importers of disease (Ahmad, 1993; Marks and Warboys, 1997; Fassin, 2000).

The picture in relation to the effects of migration on health lacks clarity. Mortality rates of migrants are often compared to those in their countries of origin, or to those of the host society. Evidence suggests that following migration, migrants' mortality rates either stay the same, increase or decrease, in relation to mortality rates in their home countries (McKay, Macintyre and Ellaway, 2003). Mortality rates may also be influenced by the selective nature of migration; whether people with good or poor health migrate. Migrants may be 'positively' selected for health, for example, when healthy and ambitious people move to another country in order to improve their job prospects, or 'negatively' selected when, for example, poor countries or communities are unable to adequately support members with poor physical or mental health (Smaje, 1996). Mortality rates can also be affected by conditions in the countries of origin, conditions in the host country, access to health services, individual behaviours and whether migration is voluntary or involuntary. Nyer-Malbet (1996) argues that the stress of migration puts migrants at risk of health problems; circumstances of welcome and new ways of life account for the relative frequence of social marginalisation.

A similar mixed picture exists concerning mental health; migration does not necessarily cause mental illness, but migrants may find the experience of migration stressful and will benefit from social support from both the already established migrant community and from the host community (Beiser, 1991; Baker, Arseneault and Gallant, 1994; McKay et al, 2003). Migrant groups tend to differ in their vulnerability to mental illness, for example, Irish immigrants to the UK have rates of alcoholism that are higher than those of the majority population and other migrant groups (Helman, 2000); migrants from the Caribbean have the highest rate of schizophrenia of all migrant groups (Helman, 2000). Littlewood and Lipsedge (1997) argue that there are no simple explanations for these differences, rather there is a multitude of contributory factors. Migration from one culture to another, for whatever reason, may result in cultural bereavement, especially for involuntary migrants such as refugees and asylum seekers. Cultural bereavement is defined as:

> *"Grieving for the loss of all the familiar cultural reference points that defined who they were and how they were to live their lives."*
> (Helman, 2000, p214)

The evidence relating to migrants' health thus suggests that there are many factors involved and any individual's health will be affected by his/her particular situation though involuntary migration, experienced by refugees and asylum seekers, is known to be more stressful than voluntary migration (Harrell-Bond, 2000). Migrants' health will, no doubt, also vary depending on the stage at which it is measured or investigated. Menke et al (2003) conclude that across Europe, compared to citizens, the conditions of life are unsatisfactory for most migrants and these are not conducive to good health. Most migrants in Europe experience low-paid work, which is further characterised by unfavourable working conditions, together with poor housing. These factors generally place migrants in low socio-economic positions.

Ethnicity and health

Data relating to ethnicity and health in Britain has been sparse until recently. At the time of the Black Report, 'race' had rarely been assessed in official censuses and surveys in Britain (Townsend, Davidson and Whitehead, 1992). Neither has it been clear which indicator should be used when investigating health - either 'race' or ethnicity (Townsend, Davidson, and Whitehead, 1992). Researchers have utilised varying indicators, for example, mortality rates relating to country of birth of the deceased (Balarajan and Soni Raleigh, 1993), country of family origin (Nazroo, 1997), but all have their limitations resulting in an incomplete picture of the health of minority ethnic groups in Britain. While knowledge of patterns of health and illness relating to ethnicity is emerging, for example the high rates of coronary heart disease among the Asian population, Ahmad (1997p*vii*) points to a "*glaringly obvious gap*" in research and health, particularly among the "*forgotten minorities*" such as numerically small groups of people like people from Somalia and Ethiopia. The DRC can also be added to this list.

In France, the picture is even more complicated by the fact that health statistics in France do not record ethnic origin, let alone any data that would allow any measurement of discrimination (Fassin, 1999; Crenn, 2000). In 1978 a law was passed that included a clause that outlawed computerized storage of data on racial origins without the express consent of the individual or the state; in practice this has meant that no systematic data have been collected on race (Bleich, 2003). Bleich states that Tribalat (1995) did obtain permission to conduct a study on immigrant integration using an ethnic variable, but use of such data has been criticized in France. Fassin (1999) argues that this is partly due to the Republican model of integration but also because of a fear of stigmatising certain groups of people for whom it is possible to identify a high rate of certain illnesses, aware that threats to public health have been behind calls for the closure of hostels for immigrant workers. Data that does exist in France in relation to inequalities in health concerns social class or geography and highlights the role of certain factors, such as poverty, professional category, unemployment, work conditions, housing and education. However, 'foreigners' are nearly twice as likely to be working class than the French and intergenerational upward social mobility is less for 'foreigners' than for French people; this is believed to be as a result of having less qualifications and more difficulties in getting promotion. Leclerc et al's (2000) book on health inequalities in France does not include a chapter devoted to ethnic health but there is a growing literature in France on the health of 'migrants'. This is as a result of information collected, for example via the census, which does collect data concerning country of birth.

Physical health

Diseases of minority ethnic populations, and causes of death, do not differ fundamentally from those faced by majority populations in Britain and France (Smaje, 1995a; Gliber, 1997). Cardio-vascular disease is the leading cause of death in both developed and developing countries, with marked variations between populations (McKay et al, 2003). However, it is known that rates of ill-health and mortality among minority ethnic groups differ from those of the white majority population and differences exist between ethnic groups. For example, Wild and McKeigue (1997) compared mortalities for selected groups of immigrants with the national average (for England and Wales) and found that during 1989-92 mortality from all causes was higher than the national average for Scottish and Irish immigrants. For other migrants the picture was mixed, for example, for migrants from South Asia excess mortality from circulatory disease was balanced by lower mortality from cancer (Wild and McKeigue, 1997).

One early and important study in Britain (Balarajan and Soni Raleigh, 1993) identified the biggest difference in health and illness in relation to coronary heart disease; mortality from coronary heart disease (CHD) being higher among people born in the Indian sub-continent than among the white majority population and also than other minority ethnic groups. However, later studies (Balarajan 1996; Bhopal, Unwin, White et al, 1999) were able to demonstrate that grouping disparate ethnic groups under one heading can be misleading. When people born in the Indian sub-continent were identified in separate groupings it was found that mortality from CHD was highest among Bangladeshis, followed by Pakistanis, and then Indians. There is a tendency for Indians to enjoy a better socio-economic profile than Pakistanis and Bangladeshis leading Balarajan (1996) to suggest social class as a mediating factor among the determinants of CHD.

Generally, deaths from cancer are lower among minority ethnic groups but the incidence may be changing as members of minority ethnic groups adopt some of the lifestyles of the majority population (Balarajan and Soni Raleigh, 1993; Smaje, 1995a). Variations are seen in cancer mortality rates of different immigrant groups in different countries. Cancer mortality is governed by genetic and/or environmental factors (McKay et al, 2003). Evidence from studies of the health of migrants has stressed the importance of the environment in determining health and illness (Marmot, 1999), for example studies investigating the patterns of heart disease and stroke in men of Japanese ancestry found that, for Japanese men living in California, the rate of heart disease increased with the degree of acculturation (Marmot, 1999). Exposure to cancer risk factors in minority ethnic groups was investigated in the Health Survey for England (Erens, Primatesta and Prior, 2001). Some members of minority ethnic groups, for example, Bangladeshi men and women, were found to have a low intake of fruit and vegetables. Compared with the 27% of men in the majority population who smoked cigarettes, higher levels of cigarette smoking were reported by male members of minority ethnic groups (Erens, Primatesta and Prior, 2001).

In France, anaemia in women and children and digestive tract and respiratory problems in adults have been found to be more frequent in migrants than in French people (Nyer-

Malbet, 1996). Rates of tuberculosis are higher among 'foreigners' than among French people (Fassin, 1998; Gliber, 1997). Fassin also notes that 'foreign' women in France experience twice the rate of complications in pregnancy compared to French women.

Mental health

Studies have identified higher admission rates to psychiatric hospitals for black men than those among the white majority population (Balarajan and Soni Raleigh, 1993; Smaje, 1995a). The issue of mental health and illness and ethnicity is a complex and controversial one. The boundary between mental health and mental disorder is concerned with the question of normality, which is culturally relative (Sashidharan and Commander, 1998; Fernando, 2002). Mental health and illness are socially constructed, both in terms of the person suffering from the 'abnormality' and the person making any judgement on 'abnormality' (Helman, 2000), suggesting that cultural misunderstanding may contribute to some misdiagnosis. Helman notes that, as well as having a higher rate of mental illness than the majority population, immigrants also have higher rates of mental illness than the populations of their countries of origin.

While it is suggested also that some diagnoses may reflect lack of understanding of culture and be the result of labelling behaviour deviant that might be seen as normal if viewed within its cultural context in both Britain and France (Fassin, 2000; Helman, 2000), the role of social disadvantage cannot be ignored. A study in Manchester (Thomas, Stone and Osborn, 1993) concerning compulsory psychiatric admissions found that second-generation (UK born) Afro-Caribbean people had 9 times the rate of schizophrenia than white people. However, it is possible that this could be explained by their greater socio-economic disadvantage, with poor inner-city housing and higher rates of unemployment, rather than psychiatric misdiagnosis; socio-economic disadvantage is known to be correlated with schizophrenia (Thomas et al, 1993). In France, Gliber (1997) argues that unemployment, low paid work, poor language skills, second generation identity and a feeling of not belonging, all contribute to mental health problems among migrants.

The current western medical model of psychiatric illness is one that is relatively, if not completely, free from religious, ethical and spiritual aspects of the culture in which it is based. In the west there is a dichotomy between mind and body; this is not necessarily so in other cultures. Western healing doctrines tend to focus on the individual (rather than society). Healing of mental illness is generally seen as a matter of correcting a biologicalchemical-physical machine. African ways of thinking about mental and psychological matters are very different from those in the west. In African culture, the concept of health is more social than biological. In African cultures mind and body do not exist apart from each other (Fernando, 2002).

Comparison of mental health in minority ethnic groups is compounded by the existence of variations in the clinical criteria used to diagnose some mental illness between British and French psychiatrists and also some diagnostic categories used in French psychiatry are different from those used in Anglo-American psychiatry (Helman, 2000). Given that Berthoud and Nazroo (1997, p309) claim that "*measuring the prevalence of mental illness is difficult at the best of times*", comparisons between Britain and France are difficult. Further, the questions required to diagnose mental illness may be unreliable when used cross-culturally (Berthoud and Nazroo, 1997).

Socio-economic status and ethnicity

Factors relating to socio-economic status are important when considering ethnic health in both Britain and France (Smaje, 1995a; Fassin, 1999). People from minority ethnic groups are likely to experience poverty and disadvantage, as identified by higher unemployment rates, a greater reliance on social housing, lower incomes and lower car ownership, which, together with racism, may affect their health (HEA, 1994; Smaje, 1995a). Nazroo (1998) found that members of minority ethnic groups had a lower income than members of the white majority population in the same class, that unemployed people from minority ethnic groups had been unemployed for longer than their counterparts in the white majority population, and that some members of ethnic groups had poorer quality housing than the majority population, regardless of tenure. A survey conducted by the Health Education Authority (HEA) in 1994 asked respondents to assess how social and environmental factors, such as smoking, diet and physical activity, affect their health. The most frequently mentioned health risks for respondents from the UK white majority population were obesity, smoking, stress or worries at work, and diet. Respondents from minority ethnic groups mentioned these risk factors less frequently and other social and environmental factors gained in importance, for example, unemployment and violent crime in their neighbourhoods and the quality of housing. Thus it is not possible to relate all ethnic health problems to culture (Dewitte, 2000). In France Fassin (2000) argues that rather than immigrants being seen as an 'at risk' group (in terms of risks for themselves and for others) there is a need to consider the health of migrants in relation to education, work, housing and citizenship, and the sharing of experiences of exclusion with others.

Noting the damaging effects of exclusion on health and health behaviour, Fassin (2000, p8) claims that:

> *"The permanent search for financial resources, the lack of a right to stay, can often better account for behaviours in relation to health and care........."*

Balarajan and Soni Raleigh's (1993) study relied heavily on mortality data and identified ethnicity in relation to the country of birth of the deceased and thus provided no information about second and third generation members of minority ethnic groups. Nazroo's (1997) study asked respondents to identify their ethnicity in relation to the country of family origin. He also asked people to report on their own self-assessed health and illness status: a third of minority ethnic respondents described their health as fair or poor, with lower levels of long-standing illness than the white majority population. In contrast, the Health Survey for England (Erens, Primatesta and Prior, 2001) found that limiting longstanding illness was higher for men and women in minority ethnic groups than for men and women in the general population. These findings demonstrate that different approaches to gathering data will yield different results.

Access to health services

Balarajan and Soni Raleigh (1993) state that social class is an important factor in access to health services. Thus both the majority population and members of minority ethnic groups in similar social classes may experience similar problems. However, minority ethnic groups may also experience racism and language difficulties and cultural misunderstandings. The Audit Commission (1993) found that in addition to all the problems faced by patients who speak English, non-English speakers have particular problems concerning access to health services.

In terms of access to health services, GP consultations were found to be higher among members of minority ethnic groups than among the native population and attendance at out-patients was found to be lower (Balarajan and Soni Raleigh, 1993; Smaje and Le Grand, 1997). This is a trend that has continued over time and it is possible that members of minority ethnic groups may be referred on to secondary care less than their counterparts in the white majority population. Further investigation suggests that inequalities in access to health care are not a result of members of minority ethnic groups failing to present themselves to primary care or accident and emergency care, rather the evidence suggests that barriers exist at the level of health care provision (Adamson, Ben-Shlomo, Chaturvedi et al, 2003). There is also evidence that refugees and asylum seekers have experienced difficulties when attempting to register with General Practitioners in Britain (Jones and Gill, 1998a).

In France, Fassin (1998) notes that 'foreigners' are heavy users of the free health centres. While representing 6.3% of the population, 'foreigners' form 62% of the users of these centres. Patients consulting the free health care centres have been found to have conditions that are often aggravated by their insecurity and also by delay in presenting for care (Mizrahi and Mizrahi, 2000).

Acheson (1998) reports on a review of recent available information on inequalities in health in England that found that inequalities affect the whole of society and they can be identified at all stages of the life course from pregnancy to old age. Inequalities in health exist, whether measured in terms of mortality, life expectancy or health status, whether categorised by socioeconomic measures or by ethnic group or gender (Acheson, 1998). In spite of growing prosperity and substantial reductions in mortality for the people of Britain as a whole, this widening gap in health between those at the top and those at the bottom of the social scale raises issues of social justice (Acheson, 1998). As a consequence, refugees and asylum seekers arriving in Britain have to live in a society that has growing inequalities in health. A similar situation pertains in France.

Explanations for health inequalities

When the Black Report was published four explanations for these health inequalities were considered and the Working Group examined the evidence relating to class differences in health under four main headings:
Artefactual explanations involve the use of data that are possibly misleading or inappropriate. **Selectivist** explanations argue that health inequalities result from social mobility as healthy people are able to acquire better jobs and rise up the social scale. According to selective explanations, it is health that determines an individual's social position, not vice versa. Explanations relating to artefact and selection have not been seen as very important (Bartley, Blane and Davey Smith, 1998). **Cultural/behavioural** explanations locate causes of inequalities in health in individual behaviour; in choices people make concerning their lifestyles. As such, cultural explanations ignore issues of power, deprivation and racism and can result in victim-blaming. **Materialist** explanations refer to the relationship between low socio-economic status and poor health, for example, due to the effects of being unable to afford a healthy diet, living in unsatisfactory accommodation, and/or the stress of unemployment on health. There has been a

general acceptance that material deprivation and behavioural factors compound each other, expressed in Le Grand's (1987) theory of human capital. According to this view, health may be viewed as a stock of capital which can depreciate over time naturally. However, individuals can influence the depreciation process by their own actions, that is, they can invest in activities that improve health or they can increase the rate of depreciation by engaging in activities that may have an adverse effect on health. Le Grand (1987) stresses, though, that such decisions concerning health-related behaviour are not made in a vacuum, but in a socio-economic context. Health-related behaviour is mediated by material deprivation.

Smaje (1995a) has added three further explanations in terms of health inequalities relating to members of minority ethnic groups. Firstly, genetic explanations can account for inherited diseases affecting some people, for example, sickle-cell disorder in people of Afro-Caribbean descent or Tay Sachs disease in Jewish people. Inherited diseases only account for a small percentage of the health problems experienced by minority ethnic groups (Smaje, 1995a). Secondly, Smaje refers to racism which may in turn compound the effects of social class, and thirdly migration is cited as an explanation for poor health, particularly if it is enforced as in the case of refugees and asylum seekers. While Smaje (1996) accepts that selection can play a part, suggesting that positive selection has taken place in relation to people from the Caribbean, the so-called healthy worker effect, and negative selection for people from Ireland, the selection effects are likely to be weak in relation to refugees.

Psycho-social factors

Macintyre (1997) has called for a re-orientation of research towards better understanding of the manner in which social structure influences individuals' health risks, as many modern health problems reflect people's subjective experience of the circumstances in which they live. This challenge has, to some extent, been addressed by Wilkinson (1992, 1996, 1997). While inequalities in health had mostly been explained by health-related behaviour and material deprivation, Elstad (1998) argues that these seem insufficient. Wilkinson's (1992, 1996) work brought a further dimension to the debate, arguing that social, rather than material, factors are now an important component in the quality of life in developed societies. Wilkinson (1992, 1996) pointed out that among the developed countries it is not the richest societies that have the best health, but those that have the smallest differences in income between rich and poor, that is, the most egalitarian countries. Wilkinson (1992, 1996) argues that the quality of the social life of a society is one of the most powerful determinants of health and that this, in turn, is very closely related to the degree of income equality. While not denying the importance of poverty and standard of living in determining health, Wilkinson (1992, 1996) argues that the social consequences of people's differing circumstances in terms of stress, self esteem and social relations may now be one of the most important influences on health. Laverack (2005) claims that a person's self esteem derives from friends, family, colleagues, and communities and settings in which they live or work. He further argues that these relationships, communities and settings are influenced by the political, cultural, social and economic context that includes some and excludes others.

In order to arrive at this conclusion, Wilkinson (1992) considered income distribution and life expectancy in a range of developed countries, and concluded that above a certain level of development, average life expectancy is not related to average income but to the distribution of that income. Countries with a relatively equal income distribution were found to have relatively high life expectancy, with a tendency for mortality to be lower than less egalitarian countries. Wilkinson (1992, 1996) argues that whereas absolute income will affect health through the direct physiological effects of material circumstances, relative income involves social elements in the causal process, for example, one's standing in relation to others and the impact of this on one's psychological, emotional and social life. Egalitarian societies seem to be more socially cohesive, and a strong community life appears to protect health (Wilkinson, 1996), in that people with more social contacts and more involvement in local activities seem to have better health. Such findings lead Wilkinson (1996) to conclude that the social life of a society is one of the most powerful determinants of health and this, in turn, is very closely related to the degree of income equality.

Wilkinson is not without his critics (Judge, 1995; Judge, Mulligan and Benzeval, 1998; Forbes and Wainwright, 2001). Judge (1995) and Judge et al (1998), in particular, have raised questions about Wilkinson's theory; having looked at the sources of data on income distribution used by Wilkinson, they suggest that analysis of the data does not support the conclusions that Wilkinson draws to support his theory. Instead, Judge (1995) and Judge et al (1998) argue that life expectancy is the product of a variety of interacting cultural, economic and social influences, acting over periods of time. Further, Lynch, Davey Smith, Kaplan et al (2000) argue that interpretations of links between income inequality and health must begin with the structural causes of inequalities, that is factors relating to material deprivation, and not just focus on perceptions of that inequality. The structural, political-economic processes that generate inequalities exist long before their effects are experienced at the individual level (Lynch et al, 2000). In response, Marmot and

Wilkinson (2001) do not deny the importance of material factors, but stress that psychosocial factors exacerbate other social problems.

Other research that lends support to Wilkinson's argument relates to the acknowledgement of the step-wise gradient in health experience (Power, 1994; Levine, 1995) that gains credence from the findings of the Whitehall studies (Marmot, 1996; Bosma, Marmot, Hemingway et al, 1997; Marmot and Davey Smith, 1997) and the developing research base that relates disease patterns to the organization of society (Marmot, 1999). The findings of the Whitehall studies suggest that the larger part of the social class differences in mortality cannot be explained by what seemed to be the important explanations for individual differences in health, for example, cigarette smoking (Wilkinson, 1996). The Whitehall studies of a large number of civil servants working in government offices in London found that death rates were four times as high among the most junior office support staff as they were among the most senior administrators. Another startling finding was that men in the second from top grade have a higher mortality rate than that of the top grade civil servants, identifying a step-wise gradient relating to the respondents' relative position in the hierarchy, which is a psycho-social concept (Brunner and Marmot, 1999). The findings of the Whitehall studies have led to explanations emphasising psychosocial factors, giving consideration to the pathways through which the social structure influences health in its widest sense. Gradients of disease similar to those found in the British civil service have been identified for a range of diseases across the developed world (Syme, 1996); Syme's explanation for this is that as individuals move down the hierarchy they have less control over their lives. By less control he means *"less opportunity to influence the events that affect one's life"* (p28).

There is increasing evidence of the physiological channels through which chronic stress can invoke endocrine and immunological processes. Racism may also provoke the same physiological response (McKenzie, 2003). Brunner and Marmot (1999) argue that it is plausible that factors like social isolation and lack of control over one's life can affect health and illness. Such experiences produce low level psychological stress as a feature of daily life and raise the possibility of frequent activation of the 'flight-or-fight' response; this response evolved as a protective measure for emergency use to ensure survival when faced with threats. Biological changes take place in the body when the flight-or-fight response is evoked, for example, there is a rise in blood pressure. When the threat is no longer present the blood pressure will return to normal. However, if, as a result of prolonged stress, the response is evoked too often, the blood pressure might not return to normal but may be re-set at a higher level and hypertension might ensue (Brunner and

Marmot, 1999). High blood pressure and accumulation of cholesterol in the blood vessel walls present a risk of heart attack and stroke (Brunner and Marmot, 1999). Brunner and Marmot cite evidence of the detrimental effects of stressors on existing medical conditions such as diabetes mellitus and rheumatoid arthritis, and also as factors precipitating myocardial infarction. Further if the response is activated too often and for too long the effect may be maladaptive and can lead to depression, increased susceptibility to infection, or diabetes mellitus.

More egalitarian societies are also argued to be more cohesive (Wilkinson, 1997), resulting in better integration into a network of social relations that is known to benefit health. Socially isolated people have higher mortality rates than socially integrated people (Kawachi and Kennedy, 1997). Rejection, low social status, feelings of inferiority and not being respected as equals would all appear to be detrimental to health (Wilkinson, Kawachi and Kennedy, 1998; Wilkinson, 2000). Research shows that emotional distress creates susceptibility to physical illness, while social and emotional support can protect against premature mortality, prevent illness and aid recovery (Stewart-Brown, 1998). Power (1994) argues that mortality differentials in western European countries are smallest in countries with well established social policies to improve the living conditions of the most disadvantaged sections of the population.

The publication of Wilkinson's (1992) paper in the British Medical Journal has prompted much international debate, essentially concerning the relative importance of psychosocial pathways and material pathways in explaining health inequalities (Mackenbach, 2002). The paper has added a new dimension to the study of health inequalities. While there is no doubt about the effect of individual income on individual health, the debate concerns the relationship between income distribution and population health. Wilkinson has continued to respond to his critics by reiterating accumulating evidence and drawing on the work of his proponents.

Wilkinson's argument has found support from other authors (Kaplan, Pamuk, Lynch et al, 1996; Kennedy, Kawachi and Prothrow-Stith, 1996; Bartley, Blane and Davey Smith, 1998) and there is a large body of evidence demonstrating that various forms of psychosocial stress[2] can have a powerful influence on death rates and rates of illness.

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[2] Bowling (2002, p24) defines psycho-social stress as "a heightened mind-body reaction to fear or anxiety-arousing stimuli (e.g. illness)".

Wilkinson (1996) in Britain and Fassin (1999) in France both refer to a study in the United States that found that at most ages death rates were higher in Harlem, New York, than in rural Bangladesh; both authors suggest that this pattern of raised mortality in a deprived area (Harlem) is a result of the direct effects of social exclusion. Smaje (1995b) suggests that there may be a decline in health status when inconsistencies arise between social standing, command over material resources, aspirations and lifestyle. In a similar vein, Schnapper (1992) describes how poor people internalise their social inferiority, for example, Crenn (2000) describes the internalisation of the negative attitudes in French society towards North African immigrants.

In 1993, Kharmi warned of the impending increase in demand on health services following an increase in the numbers of people seeking asylum in Europe, acknowledging the link between migration and ill-health, in terms of both psychological and physical effects. Kharmi argued that the health service response in European countries has been inadequate and there has been no systematic policy or strategy to cater for the special needs of migrant groups.

Bollini and Siem (1995) take up this issue and review the available evidence on access to health care and two health outcomes, perinatal mortality and accident/disability for migrant and ethnic minorities in selected host countries. These authors cite a publication from the European Office of the World Health Organisation (WHO) which made an interim evaluation of the performance of various European countries towards achievement of 'Health for all by the Year 2000', which indicated that in spite of an overall health improvement in Europe, there was a lack of progress towards equity during the 1980s in relation to migrants and minority ethnic groups. Bollini and Siem (1995) argue that poor health outcomes for migrants and minority ethnic groups are linked to the lower entitlements for these groups in the receiving societies, while at the same time being exposed to poor working and living conditions and reduced access to health care for a number of political, administrative and cultural reasons. The authors argue that there is a need for policies that promote integration and full participation of these groups into mainstream society in order to reduce health gaps.

Graham (2000) argues that too often the search for causes of health inequality concentrates on the individual, rather than seeking to understand the effects of the underlying structures of inequality. Refugees and asylum seekers in countries of settlement share many characteristics in common with people in low social classes and with members of minority ethnic groups, for example, they are more likely to be unemployed or in low paid employment than the white majority population. While many refugees and asylum seekers may have held professional, well paid and highly esteemed occupations in their home countries, policies and lack of opportunities work against the majority of them maintaining such positions in western European countries of asylum. Furthermore, they also experience similar problems to other migrants, but also have their own distinguishing features, for example, forced migration and sometimes lack of choice over destination. Refugees and asylum seekers also are located low down in the social hierarchy and thus may experience the effects of a low status relative to others in society. It is necessary therefore to consider the structural arrangements that place refugees and asylum seekers in these positions.

Refugee health

Accounts of the health of refugees and asylum seekers in host societies arrive at varying conclusions, as a consequence of the different research methods used to acquire the information, the different groups studied, and the various stages of settlement, for example, soon after arrival in the host country or some time later. For example, Shaw, Dorling and Davey Smith (1999) posit that refugees and asylum seekers experience increased risks of mortality in the period following their migration, while Woodhead (2000) claims that most asylum seekers arrive in good health.

There is a lack of accurate demographic data on refugee and asylum seeker populations (Bariso, 1997; Haringey Council, 1997), as they are often very mobile populations and may choose to exclude themselves from data sources as a result of their natural suspicion of officialdom. Consequently data relating to health is sparse. The one national systematic study carried out in Britain on settled refugees (Carey-Wood, Duke, Karn et al, 1995), and the findings of small local studies concerning the health of refugees and asylum seekers, conclude that health can be affected by the 'refugee experience'.

Ager (1999, p2) defines the refugee experience as:

> *"the human consequences – personal, social, economic, cultural and political – of forced migration."*
> (Ager, 1999, p2)

There are many aspects of the 'refugee experience' that can affect health. Ager (1999) describes discrete phases within forced migration: pre-flight, flight, reception, settlement and resettlement. The health of refugees and asylum seekers can be harmed at all of these phases. This framework will be used to consider the threats to the health of refugees and asylum seekers, but it is important to note that not all refugees and asylum seekers will necessarily experience all of these phases. In the case of my informants, all will have experienced a range of difficulties during the pre-flight and flight phases. Some arrived in Britain and France via other countries, while some were able to travel directly to Britain and France.

Pre-flight

Apart from the direct effects of conflict on the health of refugees and asylum seekers, economic hardship may result in disruption to livelihoods either as a result of political persecution or breakdown in the country's economy, or both (Kalipeni and Oppong, 1998; Ager, 1999; Pedersen, 2002). Social disruption can become so widespread that food supplies are interrupted and schools and health facilities may be to unable to continue to function (Rutter, 1994; Kalipeni and Oppong, 1998; Ager, 1999; Coker, 2001). Disruption of health service delivery can result in incomplete immunization programmes and lack of facilities for those people who may be in need of treatment. Political oppression can result in physical abuse, powerlessness and resultant detrimental effects on physical and mental health.

Flight

The whole process of flight can be traumatic as often family members are left behind. The experience of passage can also be dangerous (Muecke, 1992a), especially if asylum seekers resort to human traffickers in desperation. For example, in June, 2002, the dead bodies of 54 men and 4 women were discovered in a lorry at Dover during a routine inspection by police. The victims had died of asphyxiation and were attempting to seek entry to the UK; they had paid thousands of pounds to a criminal gang for the chance to start a new life in the UK (Hopkins, Vasagar, Kelso et al, 2000). While this is an example of extortion, it is also a consequence of the UK's restrictive immigration policy.

During flight women and children are particularly vulnerable and can become the victims of rape and sexual exploitation (Kalipeni and Oppong, 1998; Coker, 2001). Such risks are not confined to the period of flight but extend throughout the entire refugee experience.

Reception

Reception occurs in the first country of asylum (Ager, 1999). Countries of first asylum are often poor and politically unstable themselves, often neighbouring countries, and the first 'safe haven' might be a refugee camp. Camps are often near the borders of the countries from which asylum seekers flee. The conditions in refugee camps are often poor; they often have inadequate sanitation and nutritional support, contaminated water supplies and severe overcrowding. These conditions are ideal for the transmission of infectious diseases (Dick, 1984; Clinton-Davis and Fassil, 1992; Gellert, 1993; Weekers and Siem, 1997; Kalipeni and Oppong, 1998). Women are, again, particularly at risk of sexual violence (Forbes Martin, 1992; Callamard, 1999; Coker, 2001). There is also the danger that dependency might be created among refugees and asylum seekers in camps (Ager, 1999). Reception might also occur in western countries where the experience is characterised by registration procedures.

Settlement

Many refugees and asylum seekers do not reside in camps on arrival in the country of first asylum, for example, in many African countries numbers of refugees and asylum seekers have settled among the host population (Ager, 1999). However, onward migration to countries which appear to offer better prospects is usually only possible for a small number of refugees and asylum seekers (Castles and Miller, 2003).

Resettlement

Resettlement in the developed world is possible for only a minority of the world's refugees and asylum seekers (Ager, 1999), who may have greater difficulty adjusting to their host country than voluntary migrants (Kemp, 1993). The attitudes of both the refugees and asylum seekers and the host country will influence the extent and mode of resettlement (Ager, 1999). Of particular importance are attitudes towards cultural identity and relationships with other groups of people. Baker et al (1994) conducted a phenomenological study in Canada to illuminate the experience of resettlement for migrants who did not have access to a community of their own culture. Their informants, who included refugees, described feelings such as powerlessness, inability to understand people, feeling bewildered and unable to understand customs. The informants did express a strong commitment to adjust to their host society and were receptive to support from others. Informants reported somatic problems such as headaches, anxiety and tension. Informants emphasised the emotional and social aspects of integrating themselves into the society: physical changes such as different climates or new foods were given little attention.

Refugees also suffer an inordinate amount of loss (Kemp, 1993;Coker, 2001). Loss relates to the past as lifestyles change in order to survive in a new culture, leading Kemp to ask "*What value is the village elder in urban Paris, London, or New York?*" (p22). Loss also relates to the present as role, status and employment patterns change and children begin to adopt values of the host community, compounded by the effects of loss of cultural reference points (Lamour, 1994; Coker, 2001). Further, loss relates to the future as everything is uncertain (Kemp, 1993).

Research relating to the health of refugees and asylum seekers is limited. There is little clear evidence that refugees and asylum seekers experience health inequalities in relation to host societies, but their civic stratification and ethnicity place them at risk.

Kemp (1993), writing from experience in the United States of America (USA), claims that the health of refugees and asylum seekers is generally compromised on arrival in a host country, though it is not necessarily a priority; claiming asylum, food and housing are more likely to take precedence (Clinton-Davies and Fassil, 1992; Kemp, 1993; Deane, 1997; Haringey Council, 1997; Woodhead, 2000; Hargreaves, Holmes and Friedland, 2001). Frequently encountered problems include untreated communicable diseases, chronic conditions exacerbated by lack of health care, and nutritional problems resulting from the disruption of food supplies (Kemp, 1993; Coker, 2001). Typically refugees and asylum seekers migrate to countries where residents have little exposure to communicable diseases such as malaria and tuberculosis, and medical professionals may not suspect such diseases (Weekers and Siem, 1997). Migrating communities are also exposed to new diseases (Dick, 1984). There is also the problem of psycho-social distress resulting from torture to the refugees and asylum seekers themselves, or to their relatives, or from the experience of flight (Kemp, 1993; Coker, 2001). Access to health care is often a problem as a result of lack of knowledge concerning how to access care, and communication problems if access is achieved (Coker, 2001). This is important, as Woodhead (2000) argues that while most asylum seekers arrive well and in apparent good health, an important minority arrive in considerable distress. Woodhead (2000) argues that asylum seekers may arrive with physical disabilities as a result of torture or conflict, but often experience continuous minor health problems as a result of debilitation, e.g. coughs and colds. Obviously, asylum seekers can develop more serious complaints, which may manifest after they have been in a country of asylum for some time, as they may delay presenting their symptoms to a doctor while they are giving priority to other areas of their lives.

In France, Lamour (1994) acknowledges that refugees and asylum seekers frequently require health care, often as a consequence of the various stages of the 'refugee experience', including a poor welcome in France, all of which can aggravate the anxiety caused by oppression in their countries of origin.

Women are vulnerable at all stages of the refugee experience, particularly from physical abuse and rape (Forbes Martin, 1992; Muecke, 1992a; Callamard, 1999; Coker, 2001). They will be faced with new family relationships in their host country as family members may be lost and parent/child relationships change as children often become translators (Forbes Martin, 1992). Traditional family patterns are disrupted and intergenerational problems can arise.

Refugee children face threats to their development and survival (Ahearn, Loughry and Ager, 1999). They may suffer physical health problems in a similar way as adults, but separation from family is particularly traumatic. Schooling may be disrupted. Some children act out their distress and there are reports of school children hiding under tables when aircraft fly overhead (Marchant, 1994). Refugee children's drawings often convey stories of trauma and pain. Ahearn, Loughry and Ager (1999) argue that refugee children's social and emotional adjustment is greatly influenced by events occurring pre-flight, during flight and post-flight. However, they also stress that most refugee children adapt to their host countries and have productive and satisfying lives.

Physical health

There are reports describing a range of specific diseases that may affect refugees and asylum seekers. For example, Dick (1984) describes how refugees and asylum seekers are vulnerable to a variety of physical diseases during the successive phases attached to the 'refugee experience'. This is due to factors including the conditions in the country of origin, during flight and in the host country, and also due to the vulnerability of the refugees and asylum seekers and their ability to adapt to changing circumstances. Communicable diseases have been reported to be among problems experienced by refugees and asylum seekers; these diseases are in part determined by the country of origin and the situation from which refugees and asylum seekers have fled but may include tuberculosis, malaria, hepatitis, HIV/AIDS (Gellert, 1993; Taylor and Gair, 1999).

Debates have taken place about health screening for refugees and asylum seekers on arrival in UK, particularly for tuberculosis, amid concerns whether the perceived benefit is for the protection of the general public or for the health of the refugees and asylum seekers (Burnett and Peel, 2001a). Screening can be stigmatising, but, if conducted properly, of benefit to recipients in that disease can be detected, and thus treated, earlier rather than later.

The first systematic national study in relation to refugees, by the Home Office in Britain (Carey-Wood, et al, 1995), involved people who had been granted refugee status or exceptional leave to remain and investigated how they had fared over the last decade in terms of settling into the community. Ten per cent of Carey-Wood et al's (1995) informants said that they had "*some sort of disability sufficient to affect their daily life*" (p77). A study carried out in London (Aldous, Bardsley, Daniell et al, 1999) found that many of the health problems of refugees are not necessarily specific to the refugee experience, but overlap with the health problems of deprived or other excluded groups in the host country. As such, it does not appear to be helpful to construct a list of 'disorders' suffered by refugees and experiences. It is important to note, though, that health problems that are specific to, and characteristic of, refugees and asylum seekers include the physical after-effects of war, torture, displacement and their journey to a host country (Aldous et al, 1999). Carey-Wood et al's study also found that physical and mental health may be one of the most significant factors affecting settlement; sixteen per cent of respondents reported physical health problems sufficient to affect their daily lives.

Mental health

It is known that people who have been forced to migrate are at greater risk of mental health problems than those who migrate voluntarily (Harrell-Bond, 2000). Beiser (1991), writing from experience of working with refugees in Canada, describes the stresses of displacement and resettlement as including intolerable memories, culture shock, social isolation and an inhospitable host society, defining a stressful situation as "..... *one that challenges habitual patterns of coping*" (p430). Some refugees and asylum seekers suffer considerable distress (Aldous et al, 1999; Woodhead, 2000), including witnessing people being killed (Kalipeni and Oppong, 1998). The mental health of refugees can derive from conditions at home, refugee camps, relationship breakdowns, as well as conditions in the country of asylum (Gliber, 1997).

Peel (1996) comments on asylum seekers, seen at the Medical Foundation for the Care of Victims of Torture, who had experienced ill treatment in Zaire, some having being imprisoned. All of these asylum seekers had been beaten and many had suffered sexual abuse. Many were suffering from severe major psychological effects, and Peel warns that such experiences may be unimaginable to the ordinary Briton. In the study of settled refugees (Carey-Wood et al, 1995), two-thirds of respondents said that they had experienced anxiety or depression, attributed mostly to problems in their home countries.

There is no doubt that refugees and asylum seekers are susceptible to psychological problems (Ahearn, 2000a), and the range and extent of trauma experiences varies among refugees and asylum seekers (Momartin, Silove, Manicavasagar et al, 2003). However, there is a debate concerning the diagnosis, and extent, of clinical mental illness in refugees and asylum seekers. From research conducted after the Second World War, it has been accepted that those who have been forcibly uprooted are at greater risk of mental ill-health than those who voluntarily migrate (Harrell-Bond, 2000). Shackman (1995) describes exile as a kind of bereavement; as such, various psychological reactions can be expected. Summerfield (1994) warns of the dangers of employing a Western discourse to address mental health issues of refugees and asylum seekers, as doing so can result in mental illness becoming a self-fulfilling prophecy and of incapacitating refugees.

> *"What constitutes psychological knowledge is the product of a particular culture at a particular point in time and there is more than one true description of the world".*
> (Summerfield, 1999a, p1455)

Of particular concern is the concept, and possible diagnosis, of Post Traumatic Stress Disorder (PTSD) which was recognised as a distinct psychiatric category in 1980 following the war in Vietnam (Summerfield, 1999a; Watters, 2001).

Some refugees and asylum seekers will have been exposed to traumatic experiences beyond the imagination of the average west European, and it is important not to mistake natural distress for mental pathology (Summerfield, 1994; Burnett and Peel, 2001b). Summerfield (1999) acknowledges the misery engendered by war and the potential long term effects but claims that there is a lack of evidence to demonstrate increased rates of psychiatric morbidity among refugees and asylum seekers. Equally he claims that there is a lack of evidence that talk therapies are preventive, particularly as many non-Western cultures have little place for the revelation of intimate material outside a close family circle. Indeed, Summerfield (1999a) claims that when most refugees are asked what would help their situation they are much more likely to point to social and economic factors than psychological help. On the other hand, Thompson (2001), writing in Britain, estimates that refugees experience up to five times more incidence of mental illness than the general population and yet they are not well served by statutory services. This is partly due a lack of familiarity with counselling but also due to a reluctance to report their mental distress. Many refugees and asylum seekers come from societies that stigmatise mental illness. A study in Cardiff (Ruddy, 1992) concerning Somali refugees and asylum seekers, found significant mental distress and disease but the sufferers were not seeking help as mental illness is believed to bring shame on the family. However, Thompson (2001) also asserts that it is important that professionals do not rush to label those with severe distress as having a clinically defined mental illness.

Muecke (1992a) and Watters (2001) point to the danger of locating the problem within the individual and negating the psychological impact of specific policies directed towards refugees. Asylum seekers awaiting decisions on their applications for asylum remain under particular stress (Jones and Gill, 1998a). For example, Silove, Sinnerbrink, Field et al (1997) report on interviews with 40 asylum seekers attending a community resource centre in Sydney, Australia; the authors argue that post-migration stresses, such as waiting for a decision on their application for asylum and lack of work permits, may interact with and possibly exacerbate their existing problems. In a similar vein, Gorst-Unsworth and Goldenberg (1998) interviewed 84 Iraqi refugees in Britain and found that social factors in exile, particularly the level of social support, proved important in determining the severity of both PTSD and depressive reactions. They concluded that poor social support is a stronger predictor of depressive illness than trauma factors. Also, Lavik, Hauff, Skrondal et al (1996) interviewed 231 refugees and asylum seekers in Oslo, Norway, and commented on the destructive effects of being without employment or having educational possibilities in exile. It would appear, then, that some of the most important factors in producing psychological morbidity in refugees may be alleviated by planned, integrated rehabilitation programmes and attention to social support and family reunion (Gorst-Unsworth and Goldenberg, 1998). This is particularly important as there may be a time lag between migration and the appearance of mental health problems (Beiser, 1991; Sales, 2002a; 2002b).

Beiser (1991) suggests that experiences in a country of permanent asylum probably have a greater effect on the mental health of refugees and asylum seekers during the first year of resettlement than what happened to them before, with the obvious exception of torture or exposure to war. Two of the most powerful post-migration stressors are unemployment and separation from family.

Beiser (1991) concludes that migration is a risk factor for developing mental health problems but mental ill-health is not inevitable. Despite traumatic experiences and difficulties related to resettling in a strange culture, most refugees are resilient and both adapt and contribute to their new society (Beiser, 1991). Refugees and asylum seekers are able to surmount many obstacles and overcome much adversity when fleeing their home countries and arriving in countries of asylum and it would be inappropriate to view them as helpless survivors (Karmi, 1998). Ager (1999) urges an appreciation of the considerable resources that refugees and asylum seekers demonstrate in responding to the challenges of forced migration.

Access to health services

While refugees and asylum seekers are entitled to use the National Health Service in Britain, many have experienced difficulties accessing services (Jobbins, 1997; Jones and Gill, 1998a). Carey-Wood et al (1995) report high levels of registration with GPs, but respondents in this study were settled refugees, or had Exceptional Leave to Remain, and, even so, only 40% of respondents who said they had a medical or psychological problem actually sought help from their GP. However, there are reports of problems achieving this registration (Aldous et al, 1999), of language difficulties and also lack of information about the NHS (Aldous et al, 1999). In France there are reports of undocumented asylum seekers, or those whose applications have been rejected, being unable to access health care due to lack of the relevant papers.

Health screening on entry to the UK is inconsistent and controversial. There is no mandatory initial health assessment for refugees and asylum seekers, who are often registered with GPs on a temporary basis. This confers no financial incentive to undertake an initial health assessment or to offer preventive measures like immunizations and cervical smear tests (Jones and Gill, 1998a). In contrast, when GPs offer permanent registration to new patients, an initial health assessment is conducted. In future, health assessments will take place in the proposed induction centres for refugees and asylum seekers in Britain; the results of these assessments will be documented in hand held records.

Karmi (1998) argues that doctors in Britain are not formally trained in the health care of migrants and refugees, know little about the legal status or rights of refugees and many do not realise that they are entitled to NHS services. Information on refugee health is haphazard and there is a tendency to focus on psychological aspects.

In summary, refugees and asylum seekers form a fairly young population (Aldous et al, 1999; Mizrahi and Mizrahi, 2000). Evidence suggests that most refugees and asylum seekers arrive in Britain in reasonably good health (Aldous et al, 1999; Woodhead, 2000), but there is a suggestion that health may deteriorate over the ensuing years. While some studies identify a lack of serious health problems on or soon after arrival in the UK, Carey-Wood et al's (1995) study did identify significant health problems after 10 years of settlement. However, a significant number of refugees and asylum seekers do exhibit particular problems that arise as a result of physical trauma, psychological trauma and communicable diseases.

Various small studies, located in 'grey' literature, have been carried out in local areas, usually to explore the health and health needs of particular refugee groups. These studies usually employ non-probability convenience samples and thus findings are not generalisable to wider populations. However, there were some common themes emerging from these studies:

- Communication emerged as a major problem in many studies (Gammell, Ndahiro, Nicholas et al, 1993; Brent and Harrow, 1995; Carey-Wood et al, 1995; Haringey Council, 1997);
- Employment is also a key issue in relation to resettlement (Gammell et al, 1993; Brent and Harrow, 1995; Carey-Wood et al, 1995 Haringey Council, 1997);
- Accommodation also featured in many studies (Brent and Harrow, 1995; Haringey Council, 1997).

The findings from these studies will be discussed further in Chapters 5, 6 and 7 in relation to the findings of this study. Most of the projects combined both qualitative and quantitative approaches utilising focus groups, individual interviews and questionnaires. This 'grey literature' tends to recognize the different statuses of refugee and asylum seeker but does not clearly differentiate between the two, and does not draw conclusions about the effects of the different statuses on health.

It is apparent that there are different assertions concerning the health of refugees and asylum seekers, but there are some commonalities. So far, studies have not reported differences between the health of refugees and asylum seekers or considered the consequences of civic stratification.

Health-related quality of life

Changing definitions of health have been accompanied by a cultural shift from a preoccupation with illness to health, replacing negative definitions with positive ones (Bury, 1997). In view of the complexities involved in attempts to define health, and the earlier discussion concerning the problems attached to attempting to measure health, the attention of health professionals, epidemiologists and social scientists has turned to the concept of 'health-related quality of life'. Seedhouse (1986, 2001) argues that a person's way of life can influence her/his chances of becoming diseased and ill. It is only one or two steps further to say that a person's health is intimately linked with her/his quality of life (Spitzer, 1995; Seedhouse, 2001); indeed, Lerner and Levine (1994) claim that the term health-related quality of life is often used interchangeably with health status, while Bowling (1997a) claims that they are two distinct conceptual terms and that health status is one domain of health-related quality of life. The World Health Organization (1998) claims that health is a precondition for quality of life. While instruments measuring health status have traditionally focused on areas such as biochemical data and the ability to carry out activities of daily living, quality of life in relation to health is a broader concept than personal health status and also takes social well-being into account (Bowling, 1997a).

Quality of life

Quality of life has been used as a concept in instruments devised to measure the outcomes of health care interventions for some time. The measurement of quality of life was introduced into studies of health and illness due to a perceived need to measure subjective areas of life, as biological and physical measures were believed to be unsuitable for measuring all the effects of medical treatment (Levine, 1987; Fallowfield, 1990; Patrick and Erickson, 1993; Lerner and Levine, 1994; Brenner, 1995; Levine, 1995; Albrecht and Devlieger, 1999). This situation arose particularly as a result of the increase in the numbers of people suffering from chronic diseases, accompanied by the proliferation of life-prolonging technology and the increasing costs of health care. As a holistic concept, quality of life goes beyond activities of daily living and disease categories because it directs attention to the more complete social, psychological and spiritual being (Rosenberg, 1995).

Several meanings have been imputed to the term quality of life, ranging from individual fulfilment to the ability to lead a 'normal' life, to the satisfaction of human needs. Quality of life is also dependent upon the individual's subjective perception of various factors including his/her achievement, social and community interaction, and life satisfaction (Bowling, 1996). Yet, despite much interest in the concept of quality of life from many disciplines, including medicine, psychology and sociology, there is no agreement on a single definition of the concept (Bowling and Brazier, 1995). Skevington (2002) goes as far as suggesting that there is a definition for every study. Albrecht (1996) states that health-related quality of life is not a well defined concept though acknowledges that while experts disagree on its definition, they generally concur on the components which ought to be included, i.e. physical condition, functional ability, psychological factors, sense of self-worth and intellectual functioning, social variables like social role performance and support networks. Thus, such definitions reflect positive and holistic views of health.

Levine (1995) reports confusion surrounding the relationship between health-related quality of life and the broader topic of quality of life and the components of measurement instruments. Bowling (1995b) and Albrecht and Devlieger (1999) draw a distinction between the two concepts, the latter authors stating that quality of life is broader than the notion of health-related quality of life, which is attracting a rapidly expanding literature (Bowling and Brazier, 1995; Rosenberg, 1995).

Albrecht (1996) concludes that there is an apparent lack of theory underpinning the concept of health-related quality of life but emerging theory perceives the individual as a biological, emotional, spiritual and social actor, and may provide a holistic framework within which to understand health.

Health-related quality of life

This is my preferred definition of 'health related quality life', as it acknowledges the role of the wider social environment, and also health policy, which can have an impact on health, but particularly on the health of refugees and asylum seekers.

> *"...... the value ascribed to a person's life, by the individual or society ,as a result of her own health, and influences such as personal behaviour, medical care, health policy, or larger social forces ".*
> (Lerner and Levine, 1994, p45)

Perspectives on health-related quality of life are based on the premise that health is socially valued (Lerner and Levine, 1994). Levine (1995) acknowledges that, as well as physical factors, 'health-related quality of life' is also dependent on social factors such as social supports and social integration and, like Wilkinson (1992, 1996), draws attention to the inequalities in health that exist between those at the top of the socio-economic hierarchy and those at the bottom, pointing out that this is not a matter of polarisation between these two extremes, but one of a step-wise gradient with differences in health experience between people at each stage in this hierarchy. Levine (1995) thus argues that there is a need to learn more about the mechanism by which structural and cultural factors in society may influence people's health-related quality of life, stressing that insufficient attention has been paid to role performance, which he views as an important determinant of health. It follows that it is appropriate to study the health-related quality of life of refugees and asylum seekers, a group of people whose social-role functioning will have changed as a result of their decision to seek asylum in another country. Also their social context is one of insecurity and is determined by structural factors in society.

Writing in 1994, Lerner and Levine suggested that there are large gaps in the understanding of social influences on health-related quality of life and it would be unlikely to be able to determine universal indicators of health-related quality of life that would be suitable for all people. They thus recommend research to determine whether the content of measurement tools is useful for different socio-economic groups and for assessing the impact of a wide range of potentially important social variables. There is also increasing recognition that the evaluation of health-related quality of life is dependent on the individual who experiences it (Bowling, 1997a).

Conclusion

This literature review has identified that refugees and asylum seekers are a vulnerable group of people as a result of their varied 'refugee experience'. On arrival in Britain or France refugees and asylum seekers will find themselves in countries that are characterised by health inequalities in relation to social class and ethnicity. Their location in the social class structure and their ethnicity will have an impact on their health. Health may be further compromised during the time spent en route to Britain or France, placing refugees and asylum seekers in 'triple jeopardy'. As well as the health problems that refugees and asylum seekers might share with people in the host countries there are specific problems that attach to their status. Available evidence shows that many refugees and asylum seekers experience problems with communicating in their host countries due to being unable to adequately speak the language of the host country. This obviously poses problems with access to any service but importantly in relation to health care. Health is not usually an immediate concern for refugees and asylum seekers; securing accommodation and employment often take priority. Hence, health problems may be unnecessarily exacerbated by the time they are presented to health professionals. A variety of health problems may be presented and there is likely to be some degree of distress. The acknowledgement of problems with mental health may come later. Existing literature describes health problems of diverse groups of refugees and asylum seekers, but does not differentiate between refugees and asylum seekers as two separate groups.

This thesis explores the health of these two different groups of people at a time when the rights attached to the two different statuses are becoming increasingly divergent. Refugees and asylum seekers have been interviewed in Britain and France, two countries with different approaches to the integration or assimilation of migrants into their respective societies. As a consequence of the identified problems with attempting to measure 'health', the concept of 'health-related quality of life' is explored in this thesis. This concept has been chosen because it encompasses factors that lie beyond the individual's health status to include structural factors in the host society. Health-related quality of life is a subjective phenomenon and thus lends itself to qualitative research.

CHAPTER FOUR

METHODOLOGY

Introduction

Health-related quality of life is the key concept being explored and thus this study aims to understand health and illness in the context of people's daily lives. A methodology is required which permits the expression of their experiences in the informants' own words. This chapter makes a claim for the use of qualitative research in order to explore health-related quality of life and further justifies the use of qualitative research with refugees and asylum seekers. The previous chapter has introduced this concept, which has traditionally been investigated through the medium of quantitative research. Yet, Saxena, Carlson, Billington and Orley (2001) claim that the concept requires subjective measurement. A critical appraisal of approaches to the investigation of health-related quality of life precedes the justification of the choice of qualitative research for this study; the methodology used is informed by phenomenology. Phenomenology may be used to refer to a philosophical stance or to the research method (Morse, 1991a; Morse and Field, 1995). The philosophical stance of phenomenology has informed the thinking behind this study, particularly in relation to the conceptualisation of citizenship as a sense of belonging to a society, and thus a subjective experience, and to health-related quality of life as a subjective experience. The research method has been informed by phenomenology in that informants' health related experiences are explored through in-depth interviews and data analysis seeks to interpret the informants' responses. Procedures relating to sampling, data collection and data analysis are addressed. Ethical issues that needed to be considered are acknowledged, particularly those that are specific to refugees and asylum seekers. Critical reflection on the role of the researcher in the study is included.

The initial plan for this study was to use the instrument devised by the World Health Organization (WHO) (WHOQOL Group, 1993; 1995) in order to investigate the health-related quality of life of refugees and asylum seekers from the DRC. It was felt that there were benefits attached to using an instrument that was already well, but not completely, developed. The instrument was still in the testing stage and there were plans to develop specific instruments for use with special groups, including refugees and asylum seekers. This would, of course, have required a quantitative approach to the study. Researchers at the WHO were extremely helpful and encouraging concerning my potential use of the instrument, but it was apparent that the work required was beyond the scope of a lone researcher working towards a PhD. For instance, it would have been necessary to pilot any new version of the instrument with a sample of 300 people: it is doubtful that it would have been possible to contact 300 Congolese refugees and asylum seekers in the London area. Further reading also revealed that the use of quantitative research might not be the most appropriate way to investigate such a subjective concept, especially in relation to refugees and asylum seekers.

Measuring health-related quality of life

Despite the popularity of research into health-related quality of life, problems and tensions exist concerning its measurement. The concept is complex and dynamic in nature and people may change the standards by which they assess their health-related quality of life (Levine, 1995; Allison, Locker and Feine, 1997). Such acknowledgement renders instruments problematic when measuring health-related quality of life over time, for example, during progress of a disease or course of treatment. However, in this study health-related quality of life is being investigated at one particular point in time, and within a particular socio-political context, in order to determine the attributes of the concept from the point of view of Congolese refugees and asylum seekers.

Early instruments for measuring health-related quality of life reflect negative definitions of health; instruments have traditionally been reserved for the assessment of response to treatment. While Spitzer (1995) reserves the measurement of quality of life for those who are sick and measurement of health status for healthy people, there is now scope for the measurement of health-related quality of life in healthy populations (Patrick and Erickson, 1993; Lerner and Levine, 1994; Bullinger, 1995; Ebrahim, 1995; Bowling, 1995, 1995a, 2002; Albrecht, 1996; Bury, 1997). This situation has arisen as a result of increased attention being paid to population health following a revival of interest in public health, and the consequent focus on promoting health and preventing disease. Patrick and Erickson (1993) argue, though, that well populations require an assessment strategy and measures different from populations with significant symptoms and disability. Existing measures deal with phenomena such as role performance, mood states, inner experiences during periods of illness and changes in such states, overall psychological status and happiness or life satisfaction; these are phenomena which are usually understood and described in qualitative terms but are used in quantitative instruments (Brenner, 1995). Stenner, Cooper and Skevington (2003, p2161) describe health-related quality of life as a "*largely subjective construct of increasing importance in health discourse and practice*". An increasing recognition of the subjective nature of health-related quality of life has resulted in support for the use of a phenomenological approach to its investigation (Hunt, 1995; Bowling, 1997a; 1997b).

Hunt (1995) further argues that most questionnaires that are now referred to as quality of life measures are heavily reliant on old measures of general health status, and points out that quality of life is dependent on cultural norms, indigenous patterns of behaviour and expectations, so caution needs to be exercised when attempting to use such instruments in different cultures. The WHO claim to have addressed this in the WHOQOL (World Health Organisation Quality of Life), and Skevington (2002) acknowledges that concerns relating to aspects of quality of life do differ among cultures, and that quality of life is socially constructed, and as such it is necessary to describe cultural behaviours using the culture's own terms. However, Hunt argues that the attributes of quality of life in the WHOQOL seem to have been decided in advance, rather than being allowed to emerge from qualitative studies. Fox-Rushby and Parker (1995) also support the argument that there is a tendency for instruments to be 'culture full' rather than 'culture free', with the constituent items reflecting the values of the people who constructed the instruments, rather than the respondents. This view is also supported by Bowden and Fox-Rushby (2003) who argue that the WHO used an imposed concept of health in their instrument. Hunt claims, therefore, that an ideal study of quality of life would need to begin with local phenomenological descriptions, asking informants directly what is important for their health-related quality of life. Lerner and Levine (1994) also argue that research is needed in order to determine whether the content of currently accepted instruments for measuring health-related quality of life is useful for different sociodemographic groups.

However, problems abound with the concepts of health-related quality of life and culture, particularly in relation to meaning when an instrument is translated from one source language into another. Fox-Rushby and Parker (1995) have examined a range of popular instruments and question this practice. For example, these authors claim that the WHOQOL team assumed that informants understood the notion of quality of life. Hunt (1995) claims that quality of life is a cultural category constructed largely by social scientists in the United States of America (USA) and thus cannot be assumed to have universal relevance or meaning. Herdman, Fox-Rushby and Badia (1997) further claim that, in the case of the WHOQOL, an initial assumption was made that certain domains of quality of life would be common to all cultures. Fox-Rushby and Parker (1995) therefore recommend moving away from a concentration on translating existing instruments (based on an assumption of universal understanding of health-related quality of life), towards a process of recognition of cultural beliefs and behaviours of the populations being studied. Rapley (2003) notes the danger of not consulting with people when researching concepts like health-related quality of life, arguing that if research is to be of use, it must be conducted with those directly affected. He further stresses the necessity of explicit links between the way health-related quality of life is theorized and methods chosen to study it. In this study, my assumption is that there is something specific about the experiences of refugees and asylum seekers that is different from the experience of other people and that this affects their health. While refugees and asylum seekers share experiences with others, i.e. lower social class and ethnicity, it is the 'refugee experience' that is different. This experience is directly known only to refugees and asylum seekers and, like health-related quality of life, is subjective. Therefore in this study the most appropriate way to approach the investigation is through the qualitative research, informed by phenomenology.

In further support of this approach, referring to research with refugees and asylum seekers, Muecke (1992b) describes how the research designs are primarily inductive because the problems studied are ones about which too little is known. It follows that ethnography and phenomenology feature prominently in research carried out with refugee groups. Themes identified from the data derived from qualitative research can then be used to inform questionnaires in order that tentative theories arising from qualitative research can be 'tested' in large scale quantitative studies. Crucially, the questions posed in such questionnaires would be derived from the responses of refugees and asylum seekers and so would be relevant to them.

Qualitative investigation of 'health-related quality of life'

Qualitative research is appropriate for research for which relevant variables have yet to be identified (Marshall and Rossman, 1999) which is the case in this study, which aims to identify factors that affect the health-related quality of life of Congolese refugees and asylum seekers. Qualitative research is used in this study as this approach allows the researcher to understand naturally occurring phenomena in their naturally occurring states (Hammersley and Atkinson, 1995; Denzin and Lincoln, 1998a; Patton, 2002). The aim is to describe the world as seen by the informants, adopting an holistic approach by attempting to understand a person's social environment (Denzin and Lincoln, 1998a; Pope and Mays, 2000) and how that social world is interpreted, understood and experienced (Mason, 1996), as human actions are based upon social meanings (Hammersley and Atkinson, 1995). Qualitative research produces data that are a source of rich descriptions and explanations of processes in identifiable local contexts (Miles and Huberman, 1994) and as such may not be generalized to other contexts. Qualitative interviews may be used to explore the beliefs of individuals or sub-cultures and can explore areas of broad cultural consensus and people's more personal, private and special understandings (Arksey and Knight, 1999).

Critics of qualitative research have argued that the approach is too subjective (Hammersley and Atkinson, 1995), sometimes charging qualitative researchers with 'anecdotalism' and a lack of reliability (Silverman, 2000). However, supporters of qualitative research acknowledge the effect the presence of the researcher may have on the research and recognise that complete objectivity is impossible (Mason, 1996). Patton (2002) suggests that qualitative researchers may aim for "empathic neutrality", adopting a neutral and non-judgemental stance to whatever may emerge from the study. Patton claims that 'empathy' refers to understanding the position, feelings, experience and worldview of others, and is a stance adopted towards informants. 'Neutrality' is a stance adopted towards the findings. As such, researchers remain responsive to the emerging findings and open to adapting the inquiry as understanding deepens or situations change (Patton, 2002). Thus the researcher should be aware of her/his prior assumptions concerning the research. Approaching fieldwork without being constrained by predetermined categories for analysis contributes to the depth and detail of qualitative inquiry (Patton, 2002). Any theory that emerges from the research can then be grounded in experience. The approach used in this study is informed by phenomenology.

Patton (2002) claims that the term phenomenology has become so widely used that its meaning has become confused. However, he states that phenomenological inquiry focuses on the question:

> *"What is the structure and essence of experience of this phenomenon for these people?"* (p69).

Phenomenology is a philosophical tradition introduced by the German philosopher Husserl (1859-1938) and adopts an interpretive approach to an individual's own reflection on everyday life. Husserl's phenomenology is a product of his opposition to the view that philosophy could be reduced to a factual science (Husserl, 1964). He claims that phenomenology proceeds by "seeing", clarifying and determining meaning; the analysis of essence is obtained by holding all natural prejudices at arms' length. Husserl's work has been controversial but has been influential on philosophical movements (Nakhnikian, 1964) and its popularity has been promoted by Schutz's (1899-1959) work, which has been an important influence in establishing phenomenology as a major social science perspective (Anderson, 1991; Patton, 2002). The focus of phenomenology is how people make sense of their experiences and, in so doing, develop a worldview which entails both individual interpretation and shared meaning (Anderson, 1991; Patton, 1990). This being the case it is appropriate to use both individual and group interviews. The experiences of different people are analysed and compared to identify the basic essences of the phenomena being studied. Phenomenological philosophy aims to understand consciousness, but most researchers accept that this is impossible because they "*cannot get inside their subjects' heads in order to perceive the world as they perceive it*" (Donovan, 1986, p72). In effect, the researcher 'borrows' the experiences from the informants.

Schutz (1972) thought that the aim of social sciences should be to interpret the subjective meaning of social action and achieved this in a seminal essay, 'The Stranger' (Schutz, 1964). In this essay Schutz analysed the problems of orientation and adaptation which are faced by someone who has been raised in one cultural community and is transferred to another. Schutz defines a 'stranger' as:

> *"... an adult individual of our times and civilization who tries to be permanently accepted or at least tolerated by the group which he approaches."*
> (Schutz, 1964, p91)

Through using an immigrant as an example of a 'stranger', Schutz describes how, unable to share the culture of the host society, the stranger questions nearly everything that the host society takes for granted. As such, Schutz shows how phenomenological principles can allow us to 'view' the experiences of refugees and asylum seekers.

Reflexivity/ the researcher as instrument

Silverman (2000) refers to Max Weber's (1946) claim that all research is contaminated to some extent by the values of the researcher. It is through these values that problems are identified and studied in certain ways. In qualitative research, the researcher is the instrument of data collection (Marshall and Rossman, 1999; Patton, 2002) and as such qualitative research should involve critical self-scrutiny by the researcher, or active reflexivity (Mason, 1996; Patton, 2002). This entails sensitivity towards the situations in which the research takes place and recognition that the researcher cannot be neutral, objective or detached, and they should seek to understand their role in the research process, as well as the political or cultural perspective that they bring to the interviews (Hammersley and Atkinson, 1995; Mason, 1996; Patton, 2002). Patton (2002) borrows Husserl's term 'bracketing' to refer to the need for the researcher to set aside his/her own presuppositions in order to identify the data in its pure form. The researcher selects segments from the data in order to support categories/themes presented as deriving from the fieldwork, and to effect an 'audit trail'. However, as well as relating to the evidence presented, the research is also assessed in terms of its credibility and the way in which the research was conducted (Boulton and Hammersley, 1996). It is possible that the presence of the researcher may have influenced the way in which informants replied to questions, and there is always the possibility that either the researcher or informant, or both, could select evidence to support their beliefs, neglecting other important, but possibly less desirable, information (Lee, 1993; Boulton and Hammersley, 1996). Hammersley and Atkinson (1995) thus propose that the researcher should become a reflective practitioner, continually thinking about the process of research and about her or his role in it, the effects this may have on the fieldwork and ultimately the implications for data analysis. The process of data collection and analysis should, therefore, be made sufficiently explicit for a reader to make an assessment of the credibility of the findings (Boulton and Hammersley, 1996). Qualitative inquiry requires the researcher, as instrument, to report potential sources of bias and error (Patton, 2002).

When sensitive topics are being researched, the relationship between the researcher and informants may be affected by mistrust (Lee, 1993). Informants may be asked to reveal a great deal about themselves, perhaps at an emotional cost (Lee, 1993). I was mindful of this possibility during the interviews I conducted, as talking about their experiences as refugees and asylum seekers could evoke painful and distressing memories in my informants, and I was constantly grateful for my close contacts with the respective community leaders who would have been able to assist should any of the informants have needed support, or even referral to a specialist counsellor. It was also necessary to be constantly aware of balancing my need for information with the needs for security of the informants. It was desirable for me to elicit the immigration status of my informants, in order to draw conclusions about the influence civic stratification may have on their health. I was therefore aware that posing such questions might cause concern to some of my informants and might further reduce any trust they had in me. This was most evident when interviewing two informants (individually) who had been refused refugee status and therefore did not have a legal status in France (*sans papiers*). Interviews with these two informants did not, of necessity, engage in the same depth as some of the interviews with informants who felt more secure, as the undocumented informants were clearly afraid of being identified by anyone in authority, a situation that could possibly result in their deportation. For these reasons I felt that to audio-tape the interviews may have been threatening and I made notes instead.

Population

The populations being studied are Congolese refugees and asylum seekers in Britain and France. These groups were chosen because they were located in the two countries of interest, Britain and France. They also shared some experiences of being forced to flee from the DRC, though the informants fled from different regimes and thus may have had different ethnic affiliations. The two groups of informants were not recruited through the same contact, so there was no evidence that they actually knew each other. However, each respective group, in Britain or France, was keen to hear 'stories' or 'news' about the other group, telling me that "*we are the same people*". I was comfortable to talk about the general situation for refugees in either country, but was careful not reveal any identities in either country, in case members of the two groups supported different political regimes, and thus may be in opposition. I believed this to be a necessary caution, as all the informants in Britain had fled the Mobutu regime, while many of the informants in France had left the DRC at a later date, fleeing the Kabila regime. However, there were among the group of informants in France, a few informants who had fled former President Mobutu and as all informants were members of the community organization, it was apparent that there was no hostility or suspicion between supporters of different regimes. The two groups also may have shared some aspects of culture, though it is important to be aware that culture is not static or uniformly distributed within any group. Individuals' cultural repertoires are shaped by their social experiences, for example by class and gender, but are also adapted by everyday interactions and contexts (Eastmond, 2000).

Sampling

The phenomenological tradition seeks to understand the experiences of individuals within their 'life-world' (Morse and Field, 1995), and usually involves interviews with people who have 'lived experience' (Patton, 2002), and therefore necessitates purposive samples. When seeking purposive samples, informants are selected because they are 'information rich' (Morse, 1991b; Patton, 2002), and they are likely to have been exposed to the issues being studied. There are no rules for sample size in qualitative inquiry (Patton, 2002), but it usually accepted that there is no longer a need to seek more informants when the data acquired becomes 'saturated', that is, nothing new is being added to the data collected. There will inevitably also be practical constraints to consider when seeking informants. In this study informants were chosen by gate keepers in both countries. This is usual practice as research with refugees and asylum seekers is known to rely heavily on community organisations (Bloch, 2004).

The populations from which the samples were drawn in this study are the Congolese community in Hackney, London and the Congolese community in Paris. In each case, the samples were identified by the leaders of the respective community organisations: in London by the Chairperson of the Hackney Congolese Community Support Group, a relatively newly established organisation at the commencement of this project; and in Paris by the President of 'Le Souffle', a well established and formal organisation for Congolese refugees and asylum seekers. It is acknowledged that the members of the samples are not necessarily representative of the wider Congolese community in both countries and these individuals may have been selected by the leaders for particular reasons. However, it is necessary to make contact with such communities via their respected leaders who act as 'gatekeepers' to the communities, as realistic suspicion is a survival skill for refugee groups and thus a researcher may not be trusted, unless introduced and sanctioned by a respected and trusted member of the community (Muecke, 1992b). Hammersley and Atkinson (1995) argue that such suspicion can dissipate as contact increases, but this is not necessarily always the case.

Graham (1995) has demonstrated that the methods of data collection and data analysis that are used for national surveys and official statistics in Britain result in the exclusion of members of minority ethnic groups, thus affecting the samples of people engaged in research. Exclusion can arise from the criteria that govern entry into official statistics and social surveys. Many of the sampling frames that are used when conducting large scale surveys also exclude members of minority ethnic groups, for example electoral registers and the Postcode Address File, which makes use of private addresses. The difficulties attached to identifying sampling frames are recognized (Chaturvedi and McKeigue, 1994; Graham, 1995; Hughes, Fenton and Hine, 1995; Rehman and Walker, 1995; Bloch, 2004). There were no sampling frames for either group of informants, and the respective communities were not sufficiently concentrated to permit the recruitment of participants from localities, for example through Congolese restaurants, shops or clubs. Furthermore, as well as being excluded from such sampling frames, Graham (1995) stresses that marginalised people may choose to exclude themselves, as they may be doubtful about the use that may be made of such information.

Hughes, Fenton and Hine (1995) argue that simple random sampling should not be a realistic aim of health services research when attempting to contact small hard-to-reach groups and argue that alternative strategies need to be considered, such as, *inter alia,* selection of a geographical area and 'snowball' sampling, making use of existing social networks. Two purposive samples of refugees and asylum seekers were identified by the community leaders in London and Paris. The community leaders did respond to my request for samples that included both female and male refugees and asylum seekers.

The sample

The sample consisted of 24 Congolese men and women for the initial three focus groups in London and then 10 Congolese men and women in London and 14 Congolese men and women in Paris for the individual interviews. These informants were all selected by the respective Community Leaders. Reliance on Community Leaders for the selection of informants may limit the scope of the data collected, as Community Leaders may approach only those informants who might be relied on to tell a particular story. The sample is also limited to only those refugees and asylum seekers who are in touch with the Community Groups, and consequently the most isolated individuals, who might have the most problems, do not get interviewed. Brief biographical details of the informants for this study are to be found at the beginning of the next chapter.

Data collection

When used in relation to qualitative research, Mason (1996) prefers the term 'data generation' to 'data collection', as it indicates the much wider range of relationships between researcher and the social world: the researcher is not a neutral collector of data but instead he/she actively constructs knowledge about the world during the course of data collection and data analysis. Researchers do not enter the field with a completely blank slate and therefore need ideas that will orient their work. Patton (2002) refers to 'sensitizing concepts' which are categories that the researcher brings to the study to provide some initial direction. The researcher then explores how the concept is given meaning in a particular set of circumstances.

Some thought had to be given to the use of terms during data collection. Broadly speaking, health tends to be discussed and debated within the contexts of physical health and mental health. While the term physical health is uncontroversial and widely understood, the concept of mental health is less well defined. A debate continues about the meaning of the term mental health (Stewart-Brown, 1998). Stewart-Brown refers to a study that showed that lay people were more comfortable with the term psychological health because they equated the term mental health with mental illness. Thus, the term psychological health was used in this study and it was acceptable to the informants. Hunt (1995) also suggested that health-related quality of life is a western concept and therefore may not be familiar to non-western cultures. Bearing this in mind, I chose not to use the term in the earlier stages of the interviews, but to pose questions that addressed the potential, and broad, attributes of health-related quality of life that are included in my chosen definition. I subsequently introduced the term 'health-related quality of life' later on in the interviews.

As my main concern with previous research into health-related quality of life was that existing instruments imposed concepts and thus set the agenda for responses, a limited number of open questions were used for the initial focus groups. Three focus groups were held in London, each group comprising eight people, with a mixture of women and men. The informants in London chose to hold the focus groups in their homes. Unfortunately I was not able to hold focus groups in Paris. This was because the informants preferred to be interviewed in the foyer of the hotel in which I was staying and I did not have access to a venue for a group meeting until the end of my stay. On my last day in Paris, the Community Leader arranged a 'get together' at his home with most of the people who had participated in interviews. Presumably, by then a degree of trust had built up between the Congolese community and myself; contact had been established with the Community Leader in Paris via a mutual 'contact' and the only communication I had with this Community Leader, prior to my arrival in Paris, was by phone. In contrast, in

London, I was able to meet with the Community Leader to discuss the research before he arranged the initial focus groups.

Analysis of the data from these focus groups provided topics that were to be explored in greater depth in the individual interviews. An interview guide was produced that listed the issues that were to be explored in the course of the interviews; ten in London and fourteen in Paris. This interview guide was thus determined by the responses from the informants in London. The use of a series of topics to guide the interviews, rather than a list of questions, allowed the informants in Paris some control over the content and direction of the interviews and allowed them to provide data that was, in some cases, contradictory to that acquired in London, and also to introduce issues that I might not have had on my list.

- ***Focus Groups***

Initially, three focus groups were conducted with informants from the Congolese community in Hackney, London. In each of the focus groups all of the participants were known to each other. The purpose of conducting initial focus groups was to explore areas of concern, relating to health-related quality of life. These issues could then be explored further in individual interviews, and ultimately might constitute domains for further study (Carey, 1994).

During these focus group interviews the concept of health-related quality of life was explored, aiming to identify what it meant to the group of people concerned. Broad questions were asked relating to the major health problems among the Congolese community, leading up to the broader concept of health-related quality of life.

Focus group research usually involves conducting one or more group discussions, in which participants focus upon a given topic, and analysing the resulting data using conventional qualitative techniques (Wilkinson, 1998). Research on health-related topics is a major area of focus group research (Wilkinson, 1998), including assessments of quality of life. The discussions were audio-taped, transcribed and analysed. Crucially focus groups are characterised by the interaction of the group participants, as such interaction may reveal not only shared experiences but shared ways of making sense of these experiences (Kitzinger, 1994; Morgan, 1997; Wilkinson, 1998). Focus groups also have the potential to reduce the researcher's power and control over the discussion and, while Krueger (1994) sees this as a limitation, Morgan (1997) and Wilkinson (1998) see it as a benefit for researchers who are primarily interested in participants' own meanings. I was conscious of this potential power difference when conducting the focus groups and I will never know what informants felt unable to divulge. However, the presence of the Community Leader sanctioned the conduct of the focus groups and thus participants would not have had fears that anything they said might be relayed to the Home Office. On the other hand, I was conscious that the presence of the community Leader might also inhibit some expression. Informants voiced much criticism of the health services in Britain, so in that respect, at least, they felt able to express their opinions. Participants also appeared to gain confidence as the discussions progressed.

Focus groups can also 'give voice' to socially marginalised groups (Morgan, 1997); this was demonstrated in this study by the voicing of accounts of perceived poor treatment by health professionals, reference to human rights and also, in one focus group, by laying the blame for many of the problems in the DRC with Western governments . One reason for using focus groups is when insights are needed in exploratory studies (Krueger, 1994; Morgan, 1997), for example, as in this study, prior to individual interviews. The advantages of the group interview include the opportunity to elicit participants' own meanings and understandings of health and illness (Wilkinson, 1998) and the value of the rich data which may emerge. However, the emerging group culture may interfere with individual expression (Fontana and Frey, 1998), and one person may dominate the group.

Groups may be difficult to assemble; people have to take time to come to a designated place at a prescribed time to share their perceptions with others (Krueger, 1994). The environment must be conducive to conversation. However, focus group interviews have been successfully conducted in a variety of locations, such as restaurants, hotel rooms, private homes, and public buildings. Kitzinger and Barbour (1999) acknowledge that researchers often need to be flexible in their use of venues and often have little choice as people are more likely to attend a familiar venue; however, the discussion must be conducted in an environment conducive to conversation (Krueger, 1994). The room should be free from outside distractions. In this study the focus group interviews were held in the homes of the informants and unfortunately it was not possible to control for distractions. For example, the first meeting was held in a room, which overlooked a main road, and as it was a very hot day it was necessary for the window to be open, so there was background traffic noise on the recordings of the interview. At the second interview, although the room was more suitable for the focus group, there were children present who, at times, were closer to the microphone than the individual who was speaking, so some of the recording is affected by the sound of children at play. It would have been inappropriate to ask the informants to move the children to another room, as I was a guest in the house. This is, however, the reality of researching with vulnerable, marginalised groups when the desire is to conduct interviews in natural settings where the informants will feel comfortable. Krueger (1994) comments on the value of having a moderator with similar characteristics as the participants, for example, a respected leader who can sanction the study and ensure that the focus group method is culturally sensitive and acceptable. On the other hand, Kitzinger and Barbour (1999) and Hammersley and Atkinson (1995) warn that such reliance on 'gatekeepers' can present problems relating to recruitment as the 'gatekeeper' may screen potential participants. In this case, the Chairperson of the Hackney Congolese Community Support Group recruited participants to the focus groups and acted as moderator. The benefits of this include the sanctioning of the research taking place and the fact that the Chairperson was able to interpret when necessary, but I am also aware of the potential limitations posed by his presence. One of the limitations of focus groups is the potential for censoring, which occurs when a person withholds potential contributions, or conforming, which occurs when a person elects to tailor his or her contributions to be in line with perceptions of the group members and/or the leader (Carey, 1994).

Three focus groups were held at the homes of the informants; this was their choice of location. The first meeting took place at a house in Hackney inhabited by a group of Congolese refugees and asylum seekers. Eight people were present; three women and five men. However, the women were initially reluctant to talk much, though did become more vocal as the discussion progressed. The people were living in particularly poor housing and the discussion took place in an area that was not free from distractions, as described above. The second meeting took place at a flat in Camden on a Friday evening, following a prayer meeting, prayers being concluded as I arrived. Seven people were present; four men and three women. The Pastor featured prominently in the discussion, yet this time the women were more prepared to talk. For reasons described above, the tape recording of this discussion was of poor quality, as, although I was aware of the noise the children were making, I did not appreciate how close they were to the microphone and the extent to which their chatter would override other discussion on the tape. Thankfully, I had notes to help with the transcription but a lesson was learned. The third focus group took place on a Sunday afternoon at a flat in Clapton. Again, eight people were present; three women and five men. There were no distractions during this focus group.

Krueger (1994) states that often the questions asked in a focus group are deceptively simple and could be answered briefly. However, when such questions are asked in a group environment, probing can result in detailed accounts of the informants' perceptions. I asked follow-up and probing questions whenever I felt it appropriate, but my main aim was to allow the informants to set the agenda for these discussions. The interviews were audio-taped and transcribed. The analysis of the data must be verifiable (Krueger, 1994); this was achieved by participant verification. A 'trail of evidence' (Krueger, 1994) should be evident ranging from the raw data, through descriptive statements to interpretation.

The major themes arising from these interviews were used to inform the questions posed in a series of individual interviews with members of the Congolese communities in both London and Paris.

- ***Individual interviews***

The interview is a conversation in which the interviewer creates the situation in which responses are provided (Denzin and Lincoln, 1998b) and thus shapes the inquiry (Denzin and Lincoln, 1998b). While the subject of the interview has been pre-determined, the interviewer remains free to develop a conversation using an interview guide, which provides the topics to be explored. The questions must be open-ended in order that informants respond in their own words to express their own personal perspectives (Arksey and Knight, 1999).

Early interviews are likely to be more unstructured, with increasing structure developing as analysis of interview data progresses (May, 1991). In this study the focus groups were less structured in order that the informants could contribute their own ideas about issues surrounding health-related quality of life, which could then be explored in greater depth in individual interviews. These subsequent interviews therefore tended to have more structure. While a structured instrument may blind the researcher to a situation, a lack of structure can result in irrelevant information being collected (Miles and Huberman, 1994). Some structure is necessary to allow for comparison. A topic guide was used for the individual interviews. However, not all the same questions were posed to each informant and not in the same order. The aim was to develop a conversation during which individual informants were able to set their own agenda, and often the information I required was offered without having to ask the respective question.

Ten interviews were conducted in London and fourteen in Paris. The interviews consisted of a list of topics (Appendix 1), which formed the basis of questions. These were supplemented by some prompts, which were used if necessary. Demographic questions were asked in order to determine the age, marital status, educational and occupational background of the informant. Also, how long the informant had been in the country and his/her immigration status. Subsequent questions related to the themes that emerged from the focus group data. While most of the interviews were conducted in English or French it was felt that valuable information could be lost if non-English or non-French speakers were excluded. Therefore a member of the Congolese community in London acted as interpreter when interviewing those informants who did not speak either English or French. Lingala is the language spoken by some members of the Congolese community. Working with interpreters when interviewing is generally regarded as fraught with difficulties (Edwards, 1998) and it is necessary to be aware of the effect the interpreter may have on the research, as much as the presence of the researcher. The fact that the interpreter was known to the informants could have the effect of putting them at ease, but equally, as a respected community leader, could also inhibit some of the responses. Patton (2002) describes how interpreters often want to be helpful by summarising and explaining informants' responses, however, Edwards (1998) and Jentsch (1998) both stress that the interpreter is present not just to relay messages. While Jentsch (1998) is concerned that much important information may be lost in interpreters' attempts to summarise responses, Edwards (1998) feels that independent action on the part of an interpreter is not necessarily a problem as he can provide information and give support to the informants, if necessary, and act as a cultural consultant (Jentsch, 1998).

Another important, and related, issue is that of the differences between the researcher and the researched. Kauffman (1994) argues that such differences, for example, ethnicity, age and class, can impede the process of gaining and maintaining the trust of informants and thus affect findings. The presence of a white researcher among black informants may have an impact on the way they respond particularly if the informants have experienced racism. Researchers need, therefore, to observe the rules of etiquette and be non-judgemental in order to gain the trust of the informants. However, the findings from the research could still be compromised if informants feel unable to co-operate, misunderstand the researchers' expectations or distort responses (Kauffman, 1994). Thus, the acknowledgement is made in this study that the presence of an interpreter, as much as the researcher, can influence the informants' responses. The dynamics of interaction in interviews, and the exercise of power within them, are complex three-way processes (Edwards, 1998). It is felt, though, that in a study of this nature, much valuable information could be lost if the research were confined to refugees and asylum seekers who spoke English. In France all the informants spoke French; minimal interpretation was required.

The interviews in this study were audio-taped, with the permission of the informants, and with the exception of interviews that were conducted with undocumented asylum seekers in France. These men were clearly nervous about the situation, but still insisted that they wanted the interviews to go ahead and for their stories to be heard: I felt that taping the interviews would add to their fear and insecurity. Audio-taping interviews allows the interviewer to concentrate on what is being said, while retaining a permanent record of the conversation (Arksey and Knight, 1999). The interviewer takes notes during the interviews, noting key phrases. This proved to be of enormous value, especially when tape recordings were not completely clear. All of the interviews were conducted in places chosen by the informants. In London the interviews took place in the informants' homes. In France the initial interviews took place in the foyer of the hotel in which I was staying. Again, this was the choice of the informants. As a consequence I was not able to see the conditions in which informants were living, as I did with the informants in London. Also, the use of the hotel foyer did mean that on occasions there was background noise, which affected the quality of the tape recording. Generally, the hotel foyer was suitable as it was a small and fairly quiet hotel and there was space in the foyer for me to sit in a corner with informants where they would not be overheard. The last four interviews were conducted on the same day during a social gathering of members of *'Le Souffle'*. The interviews were conducted individually. However, there was also an opportunity to listen to a group discussion during the course of this social event which permitted the sharing of ideas.

Flexibility in topic selection and in questioning is essential to allow the individual informant to tell their own story (May, 1991). However, some consistency is also essential in types of questions asked, depth and detail, in order that conclusions can be drawn. Thus an important challenge in qualitative research interviewing is maintaining enough flexibility to elicit individual stories, which are likely to vary a great deal, while gathering information with enough consistency to allow for comparison between and among subjects. This was indeed a challenge in this study when individual stories were so interesting that it was easy to forget to follow up with questions about background information that may be important in understanding an informant's responses (May, 1991). Some of the informants were only too pleased to talk at length and in depth about their experience and considerable depth was achieved quickly; other informants were more reluctant to divulge information.

Data analysis

Data collection in qualitative research deconstructs and data analysis reconstructs the phenomena being studied (Field and Morse, 1985). Data analysis involves transforming interview interaction into data. Data analysis is inductive, beginning with specific observations and progressing towards general patterns. Once audio-taped, the interviews have to be transcribed. Each transcript is one interpretation of the interview (Arskey and Knight, 1999). Transcription is neither neutral nor value-free as there are invariably guesses about what was said and decisions are made about how to turn speech into written prose (Mason, 1996; Arksey and Knight, 1999).

Data takes the form of narrative text derived from transcribed interviews and the researcher's notes taken during the interviews. Tapes of interviews were transcribed as soon as possible following the interviews. Reading of the transcripts several times was necessary in order to become sensitised to the content of the transcripts and to deconstruct the data. Data analysis in qualitative research assumes the uniqueness of each informant's story (Patton, 2002). Data analysis is driven by the data and developed from phenomena which derive from the data. First level analysis addresses the details of the individual stories; analysis across the cases then reveals themes and interrelationships (for example, in this study, the interrelationship between communication and suspicion). This enables the researcher to recognise recurrent words or phrases within the data and is referred to as coding. I made initial notes in the margins of my transcripts and then attached names (codes) to sentences and phrases and used a series of differently coloured highlighter pens to identify sentences and phrases that were associated with the various themes. Broad themes were derived from the transcripts of the interviews, which were then enhanced by smaller categories. This process leads to creative synthesis (Patton, 2002) or reconstruction (Field and Morse, 1985). This aids the process of concurrent data collection and analysis and helps the researcher to gain insight into the research problem and so facilitates the progress of the research as the researcher may want to add new questions into the interviews as tentative patterns begin to emerge from the data. This is not a linear process as the researcher returns to the interview data and field notes and listens to the interviews again and again. Thus the emergent themes are grounded in specific cases and their contexts, as the researcher works inductively. The researcher attempts to reconcile the meanings the informants provide with the wider socio-political context that shapes the informants' experience. This is achieved by providing description, supported by sufficient direct quotations to allow the reader to understand the thoughts of the informants (Patton, 2002). The next stage is interpretation which involves attaching significance to the data and offering explanations and drawing conclusions, that is connecting individual situations to larger public issues (Patton, 2002). This is in keeping with the principles of induction; moving from specific observations to general patterns.

The findings of this research are presented in Chapters 5, 6, and 7 in the form of themes and sub-themes. Verbatim quotes, or what Seale (2004) terms 'low inference descriptors', are provided to substantiate and illustrate the themes and sub-themes. 'Thick' description of the study allows readers to assess the transferability of the findings to other settings (Seale, 2004).

Ethical considerations

The British Sociological Association's (BSA) Statement of Ethical Practice (1996) provides a set of principles; an attempt has been made to adhere to these in this thesis. Above all there is a responsibility to safeguard the interests of those involved in, or affected by, the research and to report findings accurately and truthfully. In terms of relationships with research participants the researcher has a responsibility to ensure that the physical, social and psychological well-being of the informants is not adversely affected by their participation. There is always the potential for harm during an interview as a result of undue intrusion into private and personal spheres, embarrassment, distress, and a sense of coercion (Arksey and Knight, 1999). This is especially the case with refugees and asylum seekers who may have experienced oppression and torture. Research relationships are sometimes characterised by disparities of power and status (BSA, 1996) and people may feel that they have been treated as objects rather than collaborators (Arksey and Knight, 1999). Working in partnership with research informants should go some was to reduce such feelings.

Muecke (1992a) states that participatory research is necessary to help reduce the power differentials between researchers and refugees that silence the authentic voices of refugees. The fundamental rationale for studying a vulnerable population must be the expected value of the findings for the population (Muecke, 1992a).

Truman (2000) claims that the success of participatory research is best achieved when research participants become the direct users of the research findings, or when participants use the research to influence the thinking and inform the knowledge base of those in powerful positions. For Reason (1994, p198) "*the ideology of co-operative inquiry tends toward that of direct democracy*". Participatory research is premised on a democratic ideal where the concept of participation may usefully be understood with reference to citizenship. As informants give of themselves there is a perceived need for some form of reciprocity (Marshall and Rossman, 1999). In this study I have been able to return the analysed data to informants and, in the case of the Hackney Congolese Community Support Group, this data was used to contribute to their own assessment of the health and social needs of the community, which in turn has formed the basis of a successful application to a charitable organisation for funding for community projects. I have also been able to write references to funding agencies in support of successful claims for funds to progress the work of the Community Support Group. I have, however, been unable to offer practical support to the group in France.

The researcher also needs to be aware of her responsibilities (Silverman, 2000). Mason (1996) argues that the nature of qualitative research can necessitate close engagement with the public and private lives of individuals and that unexpected situations might arise during the course of the research as directions and interests change. Mason (1996) further stresses that when considering ethical issues it is helpful to clarify intentions. This can be achieved by giving consideration to the purpose of the research; in this case it was to work towards a PhD, but also to make some small contribution towards greater understanding of the experiences of refugees and asylum seekers. When deciding on informants it is necessary to consider the implications for these people. It is also important not to make promises that cannot be kept (Patton, 2002). Informants might have high expectations of a researcher and might entertain false hopes that the researcher can achieve more than is within his/her remit. On several occasions, both in Britain and France, I was asked if there was anything I could do to help with individual applications for asylum. This is a reflection of the high premium placed on the acquisition of a secure status by my informants; unfortunately, I had to inform them that it was not an issue I could help with.

Another important ethical issue is consent, and sociological research should be based on the freely given informed consent of those studied (BSA, 1996). Muecke (1992b) claims that the ethics of studying refugees in asylum is problematic because of the difficulties in avoiding coerced participation, in providing consent that is truly informed about the possible risks of participation, and in preventing the formulation of false expectations. People taking part in qualitative interviews, which are more likely to touch on sensitive issues, should be given detailed information about the proposed studies (Arksey and Knight, 1999). Written consent was not requested in this study, as Muecke (1992b) argues that the standard request for signed consent may be distressing as it may cast doubt on assurances about the informant's anonymity. Also, informed consent in qualitative research is not necessarily a one-time event but a continuously negotiated process. Instead, in this study, all informants were given an information leaflet informing them about the research. Informants were made aware of their right to refuse to take part in any interviews, to withdraw from the interviews at any time and also that everything they said would be treated with confidence. Confidentiality is about not disclosing the identity of study participants and not attributing comments to individuals in ways that can permit the individuals to be identified (Arksey and Knight, 1999). In order to protect the identity of my informants 'codes' have been attached to the informants' responses; names have been kept separately. I have not recorded any addresses of individual informants; I only know the official addresses of the respective Community Organizations.

Conclusion

This chapter has described and justified the choice of qualitative research methodology for this study, informed by the philosophical stance of phenomenology on the basis that the concept being investigated, health-related quality of life, is a subjective phenomenon and requires exploration of the informants' individual experiences and the shared meanings they attach to those experiences. The sampling method has been described, together with some critical discussion concerning approaches to sampling with vulnerable groups of people. Some brief information has been provided in relation to the sample. Methods employed for data collection and data analysis have been described. Some reflection of the role of the researcher in this study has taken place.

The following three chapters will present and discuss the findings from the data collected for this study. The next chapter will introduce biographical information relating to the informants, and address themes arising from the data that relate to the psychological health of the informants. The subsequent chapter will discuss themes arising from the data relating to the informants' experiences of health care, and then the following chapter will address various aspects of social exclusion. In keeping with the principles of qualitative research, the data from this study will be discussed in relation to the findings of other studies concerning the health of refugees and asylum seekers.

Having presented and discussed this data in the form of the themes that have emerged, there will be a further chapter (Chapter 8) that will consider these themes in relation to health-related quality of life, civic stratification and citizenship status. It is as this stage that a more critical analysis of my data will take place, alongside that of related literature, and will place my findings in the context of existing theory. This chapter will further demonstrate what this study has contributed to existing knowledge.

CHAPTER FIVE

REFUGEES, ASYLUM SEEKERS AND PSYCHOLOGICAL HEALTH

Introduction

This chapter begins with some biographical information about the informants. Some information has been omitted in order to maintain confidentiality and avoid comments being attributed to individual informants. A brief account of the situation in the Democratic Republic of Congo serves to set the context from which the informants have fled.

The findings of the research are presented in this, and the following two chapters; these are organized in themes and sub-themes. Verbatim quotes are provided to illustrate and support the choice of theme and also to allow the reader to judge the veracity of the interpretation. Where appropriate, quotes are included from informants in both countries in order to illustrate similarities and differences. Individual informants are not identified by name, but instead are referred to as L1 (London informant, number 1) or P2 (Paris informant, number 2).

This chapter discusses the psychological health of the informants. In both countries problems relating to psychological health dominated the interviews; all informants talked about problems with their psychological health, to varying degrees. A small number of informants had experienced direct personal persecution or oppression; the fear engendered by the authorities opposed by the informants resulted in a situation of learning not to trust people. Asylum seekers cited worry about the immigration process as their main source of psychological problems; refugees were more concerned with family members remaining in the DRC and/or lack of sufficient money to maintain a satisfactory standard of living. The immigration process thus resulted in a sense of loss the for informants; loss of control over their lives, loss of family members who remained in the DRC, loss of financial independence and loss of reference points. For some informants, psychological problems were believed to lead to health damaging behaviour. A holistic approach to health and illness was adopted by the informants, many of whom were quick to explain that their psychological problems can manifest as physical health problems. Some of the informants conveyed a sense of normalisation of illness, in that they were resigned to the idea that illness would inevitably accompany the problems they experienced during the immigration process.

An issue that was common to all informants was lack of trust in people, services and institutions. The issue of trust is introduced in this chapter and forms the focus of the following chapter; the contribution of the informants' experiences in their home country to their lack of trust is discussed in this chapter, together with the consequences for their psychological health. The next chapter shows how this learned mistrust continues in Britain, particularly during encounters with health professionals. In France, lack of trust in state officials was demonstrated, particularly in relation to attempts to gain employment.

There are similarities between the informants' responses in both Britain and France in relation to the themes presented in this chapter. The similarities are found between asylum seekers in Britain and France and between refugees in Britain and France. The differences are between the statuses of asylum seeker and refugee; asylum seekers experiencing a greater sense of unease due to their less secure status. The effects of this on psychological health are described by the informants, and related to manifestations of physical health problems.

Themes and sub-themes relating to psychological health

Psychological health

Oppression

Persecution

Immigration process
Normalisation of illness
Loss of control over one's life
Loss of family in the DRC
Loss of financial independence
Loss of reference points
Health damaging behaviour

Biographical information about the informants

Table: 5 Characteristics of Focus Groups:

Focus Group 1 (FG1)
8 people attended: 5 men and 3 women

Focus Group 2 (FG2)
8 people attended: 5 men and 3 women

Focus Group 3 (FG3)
8 people attended: 5 men and 3 women

Table: 6 Informants in London

Number	Sex	Age	Martial Status	Immigration status
L1	M	30s	Married. Wife and children in Britain.	Asylum seeker. In Britain 4 years.
L2	M	35	Married. Wife and children in Britain.	Refugee. In Britain 3 years.
L3	F	22	Married. In Britain with husband.	Husband is a refugee. In Britain 6 months.
L4	F	33	Married. In Britain with husband and children.	Asylum seeker. In Britain 4 years.
L5	M	37	Married. Wife and children in Britain.	Refugee. In Britain 9 years.
L6	M	30s	Married. Wife and children in Britain.	Asylum seeker. In Britain 4 years.
L7	F	40s	Married. In Britain with husband and children.	Husband is a refugee. In Britain 7 years.
L8	M	40s	Married. Wife and children in Britain.	Refugee. In Britain 7 years.
L9	F	30	Married. Husband and children in Britain.	Refugee. In Britain 5 years.
L10	F	30s	In Britain alone, staying with sister.	Asylum seeker. In Britain 8 months.

Table: 7 Informants in Paris

Number	Sex	Age	Marital status	Immigration status
P1	M	26	Single.	Asylum Seeker. In France 2 years.
P2	M	35	Married. Wife in DRC.	Refugee. In France 18 months.
P3	M	36	Married. Wife in DRC.	Refused refugee status.
P4	M	44	Married. Wife and children in DRC.	Asylum seeker. In France 4 months.
P5	M	45	Married. Wife in France.	Asylum seeker. In France 2 years.
P6	M	40s	Married. Wife and children in DRC.	Asylum seeker. In France 16 months.
P7	F	27	Married. In France with sister. Children in DRC.	Asylum seeker. In France 2 years.
P8	M	40s	Married. Wife and children in France.	Wife has refugee status. In France 12 years.
P9	F	30s	Single.	Refugee. In France 4 years.
P10	M	40s	Married. Wife and children in DRC.	Refused refugee status. In France 4 years.
P11	M	40s	Married. Wife and children in DRC.	Refugee. In France 1 year.
P12	M	50s	Married. Wife and children in DRC.	Refused refugee status. In France 6 months.
P13	F	30s	Married. Husband and children in France.	Refugee.
P14	M	30s	Married. Wife and children in France.	Refugee. In France 7 years.

The informants, both in Britain and France, had all come from the DRC. All had fled the DRC seeking asylum in either Britain or France because of a fear of persecution if they stayed. Most of the informants in Britain had fled the regime of former President Mobutu, while in France some had left the DRC later, fleeing from the regime of the former

President Laurent Kabila. All informants had grown up in the DRC. Most of the informants had been employed in the DRC; some held prestigious professional positions. The family is highly prized among Congolese people (Rousseau, Rufagari, Bigilishya et al, 2004) and separation from family members represents severe disruption to an accustomed way of life. These community members practised a Christian religion, and the church played an important part in their lives. Provision of health care in the DRC forms an example of 'medical pluralism' with techniques of traditional healing practised alongside Western medicine (Fernando, 2002).

When asked why they had chosen either Britain or France, the informants in Britain replied to the effect that they had little choice and their sole aim was to leave the DRC. One informant in France told me that the choice was either to leave or to die.

> *"When you run away, you don't have a choice."*
> (P5)

While some of the informants in Britain spoke English, most spoke French or Lingala. In contrast, most of the informants in France had chosen France because of language; all of the informants in France spoke French. One informant chose France because there are "*Plenty of Africans*" (P3), others because they knew people in France. Some mentioned that they chose France because it has a tradition of *"respecting the rights of man"* (P1). However, during the course of this study, the informants' testimonies did not appear to reflect this tradition. Some of the informants in France implied that life for a refugee or asylum seeker would be better in Britain, a widely held belief among asylum seekers from former Zaire (Refugee Council, 1993; Kushner and Knox, 1999). Noiriel (1996) reports numerous testimonies to the disappointment experienced by refugees in France who discovered that the "*fatherland of human rights*" (p115) did not live up to expectations.

Kushner and Knox (1999) cite a Congolese informant affirming that a lot of asylum seekers from DRC prefer to go to France or Belgium because they can speak French, but also a lot of Congolese living in France and Belgium would like to go to Britain, which was also seen as being a just society. This informant said that "*England is better if you are black*" (p384). This view was reiterated in my interviews in France. Kushner and Knox (1999) point out that these impressions may in part be due to the publicity on the television in the DRC concerning the anti-immigrant stance of France's National Front leader, Jean Marie Le Pen. However, the reality is that asylum seekers from former Zaire have experienced hostility in Britain also. Choices between Britain and France might also be influenced by the belief that former President Mobutu's external intelligence service was operating in Belgium and France, putting asylum seekers at risk of forcible repatriation (Refugee Council, 1993). This fear was certainly raised by an informant in France (P14) who believed that the intelligence service was operating in Belgium. Belgium might otherwise be a natural choice for asylum seekers because of the colonial links with the DRC.

Zaire acquired independence from Belgium in 1960. Westin (1999) is critical of the role of the West, arguing that it is responsible for conflict in Africa, and that arbitrary boundaries drawn by European imperial powers in 1878, and inherited by independent successor states in the 1950s – 1970s following the end of colonialism, have contributed to continuing conflict. Few of these boundaries coincide with ethnic, cultural, linguistic, religious or national groupings. The transition to independence was particularly difficult in the former Belgian Congo (Westin, 1999; Dobbins, Jones, Crane et all, 2005). Political unity did not follow independence, as the newly named Zaire was characterized by the existence of some 200 ethnic groups, each with their own regional interests and social and economic divisions (Kushner and Knox, 1999). The resulting unrest allowed for a military coup by General Mobutu in 1965. During President Mobutu's reign, oppression of opposition was considerable in Zaire (Kushner and Knox, 1999). Former President Mobutu allowed a small loyal clique to become rich on the profits of natural resources, such as gold and diamonds, while most people lived in abject poverty (Rutter, 1991; Brittain, 1999). During 1989 and 1990 students in Kinshasa and Lubumbashi were involved in anti-government demonstrations (Rutter, 1991). Mobutu's army and secret police committed atrocities against opposition activists and civilians, including the killing of 100 – 150 students at Lubumbashi university in 1990 when security forces entered the university and took students from their beds; a situation witnessed by some of my informants (Kushner and Knox, 1999; Refugee Council, 2000). As international support for Mobutu's regime waned, an opposition leader, Laurent Kabila, was able to seize power in 1997 and declare himself ruler of the renamed country – the Democratic Republic of Congo (Kushner and Knox, 1999). This change of power resulted in an exodus of refugees. Following Mobutu's downfall the war evolved into a struggle for control of the country and its rich natural resources, involving the armies of six countries and several non-state armed groups (UNHCR, 2000). Human rights abuses continued under President Kabila (Refugee Council, 2000) and the exodus has continued, as the civil war continues (McGreal, 2001a) and a picture emerges of mass murder, rape, starvation and disease among a population under persecution by a variety of armies and groups (McGreal, 2001b; UNHCR, 2006c). The situation in DRC is complex and is characterised by inter-ethnic conflict that involves international support in the form of military aid from other African countries (UNHCR, 2006c). The humanitarian crisis continues and is described by the UNHCR as one of the worst in the world but at the same time "forgotten".

The community organizations

All of the refugees and asylum seekers interviewed in this study were members of community organizations. In France, the assumption of uniformly equal individuals *vis à vis* the state has traditionally prohibited intermediary structures in the form of migrant groups. Since 1981, such group formation has been allowed and organized migrant associations have developed and are increasingly recognized by state authorities as representatives of migrant interests (Soysal, 1994). These migrant associations are usually small but much more centralized and politicized than those in Britain, which tend to be founded by local initiative and thus are more localised (Soysal, 1994). These definitions have resonance for the two community organizations featuring in this study, the Hackney Congolese Community Support Group in London, and Le Souffle in Paris. The group in London was in its infancy when my study commenced, was fairly loosely structured and had emerged locally. During the course of my study, Hackney Congolese Community Support Group developed considerably and was able to acquire charitable status. In contrast, the group in Paris was far more organized and politicized, and was registered with the local authority.

Such community organizations have proved to be vital to the resettlement of refugees and asylum seekers in Britain, fulfilling many roles, for example, orientation to life in Britain, contact points for isolated individuals, cultural and social activities and support and advice concerning a wide range of areas, like accessing health care (Duke et al, 1999).

Psychological health

All of the people who took part in the individual interviews expressed problems with their psychological health, for a variety of reasons. During the interviews in London, using the English language, or translated into the English language, the term "*depression*" was used widely. There was no evidence from the interviews that any of the informants had been diagnosed as clinically depressed by a doctor, or that any of them were being treated for depression. In general parlance, the term depression does tend to be used widely and can cover a variety of situations, ranging from generally feeling 'down' to severe mental illness. It is not possible to gauge the extent of *"depression"* experienced by these informants in London as the absence of any reference to diagnosis and treatment may be due to the lack of serious illness, or reluctance to talk about conditions that are stigmatised within the community. However, the fact that informants were prepared to use the term "*depression"* suggests that the latter is not the case. It is also possible that informants did not want their *"depression"* to be treated within the confines of Western medicine, as it was frequently stated that this sort of problem was addressed within the community group. In Paris, informants used words that translate as "*nerves*", "*worries*" or "*problems*" when talking about psychological health. Eastmond (2000) claims that 'nerves' is an expression that is widespread and well documented in diverse societies and cultural contexts, as an expression of disrupted normality. Littlewood and Lipsedge (1997, p7) raise the issue of distinctions between terms like tension, disquiet, stress, anxiety, nervousness and agitation and confirm that the three French concepts *anxiété, angoisse* and *inquiétude* are described in everyday English by the single idea 'anxiety'. Such "*problems*", whether described as "*depression*" or "*worries"* were also related by four informants to *"thinking too much"*, which, in turn, was believed to be responsible for symptoms like stomach pains. The following quotes from informants in London and Paris are typical of the experience of problems with psychological health:

> *"Something wrong with my consciousness, within my brain, my head, because I think too much about so many situations, my stay here and the situation back home ...."*
> (L1)

> *"I think a lot........ of the trauma."*
> *"Nervousness, problems, stomach pains ...... because I think too much."*
> (P1)

These quotes reflect general psychological distress experienced by my informants, but my findings also identified specific causes of distress. In both countries the origins of the problems with psychological health were located in particular experiences, three of which, oppression and persecution and problems with immigration, are specific to the 'refugee experience'. Many informants feared oppression and persecution if they returned to the DRC, but a few described specific events they had experienced. In terms of immigration, there was a marked difference between those who had been granted refugee status and the asylum seekers, in that the latter all cited the immigration process as a major cause of their psychological problems. Refugees, having acquired a more secure status, tended to turn their concerns to other issues. For example, there was widespread concern for family members remaining in the Congo, especially if they were wives and children. Refugees who had overcome the hurdle of immigration often cited lack of sufficient money as a problem.

Persecution and oppression

All of the informants had fled the DRC, or former Zaire, for political reasons. Those in Britain had all fled oppression from former President Mobutu, as had some of the informants in France, while some of the later arrivals in France had fled oppression from the then President Kabila. As such, some of the informants in both countries described how they felt forced to flee their country as members of their families had worked for the deposed government and/or had been persecuted. Four informants described particular experiences of personal persecution.

The impact of persecution and oppression, either experienced directly or witnessed by informants, was identified as a contributor to feeling *"mentally depressed"* and resulting in *"sickness"*.

- ***Persecution***

Persecution includes harassment, torment, putting to death. Some of the informants reported having been persecuted in the DRC, for example:

> *"I came to France because of the problems in my country. I was a member of a political organization .... When I was a student I was arrested, just after Kabila came to power. That day there was meeting at my house .... I lived in a residential quarter ..... our meeting involved political discussions, planning projects. It was the custom for me to write a report, I had documents. During the night I was arrested and tortured. I was arrested because of my involvement in political meetings. I managed to escape and I hid in the city for a month. I was helped to board an aeroplane to Switzerland, and then on to France."*
> (P5)

The following informant had worked for a Human Rights organization in the DRC and had been arrested for being a threat to state security, having published a report criticizing the human rights record of the DRC government.

> *"Before coming to France I was arrested ..... I was seen as threat to the security of my country. Now that I am in France, I have been told that if I return to my country, to Kinshasa, I will be arrested again. My name is on a list of co-ordinators of the rebels".*
> (P6)

> *"I came to France because I was engaged in political movements, student movements, intellectual movements. These movements opposed the Mobutu regime. My mother and father were assassinated by the military. I went to Belgium, but at the time the Mobutu regime had a lot of influence there. I obtained refugee status there. I came to France and requested asylum. I can't go back to my country. Its very difficult to obtain refugee status in France. Most of the asylum seekers warrant the status because they have been tortured, they have suffered political oppression there. Sadly, it is not always evident..."*
> (P14)

The last statement refers to the difficulty asylum seekers can experience when trying to prove that they would be persecuted if they return to the DRC. Such proof can take the form of the evidence of physical injury if the individual has been tortured. However, in this case, my informant fled in fear of torture as his parents had been assassinated. In such cases, asylum seekers are usually required to produce documentary evidence to prove their "*well-founded fear of being persecuted*"; this can take the form of press cuttings. Asylum seekers in such perilous situations do not always have the time, or the inclination, to gather documentary evidence when fleeing, as they may be in fear of their lives.

- ***Oppression***

Oppression includes causing distress to people, treating them with injustice, governing with tyranny. Two quite prominent members of the community organisations (one in London and one in Paris) described very similar situations that occurred when they were university students. Both described soldiers terrorising staff and students at their respective universities in the DRC while President Mobutu was in power. The informant in London, a man who is currently active in the Hackney Congolese Community Support Group, described soldiers arriving at the university where he was studying in the DRC, beating people and destroying the fabric of the university. He described how frightened students ran from their classrooms to seek him out for help, running into his room, trying to hide under his bed.

> *"I remember I was in my room in the morning when they sent soldiers to beat people, to kill people. I was in my room, a small room like this. All my colleagues were running from classrooms to my room. Everybody was running and I received people running into my room, I think something like 35 people in a small room like this. Some were trying to hide under the bed because there were soldiers downstairs beating people, destroying everything. You see, that's what Mobutu was doing to people, and he was stopping the influence of education, destroying everything related to education. He didn't want to get people educated, so as a result there was a high percentage of illiterate people opposed to a few people who went to school, so educated people could do nothing. And now those people, the uneducated people, he was using them, brainwashed them, used them in the army, like people can't think, who have simply to obey the instructions, to do wicked things to people just to protect his power, to protect his government, to move forward in his dictatorship".*
> (L1)

Now that he is in London, this informant always has video-tapes ready to record media reports on the situation in the DRC in order to remain informed and to share the information with the community group. It is clear that he is very concerned for his compatriots in the DRC but also for the political situation and the future of his country:

> *"Imagine in my country now, there is no parliament. Who are the law makers, who are the policy makers? The President is ruling on his own will, he does whatever he likes with his people he has chosen to rule the country. How can people feel safe in such a situation? Imagine you are here and you see soldiers come and kill your mother, your sister, your son, your wife? What is the impact of this on an individual? People get sick ....."*
> (L1)

This is an example of the stress that can be experienced by refugees and asylum seekers pre-flight and the fear of living in opposition to an unelected leader. It is easy to see how mistrust arises. This informant is also making connections between these experiences and becoming ill.

This was also linked with feelings of continuing oppression as a result of general living conditions, feeling not accepted in society, isolation and discrimination, in short a perception of exclusion in the host country. The continuing lack of trust that begins in the country of origin and characterises the entire refugee experience was expressed by informants:

> *"I do not feel at ease. As an asylum seeker I can't work, can't go to class....... I fled oppression in the Congo and I still feel oppressed here."*
> (L10)

> *"... one has lived in trauma ..... waiting for papers .... you are nothing, you can't work, you can't do anything .... you are in total exclusion."*
> (P13)

These references to continuing oppression in a country of supposed safety are important in terms of the possibility of successful resettlement. Rousseau et al (2004) cite De Certeau's (1986) description of a form of violence that is associated with technocratic organisations and is more subtle but just as damaging as other forms of organisational violence. Such technocratic violence might relate to the problems associated with the immigration process. There is a certain paradox in that although informants who had acquired refugee status expressed relief and acknowledged the value of personal safety, at the same time they felt disappointed by the conditions in which they were forced to live (Rousseau et al, 2004).

Immigration process

The immigration process featured prominently during interviews in London and Paris, though there was a marked difference between the responses of asylum seekers and refugees. All eleven informants in both countries (including the two refused refugee status in France) who were awaiting a decision from the respective authorities on their applications for asylum linked their "*depression*" with their insecure status and uncertainty of not knowing whether they would be able to stay in the country or whether they would be forced to return to the DRC, where they feared persecution. Asylum seekers were deeply affected by the uncertainty caused by waiting for such a decision, stating that they had no direction in their lives, and no purpose. Some asylum seekers had been waiting years for a decision on their applications. While fears of *'refoulement'* predominated, such sentiments were often also related to the reduced range of rights attached to the status of asylum seeker, for example, being ineligible to apply for work in Britain for the first six months of asylum (at the time these interviews were conducted), or until granted refugee status in France.

> *"Immigration brings pressure .... Affects your mind...... You come here due to severe problems back home. You come here fleeing oppression, you stay here for one, two three, ... seven years. Immigration doesn't say anything to you and the situation back home is still worse. So what's the purpose of your life then? There is no direction in your life at all. Brings health problems into your body, for example, people suffering from high blood pressure. Your mind first and then later affects your body. So what is going on with immigration brings problems".*
> (FG1)

> *"I am not well ... I've been here for two years and I still don't have refugee status. It irritates me, it gets on my nerves. I think too much. I can't work and I'm not eligible for social security."*
> (P1)

This informant has exhausted his one year entitlement to financial support from the French state.

- ***Normalisation of illness***

Problems with sleep are recognised as symptoms of psychological problems and were frequently expressed by asylum seekers.

> *"I suffer anxiety, I have difficulty sleeping because I'm awaiting a decision on my asylum application."*
> (P5)

The desperation felt by an asylum seeker whose request had been refused (a *sans papiers)* can be seen in the case of an informant in France who claimed to be suffering from "*the illness of undocumented refugees*" (*"La maladie des sans papiers"*), describing how he had difficulty sleeping and how it is normal in his situation to have problems with psychological health and describing his quality of life as "*miserable*". By identifying an *"illness of undocumented refugees"* this informant appears to be accepting that illness is normal among this group of people.

- ***Loss of control over one's life***

On the other hand, one informant (L2) described how he used to have difficulty sleeping prior to being granted refugee status, but that difficulty has since disappeared. Those who had been granted refugee status expressed "*relief*", which is expressed vividly in the following quote:

> *"People view life differently, they feel very much relieved when they learn that they've been accepted into this country as refugees and they may stay here. They are no more subject to any immigration control - that makes things better even on health grounds. You see, people change the way they view their lives, they stop being worried day after day, hour after hour, they can plan things because they know that they can stay."*
> (L1)

Again, this informant is linking the worry about immigration status with health. He is also stressing that the acquisition of the more secure status of refugee confers the ability on the individual to exert some control over his or her life, when he states *"they can plan things".* The sense of control, or autonomy, is important for health.

Worry about immigration status is understandably common among asylum seekers and the findings from these interviews confirm the reports in other studies in Britain (Healthy Islington 2000 and Islington Zairean Refugees Group, 1995; Directorate of Public Health, Croydon Health Authority, 1999; Papadopoulos and Gebrehiwot, 2002).

- ***Loss of family who remained in the DRC***

Refugees and asylum seekers have many worries; most informants in both London and Paris expressed worry about their family members who have remained in the DRC; family life is highly valued by the Congolese community. Most watched the news on television and felt "*depressed*" about the situation in the DRC.

> *"I'm unhappy because I am in a strange land and I've left so much at home. I cannot speak English properly. I think of my family back home. I can't sleep properly, can't feel happy."*
> (L6)

> *"I suffer psychologically .... my head, my nerves...... my family is in the Congo."*
> (P11)

Both these informants are conveying expressions of the loss that is experienced by refugees and asylum seekers, in particular loss of family life. Refugees and asylum seekers who have left their home countries may feel guilt concerning family members they have left behind, and experience powerlessness in a situation over which they have little control (Rousseau et al, 2004). As well as being separated from family members, some informants stated that they did not know if their family members were still alive in the DRC. These concerns are not surprising, given that the UNHCR (2006c) describes DRC as a being characterised by a "collapsed state" with high levels of violence and human rights abuse. The conflict has resulted in poverty, a crumbling infrastructure and high levels of hunger, disease and death. Women and children, often the ones who remain in DRC, are particularly vulnerable with reports of sexual and gender-based violence being carried out (UNHCR, 2006c). The UNHCR (2006c) estimate that more than 3.8 million civilians have died as a result of the conflict since 1998. Such concern about family members remaining in the DRC raises questions about rights to family reunion. Separation from family members has been found to be a major source of stress during exile (Duke et al, 1999). The right to family life is enshrined in various international documents (Duke et al, 1999). There is a difference between rights of refugees, those granted humanitarian protection, and asylum seekers, concerning family reunion, which, again, concern the different rights attached to the respective status. One particular informant in France (P6) had been trying to arrange visas for his wife and children to travel from the DRC and join him in France, but he was finding the cost of the visas prohibitive. Again, the findings of this study confirm those of other studies conducted in Britain relating to worry about the family members of refugees and asylum seekers left behind in the countries of origin (Gammell et al, 1993; Brent and Harrow, 1995). As well as the discontinuity of relationships that results, refugees and asylum seekers may have to accustom themselves to a reconfiguration of roles within the family.

Citizens of the European Union have the right to family reunion, but of course this right is denied to non EU citizens. The European Convention on Human Rights claims that respect for family life is a universal right. While all EU member states are signatories to this Convention, the assertion of this right is not legally binding (Morris, 1997). States often require that one's family can be provided for without recourse to public funds as a condition of family reunion.

- ***Loss of financial independence***

Material factors, for example, lack of money, poor housing and living conditions, were all raised as concerns which affect psychological health and, in turn, physical health. These will be explored in depth in relation to social exclusion in a later chapter. However, it is important to raise the issue of lack of money in relation to psychological health as there appeared to be an emergent hierarchy relating to the various factors that were causing problems with psychological health. While the immigration process was the prime concern for all of the asylum seekers in both countries, those who had been granted the relative security of refugee status tended to cite lack of money as a worry more frequently than did asylum seekers. For example, a female informant in London cited the fact that her husband had acquired refugee status as a positive aspect of life in Britain, while a negative aspect was the fact that he was subsequently required to find work or be dependent on income support.

> *"What my husband is getting at work, it is not sufficient to meet all the needs, to pay the bills, to pay the rent, to pay the taxes, to buy food, to buy clothes".*
> (L3)

Financial worries are common among refugees and asylum seekers in Britain (Brent and Harrow, 1995;Directorate of Public Health, Croydon Health Authority, 1995). Informants in France had the added complication of their income from the state being stopped after one year of being an asylum seeker.

> *"In France, it is for one year. Asylum seekers are given money for food, clothing, for one year. After one year, it is stopped."*
> (P1)

- ***Loss of reference points***

There were examples of expression of loss of status. For example, in France one female informant (P9) talked about her early days in France when she was waiting for a decision on her application for asylum and described a feeling of *"not having any landmarks or reference points"* and having to *"start her life again"*, also claiming to feel *"diminished"*. Another female informant in France (P13) talked about her loss of status, depicted by low self esteem, unfulfilled roles, psycho-social stress and not being able to achieve potential. The following quote, form an informant in London, arose when I asked him about his health-related quality of life. He said that he was not happy. I asked him why he was not happy and his response was:

> *"Unhappy because in a strange land.. Have left so much at home. Cannot speak English properly, think of family back home. Can't sleep properly, can't feel happy."*
> (L6)

The above examples of factors causing problems with psychological health confirm the findings of other studies carried out with refugees and asylum seekers in Britain (Gammell et al, 1993; Brent and Harrow, 1995) with uncertainty about the future and separation from family and friends contributing to problems with psychological health. Paradoxically, a low uptake of counselling and psychiatric services was reported among refugees and asylum seekers in these studies. While this might be for a variety of reasons, stigma attached to mental illness leads some groups to be reticent or secretive about mental health problems (Ruddy, 1992; Fernando, 2002; Papadopoulous and Gebrehiwot, 2002). Zairean refugees and asylum seekers in Islington (Healthy Islington 2000 and Islington Zairean Refugees Group, 1995) stated that the most serious problem facing them was their immigration status as they were uncertain about their future and anxious about separation from their families. Thompson (2001) cites a psychologist working with refugees in London as saying that she sees a lot of mental distress due to violence, but the most striking ailments are those due to isolation and loneliness and missing families. Shackman (1995) reports on a Bosnian woman, and mother of two children, who committed suicide after UK government officials refused to allow her husband to join her. Psychological distress is widespread among refugees and asylum seekers (Jones, 1999). Carey-Wood et al (1995) found that two-thirds of settled refugees said they had experienced anxiety or depression, with higher rates amongst those without jobs or with poorer command of the English language. Although most were registered with medical services, few had found doctors helpful with problems of a psychological kind. Another study in Britain found that the mental health of refugees and asylum seekers was worse than that of the general population (Brent and Harrow, 1995) and in Newham, London, (Gammell et al, 1993), one third of respondents described themselves as depressed.

A hierarchy of concerns for refugees and asylum seekers

It was very apparent in this study that there was a hierarchy of concerns for the informants. All asylum seekers cited the immigration process as their major and predominant concern, some also cited concern about their family members in the DRC and a few cited lack of sufficient money. The overriding concern is thus for security in the sense that asylum seekers desperately need to know that they will be allowed to stay in the host country. As well as conferring some degree of security, refugee status also provides some sense of control over their lives in that refugees can begin to make some choices about the future. Concern of asylum seekers for their own security is closely followed by concern for that of their families who have remained in the DRC, though for many asylum seekers these two concerns co-exist. Lack of sufficient money was more important for refugees than for asylum seekers, suggesting that the need for security has to be satisfied before worry about lack of money can emerge. An immediate concern for refugees and asylum seekers is survival and many fear that they will not survive if they are returned to the DRC.

None of the informants in this study admitted to being diagnosed with mental illness, but this is something that might appear later (Sales, 2002a; 2002b). Sales found that Turkish and Kurdish refugees in London had a high incidence of mental health problems which were associated with anxiety over legal status in the early years; mental health problems thus may manifest later, after pre-occupation with immigration has abated (Sales, 2002a; 2002b). Littlewood and Lipsedge (1997) argue that the longer a migrant stays in a host country, and the longer his or her goals remain unfulfilled, the greater the potential for mental health problems to develop. These authors also assert that even isolated individuals are able to function adequately if their expectations are met and they enjoy a certain degree of economic and psychological security. The informants in this study did not have their expectations met, nor were many of them enjoying economic and psychological security.

- ***Health damaging behaviour***

During one of the focus groups held in London concerns were raised about younger members of the Congolese community resorting to smoking, drinking and drug abuse because they feel themselves to be in a hopeless situation from which they do not know how to extricate themselves. This confirms similar concerns relating to alcohol or drug misuse in other studies in Britain (Gammell et al, 1993; Brent and Harrow, 1995). Johnson and Akinwolere (1997) have also reported smoking and substance use by refugees and asylum seekers in response to the stress of the "refugee experience" during the period of settlement in Britain. Summerfield (1999b) refers to Agger et al's (1995) claim that lack of attention to trauma issues can impact on the next two generations via, *inter alia*, increases in alcohol and drug abuse. Social and economic exclusion are risk factors for problematic drug use among young people, exclusion contributing to a lack of a sense of belonging (GLA, 2004). A close supportive family can protect against drug misuse and for many young refugees and asylum seekers family disruption is common. Further, attempts by refugees and asylum seekers to assimilate may result in the adoption of local drug using patterns (GLA, 2004).

Conclusion

It is clear from this, and other studies, that refugees and asylum seekers experience high levels of psychological distress, for a variety of reasons. There would appear to be some sort of hierarchy of worries, with immigration status at the peak. Once granted refugee status, relief is experienced and attention turns to other things. In this study informants were happy to talk about their psychological problems but did not appear to be seeking professional help in this respect; such help was gained from within the community. In general, there is a worrying trend of not seeking help. Refugees and asylum seekers do not use mental health services for a variety of reasons, including fear of being labelled mentally ill in cultures that stigmatise mental illness, lack of familiarity with 'talk therapies' like counselling, language skills, fear of institutions, and/or lack of cultural understanding (Evelyn Oldfield Unit, 1997).

Experiences in the DRC initiate a protective mechanism in the form of a failure to trust officials; this has been identified in the accounts of the informants who were subject to persecution in the DRC. Thus it is evident how refugees and asylum seekers find themselves unable to place trust in people; indeed, Muecke (1992b) has described suspicion as a "*survival skill*". Threats to themselves, family members, friends and associates provoke a lack of trust in officials in their home country but this is also extended to officials in countries of asylum. Further, the lack of trust can be extended to health care professionals, who may be viewed as agents of the state and thus potential collaborators in the immigration process. This lack of trust originates in a lack of trust in officials in the home country but continues as a survival skill following arrival in Britain and France. This is demonstrated in the following chapter where it is shown how, in Britain, the informants did not trust health professionals and, in Chapter 7, how, in France, informants did not trust potential employers.

It is difficult to classify health problems in purely physical or psychological terms, as health problems result from a complex mixture of physical, psychological, social and environmental factors. Although the informants did not appear to be approaching the health services for help with their psychological problems, there were expectations that GPs would treat their physical health problems. This theme is continued in the next chapter.

CHAPTER SIX

HEALTH, ILLNESS AND HEALTH SERVICES

Introduction

This chapter identifies the themes emerging from the data that concern refugees' and asylum seekers' experiences of their own health and illness, and also the provision of health care. Their experiences of relationships with providers of health care are also included. The major themes of physical health, communication, suspicion and lack of trust, and satisfaction/dissatisfaction with health services are addressed here. Again, there are similarities between informants in Britain and France in some themes and differences in others.

In Britain, in particular, informants cited communication as the most important factor affecting their health, primarily the difficulties that many were experiencing when interacting with providers of health care. Such problems fuelled their natural suspicion and contributed to a lack of trust in the professionals who were providing health care. As a result, some of the members of the Congolese community in Hackney were paying to see French doctors privately, as they could communicate with them and they felt that they provided better health care. Dissatisfaction with the British National Health Service was widespread. In France, informants expressed satisfaction with the health care they received; they did not experience any problems communicating with professionals as they all spoke French, and thus shared the same language. The different health care systems in the two countries will also be addressed.

Most of these themes also include sub-themes. Communication has been identified as a theme as it was very apparent as a major problem for non-English speaking informants in Britain. It is difficult, though, to separate communication from the other themes as it constitutes an important factor in the suspicion of, and lack of trust in, the providers of health care, dissatisfaction with health services in Britain, and perceptions of discrimination. Three sub-themes; doubting the diagnosis, doubting the treatment prescribed and reluctance to visit General Practitioners (GPs) in Britain are components of the major theme 'suspicion and lack of trust'.

In relation to reports of discrimination in health care in Britain, registering with GPs was particularly problematic. Such dissatisfaction arose from the expectation of health care held by the informants. In spite of a resignation to feeling generally unwell, my informants expected their signs and symptoms to be treated by GPs. Informants also believed that restrictions had been placed on GPs, by the British government, concerning what treatments they could provide for refugees and asylum seekers. Informants in Britain also experienced a sense of helplessness, a lack of understanding of their culture and also of the 'refugee experience', on the part of health professionals. Informants in Britain further appeared to lack knowledge about the British National Health Service.

Themes and sub-themes relating to the experience of health, illness and use of health services

Physical health

Communication

Suspicion and lack of trust

Doubting the diagnosis

Doubting the treatment prescribed

Reluctance to go to GPs

Registering with GPs

Restrictions on GPs

Helplessness

Satisfaction/Dissatisfaction with health services

Culture

The 'refugee experience'

Discrimination in health care

Lack of knowledge of the British National Health Service

Physical health

Informants in both countries had much less to say about their physical health than their psychological health, although there was ample evidence of visits to GPs and hospital Accident & Emergency departments in London in relation to physical health problems. Informants in London were more concerned to talk about processes and overall experiences of being patients than their actual signs and symptoms. Physical health problems raised included back pain, stomach pain, headaches and hypertension.

Similarities were identified among informants from both Britain and France in relation to the nature of their physical health problems. During the individual interviews in London and Paris approximately half of the informants made reference to some sort of physical health problem, most commonly headaches, back pain and stomach pains. Some informants in London mentioned the weather conditions that were very different from those experienced in the DRC, relating these to discomforts like a runny nose and headaches. Some informants identified different food in their host countries resulting in some digestive problems. In London the female informants drew attention to their experiences before, during and following childbirth. These experiences appeared to be inextricably linked with other problems in relation to health care services, for example, being unable to communicate adequately with care providers due to language problems, and suspicion of professionals, and will be discussed later in this chapter. The physical health of refugees and asylum seekers can be affected during any stage of the 'refugee experience'.

- Pre-flight problems can affect health:

Only one informant (in France) admitted to having a long-standing health problem that required regular monitoring. He was a diabetic and pointed out that because of the problems in the DRC he had not received care there for three months, a situation that resulted in difficulties with maintaining control of his diabetes.

- Health problems arising during flight:

One informant in Paris described how, during flight, he was forced to hide in the forest in the DRC for five months and therefore had to exist by eating plants growing there; a situation that resulted in him being unwell on his eventual arrival in France. Malnutrition can weaken the immune system in people who hide in forests without shelter or medicine, eating berries and nuts for months; also otherwise treatable diseases may become fatal (Carroll, 2003).

- Health problems arising in the host country:

Two other informants in Paris mentioned having developed hypertension and one a raised level of cholesterol in his blood, again, portraying a sense of 'normalisation' of illness among refugees and asylum seekers. It seemed to be accepted by some informants that asylum seekers suffer from high blood pressure and heart problems as a result of their traumatic experiences. Research has shown that emotional distress creates susceptibility to physical illness (Wilkinson, 1996; Brunner, 1997; Stewart-Brown, 1998). Prolonged uncertainty about the decision made on an asylum claim can cause not only stress but also stress-related physical ill health (BMA, 2002). The informants were clearly aware of this relationship, one of them informing me that the problems "*affect your mind first and then later your body*" (FG1). Helman (2000) refers to somatization, the process by which psychological and social problems come to be expressed mainly in physical symptoms and signs – "a way of speaking with the body", for example, through expressions of tiredness, headaches, pains everywhere.

In contrast to the resignation to illness displayed by some informants, one informant in Paris (P13) was at pains to point out that people who are not refugees or asylum seekers become ill too; claiming that it is not necessarily the case that there is a logical progression from being a refugee to becoming ill. This informant was clearly concerned that refugees and asylum seekers might be portrayed stereotypically as unhealthy people. During this interview I was reminded of comments made by informants in an earlier project in which I was involved. In the early 1990s I participated in a project which aimed to identify the health needs of a group of refugees and asylum seekers in relation to their perceived needs for information about tuberculosis. During interviews, some informants asked "Why us?", concerned that they were being singled out as being at risk of tuberculosis, a disease that can attract some stigma in some cultures. In Paris, my informant provided me with an example, explaining that when winter arrives anyone who is frail can catch influenza, whether a refugee or not. The problems, she stressed, are at a psychological level resulting in psychosomatic illness, for example, gastritis, stomach pains, headaches, high blood pressure, resulting from the experiences from which the refugees and asylum seekers had fled and from the experience of flight. This view was supported by members of both groups of informants, some of which explained that they were not physically sick but *"mentally sick"* and *"simply not healthy people"*, for example:

> *"Not sick of tuberculosis, not sick of AIDS, but mentally sick, depressed, and simply we are not healthy people."*
> (L1)

Other studies in Britain include mixed reports on physical health; Haringey Council (1997) found that 90% of their respondents were physically healthy on arrival and most remained healthy after arrival. In the Horn of Africa study (Bariso, 1997) the majority of informants did not have a long-term illness or disability. Jones (1999) found low levels of physical morbidity. In Newham, London (Gammell et al,1993) perceived health status of respondents appeared to deteriorate over a period of time in UK. Recent arrivals were less likely to report a long-standing illness and there were low percentages reporting major illnesses either before or after arrival. In contrast, Carey-Wood et al (1995) found that 16% of their sample was suffering from physical health problems sufficient to affect their way of life. This may reflect the length of stay of respondents in Carey-Wood et al's study. Many found it difficult to adapt to a different culture, climate and cuisine.

Communication

Communication emerged in all three focus group interviews in London as a unanimous and major problem, and was the first problem cited by all three groups in response to the question "What are the major issues affecting your health?" As most of the informants spoke Lingala or French, with limited English, there was an enormous language barrier when attempting to communicate with health professionals. In particular, within the wider concept of communication, a lack of medical language was cited as a problem. There were reports of misunderstandings occurring, and also of people not being able to understand how to take their medicines. Limited access to interpreters was reported, particularly at doctors' surgeries: sometimes interpreters are available at hospitals. Two informants went to see their GPs and were told to go away and return with their own interpreters. Members of the Congolese community organisation were functioning as interpreters when requested, and this is a service that the organisation wants to develop further. Some health-related literature is available in French, but the organisation wants to translate some of the literature into Lingala. Many of the Congolese refugees and asylum seekers in London are attending English classes. Members of the community group contribute money and use it to pay for some members to go to private clinics run by French doctors where they are able to communicate adequately, and in whom they placed greater trust. In France, none of the informants raised communication as a problem as all informants spoke French. However, it is possible that other groups of refugees and asylum seekers in France who do not speak French may experience problems with communicating with health care professionals, similar to those identified in Britain. For example, Kotobi (2000) reports on a study relating to migrant Africans and hospital attendance in France, which identified language barriers as factors contributing to a cultural distance between African patients and professionals and Fanello et al (1994) also identified communication problems among migrants in France.

Language has been found to be a major factor affecting re-settlement (Carey-Wood et al, 1995) and other studies have reaffirmed this (Gammell et al, 1993; Brent and Harrow, 1995; Healthy Islington 2000 and Islington Zairean Refugees Group, 1995; Bariso, 1997; Deane, 1997; Haringey Council, 1997; Papadopoulos and Gebrehiwot, 2002; Sales, 2002a). The difficulties relating to the availability of interpreters has also been raised frequently. The British Medical Association (2002) has acknowledged a deficit in interpreting facilities in health care. Some community groups were supplying interpreters, but there was also use of friends and family members. While Cohen et al (1999) argue that the most effective consultations are those occurring between GPs and patients who not only speak the same language but are also from the same cultural background, there is a history, when using informal interpreters, of mistranslation for anatomical and technical words because of cultural differences in the ways that body parts are named. Questions or terms that were not translated at all tended to reflect bodily taboos.

In my study language was also inextricably linked with being identified as a 'foreigner' and this will be explored in the following chapter, but lack of ability to communicate in English was also linked with overall lack of trust in the health care system (National Health Service) and in the people who provide care, exemplified by the following quote from one of the informants in London:

> *"But some GPs, when you go there, when they see that you don't speak good English, they don't want even to listen to you, they pretend that they don't understand you when sometimes they do."*
> (FG3)

Suspicion and lack of trust

The previous chapter has demonstrated how refugees and asylum seekers learn to mistrust people, especially those in authority. Although few informants actually used the word 'trust' it was apparent that varying degrees of lack of trust were felt by all informants, but for different reasons in Britain and France. In both countries lack of trust was directed at the immigration process which caused serious problems with psychological health. Health care professionals were generally not trusted by informants in London, but even greater lack of trust was felt for the policies and institutional rules and regulations within which these professionals practice. The links between trust and communication were important in that one informant in London (FG1) told me that the doctor can identify a patient as a "foreigner" from the way he talks, and consequently the doctor is not prepared to listen to the patient, or to try to understand the patient's problems. In this situation the lack of trust arises at the beginning of the encounter between doctor and patient and thus influences any subsequent interaction. The lack of trust transcends the individual doctor–patient relationship, as informants in London were convinced that the government has a special health policy for refugees and asylum seekers that places limitations on the services that individual health care providers can offer refugees and asylum seekers. This results in a reluctance to trust the diagnoses made by doctors, the efficacy of the medications that doctors prescribe, and the other treatments that are offered. The belief was expressed that even if a doctor knows the correct diagnosis, the refugee or asylum seeker will not be told, as the doctor would then be obliged to treat the disorder and the treatment might be expensive. Recourse was often made to private French doctors in London, in whom informants had confidence. Informants were adamant that these French doctors would treat them appropriately, supplying treatment that was not available to them through the National Health Service, albeit at a price.

In contrast, in Paris, all informants, with one exception, expressed total trust in the health care professionals and services; this was related to the ability of all my informants to speak French and thus to communicate with the providers of health care. This trust was also linked with the choice of health care that is afforded to people in France. However, in France my informants conveyed a lack of trust in employers; informants who had been granted refugee status and were thus eligible to seek employment found it extremely difficult to acquire jobs, and those who were successful were working in low paid jobs that did not enable them to make use of their qualifications and experience. Informants believed that employers discriminated against them. This is explored further in the following chapter.

Lack of trust thus permeates the entire 'refugee experience' and endures in the post-settlement period (Hynes, 2003). Suspicion is a survival skill for refugees and asylum seekers (Muecke, 1992b) and this is evident in the comments from the informants in both countries, but in London the suspicion particularly related to the providers of health care.

> *"I am the patient but he does not feel it as I am feeling, what I am explaining to him. He does not understand ...."*
> (FG1)

This informant clearly did not trust his General Practitioner.

There was an overwhelming perception of poor, inappropriate, delayed and even incorrect treatment by doctors. In all three initial focus group interviews the issue arose of GPs prescribing paracetamol indiscriminately and for a variety of illnesses, with overwhelming agreement from all participants, accompanied by much laughter.

> *"... the very most common thing they prescribe you is paracetamol ...."*
> (FG1)

> *"... the medication they will give you, the same thing they will give for any kind of illness ..."*
>
> (FG2)

> *"Always paracetamol".*
> (FG3)

> *"We have good experience of paracetamol".*
> (FG3)

Such comments were accompanied by humour as expressed by the following quote:

> *"We are probably going to develop an antibody, anti-paracetamol, because we have been taking it so much."*
> (FG3)

This represents an example of the shared meanings that can be demonstrated when focus groups allow social facts to be sustained and reaffirmed in the course of social interaction (Donovan, 1986). One striking finding during my fieldwork occurred when I discovered awareness of the 'paracetamol' situation (described in London) in Paris, as one of the informants (P13) told me that she had friends in London, whom she had known in the DRC, and that they complain about the health care system. She explained to me how it is necessary to see a GP, before being referred to a specialist[1]. She then told me that all a GP prescribes for refugees and asylum seekers in Britain is paracetamol, and laughed, but then stated that her friends are frightened. The issue of paracetamol was also raised in a study concerning refugees and asylum seekers in Newham (Gammell et al, 1993).

Informants made sense of these prescriptions through a feeling of rejection by GPs, increasing their lack of trust in providers of health services. This resulted in them turning to other treatments, for example, buying their own medicines from pharmacies.

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[1] GPs do not function as gatekeepers to specialists in France, people can refer themselves.

- ***Doubting the diagnosis***

Suspicion also caused some informants in London to doubt the diagnoses they had been given, either for themselves or their children. One woman (L4), who joined her husband in London with their two young children, told me a story relating to her son. When the boy was a baby, midwives told her that the boy had problems with hearing, but when the GP examined the boy he said that her son could hear, and that he could find nothing abnormal. However, the family is still receiving letters from the hospital offering an appointment to assess the boy's hearing. The woman said *"It's confusing – who shall we trust?".* A similar experience was reported by a male informant in London whose GP referred him to an Accident and Emergency Department where he was told that he did not require any treatment; and by a female informant who took her children to her GP who sent the children away saying that they were not ill.

> *"...what we expect the GP to do when you put in a complaint, a health problem, they have to check seriously but they don't do that, they just listen to you and make a prescription. When they make the prescription the asylum-seekers are not foolish people, they know what the GP is doing. So I'm suffering from chest pain but when I explain it to the GP maybe I'm expecting the GP to send me to the hospital to go through radiology to take some x-rays to check what's wrong inside me but they never do that, they will not send you to the big hospital for health check or medical examinations. But the GP will just listen to you and make a prescription, and in what he prescribes you as medicine there is nothing to do with chest pain, he will give you, the very most common they prescribe you is paracetamol, and we know, the people know that when you prescribe paracetamol it has nothing to do at all with chest pain. I know that the way I'm feeling I can't take paracetamol, I need some serious medical check and prescribe something serious but they will not do that, they just take paracetamol and prescribe it and send you to the pharmacist ..... Everybody is right, you see them, they say yes to that."*
> (Members o the focus group nod in agreement.)
>
> (FG1)

- ***Doubting the treatment prescribed***

Doubts were also expressed by some informants concerning the treatment that had been prescribed for them. One woman (FG2) described her experience of visiting her GP with her baby who had eczema. The woman had explained to the GP that she did not speak English and asked him to find an interpreter, but he reportedly declined, claiming that only English was spoken at the surgery. The GP prescribed some medication for the baby and the woman took the baby home and applied the medication to the baby's skin but it was not effective and so she had to return to the GP with the baby and another medication was prescribed which was effective. When this story was told during the focus group interview, it was followed by further concerns from informants that they sometimes have to go to the GP two or three times in order to acquire satisfactory treatment.

There is a widespread fear of going into hospital among the Congolese community in Hackney. One man (FG2) described the *"shocking"* experience of a member of the community who was admitted to hospital and whose condition deteriorated due to what was believed to be *"bad"* treatment. Such experiences caused some informants to wonder if the deterioration was accidental or as a result of some voluntary act on the part of the providers of health care. Other examples were provided by the informants, for example, one man's young daughter was very ill and in intensive care. However, his perception was that doctors were not doing anything for her. The raising of the above example during FG2 prompted a discussion concerning human rights and also the perceived lack of rights of asylum seekers to seek redress in such situations. A lack of confidence in GPs, coupled with a perception of GPs merely writing hasty prescriptions, was reported by another group of refugees from the DRC (Healthy Islington 2000& Islington Zairean Refugees Group, 1995).

- Women's health:

Even though this study did not aim to address women's specific health issues in any depth, women's perceptions of health care were difficult to assess. At the first focus group held in London, in response to the opening question concerning major health issues for the Congolese community, the men present invited the women to respond on the assumption that women visit their GPs more frequently than men do. Initially, the women were reluctant to talk, but eventually they did voice their concerns. It is possible that, in order to explore the health-related quality of life of female refugees and asylum seekers, it would be desirable to interview women without the presence of their men-folk. I believe that such exploration would warrant a separate study, in its own right, informed by different theoretical frameworks.

Three of the informants in Britain had experienced miscarriages, two women had experienced caesarean sections.

Some specific women's problems were evident in Britain, especially in relation to pregnancy and peri-natal care; for example, three women who had lost babies during their pregnancies believed that this was due to delayed treatment of their problems. One woman (FG1) described how she was in pain during her pregnancy and her GP referred her to a hospital, where she was told that there was nothing wrong. The woman continued to experience pain and eventually lost the baby as a result of what she described as "*an untreated infection*". Three of the informants in Britain had experienced miscarriages. One woman (L3) suffered a miscarriage which she attributed to the hospital not attempting to "*stop the bleeding*". She saw other people arriving in the Accident and Emergency Department after her arrival, yet appearing to be treated before her. Another woman (L7) described her pregnancies as "*hard experiences*" but would not say anything further than that she had lots of problems with GPs and hospitals. Concern was also expressed over the numbers of caesarean sections being performed on Congolese women; two women had experienced caesarean sections. This issue was initially raised during Focus Group 2, when the belief was expressed that such operations were performed for political reasons; in their opinion, the received wisdom is that people in Britain think that asylum seekers come to Britain to have a lot of children, and caesarean sections are performed to reduce the number of children born to asylum seekers. This issue also arose among female Somali respondents in Brent and Harrow (Brent & Harrow, 1995). There has been some concern, among the general British population, with the increase in the numbers of caesarean sections being performed, amid concerns that this could present problems with further conceptions (Mulkerrins, 2002). Again, concerns about reproductive issues are not surprising, given some of the events of the past. For example there is a history of methods of birth control, e.g. Depo-Provera, and sterilizations being aggressively thrust upon black women (Ahmad, 1993). Also, birth outcome is generally less favourable for people from minority ethnic groups in Britain than for the majority population (Kuntz, 1998), with experiences of higher perinatal mortality than the babies born to UK-born mothers. Language and cultural barriers may compound problems of access. Difficulties will arise if women are in temporary accommodation or move frequently and thus do not receive consistent primary care services. There was also a belief among my informants that medical staff in the UK consider that people from Africa come to the UK to benefit from health care, particularly in relation to peri-natal care. This belief was supported by media accounts referring to refugees and asylum seekers as 'welfare scroungers' and contributed further to the lack of trust placed in health care providers and the health care system.

Informants in Paris did not mention any problems with reproductive health, however, few of the female informants had given birth there. However, writing in France, Fanello et al (1994) noted that a survey, concerning the health needs of migrants, revealed a lack of 'medicalisation' of pregnancy in the countries of origin of respondents.

One male informant (L5) saw a GP who examined him and sent him to an Accident and Emergency department. The doctor there said that everything was alright, yet gave him pain killers (paracetamol), apparently without any explanation of the reason behind the prescription. He subsequently sought advice from a French doctor in London. I asked this informant, "*Did you trust the doctors?*" He replied *"I trust the French doctor because I went to see the doctor here and he just gave me Paracetamol".*

Such experiences led to many of the informants in London expressing reluctance to seek help from the NHS, GPs in particular.

- ***Reluctance to go to GPs***

Reluctance to seek treatment from GPs emerged because of a belief that the outcome would be unsatisfactory. One informant (FG3) described how some time ago he was unwell with a headache and a raised temperature and was planning to visit his GP, but his friends were urging him not to go: they said there was no point – he would be given an appointment for some time later and all he would be given was paracetamol.

This theme, initially identified during the focus group interviews in London, continued to be evident during the individual interviews with informants in London. Informants felt suspicious that they were not being treated properly by general practitioners because of their status as refugees and asylum seekers, leading to a lack of trust.

> *"And when you go to the GP, or when you are in a hospital, ……. we don't have only to look at sickness as such, but we have so many factors, psychological factors, around the medical treatment, you see. When I have a feeling of being rejected by the GP, how can such a man treat me and get relief? If I feel already rejected by a GP, how can I trust what he's doing to help me?"*
> (L1)

This was part of an overall lack of trust in GPs, which can also be found in other studies concerning refugees and asylum seekers in London. For example, respondents from the Horn of Africa countries in Camden and Islington complained that their GPs did not see them soon enough and spent too little time investigating their health problems (Bariso, 1997). Members of the Zairean community in Islington (Healthy Islington 2000 et al, 1995) reported that their GPs did not listen to them and others stated that their GPs just hastily wrote prescriptions before making a proper diagnosis.

- ***Registering with GPs***

Registering with GPs has been recognised as a problem for refugees and asylum seekers (Jones and Gill, 1998a). One male informant (FG3) attempted to register with a GP soon after arrival in Hackney. The receptionist said that she would put him and his family on the waiting list and that they should contact the surgery again in two weeks time. When they did this they were told that the list was full, that there were too many patients and that they were not registering any new patients for a period of 6 or 9 months. Two weeks later a friend, who is black and British, moved into the area and was able to register with the same GP immediately.

> *"So I assume that our position of refugee did not help us to register with them – the fact that we are refugees is not interesting for them".*
> (FG3)

The family did eventually register with a GP, but not one close to their home and they had to produce a letter from their landlord and another from their solicitor before the practice would accept them.

In Bariso's (1997) study, with the Horn of Africa refugee community, non-registration rate with GPs was at a high level (14.6%) compared to 1% in the general population. Reasons for failure to register in this group included language problems, lack of awareness of the need for GP registration and fear of the consequences their on asylum applications. Problems were also encountered when trying to register with GPs in Croydon (Directorate of Public Health, Croydon Health Authority, 1999).

Although, when my study was conducted, all refugees and asylum seekers were entitled to the full range of NHS treatment free of charge, including the right to register with a general practitioner, there is evidence that some GPs are confused about this (Jones and Gill, 1998a).

Although registration with GPs was high among the respondents to Carey-Wood et al's (1995) study, several factors lead to under-use of primary and secondary health services , including language, lack of knowledge of the services available, and lack of awareness of refugee experience on the part of health professionals.

- ***Restrictions on GPs***

The participants of all three focus groups in London shared the belief that there is a government policy of restricting the care available to refugees and asylum seekers from the National Health Service, even going so far as believing that there is a tablet which is made only for refugees:

> *"Is it the GPs themselves or the government telling the GPs not to prescribe medicine which is expensive. We don't know who is giving these instructions to the GPs."*
> (FG2)

> *"I've heard from some friends there is some tablet they make only for refugees. When you go to the GP he is going to give you the cheap tablet."*
> (L2)

They believe that GPs and hospital doctors could, and indeed would, do more for refugees and asylum seekers but the British government has imposed limits on their spending in this respect. This may, in part, be linked to some knowledge of the GPs' limited prescribing list[2]. Such suspicion and lack of trust led to lack of faith in the efficacy of treatment prescribed by GPs with reports of informants having visited GPs, been prescribed some treatment, and returning time and again because the treatment was not effective. One informant described how he had been to his GP because he was in pain. He was prescribed some medicine which was not effective so he returned to his GP who reportedly told him that he could not give him a medicine which costs £3 or £4. Such experiences also resulted in some informants paying to see French GPs because, as well as being able to communicate with them, they trusted them and the treatment they prescribed.

> *"I don't trust them (the doctors) because I never get satisfaction from the services. At any time when the case gets worse we feel forced to abandon the health services, the NHS, and go to private people or Chinese practice or French practice and that's when we get better".*
> (L6)

- ***Helplessness***

Feelings of helplessness prompted some informants to seek treatment elsewhere, primarily with private French doctors in Britain. There are two issues related to such

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[2] During the 1980s a selected list of NHS medicines was introduced, restricting the freedom of GPs to prescribe medicines in seven categories (Baggott, 1998).

decisions; firstly, language was an important factor, and secondly, the private French doctors were seen as 'not NHS'. It was also believed that French doctors would tell the truth. Even though many of the members of the community association were not working they were prepared to contribute a few pounds of their social security to pay for members to seek private health care.

> *"Even when you are not happy, whatever you do will be still helpless because the GP can't do more .... He doesn't want to do more. What we are doing now is, as we are organizing the community group. If it gets serious, people don't want to go to the GP because ...nothing good, we contribute money from our community. Even though people are not working, from what they get from social security, they can contribute either £2, £3 or even £20 or £30 or £40, and go to private clinics to the French people, as we can speak French to these people. So we go there, we have no communication problems, we go to the French people, we explain the situation in French and since they know that we are going to pay for the medical examination, they will do their best to give you medicine, to check and the result is something different from what we get from GPs. They will find out the serious cause of your sickness and what you can't get from the NHS system. So in the end, you see, you can even meet people who are suffering but they don't want to go to the GP because he knows that when you go there the result will be nothing. The outcome will be nothing".*
> (FG1)

One informant (FG3) described how he had been suffering with back pain for the last nine months resulting in him going to his GP approximately once a month and on each visit he was given more medicine; none of it was helping the back pain. *"If I show you the pile of medicine I have it is a lot".* Subsequently he decided to go to a private doctor who examined him and diagnosed a problem with muscle spasm, and gave him some injections to relax the muscles. The informant has been feeling much better since he has received this treatment. He claimed: *"So sometimes I think maybe if you are a refugee ..... it's really a big problem".*

During one of these focus group meetings, when the use of private doctors was being discussed, I asked the group if they ever go to Accident and Emergency departments at hospitals when they are not satisfied with the treatment they receive from their GPs. The response was "*Yes, yes. But again, sometimes even more disappointing than going to the GP"* (FG3). This particular informant then relayed two examples that had arisen during the last six weeks. Firstly, one community member had experienced a swelling around his eye resulting in him being unable to open the eye. He saw his GP who prescribed some cream that proved not to provide any relief. The man telephoned the community organisation as his eye was very painful and someone from the organisation phoned the GP practice, but was offered an appointment three weeks later. So, the man went to a hospital Accident and Emergency department and had to wait between four and five hours to be seen by a doctor who said that there was nothing he could do that day and the man was given an appointment for a month's time. The man was still suffering so the next day the community organisation arranged for him to see a private French doctor who saw the man the same day and immediately referred him to a specialist eye hospital in London where he was treated immediately, within the NHS. *"They treated him that day because the French doctor intervened".* Such examples fuelled the reluctance to go to the GP, and also confirmed that appropriate treatment was available, once the correct doors were opened.

Two situations were described (FG3) when members of the Congolese community in London, who had French citizenship, became ill and actually went to France for treatment which they perceived to be far better and more effective than treatment received in Britain. One example was given of a friend, and member of the Congolese community, who has French nationality and who was admitted to a hospital in London suffering from what sounded like a stroke (*"the arm could not move any more and the leg could not move and it started to get worse").* Because he was a French citizen someone contacted the French embassy in London and arrangements were made for him to be transferred to a hospital in France where he apparently recovered and now he is back at work. So strong was the belief that refugees and asylum seekers in Britain in this study were receiving inferior care and treatment that one of the informants (FG3) asked me where I went when I was unwell – did I go to the same NHS? My informants expressed disbelief when I replied in the affirmative.

Respondents in the study in Newham (Gammell et al, 1993) were also travelling distances and paying private doctors from their own communities.

Dissatisfaction with health services

Many of the informants in London expressed dissatisfaction with the National Health Service for a variety of reasons. Dissatisfaction tended to focus on GPs, being the first point of contact with the British health care system and gate-keepers to secondary health care. In particular, half of the informants (during the individual interviews) complained about the appointment system being operated by most GP surgeries. They felt that it was inappropriate to have to wait and wanted to be seen on the same day. Dissatisfaction with the GP appointment system was also expressed in other studies (Gammell et al, 1993; Papadopoulos and Gebrehiwot, 2002).

Concerning secondary health care, dissatisfaction was expressed in relation to having to wait for a long time in Accident and Emergency Departments and also waiting for appointments to see consultants, and then, again, waiting a long time for treatment once seen by a consultant. Interestingly, when speaking in Lingala or French, informants used the words "*waiting list*" rather than the equivalent translation in Lingala (if there is one) or French, as if the waiting list is a very British phenomenon.

> *"There are long waits in Accident and Emergency ..... check details – identity etc. .... Don't go straight to the problem."*
> (FG2)

In London, dissatisfaction with the NHS was evident. However, questions were raised concerning whether the system is poor or if refugees are treated less favourably. Discrimination was apparent in Britain, in that there were reports of being asked to produce identification at GP surgeries and at Accident and Emergency Departments. One informant reported that, having arrived an hour late for a hospital appointment, he was taken to "*the manager*" who informed him that due to his late arrival he was to go home and he would be contacted by letter; however, he had not received any further communication. It is possible that their entrenched lack of trust influenced perceptions of discrimination, as many of the complaints reported mirrored those made by the general British population as waiting times increased for many services, and examples of poor care were reported in the press.

During the focus groups and individual interviews in Britain it was frequently claimed that GPs do not take health problems seriously enough and are quick to write a prescription. Following visits to GPs many informants expected to be sent to hospitals for x-rays and further medical examinations.

> *"... they don't check seriously, they just listen to you and make a prescription."*
> (FG1)

The above was a statement from an informant who felt that his illness warranted a physical examination. Some informants felt that their initial treatment from GPs was inappropriate and they had to return to the GP a few times before appropriate treatment was given.

There were also concerns raised that doctors generally were not holistic in their approach, not performing comprehensive health checks and merely treating symptoms.

Refugees who come from countries where primary health care is not well developed may expect to be referred to hospital for conditions which are usually treated by the Primary Health Care Team in Britain (Fassil and Burnett, 2001). As a result, it has sometimes been felt that some refugees and asylum seekers have unrealistic expectations of the health services in Britain (Directorate of Public Health, Croydon Health Authority, 1999). On the other hand, some may have been accustomed to hospital-based health care systems with easy and fast access to specialists. This may, in part, account for the general satisfaction expressed with the health care system in France, where people can refer themselves to specialists (Geschwind, 1999).

- ***Culture***

The need to reach "*cultural solutions*" to problems was stressed during interviews in London and community members explained that help would not always be sought from professionals in Britain as they did not understand the community's problems and may lack cultural sensitivity. Dissatisfaction with health services in Britain results from a variety of factors, including communication problems and waiting times but there was also evidence in the data from the focus groups and individual interviews in Britain that there was a lack of understanding of culture. A few informants stated that GPs do not understand them, but this lack of understanding appears to go beyond language to include wider issues of culture such as beliefs about health and illness, illustrated by one informant referring to GPs giving "*different consideration*" to health problems.

> *"The GP does not understand, ... he does not feel it as I am feeling. He takes it a different way".*
> (FG1)

I took this to mean going beyond mere language, to an expression concerning lack of understanding the context in which the encounter occurs. While listening to the words of these informants I was reminded of Freidson's seminal (1970) work on the profession of medicine, in which he argues that the exulted and autonomous position of doctors in western societies allows them to form a professional position that enables doctors to re-define the lay person's health problems within their own frameworks .

One informant referred to the health care providers not having the same sense of humour, and sometimes offending patients, while not intending to.

> *"I think there is another side of the unsympathetic relationship between GP and refugee. I think there is a cultural side of the problem. Because GPs or their receptionists don't really know about other people's culture and when we go there they will .... You know, sometime we do not have the same sense of humour. Sometimes they will tell you something that will make you upset, even though it is not maybe the thing that they want to ... its not that they wanted to make you upset, but the way they said it, the way they will treat you will make you feel bad and then the next time, even if you are in need you don't even want to approach them. So I think they should make an effort to try to understand that whatever part of the world people come from there is a need for them to be treated fairly, and they should accept them as they are. They don't want to be sensitive to your needs, your culture. They put you in the same box at the reception."*
> (FG3)

Certainly, in terms of psychiatry, Fernando (2002) explains how it is a discipline and group of practices that have developed within a Western medical tradition and argues that conditions such as depression and anxiety are usually recognised in psychiatry as symptoms of illness, but may be coping strategies for individuals in particular situations. As such, knowledge of cultural background may be important in differentiating normal coping from symptoms of illness. In interactions between a patient and a professional from different cultures, the former may be unwilling to divulge information because of misperceptions held by the latter concerning culture and lifestyle.

- ***Refugee experience***

There was a perception that providers of health care services did not understand the 'refugee experience', and those that did tended to generalize the related problems, focusing on emotional needs. Informants also felt that there was a belief that asylum seekers are really economic migrants, seeking free health care or housing.

> *"Also I think that many of them believe that refugees have the same problem, which is true, but in relation to medical problems it is wrong. Refugees are people who, you know, we were subjected to some problems in our country which can be true for everyone. But it is wrong when they consider that for medical purposes people have the same needs. They don't know the problem but they assume that because of our fleeing from the country for some reason we are afraid to go back there so it is an emotional problem and that's it; they don't want to know more."*
> (FG3)

Some professionals thus acknowledged the shared refugee experience but failed to appreciate that the presenting illnesses were different. Bariso (1997) also reported that some health professionals and support staff were unsympathetic to refugee/asylum seeking patients. Also, there was a lack of cultural awareness which proved to be a barrier to services. In Newham (Gammell et al, 1993) respondents found the appointment system for GPs stressful and felt that GPs and practice staff lacked awareness of their culture and of the psychological and social backgrounds of refugees and asylum seekers. Carey-Wood et al's (1995) respondents reported that many health care professionals did not understand or did not respond to their problems, especially those related to experiences in their home country or their cultural background. Bariso (1997) described how GPs spent too little time investigating health problems. Doctors tried to generalise refugee health problems and tended to prescribe the same kind of medicine even when illnesses are different. Stereotyped ideas were held about refugee mental health.

- ***Discrimination in health care***

Some informants reported discrimination within the health service. There was a general feeling that when they go to hospital as soon as the nurses know they are refugees they delay attending to them.

One informant stated that on arrival, with his sick child, at a hospital Accident and Emergency Department he was asked *"Are you a refugee? What are you doing in this country?"*. He was going to respond to this:

> *"I was about to tell him to go away or something like that but because we were in a position that the baby was sick I did not want to take him back home because he was really a baby and we stayed there."*
> (FG3)

This was a prime example of the vulnerable and insecure position of refugees and asylum seekers.

Feelings of abuse of human rights and unfair treatment were revealed by some informants in London. For example, a belief was expressed that refugees and asylum seekers are being experimented on in British hospitals. One female informant was concerned that a series of repeat cervical smears was forming part of an experiment. Suspicions were also aroused that the care of refugees and asylum-seekers is reserved for nurses in training, not understanding that trainee nurses can form part of the workforce in Britain, and care for all patients under supervision of qualified nurses.

> *"They have to experiment, but they want to do it on refugees and asylum seekers. And there is another point I remember, when you go to hospital they send for trainees to treat the refugees. They will be doing their studies on your body. Students from the university, student nurses who are still learning. They come for their training and they come to you when they see refugees.... So that medical*

> *practice is discriminatory, and it is even a violation of human rights. You make experiments on monkeys, not on human beings."*
> (FG2)

However, such suspicion is not surprising. Doyal and Pennell (1979) report a history of testing drugs on people in less developed countries before use in the West as well as using drugs banned in the West.

- ***Lack of knowledge about the British National Health Service***

Going to the Accident and Emergency departments at hospitals wanting to see the GP was sometimes mentioned. This could be due to a semantic misunderstanding between the terms GP and hospital doctor or it could be due to a lack of understanding of the respective roles.

FG2 *"If you go to the hospital you will want to see a GP".*

The concern that untrained health care staff are sent to care for refugees and asylum seekers conveys a lack of understanding of the nature of the NHS workforce.

FG2 *"They use all the trainees to treat the refugees".*

Other studies have reported lack of information on the structure of health services in certain languages (Bariso, 1997). The need for refugees and asylum-seekers to be provided with information concerning the NHS has already been identified by the Health of Londoners Refugee Task Group (Aldous et al, 1999).

Overall dissatisfaction with the care and treatment received is probably best expressed by the following quote:

> *"Refugees are not well treated in the NHS or is it that the whole system is not really appropriate."*
> (FG3)

This statement invites consideration of informants' perceptions in the light of the perceptions of the majority population, at a time when some of the failings of the NHS were widely publicized. Some of the areas of concern raised by the informants in Britain were the same for the indigenous population, for example, complaints about the waiting times both for appointments with GPs and also for appointments with consultants. Such concerns were also raised in other studies, for example, in Newham respondents claimed that GPs did not have time to spare because of the numbers of patients waiting (Gammell et al, 1993), also that there was a lack of information about health services.

It is important to be aware of the social-political context within which these informants in London have been receiving health care. While this study was being conducted, there were frequent media accounts of failings within the NHS, for example, a report of thousands of NHS cancer patients dying unnecessarily because waiting times for life-saving treatments were lengthening (Browne, 2002); a report of babies dying unnecessarily and women being injured because doctors are failing to follow basic procedures in maternity wards across Britain (Ahmed, 2002).

Returning to the issue of communication and the inability to communicate with professionals linked to suspicion, one informant found his suspicion was increased when he had learned to read English:

> *"When my English was very little I used to try to trust them (*health care providers), *but now watching some programmes on TV, I'm reading some newspaper and it's difficult. When I go to hospital or to the GP I have to open my eyes because there are already so many doctors killing people, giving them wrong tablets and I read last week in the newspaper the government said there are many wrong GPs .....so most of the time I have to be careful."*
> (L2)

This informant had trust in health care providers when he understood little English but when his command of the English language improved he was alerted to the problems the National Health Service is experiencing. These interviews took place at a time when there was a series of media reports of mistakes and malpractice in the National Health Service. Of particular importance is the case of Harold Shipman, the general practitioner who was found to have murdered many of his elderly female patients during the period 1974-1998 and was eventually confirmed as Britain's worst mass murderer (Leppard, 2002). This study was also carried out at a time of many reports of failings of the British National Health Service, including long waiting lists for appointments and treatments. So long were some waiting lists for treatment that patients were given the right to have NHS funded treatment, mostly operations, at hospitals in other European countries (Rogers, 2002). Indeed, research by the Organization for Economic Co-operation and Development (OECD) found that Britain's health care system is one of the least effective (Rufford, 2002). A newspaper report claimed that England has the worst record in Europe for babies dying in the peri-natal period through sub-standard care (Dobson, 2003).

The following example, offered by a man, aged 37 years, with refugee status possibly depicts the current malaise of the British National Health Service:

> *"Six weeks ago when my baby was born, the doctors told us that my wife was going to be discharged from hospital at 9 o'clock in the morning. I went there at ten to nine and waited for the midwife to come and for my wife and baby to be discharged. My wife had some pain, so she had to get some tablets to take home. The chemist is at the Emergency Department and it takes 5 – 10 minutes to go out to the Emergency Department and the midwife said "we are short of staff, there is no-one to send to get some tablets for your wife. If you want you can go there yourself to collect". I went myself to collect the tablets, then they said that she had to wait until the person who was to sign the discharge form will come. We waited until 6.30pm for my wife to be discharged. My boy was at school and I had to come back to pick him up. I was very sad, very annoyed. At 5pm I went to collect my boy from the school and then I went back to the hospital. I was going to remind them after 30 minutes .... They said "no, you have to wait, you have to wait". At half past six there was no-one to sign the discharge papers. They said "ok go home, you don't need to blame us, blame the government". And when we reached home it was very cold ....."*
> (L5)

However, there were reports of good practice: one informant in Britain (L2) was satisfied with one GP but then had to move and consequently changed GP.

> *"My first GP was understanding; he asked me some questions about my country, about my health. But the second GP did not pay any attention to it. The first GP took things very seriously".*

Papadopoulos and Gebrehiwot (2002) have also reported a lack of knowledge among some refugees and asylum seekers about their rights to free health care in the UK. Some health care professionals may also be unaware of the rights of this group. In the UK, registration with a GP is the first step in accessing primary health care services. While GP registration was high among these informants, as was the case with other studies described in Chapter 3, it is possible that use of GP services does not match the registration rates. Carey-Wood et al (1995) found that while 99% of their informants were registered with a doctor, only 40% of those who said they had a medical or psychological problem had actually sought help.

Although the evidence suggests that in established communities levels of GP registration can be reasonably high, there are still reports of problems with first registration, and with the high proportion of cases where the Health Authority has to allocate a GP (Jones, 1999; Scott and Vallely, 1999). There is also an uneven distribution of refugees between practices, with some practices taking on a much higher proportion of refugees (Jones and Gill, 1998a). Some GPs may offer only temporary registration, which means that medical records cannot be passed on and continuity of care may suffer (Health Education Authority's Expert Working Group, 1998). Temporary registration does not require a comprehensive health check, as normally happens with a new registration with a GP.

- ***Experience of health services in France***

In stark contrast, the informants in France who were refugees or asylum seekers, with one exception, expressed complete satisfaction with the care and treatment they received from the health care system. The following quote is typical of the responses to questions about the provision of health care:

> *"No problem with the health services. I have complete confidence in the providers of health care. One is cared for like the French – 100%."*
> (P1)

> *"I have confidence because I choose the doctors. When I go to the hospital, there is a list of doctors. There are also lots of refugees who are nurses and doctors who work in the hospitals and before I go I tell them I am suffering from such an illness and ask them to recommend a doctor."*
> (P13)

Most informants were in agreement that if they became ill they would be cared for like the French. Health care in France is good (Lang et al, 2002) and generally there are no major problems in meeting the needs of patients in France (Geschwind, 1999).

The one informant (P14) who was not so satisfied admitted that the structures do exist for access to health care but perceived the existence of the hospital in Paris which offers free care and treatment exclusively for asylum seekers to be performing some sort of discrimination. This informant did harbour suspicions similar to those identified in the informants in London. His suspicion may have been enhanced by his particular experience of family persecution in the DRC; further, he is a sociologist and is therefore accustomed to thinking critically about institutions. Also, while various charitable organizations do provide free care, the few informants whose applications for asylum had been refused, those undocumented asylum seekers (*les sans papiers)* said that they did not have access to health care.

However, it is worth pointing out that while this particular group of French speaking refugees and asylum seekers were satisfied with their health care, other groups may not fare so well. Kotobi (2000) reports on a study relating to migrant Africans and hospital attendance in France. The study highlights the ethnocentrism of professionals engaged in health care, and the resultant impact on their care. There is a tendency, among professionals, to draw attention to differences in lifestyles, which are also believed to contribute to their difficulties in integrating into French society.

Again, in France the informants believed that discrimination did occur in other areas of French society but not in relation to health care. In response to a question about discrimination the following comment was typical:

> *"It's the state, not the health care professionals."*
> (P2)

This statement refers to employment which will be addressed in the next chapter.

Poor relationships between staff and patients are recognised as contributors to patient dissatisfaction (Gilson, 2003). Gilson further acknowledges that this dissatisfaction may not be 'offset' by the provision of good care and treatment.

> *"Trust is a relational notion: it generally lies between people, people and organisations, people and events."*
> (Gilson, 2003, p1454)

Trust is based on expectations of how others will behave and unfulfilled expectations will lead to unsatisfactory outcomes (Gilson, 2003). Expectations of how health care professionals are likely to behave will no doubt be informed by previous experiences. In this case lack of experience of a GP gatekeeping system to secondary health care was instrumental in the expressed dissatisfaction with health care in Britain. This probably accounts, in part, for the differences in satisfaction with health care in the UK and France. Difficulties with communicating with health care providers also contributed to the unfilled expectations in Britain. The expectation is usually that the provider of health care will show impartial concern for the welfare of the patient, in keeping with professional codes of ethics and conduct that govern health professions (Gilson, 2003). In Britain informants did not perceive this impartial concern; instead there was a unanimous belief that health care providers were not acting in their best interests and that this was on the instruction of the Department of Health which was believed to have posed restrictions on what medicines and treatment GPs could prescribe for refugees and asylum seekers. Faced with the prospect of having to put their trust in strangers and social systems that are unfamiliar to them, refugees and asylum seekers were unable to place trust in the health care providers or the system. However, Gilson (2003) argues that funding arrangements for health care provision can also influence trust between patients and providers. In this study, informants in the UK may have been aware of debates surrounding the ongoing under funding of the NHS.

The establishment of a trusting relationship will offer benefits to both patient and health care provider in terms of possible adherence to prescribed medication, alleviation of symptoms, possible cure, and ultimately reduced cost of care. In this study, the converse was frequently described, in Britain, with informants relating accounts of repeated prescriptions of paracetamol, which they deemed inappropriate, the prescription of ineffective treatments which resulted in return visits to the health care providers and doubts about the diagnoses made. The costs arising from these situations include encounters that are not satisfying either to the individual patients or the health care providers but also include financial costs to the National Health Service.

Coulson (1998) states that when trust is broken individuals will anticipate problems, be instinctively suspicious and seek second opinions. Disillusionment sets in. As trust was not invested in health professionals, in this case the informants in Britain chose alternative health care provision. Deprived by their lack of status of the ability to use 'voice', they used their 'choice' and sought advice and treatment from the private sector, notably French speaking doctors with whom they could communicate.

The informants' lack of trust must also be viewed within the context of the refugee experience. It has been known for refugees and asylum seekers to be betrayed by neighbours and acquaintances in their home countries (Ager, 1999) and by teachers, doctors and nurses who have been forced to betray patients or others sheltering in hospitals; many of these 'informers' were women (Summerfield, 1999b).

Conclusion

The similarities in health problems among my informants in Britain and France are not mirrored in their experiences of using health services and there was a major difference in the perceptions of the informants' experiences in Britain and France. There can be no doubt about the importance of being able to communicate in the language of the host country. In Britain, being unable to speak English posed huge problems during encounters with health professionals, but these difficulties with communication go beyond the ability to exchange words, affecting and influencing the entire experience of living in another country and resulting in suspicion and a cumulative deterioration in lack of trust. It is clear that an inability to communicate in English with health care professionals presents a major obstacle to satisfactory health care arrangements in Britain, and, as literature suggests, might also be the case for refugees and asylum seekers who do not speak French in France. However, in this study, informants in France expressed satisfaction with the health services. Another possible explanation for the different perceptions in the two countries might lie in the different arrangements for the provision of health care; in Britain the gate-keeping role of GPs to secondary health care may be contributing to the dissatisfaction, whereas in France people can refer themselves to specialists of their own choosing. In Britain the informants had an overwhelming perception of being treated differently, while in France the informants, at least those who had the necessary papers, were confident of being treated the same as French citizens. This had an enormous effect on the relationships between the refugees and asylum seekers and the providers of health care. Trust in health care provision in France was no doubt linked to choice.

As well as causing problems concerning health care, the inability to communicate in English contributed to a sense of 'otherness' for the informants in London and also to a sense of 'not belonging' to the country, which is essential for participating in community life. This sense of 'otherness' is the focus of the next chapter.

CHAPTER SEVEN

OTHERNESS

Introduction

Socio-economic factors form the subject of this chapter, within the context of the overarching theme of 'otherness' experienced by the informants in both Britain and France. In essence, otherness in Britain was closely related to communication problems, and in France otherness was related to not being French. However, that is to oversimplify the situation, and the sense of otherness incorporated experiences of discrimination, a sense of feeling on the margins of society and perceptions of exclusion. As well as the objective aspects of social exclusion, such as poverty, inadequate housing, inappropriate employment or unemployment and discrimination, the subjective sense of feeling excluded from society was evident as informants talked about feeling isolated. Comfort was sought in religion, most of the informants regularly attending church along with their compatriots. Support networks available to the informants will be discussed, and also the aspirations the informants have for the future, including, for some, a sense of optimism. It will become apparent that a sense of vulnerability permeates all of these themes.

'Otherness' arose as a theme from the initial focus groups in London, and was echoed during the individual interviews in France. Also, in Britain the sub-theme of 'foreigner' arose when informants seemed to attach a lot of importance to being identified as "*someone not from this country*". This seemed to impose a barrier to any meaningful communication particularly with members of the health professions. Again, in France internalisation of the clear distinction between a national and a 'foreigner' was evident in responses from the informants. Other sub-themes that emerged in both countries are social exclusion, particularly in relation poverty and housing, and also lack of voice, reflecting a lack of political expression. The issue of social support also featured prominently and this was provided mostly by the Hackney Congolese Community Support Group in London; in France, Le Souffle predominantly met this need. During the individual interviews in both countries, three more themes emerged. These are aspirations for the future, the issue of work (or lack of it), and safety, which for many of the informants, was marred by experiences of, and fear of, street crime.

Some informants were able to identify with the wider range of socio-economic factors that impinge on the health of minority ethnic groups, but also raised concerns about factors that are specific to the 'refugee experience', notably the reduced eligibility of asylum seekers for financial support from the state, and lack of political rights .

Themes relating to 'otherness' that arose from the data:

Foreigner

Social exclusion

Poverty

Housing

Employment
Discontinuity

Discrimination

Lack of voice

Safety

Fear of crime

Social networks

Aspirations for the future

Foreigner

In London there was an overall perception that people would be treated differently once identified as '*foreigners*'. Some of my informants reported feeling unhappy in this country, described as a " *foreign, strange land"*, also reporting problems with integration because of an inability to speak English.

One informant (already referred to in Chapter 6) was an hour late for a hospital appointment and told me that he was taken to "*the manager"* who said that because he was an hour late he had to go home and they would write to him: this informant has not yet (at the time of writing) received another appointment, and his comment was:

> *"Nothing done, so that's being in a foreign country".*
> (FG1)

Another informant in London felt that British people had very pre-conceived ideas about African people:

> *"The community here has a negative attitude because there are people who never think that somebody from Africa can have any skills. They look at people like fools, they look at people like illiterates ..... simply on the ground that you are a foreigner from Africa, and you know nothing."*
> (L1)

This sense of being an outsider arises for a variety of reasons. Firstly, government policy in relation to immigration and asylum determines who belongs and who does not, and locates refugees and asylum seekers on the margins of society through a strategy of civic stratification. The media also plays a part in portraying refugees and asylum seekers as outsiders and in displaying very negative images.

One of the female informants (L10) in London had recently arrived in Britain and was therefore subject to the provisions of the 1999 Immigration and Asylum Act. This woman had chosen not to be dispersed to another part of the UK, instead she was staying with her sister in Hackney, and was worried that she could not find her own accommodation because she did not have the money for a deposit. She could not work, and had been told on arrival in the country that she was not allowed to do anything. While this informant expressed relief at being allowed into Britain, she was sad that she could not see any opportunities ahead.

In France, one is either French or a 'foreigner' and the system of support exacerbates the sense of isolation.

> *"If you don't have papers .... You are nothing, your are in total exclusion. You can't do anything.... Here in France, if you don't have papers, you can't have an address, if you don't have an address, you can't work, you can't do anything. Everywhere you go the first thing they ask for is papers. It is total exclusion. That gives you a headache and it is because of that that lots of refugees have high blood pressure. As a result of stress, of problems".*
> (P13)

Constructing refugees and asylum seekers as 'the other' results in social exclusion. The 'other' is a social construction that defines and secures the identity of the host population by distancing and stigmatising those who are not seen to belong (Grove and Zwi, 2006).

My interpretation of my informants' descriptions of themselves as "foreigners" was that they viewed themselves as standing outside mainstream society. They were aware of their lack of citizenship status, particularly in France where non-citizens are labelled as 'foreigners'. Informants were aware of their lack of rights, relative to citizens in their host countries, and particularly political rights in terms of a "lack of voice". In this case international laws and declarations have been insufficient to confer a sense of belonging to the host societies.

Social exclusion

The term 'social exclusion' probably originated in France, during the 1970s, where it was used to refer primarily to those who slipped through the social insurance system (Burchardt, Le Grand and Piachaud, 1999; Davies, 2005). These people (*les exclus*), included people with physical and mental disabilities who were not necessarily poor, but were disconnected from mainstream society by poor health, geographical location and/or non-participation in politics (Davies, 2005). The term 'social exclusion' appeared in British policy discourse during the late 1990s and was believed to be a result of industrial decline in the 1980s and a failure of the welfare state to support those who were affected by this decline (Davies, 2005).

According to Roche (1997), social exclusion can refer to problems of poverty and unemployment in a narrow sense, and to all forms of discrimination in a broader sense, for example, a deprivation of social rights and of access to the public sphere, and thus to social citizenship. Social exclusion may result from an individual perception of not belonging or by policies that stigmatise and marginalise people. Writing in France, Dewitte (2000) and Fassin (2000) have both drawn attention to the part played by social exclusion, for example, unemployment, poverty, insecurity, in the explanation of the symptoms of illness.

Some of the informants in both London and Paris felt excluded from society as they talked about feeling isolated.

> *"People feel depressed, for example, the fact that they are not fully accepted into society, isolation, discrimination, people can be sick."*
>
> *"We suffer a lot when we come into a society where people look more to their own selves and they look at strangers simply as strangers and people get lost."*
> (L1)

Informants in London perceived themselves as being on the margins of society. The following quote arose in the context of a discussion concerning waiting to see a GP in a busy practice:

> *"You see people coming in behind you, being called into the office, being checked before you. We are part of the minorities suffering in this country."*
> (FG1)

Informants were quick to identify with minority ethnic groups in Britain. Shaw, Dorling and Smith (1999) explain the complex situation of members of minority ethnic groups by describing how they are often in poor socio-economic positions, which can affect their health, but they may also experience the additional effects of prejudice and racism. Thus, the harm to health comes not only from material deprivation but also from the social and psychological problems resulting from their situation. Further, informed by their natural suspicion, refugees and asylum seekers have lost a status that they enjoyed in their countries of origin. They have lost their citizenship status of their home countries, but also the status attached to their social roles, e.g. family, work.

Other studies have identified a sense of isolation among refugees and asylum seekers (Gammell et al, 1993; Brent and Harrow, 1995; Haringey Council, 1997), while Jones (1999) also refers to the effects of isolation on health. Papadopoulos and Gebrehiwot (2002) also found that becoming a *'foreigner'* was a major transition for Ethiopian refugees and asylum seekers in London, compounded by losing their status as citizens.

The interviews in London took place when the implementation of the 1999 Immigration and Asylum Act substantially changed asylum seekers' rights to benefits. Informants in Britain felt marginalised by policies like that of issuing vouchers for food, being deprived of the dignity of handling cash and being asked to produce identification when exchanging vouchers for food. Some informants employed metaphors to describe their experience: the check-out assistant in the supermarket was likened to an immigration officer and the experience being *"Like Dover. Crossing the border"* (FG3).

> *"And there is more pressure when they start giving you vouchers for food. It means you can't handle the cash, money. It's a violation of human rights. Because I'm a human being I need to have access to cash, money, and when you go to the shop, into Sainsbury's or Tesco, you have to queue up, everybody sees that you queue with your food voucher and the person at the counter becomes like an immigration officer. Because he needs to see your documents, your identification, so beside you there is a queue of people with their baskets, their*

> *trolleys full of food, they are handling money, and you in another queue, you have to hand a voucher and your ID".*
> (FG3)

In a similar vein, O'Kane (2001) reports on the humiliating experience of an asylum seeker from Afghanistan at a supermarket checkout a few months after arrival in Britain. He was buying food with his grocery vouchers when someone behind him said "Look at you, eating our taxes". The system of issuing vouchers is divisive and has produced many problems. Harding (2000) describes how vouchers for asylum seekers could be exchanged for food and goods in retail outlets that agree to take them, while Gillan (2001) reveals the reality of the voucher scheme and the humiliation and embarrassment attached to it. The need to fill a shopping basket with items whose cost will equate with the value of the voucher proves difficult, resulting in cashiers, forbidden to give change, urging refugee customers to top up to the full value of the voucher with something like a handful of wrapped sweets, or the supermarket keeps the difference (Gillan 2001). There is also little choice of ethnic foods. The use of vouchers also creates dependency on the state, increases the visibility of refugees and asylum seekers and confirms social exclusion (Sales, 2002a). Given so many problems, it is not surprising that the British government, as part of its reform of immigration processes, abandoned the much reviled voucher system in April 2002 and replaced the vouchers with cash. This reversal in policy largely resulted from the campaigning activities of services providers and voluntary and statutory organizations (Sales, 2002b). Woodhead (2000) proclaims indications that the scheme had far-reaching effects on mental health, as well as nutritional status of refugees and asylum seekers.

- ***Poverty***

The detrimental effects of poverty on health have been described (Blaxter, 1989; Benzeval and Judge, 2001; Benzeval, Judge and Shouls, 2001). However, for many people, as well as the effects on physical health, psychological health is affected by poverty as well. The effects of the psycho-social stress brought about by relative deprivation have been extensively described (Wilkinson, 1992; 1996).

In France asylum seekers receive an allowance from the state but it lasts for only one year. I heard repeated and desperate claims from the informants in France that their support was "cut" after a year (*"Une année, une année .... C'est coupé"*). One particular informant, a man who had been in France for over 2 years and was still waiting for a decision on his application for asylum, said the following:

> *"I no longer have the right to support. I can't work .... I'm finished."*
> (P5)

This man's wife had joined him in France, but he had developed high blood pressure and the level of cholesterol in his blood was raised and he was experiencing desperation.

Another informant, an asylum seeker studying in France (P6), was concerned for his wife and children who were still in the DRC. He was trying to obtain visas so that his family could leave the DRC and join him in France but the French Embassy in Kinshasa was demanding a lot of money for the visas and he simply could not afford the fees, something that caused him a lot of distress.

In Britain, informants, particularly mothers with young children, referred to the supermarket being expensive and their low incomes being insufficient to meet all their needs and pay the bills. Again, it was claimed that such worries caused headaches. Refugees and asylum seekers are thus excluded from the general norms of consumption through economic hardship (White, 1998).

Poverty can affect physical health by interfering with the acquisition of prerequisites for health such as food and shelter; poverty can affect psychological health because of the stress that is caused, as has been demonstrated in the previous chapters. Health damaging behaviours may result from poverty as a way of coping (Benzeval and Webb, 1995; Shaw, Dorling and Smith, 1999).

Carey-Wood et al (1995) identified relative deprivation as an important factor in the success, or otherwise, of settlement of refugees. In Papadopoulos and Gebrehiwot's (2002) study one third of participants (Ethiopian) were struggling financially, a situation which resulted in social isolation. Informants felt that a reduced choice of food had effects on health. The effects of financial hardship on the health of refugees and asylum seekers have also been noted by Jones (1999).

- ***Housing***

While discussing poverty and the use of vouchers, the marginalisation experienced by asylum seekers in Britain was described as *"diminishing your status"*. Problems with dealing with other government departments were reported, notably immigration, social services, social security, housing, all creating *"too much pressure"*, which in turn was believed to lead to health problems. In London, the state of their housing and their general living conditions were likened to those in refugee camps and another metaphor was employed, describing themselves as being *"in a war situation, like people in Kosovo"*.

Housing plays an important part in the resettlement of refugees and asylum seekers (Carey-Wood et al, 1995). In London I witnessed some of these living conditions, as the interviews were held in the informants' homes. Some of the accommodation I saw was of a very poor standard with dirty kitchens and bathrooms. The first focus group was held in a house in Hackney in which some of the asylum seekers rented rooms and it was indeed unsatisfactory. The following quote comes from one of the group members:

> *"Housing has a direct effect on health. You can see the house when you are entering, you can walk, get into all these rooms, the toilet, the bathroom........ That's why they are talking about infections, you see, the way they feel themselves like people in Kosovo.* (Much laughter among the group). ... *They feel themselves in a war situation. The living conditions, the bad conditions, just as refugees in camps in Kosovo, because no good toilet. In Kosovo there is war, weapons, the bombing there, but here there is also bombing because the conditions are not good. If they are sick they get germs, they get infections, another form of bombing as well. Because if people die from bombing there in Kosovo, people will die here from infections. It is only a question of time, if you want to check everything here, we will stay here, they will talk, talk, talk until tomorrow morning."*
> [1](FG1)

These same informants also questioned whether English families would accept such poor accommodation. This is also indicative of lack of trust in authorities that provide housing; the participants in FG3 believed that such housing would be rejected by English families, suggesting notions of policies that are deterrent in nature and provided for people who are deemed undeserving. This is further an expression of lack of political rights, notably the right to protest.

Other informants in London described living in cold housing and one woman with young children had been housed by the local authority in a flat on the eighth floor of a tower block; she was very worried about the safety of her children. Best (1995) has reported on the risk of accidents for people living in disadvantaged circumstances, particularly those living in high-rise buildings.

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[1] Interviews in London took place at the time of the war in Kosovo and comparisons were drawn between the plight of Kosovans and the informants.

The effects of housing on health have been well documented (Townsend, Davidson and Whitehead, 1992). In Britain, studies have found that people who own their own homes have better health than those who rent their homes from a private or public landlord (Townsend, Davidson and Whitehead, 1992; Shaw, Dorling and Smith, 1999; Harkins and Stead, 2002). Homelessness is known to have detrimental effects on health, for example chest infections, skin conditions, misuse of alcohol and drugs and mental health problems can arise (Best, 1995). Also, families living in temporary accommodation are confronted with hazards to their health as they may be living in overcrowded accommodation without adequate access to hygiene and cooking facilities, or safe places for children to play (Best, 1995). For those individuals living in cold and/or damp housing, the risk of chest problems is increased due to the presence of dust mites and fungal spores, which thrive in damp housing (Best, 1995).

Concerns were expressed about their poor living conditions by informants in both countries. Informants in France told me that many asylum seekers in France are without housing, some sleeping rough. Some of the informants in France were living in hostels (*foyers)* but wanted to find their own accommodation.

In France, one in three 'foreigners' from sub-Saharan Africa live in inferior housing, compared to one in fourteen French people (Fassin, 1999, p51). In France, in the 1980s and 1990s the presence of numerous immigrant families in low-income neighbourhoods on the periphery of cities became noticeable (Body-Gendrot, 1995). The resultant segregation diminishes opportunities for social cohesion, as poor people not only have to deal with their own lack of income and resultant social status, but also with the social effects of living in a neighbourhood where most of their neighbours are also poor (Kawachi and Kennedy, 1997). Assimilationist strategies of dispersal failed to achieve integration and instead resulted in marginalisation (Body-Gendrot, 1995).

Henley (2003) reports on a public housing estate, less than 50 miles from Paris, housing people from 29 different ethnic groups in high-rise, run-down blocks built in the 1960s and 1970s for immigrant workers. The estate has high unemployment and violence is a daily fact of life. Societies in which there are high levels of income inequality and diminished social cohesion have higher levels of crime and violence (Kawachi and Kennedy, 1997). In turn, fear of violence and crime may inhibit social interaction and tend to increase mistrust (Stansfield, 1999).

The concentration of poorer households within particular locations results in pressures on local services, most importantly social services (Best, 1995; Kawachi and Kennedy, 1997). Living in such conditions can result in insecurity from, and fear of, crime. Referring to studies conducted in the USA, Wilkinson, Kawachi and Kennedy (1998) argue that violent crime is related to inequality, social trust and mortality rates. Acknowledging that people's health is affected by individual income inequality, for example, via experiences of low self-esteem consequent on low social status, worry concerning debt, financial insecurity, these authors suggest that income inequality can also have a broader societal impact in relation to social trust, as marginalised people turn to crime as a means of gaining self-esteem and respect among peers, through the breakdown of social cohesion.

Carey-Wood et al's (1995) study of refugee settlement revealed that securing somewhere to live was very important, especially in the early years. Respondents were heavily reliant on relatives, friends, acquaintances and members of community. Consequently, they tended to move frequently and were dependent on the rental market. Generally the standard of housing for the refugees was poor.

Other studies have commented on the poor standards of accommodation inhabited by refugees and asylum seekers (Gammell et al, 1993; Haringey Council, 1997; Jones, 1999; Papadopoulos and Gebrehiwot, 2002) and Jones, again, has commented on the effects on health of poor housing.

- **Employment**

The following four tables provide information about the occupations of the informants in DRC and their occupations in Britain and France at the time of the interviews. It is evident that none of the informants are working in occupations of a standing that is similar to the occupations held in DRC.

Table: 8 Refugees and employment in Britain

Sex	Age	Occupation in DRC	Occupation in Britain
M	35	Printer	None but learning English and computing.
F	22	None	None
M	37	Jeweller	None but studying languages.
F	40s	None	None
M	40s	Pastor	Pastor
F	30	None	None

Table: 9 Asylum seekers and employment in Britain

Sex	Age	Occupation in DRC	Occupation in Britain
M	30s	Teacher	Works for HCCSG
F	33	None	None
M	30s	Primary school teacher	None
F	30s	None	None

Table: 10 Refugees and employment in France

Sex	Age	Occupation in DRC	Occupation in France
M	35	Biochemist	None
M	40s	University research assistant	Security guard
F	30s	Journalist	None
M	40s	Director of NGO	None
F	30s	Television journalist	Domestic work
M	30s	Teacher	Sociologist

Table: 11 Asylum seekers and employment in France

Sex	Age	Occupation in DRC	Occupation in France
M	26	Electrician	None
M	36	Technician	None
M	44	Commerce	None
M	45	Veterinary surgeon	None
M	40s	Lawyer	Studying and works for Le Souffle
F	27	None	None
M	40s	Civil servant	None
M	50s	Customs inspector	None

While those with refugee status have rights to the same levels of social security as nationals of the two countries, social rights were felt to be affected by other influencing factors such as housing and work, or lack of it. In both Britain and France people who have acquired refugee status are allowed to seek employment, however, asylum seekers have restrictions imposed on their eligibility to work. At the time these interviews were carried out, in Britain asylum seekers could apply for eligibility to work after six months residence: in France asylum seekers are not permitted to work at all. Neither can asylum seekers in France study, with the exception of attending French language classes held by non governmental organizations. The French government finances language tuition for Convention refugees. In Britain, while refugees or those with ELR pay home student fees for Further and Higher Education, asylum seekers pay overseas students' fees. As such, asylum seekers in both countries are denied the opportunity to support themselves and their dependency on the state is reinforced.

Regarding employment, none of the five female informants in London had paid work in either the DRC or in London. Among the five male informants in London, all had worked in the DRC, but only one is working in the same capacity in London, in that he is a Pastor. The other four men are not working, even those with refugee status and thus entitlement to apply for employment. Two of these men were teachers, one works for the support group and one does not work at all; one was a printer and is now learning English and computing; one was a jeweller and is now learning languages. In France, only three informants with refugee status are in paid work. One who was a research assistant at a university in the DRC is now a security guard; one who was a teacher is now a sociologist; and a woman who was a television journalist is now doing domestic work. Refugees in

France who are not working had former employment as a biochemist, a journalist and a director of a non-governmental organization. Such 'under-employment' represents a waste of the talents of my informants, when they could be facilitated to contribute to the economies of their host societies, but also has implications for their own self-esteem, as they are excluded from the opportunity to contribute to society (White, 1998). It is also established that unemployed people have worse health than those in employment (Townsend, Davidson and Whitehead, 1992; Harkins and Stead, 2002).

Discontinuity

One informant in France, a woman who had been a journalist in the DRC and is now engaged in domestic work in Paris, talked extensively about her experience and described her situation as follows:

> *"Well, me, for example. I was a senior executive in the Congo. I was a television journalist. I had a good life, a beautiful house, several cars, domestic staff at my service. But when I arrived here ...... in France it is very hard. I descended several levels in society. I feel as if I have been in freefall. And that, ... that causes hypertension. At home* (in the DRC) *if you have the means, you have the whole family at your service, because you pay for their schooling, you pay for their health care, you help them. In return, they do things for you, they come and look after the children, they help you with the housework. But when I arrived here ..... the children need help with their homework. At home I paid a teacher. Its very hard. And I have to work ... and also the racist comments ... its very hard. If you don't work, you don't have enough money, you don't have a good life. The French think that we are taking their jobs. Its very bad. At home I was respected. I have had to swallow my pride and become a jack of all trades. There are lots of problems for people who do domestic work. When the children return from school, I have already gone out and when I come home they are asleep. I'm not there to help them with their homework, consequently their education suffers. I have hypertension, but these problems can also cause stomach problems and all sorts of psychosomatic illnesses .... It's all linked to stress."*
> (P13)

This informant was clearly describing the effects of her change in status, depicted by low self esteem, unfulfilled roles, psycho-social stress and not being able to achieve potential. These are all typical of the relative status described by Wilkinson.

Another informant in Paris (P11) talked at length about his previous work with a non-governmental organization, showing me photos of himself on official visits to other countries, including Britain and the United States of America. He clearly treasured these memories of his past and was proud of his previous responsibilities and successes. This status is now lost to him. The sense of loss experienced by refugees is compounded, for many who are professionals, by their inability to exercise their skills in the country of asylum. Noiriel (1996) notes the 'down-graded professional status' of immigrants in France.

Carey-Wood et al (1995) found that the struggle to enter the job market tended to dominate their interviewees' concerns. Work has been identified as a key factor affecting refugee settlement as it aids integration and material wellbeing (Bloch, 1999b). Other studies have found high levels of unemployment among refugees and asylum seekers (Gammell et al, 1993; Healthy Islington 2000 and Islington Zairean Refugees Group, 1995; Bariso, 1997;Haringey Council, 1997); those who were working received low pay (Haringey Council, 1997) and the expertise of professionals in the communities was not utilised (Bariso, 1997). There were some reports of downward mobility in that refugees and asylum seekers stated that they were not employed in work that was comparable to their employment in their home countries (Gammell et al, 1993; Carey-Wood et al, 1995). A study conducted by the Africa Educational Trust (1998) concerning refugee education, training and employment in inner London found that the level of unemployment is high compared with the rest of the population and identified difficulties with English language as being a major barrier to refugees gaining employment: other major barriers included lack of familiarity with the working and job-seeking culture in Britain, lack of work experience in Britain and lack of references, and discrimination. The study also found that when refugees do gain employment it tends to be in informal, short term, low paid, menial jobs with no job security.

Informants in both countries talked of the futility of lack of opportunity to use educational qualifications to the full.

> *"The whole system is just crazy."*
> (FG3)

One informant in London (L1) was a teacher in the Congo and I asked him if it was a problem for him not being in a similar position in London. His reply indicated that it was a problem for him but that he was conscious of possessing transferable skills that he could use in a different domain. He was, however, concerned about the waste of skills possessed by many refugees and asylum seekers, referring to an editorial of the British Refugee Council magazine, which stated:

> *"Among the refugee communities in the UK are doctors, engineers, teachers and university lecturers – professional people with high levels of skills and*

> *qualifications. We would welcome the opportunity to put these skills to good use and contribute to the economy of the UK. We refugees would prefer to support ourselves than to rely on Government handouts."*
> (Kawani, 1999, p2)

This particular informant was adamant that refugees should be given the opportunity to use their skills for the benefit of the wider community and was committed to helping his compatriots to use their skills in order to contribute to society and to avoid the depression that might develop otherwise. The Hackney Congolese Community Support Group had acquired some computers which they were using to train members of the community in computing skills in order to help them to enter the labour market. In France, a man (P6) who had been a lawyer in the Congo was training to be a consultant in refugee rights, thus utilising his existing skills with the hope that he might further be able to advocate on behalf of other refugees and asylum seekers.

One of the informants in France (P7) expressed the view that work is important to wellbeing and was anxious to acquire refugee status in order that she could seek employment. Another informant (P2) had worked as a biochemist in the Congo and his qualification was not recognized in France. This man had refugee status and had applied for jobs in France but claimed that discrimination was preventing him from being successful. He described a situation in which he had responded to an advertisement for a job; he had to take a competitive examination (*concours)* in which he was successful and he claimed to have achieved results that were similar to those of the French applicants. However he perceived his lack of success to be due to discrimination and/or racism:

> *"I am resident but not French."*

Henley (2004) reports that France is failing to assimilate immigrants, citing a report from a government commission describing a picture of ghettos, soaring unemployment and inadequate education in a "*socially and professionally disadvantaged community*". The report is lacking in figures as the French census cannot ask questions about race or religious belief. However, Henley also reports on a separate study by Tribalat, a sociologist, which shows that unemployment among second-generation Algerian immigrants is three to four times that among native French people. Banton (2001) refers to a report from a French newspaper suggesting that some young job-seekers from migrant communities in France have found it easier to obtain employment if they change their first names to appear more French. Again in France, Hansen (2003b) acknowledges that the state's aversion to ethnic monitoring renders statistics difficult, but cites anecdotal evidence of high rates of unemployment among France's North African communities in Paris' northern suburbs.

- ***Discrimination in employment***

While informants in London raised some examples of their perception of discrimination in relation to health care and housing, there were few examples offered of discrimination in relation to employment. Nevertheless, it is important to acknowledge that discrimination against refugees and asylum seekers does take place in Britain in relation to employment, for example, in Bloch's (1999b) study of refugees in the London Borough of Newham, informants perceived racial discrimination and discrimination against refugees to be barriers to suitable employment. In France, informants cited examples of discrimination, particularly in relation to employment. In terms of employment, informants in France believed that respect for equal opportunities was more evident in Britain than in France, believing that in Britain an individual's ability to do the job is seen as more important than the colour of his/her skin. Reference was made to British television, stressing that people *"of all colours, of all races"* can be seen as news readers, or working in banks, whereas in France only French people are seen in such employment.

> *"The difference between France and England is that in England they consider the abilities of the individual. If the person is able they give him the job that he deserves, but here even if someone is able they consider his colour and origins....... As in English television .... All colours, all races, but here, no, there are only the French."*
> (P8)

> *"French society closes the door."*
> (P9)

In France there is not a single MP of north or black African origin (Henley, 2005). Indeed, in the wake of the riots in Paris suburbs and other French cities, President Chirac demanded that the French media and political class become more representative of the reality of French society (Henley, 2005). However, positive discrimination and quotas were ruled out as they do not reflect republican values. In terms of news readers, Campbell (2005) reports on the recent appointment of Audrey Pulvar, a television journalist from the French Caribbean, as one of the first black television readers in France.

In France, 'foreigners' are nearly twice as likely as the French to be 'workers' (*'ouvriers')* and intergenerational social mobility is more evident among French citizens than among 'foreigners'; a consequence of having less qualifications and experiencing difficulties in gaining promotion; there having been pronounced discrimination in employment during the 1990s (Fassin, 1999). Life expectancy of workers is lower than that of professional classes (Aïach, 1997; Fassin, 1999). The unemployment rate of 'foreigners' is double that of the French and even three times that for those whose origin is outside the EU (Fassin, 1999) and the unemployed live less long than the employed (Aïach, 1997).

French law forbids racial discrimination but only where direct discrimination can be demonstrated; on the other hand, UK law makes it an offence to discriminate directly or indirectly against someone on the grounds of race, colour, ethnic or national origin (Smith and Wistrich, 1997).

One informant in France (P14) was involved in intellectual movements opposed to Mobutu in the Congo and fled to France following the assassination of his parents by the military regime. He studied sociology, history and law in France and acquired a doctorate. He has refugee status and feels secure in France to the extent that he can stay and work, but feels discriminated against because *"I am a foreigner"(Je suis étranger).* He does not feel that his current employment (as a sociologist) is commensurate with his qualifications and abilities.

McKenzie (2003) reports that victims of discrimination in the UK are more likely to have respiratory illness, hypertension, long term limiting illness, anxiety, and/or depression. People who believed that most companies were discriminating were also at increased risk of mental illness.

Social exclusion may be the product of material poverty but not exclusively so. Social exclusion also refers to a situation in which people may be poor in terms of power or influence in policy-making spheres (Meehan, 1997; Roche, 1997).

- ***Lack of voice***

Informants in Britain felt unable to voice their concerns due to a perceived lack of rights in Britain and they questioned whether or not English people would accept such living conditions, yet at the same time felt powerless to do anything about it.

> *".... But being foreigners there are things you can't voice".*
> (FG1)

> *"Nobody will listen to you. As you are minority ethnic groups, you understand what I mean. Minorities, minorities. We are part of the minorities suffering in this country. We are suffering all the disadvantages of the system."*
> (FG2)

In relation to a discussion concerning the rights of refugees and asylum seekers to health care in Britain, the following statement was made:

> *"I do think that they* (GPs and their receptionists) *know about it but because refugees and asylum seekers are kind of vulnerable people, they just take advantage of the fact that refugees and asylum seekers don't know that they have the right to complain when, for example, the GP doesn't give them the right treatment. They know that we don't know all that, so they just treat you to get rid of you, because they want you to go back where you came from as soon as you enter their surgery, so they don't really take care of us."*
> (FG3)

In France, informants referred to France being a country that recognised and respected the 'rights of man'. However, these beliefs do not sit comfortably with their perceptions of discrimination in employment.

Something that I also found to be of interest was that in both Britain and France older members of the respective communities talked with great conviction and at length about wider issues concerning the role of the west in conflicts in Africa, the role of western governments in creating the situations in which these conflicts occur, the supply of weapons and the relative neglect of the conflicts because of their perceived lack of political importance to the west. These were clearly strongly felt views and it is possible that these informants felt that they could express them to me but felt unable to voice these opinions in a wider political context.

The UNHCR (2006c) notes the relative neglect of the DRC by the international community, relative to higher profile cases such as Afghanistan and Iraq. Feelings of such neglect might explain my informants' references to the war in Kosovo, which was also high profile. [2] While international support for the DRC has increased since 2001, in the hope that Joseph Kabila's leadership would lead to a reduction in conflict, the UNHCR argues that efforts to help rebuild the DRC have not been sufficiently consistent to help the country address its political challenges and overall stability in the region.

Safety

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[2] Joseph Kabila is the son of former President Laurent Kabila who was assassinated in 2001.

Generally informants in both countries tended to state that they felt safe in their host countries, from the point of view that they had fled oppression in the DRC and that there is no war in either Britain or France. Whereas refugees felt safe, asylum seekers felt less so due to their insecure status. The few informants in France whose applications for asylum had been rejected did not feel safe and were in fact, understandably, quite frightened. Also, some of the informants in France who held very strong political beliefs and had been politically active in the DRC had some reservations about their safety due to their beliefs, and the possibility that there might be spies, from the government in the DRC, active in France.

Informants in both countries talked about their concerns with safety in relation to their status, but there was also another dimension to safety; that relating to fear of crime. Informants in both countries commented on a lack of safety due to street crime. So, in response to questions concerning safety, the response was invariably "*Yes, but .....*"

- ***Fear of crime***

> *"Yes, I feel safe, France is a country of liberty, but there is racism and street crime".*
> (P11)
>
> *"You don't go out at night".*
> (L2)

One informant in Paris (P8) talked about a lack of safety in relation to the presence of "*skinheads, Nazism and racism*". These were not specific to France, he explained, referring to the burning of a refugee hostel in Germany, presumably relating to the conflict in Rostock and accommodation for asylum seekers from Eastern Europe. In this situation, the number of asylum seekers exceeded the available accommodation and tents were set up in a residential area. Acculturation problems arose, for example, problems relating to hygiene and differing views about access to resources. The accommodation of the asylum-seekers became the object of protest campaigns by skinhead groups and neo-fascists who succeeded in setting fire to the accommodation; the police were slow to react and impotent to protect the home (Blaschke, 1998). It was evident that this informant feared the spread of such anti-immigrant sentiment and hostility across other European countries. Some of the informants in Britain were worried about crime committed on the housing estate where they lived, reporting sadness at the apparent lack of parental control of young people. Also in Britain, the Directorate of Public Health, Croydon Health Authority (1999) reports acts of vandalism to a building housing a refugee community organization within days of adverse reports about refugees in the local press.

Being afraid of crime at home is related to health status, as well as feeling unsafe when walking alone after dark (Harkins and Stead, 2002). Fear of crime is associated with reduced quality of life and poor health. Fear of crime acts as an important barrier to participation in activities known to enhance health, such as community, physical or social activities outside the home (Harkins and Stead, 2002).

Social networks

When questioned about where they might go to get support, informants generally sought help within the Congolese community, particularly from the respective community organisations in both countries. The community was seen as important because of the shared language and culture and also the tradition of sharing things like food.

> *"In my culture, if you don't have something to eat you can go to the next door neighbour. You can eat together .... In my culture it is the way it is done. But here, there are situations where, when you don't have money you have to go your own ways to find your money .... That's different. And that's why we suffer a lot when we come into a society where people look more to their own selves and they look at strangers simply as strangers and people get lost and are even more lost because they can't communicate."*
> (L1)

Food sharing is seen as a sign of friendship and symbolises that the individuals involved do not compete with each other for basic necessities. Other studies have reported that life in Britain is private and individualistic and the pace of life fast (Papadopoulos and Gebrehiwot, 2002).

In Britain, during the third focus group, the role of the community group was described as important, as members stated that they were more confident when talking to their own community members; there was no language barrier and they knew that they would receive a sensitive response to their problems. Community members knew that the organization was there to help them and even if they could not solve the problem within the community, the leaders would be able to refer them to the most appropriate organization. Again, a metaphor was employed to illustrate their situation in exile:

> *"Like in the jungle. You've got to survive."*
> (FG3)

In my study there was also a perception that there was nowhere else to go to for help, other than the community organization, and most informants also went to church.

> *"There is nowhere you can go to get support. There is a tradition, something which is very important in our culture, we pray a lot, we go to church."*
> (L1)

Almost all of the informants attended church. Religion formed a central part of many participants' cultural identity, as well as a source of comfort.

The situation in France was similar as informants saw the community group as a focus for communicating and sharing, for example, food and clothing. The group, *'Le Souffle',* was also seen as a source of solidarity and, for some, intellectual debate. Outside the community organizations, in both countries, there was contact with other African communities but, for the majority of the community members, little contact with either British or French people.

Ahearn (2000b) claims that social supports are important factors in facilitating adjustment to a new society. Community groups can become a partial substitute for missing family members (Rousseau et al, 2004). Support can derive from internal characteristics, for example, personality, experience, resilience, or from external characteristics, for example, family, friends, church, mutual aid associations and networks. Duke (1996) and Carey-Wood (1997) emphasize the importance of refugee community groups in the process of adaptation and resettlement in Britain, providing facilities such as interpreting, educating, campaigning, representing, advocating, to name a few. The respective Congolese communities in both countries formed a focal point for support, where cultural understandings were shared, leading to more appropriate solutions to problems. Eastmond (2000), referring to a study of internally displaced people in former Yugoslavia, states that the refugees rated the social interaction among themselves as more effective in promoting their wellbeing than psychotherapy offered by a therapeutic programme. In my study it was generally felt that social workers from outside the community might not understand the problems. Both community leaders had a wide variety of contacts with people from a range of backgrounds, commensurate with their respective roles as community leaders, however, many other community members confined their socialising to the community group or to other African people. The kind of support that was provided by the community groups included assistance with asylum claims, advice regarding accessing health care, social security, as well as activities such as sharing food and clothing. The groups were also seen as an important source of "solidarity".

The republican model of citizenship adopted in France defines the nation as a political community to which newcomers are admitted providing they accept the political norms and national culture (Kofman et al, 2000). Normally, this model would not allow the recognition of the right of minorities to make claims for cultural recognition and social rights on the basis of their group identity (Kofman et al, 2000), however, at a local level the existence of migrant groups can be noted since the 1970s. The assimilationist conception of citizenship makes if difficult to have recourse to specific claims as a minority ethnic group, as only French nationals have formal political rights (Péchu, 1999). Therefore political participation of migrants is limited to social movements. The freedom to create associations was granted to immigrants in 1981.

Kofman et al (2000) stress that community groups play an important role for many women, and indeed, in this study the respective community groups were clearly very important to all the community members interviewed. Such groups perform the function of fostering a sense of belonging to the locality and also to the country of origin. However, such groups can also serve to separate migrants from wider society (Bloch, 1999b) thus increasing isolation. During the interviews held with informants in London it became clear that the leader of the Hackney Congolese Community Support Group viewed helping his community members to integrate into wider society as a central purpose of the group. He also voiced the need for the community group to organize events where he could engage the participation of people from many different backgrounds to unite in their diversity. Participation locally in political activities may also be the first step towards a broader political involvement. Indeed, in both community groups encountered in this study the leaders were involved in helping members with immigration issues. During the course of this research both community organizations were able to celebrate the success of their leaders in helping one of their respective community members to obtain refugee status.

There is considerable evidence that social support has beneficial effects on both physical and mental health and that social isolation leads to poor health (Stansfield, 1999; Harkins and Stead, 2002). Social support is conducive to good health; socially isolated people die at two to three times the rate of well connected people (Kawachi and Kennedy, 1997). Stansfield refers to the Alameda County Study in the USA that found that people with the fewest social connections had the highest death rates. In Europe, studies from Sweden and Finland have provided evidence for the beneficial effects of social integration on health, demonstrating lower mortality rates where social integration is high (Stansfield, 1999). The benefits would appear to accrue from both practical help but also emotional support.

Stansfield defines social support as *"resources provided by other persons"* (p 155). Social networks refer to the social contacts of a group of people, social integration refers to the extent to which the individual is part of a community of mutual obligation and exchange thus linking the needs of the individual with those of wider society. In my study, social support was gained from the refugee communities and social networks were mostly maintained within the Congolese communities. The attraction of the community organizations is understandable as they can provide a 'voice' for the members and also allow them to perform roles that are denied to them in wider society (Duke, Sales and Gregory, 1999). While my informants found strong social support within their community organizations, wider social integration had not taken place.

Carey-Wood et al (1995) report that more than two-thirds of their respondents (settled refugees) felt that they were part of their local community. Feelings of belonging were most affected by success in finding jobs. Half of those interviewed said they had encountered racial discrimination, almost a third verbal abuse and 18% threats; experiences that are similar to ethnic minorities generally. The chances of such harassment grew the more contacts they had with the British community; this must present a disincentive to integration and reinforces the attraction of the familiarity of the community organization.

Aspirations for the future

Informants who were closely involved with the Hackney Congolese Community Support Group expressed optimism for the group and what it might achieve in terms of helping the community in the future. Those informants with children also expressed optimism for their children's future, believing that as their children went to school in this country and integrated more into mainstream society, there would be opportunities for them in the future; at the same time informants were sad that their own skills were being wasted. Informants wanted to integrate into British society.

> *"We are in Britain. I'm not in Congo, I'm not in Africa, I'm in UK. You have to find out all the possibilities of integration within this community otherwise it will be a disaster for our kids, for the future generations."*
> (L1)

> *"We the parents, we the grown ups, are a sort of mixture of things, of past experiences from back home, and what we are going through here, that's what makes things hard. But my children have opportunities. My daughter is going to school. She knows nothing from back home. She does not have that experience. She looks into things in a very different way".*
> (L1)

The association for the Congolese refugees and asylum seekers in Paris, Le Souffle, was much more developed than that in London and was already helping the community. It was felt that some opportunities existed for refugees, but not for asylum seekers who were not allowed to study or to work. Informants in France tended to think that French people thought that the asylum seekers had "*come to take their place".* There were also issues surrounding discrimination. Fewer informants had children in Paris, but those who did expressed a desire for their children to integrate into French society. One older man (P9) who had previously worked as an assistant in a university in the DRC, and was working as a security guard in Paris, also did voluntary work with young African children in his locality (*Les enfants afriques francophones).* This was part of a community project and his work was predominantly helping those children who were having problems at school.

There appeared to be greater optimism among informants in Britain:

> *"Opportunities, yes, once I get my computing it will help me. When the war finishes in my country if I've got money I can make a nice business there".*
> (L2)

> *"Yes, if you have papers ....can get a job even if I don't have qualifications".*
> (L3)

In France, the future looked pessimistic:

> *"The west is in the process of closing the frontiers .... Opportunities are reduced for asylum seekers".*
> (P8)

> *"French society is closing the door".*
> (P9)

There were, however, sentiments from members of both communities that it is important not to sit back and do nothing: that there is a need to "*knock on the door*", suggesting potential for political engagement.

Conclusion

This chapter demonstrates that the ability to survive in exile depends on a number of factors including support in the host society. It has been acknowledged for a long time that material deprivation can have a detrimental effect on an individual's health and it can be seen from this study, and relevant literature, that many refugees and asylum seekers in both Britain and France lack an adequate income and adequate housing. Wilkinson's (1996) claim that psycho-social stress also has adverse effects on health is supported in this study as the informants have reported discrimination and exclusion which are in turn related to their lack of status of citizen of the respective countries. These are all areas which could be addressed by changes in government policy which could afford increased rights to refugees and asylum seekers, raise their status in the public's mind, and enhance a sense of belonging to society; in short the production of policies that are inclusive. Such policy changes might also assist refugees and asylum seekers in achieving their aspirations for the future and so improve their quality of life.

This chapter has demonstrated similarities between refugees and asylum seekers in Britain and France, notably feeling '*foreigners*', feeling excluded from society. Such feelings may result from exclusionary policies that render refugees and asylum seekers visible in both countries. Aspects of exclusion vary according to civic stratification status, notably in relation to income and eligibility to work. Housing is a problem for both refugees and asylum seekers in both countries, with informants often living in deprived areas that suffer from crime. While some of these factors are held in common with other poor people and members of minority ethnic groups, some are specific to refugees and asylums seekers and result from policy.

The next chapter will critically analyse the results discussed in this, and the previous two chapters, in relation to health-related quality of life and citizenship.

CHAPTER EIGHT

HEALTH-RELATED QUALITY OF LIFE

Introduction

This chapter assesses the implications of the data outlined in the previous three chapters for the health-related quality of life of these two groups of Congolese refugees and asylum seekers. The information gathered from the informants is reviewed in relation to the components of my preferred definition of health-related quality of life. There is a critical discussion surrounding measurement of health-related quality of life for refugee and asylum seekers and recommendations are made concerning the content of instruments designed to measure this concept. This chapter critically analyses the role of civic stratification and citizenship in relation to health related quality of life, in terms of the three conceptions identified in Chapter 2, i.e. formal, substantive and sense of belonging. It also critically analyses different approaches to the integration of immigrants in Britain and France. The concept of citizenship is found to be important in this respect with differences in the British and French approaches, and these have relevance for health-related quality of life. The chapter raises issues concerning the provision of health care within the two countries; it would appear that the dissatisfaction of refugees and asylum seekers with the British National Health Service reflects a general dissatisfaction among British people. Likewise, the satisfaction expressed by informants in France reflects general satisfaction among French people with the French health care system. This then leads to a discussion concerning 'health citizenship' concerning what people expect from their health care system.

The previous three chapters have explored the themes identified in the data from the focus groups and interviews. Informants were initially asked to identify the factors that are most important for their health. Their responses, therefore, convey their views on the factors that influence their health, positively or negatively. Informants were at ease with the concept of health and were happy to talk about their experiences. As Bowling (1997a) claims that health status is but one part of the broader concept of health-related quality of life, it was felt appropriate to ask about health early on in the interviews, moving on to the broader concept as the interviews progressed.

Health-related quality of life

Health-related quality of life was introduced in Chapter 3. Hunt (1995) suggests that health-related quality of life is a western concept and may not be familiar to non-western populations. With this in mind, attempts were made to address health-related quality of life indirectly, rather than directly, during the interviews. As such, this was not a theme that arose spontaneously from the interviews, but a concept introduced by me in the latter stages of the initial focus groups. The concept was subsequently explored further in the individual interviews. While informants may not have used the term health-related quality of life, it is clear that they could identify with the concept. Once informants were comfortable talking about a range of factors that they felt affected their health, I introduced the concept of health-related quality of life. The following quotes from informants illustrate this concept:

> *"If you are not healthy your life is nothing."*
> (FG1)

> *"If people don't care about your health, so they don't care about your life."*
> (FG2)

This comment arose during a discussion surrounding the attitudes of health care providers in London.

> *"Without health you feel very small ..... I am useless."*
> (FG3)

One interesting response was offered by a man in London, with refugee status, whose wife is also with him in London. This informant was a printer in the DRC but he is not working in Britain. He is learning to speak English and is studying computing and would like to return to his country of origin, following cessation of the war, in order to start his own business. In response to questioning about his health-related quality of life, he replied:

> *"In London? I think it's not easy. It's difficult because I was born in Africa and brought up in Africa and suddenly the situation changed. I had to leave the country to go to another country where I didn't know anybody and the climate was different so it's quite difficult. At the beginning it was very difficult so most of the time I used to think about home but later on I've started getting used to the country."*
> (L2)

This informant is referring to the enormous change of culture that he experienced, and also loss of familiar reference points in his life. Like Schutz's (1964) 'Stranger' he had to question those aspects of life that no longer conformed to his 'thinking as usual'; but were taken for granted by the host society. Unable to share the culture of the host society, the informant "*thought about home*" as his own reference points were still embedded in him, but they no longer applied in the host society. As a consequence, having recovered from this 'culture shock', this informant is learning to speak English and is learning new skills in order to survive in Britain. The need to learn new skills for employment is a reflection of the fact that in a new environment he was no longer able to use the skills he had acquired in the DRC to gain employment. Refugees and asylum seekers from the DRC suffer an enormous amount of loss; loss of status, security, occupational standing, family and friends, financial independence, and loss of control over their lives.

In France, one female informant (P9) made a telling remark concerning her health-related quality of life. She had been a journalist in the DRC and was undertaking training in information technology in France. Although she felt happier once she had acquired refugee status, she talked about her early days in France when she was seeking asylum and described a feeling of *"not having any landmarks or reference points"* and having to *"start her life again",* also claiming to feel *"diminished*". She also commented on discrimination and racism in employment. In a similar vein, another female informant in France who is quoted extensively in Chapter 7 (P13), talked at length about the change in status she had experienced consequent to her arrival in France. Having previously enjoyed a prestigious occupation and comfortable lifestyle in the DRC, in France this informant described herself as *"Madame tout le monde*", inferring that she was forced to perform many of the tasks that previously had been performed by her own employees. What is crucial to the responses of these informants is their lack of status in the host society and it is clear that this *"diminished"* status, in relation to members of the host society, has adverse effects on health, via psycho-social mechanisms. To quote Schutz (1964, p104/5)) the host society becomes:

> *" ..... not a shelter but a field of adventure ..... not an instrument for disentangling problematic situations but a problematic situation itself .... The stranger in the state of transition does not consider this pattern as a protecting shelter at all but as a labyrinth in which he has lost all sense of his bearings."*

My informants' comments support Fallowfield's (1990) claim that one of the primary requisites for the enjoyment of a good quality of life is good health, and Seedhouse's (2001, p65) assertion that:

> *"A person's state of health cannot realistically be separated from a person's quality of life."*

However, responses to questions concerning the concept of health-related quality of life were not always instantaneous, informants had to stop and think, often reflecting back the question "*Quality of life?*". After contemplation, informants were able to grasp the concept and, while not using the term health-related quality of life, were able to identify factors that either contribute to or detract from it. These factors are discussed in relation to the definition below. It is possible that western researchers may be doing non-western cultures an injustice by assuming a lack of understanding of this concept.

My preferred definition of health-related quality of life is:

> *"..... The value ascribed to a person's life, by the individual or society, as a result of her own health, and influences such as personal behaviour, medical care, health policy, or larger social forces."*
> (Lerner and Levine, 1994, p45)

This definition thus comprises six main areas: the value ascribed to a person's life (by the individual, and by society); his/her own health; influences such as personal behaviour; medical care; health policy and larger social forces. Within these main areas there are a multitude of factors that can affect health-related quality of life and this chapter will suggest that for my chosen group of refugees and asylum seekers not all of these factors are currently included in instruments that claim to investigate the concept. These factors are related to their immigration status and to their attendant social rights. Issues relating to each of these six main areas were raised spontaneously by the informants during the focus groups and interviews.

The value ascribed to a person's life

Where an individual stands in the social hierarchy, on the social ladder, is related to one's chances of becoming ill and to the length of time one can expect to live (Marmot, 2004). This is a feature of stratified societies that produce the determinants of how much control any individual has over his or her life. The higher any person is in the social hierarchy, the greater his or her control over everyday life. Those with greater control over their lives experience better health than those without. This was a crucial finding of the Whitehall studies, a finding that can be generalised to wider society, and is summed up in what Marmot calls the 'status syndrome'. Echoing Wilkinson's arguments about relative status, and also Marshall's (1964) contention that equality of status is more important than equality of income, Sen (1992) argues that as important as what we have in terms of income, is what we are capable of doing, physically, psychologically and socially. Sen uses the term 'capabilities' to encapsulate notions of freedom and agency, factors which, in turn, have been viewed as crucial human needs (Doyal and Gough, 1991). The informants in this study are clearly located low down in the social hierarchy and their comments have reflected a feeling of lack of control over their lives and reduced capabilities. Both of these factors have been more deficient in the lives of asylum seekers than in the lives of refugees. This low status, lack of control, and reduced capabilities, can all affect self esteem which is central to the value ascribed to a person's life. Further, the responses from these informants suggest that inequality of status may be more important than inequality of income.

- ***By the individual***

The value ascribed by an individual to his or her life can manifest as self esteem and is mediated by the status that person holds in society. Informants gave examples of having low self-esteem as a consequence of feeling outsiders, as a result of a personal sense of not belonging to society but also as a result of government policies that seek to place refugees and asylum seekers on the margins of society. Aspects of social exclusion, for example, policy in relation to income maintenance, and exclusion from eligibility to seek employment, places asylum seekers in Britain and in France at a disadvantage when compared to Convention refugees and citizens. Such policies send messages to wider society concerning who belongs and who does not (Spencer, 1995).

The personal loss of citizenship status of their home countries and lack of citizenship status in the host countries serves to place refugees and asylum seekers 'in limbo'. In particular the precarious situation of asylum seekers leads to uncertainty and inability to make plans for the future. The perception of 'lack of voice' in terms of political rights further serves to reinforce a sense of powerlessness and lack of control over their destiny.

- ***By society***

The value ascribed to a person's life by society manifests as respect for that individual and again is mediated by the status conferred on the individual by government policies and by the portrayal of refugees and asylum seekers by the media. Many of the policies relating to refugees and asylum seekers convey the impression that they do not belong to society. Such impressions fuel discriminatory and racist tendencies and give rise to pejorative perceptions of refugees and asylum seekers. These were typified by the use of vouchers for destitute asylum seekers in Britain at the time interviews for this study were being conducted. The visibility of asylum seekers conferred by such policies rendered them vulnerable to abuse, both verbal and physical, which demonstrates that sections of society ascribed little value to the lives of asylum seekers. The media also played a large part in demonising asylum seekers. The value ascribed by a society to a person's life can be summed up in one informants comment that *"if they (health care providers) don't care about your health, so they don't care about your life".* Such sentiments are particularly reflected in the feelings of the undocumented asylum seekers in France, who are not eligible to access mainstream health services. Since the interviews for this study were conducted, the British government has also withdrawn the right to secondary care from the NHS from failed asylum seekers in Britain.

His/her own health

The biggest problem for refugees and asylum seekers in terms of personal health is psychological health. All informants identified problems in this area for a range of reasons, with the immigration process featuring prominently. The uncertainty and anxiety engendered by these problems arose as a result of government policy concerning immigration in both countries. Lack of secure status had a profound effect on psychological and subsequently physical health, resulting in the 'normalisation' of ill health among refugees and asylum seekers.

- ***Psychological health***

Feeling insecure about their status prevented asylum seekers from getting on with their lives and therefore settling in Britain and France. It would appear that for this group of displaced people there is some sort of hierarchy of concerns, starting with their own sense of security and survival. Once some degree of security is achieved there is progression to another level of worry – concern for family and friends still in the DRC. It has already been recognised that refugees and asylum seekers experience loss in many respects. In this case, loss of family members and friends, either through trauma or because of separation, together with loss of cultural reference points and loss of status, may result in a bereavement process. It is important for health care providers to understand this in order to be able to respond sensitively and offer appropriate support. The next level of concern relates to financial issues, with understandable worry about of loss of financial independence, but also anxiety about having sufficient income to meet basic needs.

It is clear that the health of refugees and asylum seekers is compromised, both physically and psychologically. The reports from my informants support Wilkinson's argument that psycho-social factors play an important part in explaining their health-related quality of life. Informants, in both countries, were able to make connections between psychological and physical health, describing how the cumulative effects of the many worries can cause physical symptoms. Further, for refugees and asylum seekers, the factors that contribute to their psycho-social stress are influenced by their immigration, civic stratification and citizenship status. Refugees and asylum seekers belong to that group of people referred to by Rees (1995) as incomplete citizens and by Heater (1999) as partial citizens, a situation which renders refugees and asylum seekers incapable of complete 'self-determination' and thus unable to compete with other members of society on equal terms (Heater, 1999). This is the essence of the different status that results in psycho-social, and consequently physical, effects on health.

- ***Physical health***

Physical health problems were raised within the context of access to health services and few problems were offered directly in response to questions concerning factors that affect health. Rather, my informants tended to convey the belief that refugees and asylum seekers were not more likely than other people to have physical problems, other than those arising as a consequence of their psychological problems. Statements made by my informants to the effect that they are *"not healthy people"*, related to psychological problems. None of the informants admitted to having communicable diseases that some authors (Dick, 1984; Gellert, 1993; Taylor and Gair, 1999) have argued are frequently reported among refugees and asylum seekers. Neither did any of my informants identify physical health problems *"sufficient to affect their daily lives"*, as Carey-Wood et al's (1995), informants claimed. However, these informants were settled refugees who had a decade's experience of living in Britain: it is possible that physical problems may emerge later once more pressing concerns like immigration status, concern for family members and financial worries have been settled to some extent and some degree of stability has returned to the lives of refugees and asylum seekers.

Personal behaviour

Personal behaviour influences health and is, in turn affected by psychological and physical health. There was evidence of some tendency towards fatalism among the informants, in that there was some degree of acceptance that poor health was normal among refugees and asylum seekers. On the other hand, the informants did not locate causes of this poor health in their own behaviour, unlike Blaxter's (1997) informants. While informants felt that they had little control over their health, they saw the causes of ill health as external to them, based in social structures. Aspects of personal behaviour that were discussed related to doubting the diagnoses and prescriptions offered by GPs, resulting in inconsistent concordance with prescribed treatments, and choosing to seek help and advice from private health practitioners, usually French doctors in London.

Personal behaviour related to health is influenced by culture and beliefs, but any health-related decisions are made in a socio-economic context. Le Grand's (1987) human capital theory describes how people can decide whether or not to invest in their health, but their decisions are not made in a vacuum. Rather they are made within a socio-economic context. Attempts to engage in health enhancing behaviour can either be successful or unsuccessful. Several factors impede the ability of the informants to engage in health-enhancing behaviour. Factors having a negative influence are lack of money, which reduces choice in relation to food, housing, leisure activity and social engagement. Personal dietary habits were affected by a lack of choice concerning the purchase of food by those informants who had been forced to use vouchers to acquire food, particularly an inability to purchase food that contributed to their natural diet. Reports of drug abuse among members of the Congolese community in London represent a more extreme example of health damaging behaviour.

Fear of crime and not wanting to go out much, especially at night, impedes social interaction (Kawachi and Kennedy, 1997). This is something that informants in this study acknowledged, as many were living in deprived areas that suffered from crime. The performance of social roles is further impeded by the inability to work, or employment in jobs that are not commensurate with qualifications.

Factors having a positive effect on health were the existence of the community associations in both countries. These provided a forum where social roles could be adopted, that were otherwise denied.

Medical care

Lerner and Levine (1994) claim that health care is an important intervening factor in health-related quality of life. Issues surrounding experiences of medical care fall into two main categories; the relationship between the health professional and the patient and the overall health policy. The health professional-patient relationship will be addressed first.

There is ample evidence that in Britain informants were not satisfied with the encounters they had with health professionals. These professionals included receptionists at GP practices, GPs, nurses, midwives and doctors in hospitals. While the engagement in any meaningful interaction was hampered by inability to speak English, for many of these informants there was also a perception of being treated unfavourably by health professionals. Lack of trust in officials, which was learned in the DRC, contributed to these unfortunate relationships with health professionals, but the unsatisfactory outcomes for the informants further entrenched their lack of trust in these providers of health care. While much of this lack of trust and dissatisfaction was directed at the individual professionals, there was also a widely held belief that these professionals were working within instructions from the British government that decreed that refugees and asylum seekers should be treated less favourably than British citizens. Such beliefs will have been fuelled by general feelings of insecurity, media reports of failures of the NHS to deliver adequate care, amid broader policies increasingly aimed at deterring people from seeking asylum in Britain. Interestingly, while French governments have been pursuing equally deterrent immigration policies, and informants expressed disappointment at an apparent inability of French governments to uphold the ideals of being a country that recognises and supports human rights, the informants in France expressed total satisfaction with both the health professionals and health policy. Further, informants in France expressed trust in the health professionals, yet were able to confirm lack of trust in other aspects of the French administration. Explanations for this may lie in the ability of the informants to speak French and thus communicate successfully with health professionals, but also in the way health care is delivered in France.

The unequal nature of the doctor-patient relationship has attracted attention in the past. Doctors maintain tight control over the consultation process (Clarke, 2001). Given that these encounters take place in clinics and surgeries, there is an imbalance of power in the encounter; the professional is on home territory, the patient on 'foreign' ground. Donovan (1986) provides an account of how people of Asian and Afro-Caribbean descent living in London described feelings of powerlessness in the face of doctors' knowledge and attitudes. The power of the medical profession has long been a topic of discussion and debate, for example, Freidson (1970) questions if the expertise held by doctors has become a mask for privilege and power. In so doing, the profession claims to be the most reliable authority on the nature of the reality it deals with. In developing a 'professional' approach, the profession changes the definition and shape of the problems as experienced and interpreted by the lay person, a situation exemplified by one of the informants in London:

> *"He does not take it as I am feeling.... What I am explaining to him ...... He does not understand. He does not take it the way, me, I'm the patient am taking it. So they take it a different way. The have a different consideration on what you say. You are suffering from something serious maybe, but they can't take it seriously as you take it yourself."*
> (L1).

Judge and Solomon (1993) found that 'non-white' informants in Britain were less satisfied than white informants with the running of the NHS and with in-patient services, but these authors acknowledge that this may reflect a more general alienation from key British institutions. Judge and Solomon's work took place at a time of increasing consumer awareness of public services. Judge and Solomon hypothesised that the factors associated with satisfaction with health services include a range of demographic, socio-economic and health status characteristics, as well as media coverage of the health debate, in addition to recent personal experience of using health services. In my study, as already explained, there was a lot of negative media coverage relating to the National Health Service in England and widespread dissatisfaction among the general population.

The lack of trust placed in providers of health care in Britain resulted in unsatisfactory outcomes for both my informants and presumably the health professionals involved. Trust enhances communication but good communication generates trust in the first place (Thiede, 2004). While exchange of information between professional and patient will allow choice and freedom to use health care (Thiede, 2004), for my informants in Britain choice was limited to exit (Hirschman, 1970) as the informants sought health care elsewhere by paying for private care outside of the NHS, which they perceived as failing them. Recognizing the potential for lapses from efficiency and functional behaviour in any organization, Hirschman argues that people can choose to 'exit' from the organization, i.e. go elsewhere, or exercise their 'voice' and, as customers, express dissatisfaction to those in charge of the organization. Hirschman (1970, p37) claims that the *"decision to exit is often taken in the light of the prospects for the effective use of voice"*. My informants lacked 'voice', as non-citizens they had no political rights, and they perceived that their status did not permit to complain, and thus, chose 'exit', though without the revenue losses to the NHS that would normally apply in a market system and that would also prompt improvement in quality of service provision.

The freedom to use the National Health Service depends on the possession of adequate knowledge of how the system works (Thiede, 2004) and without that knowledge individual autonomy cannot be exercised. Patients sometimes do not comply with prescribed treatments unless they are actively involved in the therapeutic process, and understand their condition and therapy (Albrecht, 1996). Communication has been shown to be a major determinant of patient compliance, satisfaction and appropriate use of health facilities (Kleinman, 1986). However, the use of interpreters is a policy issue as well as an issue for individual professionals. Jones and Gill (1998b) suggest that the NHS has not sufficiently met the challenge of communicating with patients whose first language is not English. These authors acknowledge that interpreting services do exist, but are not generally available outside traditional working hours. GPs can often arrange a professional interpreter for an 'important' consultation, but not always for consultations that are not planned in advance. While GPs may be able to cater for some of the needs of patients where the majority belong to a single community, where there are several small groups of non-English speaking patients there is likely to limited access to professional interpreting. Commercial telephone interpreting services are available in Britain, but are expensive (Jones and Gill, 1998b). Bischoff, Bovier, Isah et al (2003) argue that language concordance and the use of interpreters can increase the detection of traumatic symptoms among asylum seekers.

Qualitative research generates hypotheses and there are questions raised that I have not been able to answer in this study. It is possible that GPs in Britain are not 'maltreating' refugees and asylum seekers but it is an issue entrenched in communication problems that are fuelled by the natural suspicion held by refugees and asylum seekers. It is not clear whether this is an issue of power differentials or whether it is the inability to communicate that throws all these other issues into sharp relief. The fact that the responses in Britain were so different from those in France suggests that it is not necessarily a function of the individual doctors, but of the systems and structures within which they operate, unless, of course, the professional practice of doctors is very different from that of those in France. This raises questions about whether doctors in France have a different approach to their patients, whether different approaches to citizenship and integration foster a sense of equal treatment within the health care system, whether the different health care systems account for the dissatisfaction in Britain and satisfaction in France, or whether it is simply related to language.

While literature suggests that there is more awareness of the needs of members of minority ethnic groups in Britain than there is in France, this was not borne out in the evidence from my informants, some of whom perceived a lack of cultural awareness in Britain. The French approach to integration, that is averse to the identification of the special needs of minority ethnic groups, would suggest that such needs might not be met within the health care system, yet there were no expressions of lack of respect for culture.

This could, of course, be because there was no expectation, on the part of my informants, that health care providers would be culturally aware, given the French approach of assimilation. However, while this approach operates at central government level, it may not translate through to the practice of the individual health professionals, who, bound by codes of ethics and conduct, continue to treat each patient according to their needs. There are more doctors per population in France than there are in Britain; it is possible that the time of doctors in Britain is more pressured than that of those in France. The fact is that the informants in Britain desperately wanted to tell me about their encounters with doctors, whereas it was an issue I felt I had to raise with informants in France in order to make some comparison.

Health policy

At the time these interviews were conducted it was policy in both Britain and France to provide health care for refugees and asylum seekers, who had the same rights to access to health care, provided that they held the relevant documentation.. In Britain, there was widespread discontent with GPs; there did appear to be a lack of understanding of the function of primary health care in Britain, and the role that GPs play within that. It is, therefore, difficult to disentangle their discontent with the service they received from their possible misperceptions of the service that GPs should provide. The gate-keeping function of GPs in Britain was particularly poorly received. This was compounded by a lack of uniformity in the definitions of health and illness throughout society, and therefore what some groups may define as conditions requiring medical intervention others may consider normal. The decision to consult a doctor is influenced by socio-cultural factors, not just severity of symptoms (Clarke, 2001). This calls for greater understanding from both parties; while members of the host society are normally encouraged to treat themselves for apparently minor complaints like colds and coughs, such symptoms may not be viewed as minor, but as significant, among migrants from the DRC. During the interviews, some of my informants did draw attention to symptoms like “runny noses” that they associated with living in a different climate, representing a significant change in their lifestyles and exposure to illness.

As far as health policy is concerned, it has already been stated that the informants in Britain were convinced that individual health professionals in Britain would do more for refugees and asylum seekers if they were not prevented from doing so by the British government. Their natural suspicion of officialdom was transferred to health policy. Suspicion was so entrenched that some informants believed that special inferior tablets were being manufactured solely for prescription for refugees and asylum seekers. There was disbelief that I would use the same National Health Service that seemed to be serving them so badly.

The state makes decisions about the type of health care that is provided for its citizens. In Britain the National Health Service has traditionally been viewed as a paternalistic service rendering people passive recipients of health care. It is only recently that successive governments have attempted to engage people more in decision-making concerning the delivery of health services. The traditional paternalism is also reflected in the gate-keeping role of GPs, who make the decision whether or not to refer a patient to secondary health care, i.e. to see a specialist. In Britain the National Health Service functions with an acknowledged democratic deficit which, along with under-funding, has contributed to a general lack of trust in public services. The government response to this deficit has been to encourage public participation. It is against this background that refugees and asylum seekers have raised concerns about health care provision that are similar to those raised by the general public.

In contrast, in France the health care system allows people much more choice of doctor and hospital. Yet, what seems to be a better health service comes at a price. The French government has experienced problems with funding the health care system and attempts to revise the system have met with industrial action, sometimes in the form of strikes by health care professionals. Such action is possibly an expression of citizenship, something that is lacking among health care professionals in Britain. Attempts by the French government to introduce a GP gate-keeping system have met with little success; a scheme initiated in 1998 was opposed by most of the physicians' professional associations (Com-Ruelle, Dourgnon and Paris, 2006). Nevertheless, health care reforms were instituted in 2004 which have created a 'preferred doctor' scheme that approximates to the British GP system, but is not compulsory and allows greater choice of both 'preferred doctor' and any specialist referral that the 'preferred doctor' might make (Com-Ruelle et al, 2006). As such, it is a compromise between patients' freedom of choice and a desire to ensure a more cost effective consumption of health care (Com-Ruelle et al, 2006).

Aside from issues relating to degrees of satisfaction with health services, there are also policy matters to be raised concerning the undocumented asylum seekers in France, who do not have access to mainstream services. While health care is available for such people from non-governmental organizations, my 'undocumented' informants in France were buying their own medications. Further, the recent decision (2004) by the British government to restrict free health care for asylum seekers whose claims are unsuccessful can only serve to further segregate a vulnerable group of people and has serious implications for their health. While decisions are being made on their claims, asylum seekers are still entitled to free NHS care; once their claims are rejected they can continue to receive care that was previously in progress, but they face charges for all other secondary care (Kelley and Stevenson, 2006). Emergency care and treatment from an Accident and Emergency Department is still free, and treatment considered 'immediately necessary' is supplied, but NHS Trusts are expected to charge the asylum seekers for the costs afterwards. Given that the majority of failed asylum seekers are destitute, this would appear to be a pointless exercise, but will nevertheless cause distress to the recipients of bills for care. The only care that remains free is family planning, compulsory mental health care, and treatment for a range of communicable diseases that might pose a public health risk, including treatment for sexually transmitted diseases, but excluding HIV and AIDS (Kelley and Stevenson, 2006). Rejected asylum seekers in Britain are now in a situation similar to that of their counterparts in France.

The findings of my study indicate that refugees and asylum seekers do have needs that are specific to their particular experiences, but also that many of their needs are the same as those of the host population. This raises wider questions about health care citizenship – what citizens expect of and receive from their health care system.

> *"The health system's contribution to the construction of broader social value and, specifically, trust, flows directly from the interaction between citizen (not patient) and health system".*
> (Gilson, 2003, p1461)

Gilson argues that health systems that inspire trust among members of society also offer more to society. This is in addition to the benefits of co-operation with treatment. Health systems are not only providers of health care but they also convey a set of society values (Gilson, 2003). Rothstein (1998) argues that value is placed in health and welfare systems that address individual concerns but also contribute to the social good. Trust is built when individuals are allowed to participate in decision-making, their self-esteem is enhanced and the process is empowering (Gilson, 2003). Where there is decision making with clients there is more likely to be trust. Gilson (2003, p1462) argues that:

> *"decision-making mechanisms will only build trust among all groups of the population if they are developed in recognition of the particular constraints on trusting experienced by poor and vulnerable groups".*

The predominant constraint on trusting for refugees and asylum seekers from the DRC, in Britain, is that of language. Inability to communicate adequately with health care professionals is at the core of the problem. Recognition of this barrier to trust, and more effective use of interpreters should begin to improve the situation. The high degree of trust that the informants in France place in the health care professionals results, to a large extent, from their ability to communicate with them. However, it is likely that it also derives from the operation of the health care system.

Larger social forces

Health and society operate through the professions of public health and clinical medicine but also through economic development (Blaxter, 2004). While medicine and economic development have been successful in terms of prolonging life, Blaxter argues that the systems involved can have oppressive effects. Social structures produce inequalities in income which are reflected in inequalities in health. These health inequalities are socially determined, unjust and not inevitable (Blaxter, 2004). Congolese refugees and asylum seekers in Britain and France complain of very similar health problems, psychological and psycho-somatic in nature, yet in Britain the informants were dissatisfied with health care and felt they were being treated inequitably, while in France informants were satisfied with health care and felt that they were being treated equitably. The origins of their health problems must therefore lie in social structures. In both countries informants made reference to the inequalities that exist in the respective societies and were aware of being members of minority groups, whom, by definition, would be affected by the inequalities inherent in these societies.

The design and operation of the health care system, for example, provider/patient interaction, resource allocation, influences the extent to which the system provides the basis for trust building. Health care systems are complex socio-political institutions and not merely delivery points for bio-medical interventions (Gilson, 2003).

The French health care system operates within a socio-political context that professes equality of all individuals. The aim is to assimilate migrants individually into society, and the assumption is that they will make use, equitably, of the usual services that are available. In the case of health care, at least, refugees and asylum seekers from the DRC were able to access health care and claimed to the treated *"the same as the French"*. This access was, no doubt, aided by the system that allows users of the services choice in terms of doctor and hospital. The combination of these approaches to the provision of health care resulted in a high degree of trust in individual providers/professionals and the system as a whole.

The British health care system was also founded on the principles of universal and comprehensive access. While commitment to these principles has been maintained in theory, in practice there have been recurrent reports of inequalities in health, including unequal access to, and provision of, health care. The British health system also operates within a socio-political system that espouses equality, but the incorporation of migrants occurs more as a group activity than in France, with the recognition of diverse minority ethnic groups and multiculturalism. My informants were quick to identify with existing minority ethnic groups and thus their lack of trust may, in part, derive from awareness of health inequalities among ethnic groups. The lack of choice of doctor and hospital may also contribute to mistrust. While health inequalities in relation to social class exist in France, their existence is not so widely publicized.

Nevertheless, relationships between approaches to incorporation and trust are far from straightforward. In terms of employment and future prospects in the host societies, a very different picture emerges. In Britain, refugees and asylum seekers from the DRC, while not actually enjoying employment that is commensurate with their qualifications and previous occupations in the DRC, were quite optimistic for the future, especially for that of their children. It is possible that these informants perceived Britain's 'race-relations' and multiculturalist approach to be one of equal opportunity. A lot of faith was placed in the acquisition of qualifications and the expectation that they would permit them to compete in the labour market.

In France, informants had very low expectations of employment, reported incidents of perceived discrimination in the labour market and identified with the failings of assimilation in terms of access to employment; *"France closes the door".* In spite of having a privileged position *vis à vis* labour migrants, refugees from the DRC do not appear to be able to compete in the labour market on equal terms with French citizens. My informants seem to have internalised the well rehearsed beliefs about the lack of access to positions in the public arena, notably the media, for minority ethnic groups.

The ideology in France has always been that people who speak French, share the culture and political ideals, symbolised by the values of the Revolution, could be integrated into the national collectivity (Schnapper, 1992). In terms of inequalities in societies, almost as a postscript to this thesis, recent developments in Britain and France have demonstrated the consequences of the persistence of inequalities. In 2005, rioting broke out in Paris suburbs and spread to other French cities. These riots were triggered by the deaths of two French teenagers of North African descent while fleeing police because they feared harassment (Phillips, 2005). Phillips' account of these events conveyed an expression of relative status, and lack of respect, when he described how, when asked what they want, young people say "*Stop addressing us as 'tu'*". These riots further raise questions about the ability of France to integrate its immigrant population into wider society. Duval Smith (2005) describes the estates where the riots took place as having high unemployment rates (20% – 30%) and characterised by racism and where crime becomes a means of survival. Young people arrested by the French police belonged to minority ethnic groups, yet were French, and of French parents, but are alienated from mainstream society (Duval-Smith, 2005) – they have French passports but do not feel French. Even in 1992 Schnapper described individual integration as resulting in an *"often brutal acculturation"*, depriving people of their landmarks and reference points. This quickly exposes individuals to xenophobia and social rivalry, as demonstrated in the recent riots.

In Britain, recent rioting in Birmingham (2005) resulted from a declared lack of mutual respect among African-Caribbean and Asian communities. In contrast to France, the British multicultural approach allows space for cultural diversity (Stolcke, 1999), and results in a slower process of acculturation offering some degree of protection from the traumas of losing landmarks and reference points (Schnapper, 1992). The ideal of British multiculturalism reinforces the ethnic conscience and so aids the maintenance of culture, but also allows the concentration on, and institutionalization of, the differences between groups, rather than the marginalisation they share in common. The British commitment to multiculturalism, and its underpinning principles, have recently been questioned (Fortier, 2005; Lewis, 2005).

- ***Formal citizenship***

Lack of formal citizenship was perceived as a barrier to health care in Britain, and a barrier to employment in France. At a political level, informants in Britain were acutely aware of their lack of formal status and thus of voice. This reinforces Soysal's (1994) argument that political rights are often the last set of rights that migrants acquire, in contrast to Marshall's (1964) depiction of the evolutionary development of the three elements that culminates in social rights. Further, Marshall accorded primacy to social rights, but the experience of refugees and asylum seekers demonstrates that social rights cannot always be realised in the absence of political rights. The absence of formal citizenship status resulted in the hierarchy of statuses that is defined as civic stratification.

Immigration policies affect the way the rest of society views people by identifying who belongs and who does not, in fact the whole notion of being a 'foreigner', or of inclusion or exclusion. Asylum seekers awaiting decisions on their applications in both countries experienced psychological problems that they claimed affected their physical health. These problems were directly related to their status as asylum seekers, as factors such as uncertainty about the future, lack of security and fear of persecution if sent back to the DRC were expressed. Waiting for the respective government department (Home Office in London; OFPRA in Paris) to make a decision regarding immigration status was deemed to be particularly stressful, resulting in feelings of insecurity and lack of purpose in life. Thus, the following comments are examples of responses when asked about health-related quality of life:

> *"There is no direction in your life at all."*
> (FG1)

> *"We have fled from oppression back home ...... But here we don't feel secure because of the system."*
> (FG2)

When questioned about their health-related quality of life, informants, in both countries, used terms like *"It's nothing"* (FG1, P1, P10).

One informant in France whose application for asylum had been refused described himself as *"miserable"*. One informant in London who claimed to be *"not happy at all"*, having been in London for 4 years and still awaiting a decision said:

> *" ..... already 4 years have passed and ...... those years mean nothing."*
> (L6)

In contrast, the following is a response to a question about health-related quality of life from an informant in London with refugee status:

> *"It's not too bad ..... glad that refugee status has been granted."*
> (L3)

The sources of concern for informants who had acquired refugee status were of a different nature. Many of these informants admitted to feeling sad about, and missing, people they had left behind in the DRC. However, this situation will change in Britain as a consequence of the Immigration and Asylum Bill (2005), according to which ILR will no longer be granted automatically to recognized refugees. Instead, refugees will be allowed to stay in the UK for up to 5 years, but living with the possibility that their status may be revoked if the political situation in their home country improves. Thus, refugees will be denied the relief that was felt by Congolese refugees when they were granted permanent status, and instead are likely to suffer anxiety at a similar level to that expressed by Congolese asylum seekers in Britain. Some of the asylum seekers who were interviewed during this study had spent long periods waiting for decisions on their applications; this was rendered particularly stressful in France, as after one year, entitlement for income support ceases. This change of policy also has the potential to undermine the government's integration strategy, by conferring a less secure status on refugees, and may further act as a disincentive to offer employment to a refugee if there is any doubt about the duration if his/her stay in Britain (Refugee Council, 2005).

Asylum seekers in Britain and France are denied unconditional rights to family reunion, in spite of the fact that the European Convention on Human Rights claims that respect for family life is a universal right. This situation derives from their lack of either citizenship or refugee status.

The acquisition of formal citizenship makes an important contribution to security, but also naturalisation provides a way of improving life chances (Noiriel, 1996).

- ***Substantive citizenship***

Exclusionary policies confer differing rights within the stratification system for refugees and asylum seekers in Britain and France. Work has been identified as a key factor affecting refugee settlement as it aids integration and material wellbeing (Bloch, 1999b). So, as well as having to live with the material deficits due to lack of work, refugees and asylum seekers also suffer loss of status and self-esteem and a meaningful way of occupying their time. While refugees in both Britain and France have the right to seek employment, most of the informants in this study who had acquired refugee status had not been able to fulfil their potential and gain employment that was commensurate with the qualifications they had acquired in the DRC. Bloch (2000) also found that refugees were in jobs characterized by low pay and poor working conditions. Policies of exclusion operate to deny recognition of qualifications and place obstacles in the way of those who wish to pursue courses that would enable them to enhance their qualifications and allow them to practice their profession in the host country. These obstacles often take the form of high prices for training programmes that might facilitate 'conversion' of existing qualifications into the equivalent of those of host societies. In the case of asylum seekers in France, policies of exclusion confer no entitlement to work, whereas in Britain processes of deficit were in place in the form of the discretionary nature of granting permission to work to asylum seekers who had been waiting for six months or more for a decision on their application for asylum (at time of interviews). 'Deficit' processes also operate in the form of discrimination in employment, most notably in the responses of informants in France in this study, but discrimination in employment in Britain has been identified by refugees in other studies (Bloch, 1999b). French law forbids racial discrimination but only where direct discrimination can be demonstrated; on the other hand, UK law makes it an offence to discriminate directly or indirectly against someone on the grounds of race, colour, ethnic or national origin (Smith and Wistrich, 1997). While the law in relation to discrimination is inclusionary, informal processes can act to exclude. Approximately one third of employment in the French public sector and some professions, including medicine and law, precludes non-EU citizens (Kofman, 2002; Weil, 2004). This needs to be contrasted with the right of citizens of EU countries to unrestricted work and residence in any member state (Morris, 2002). Refugees are thus placed in a weaker position relative to citizens, and asylum seekers are in a weaker position relative to refugees. Again, the situation is one of relative status.

While many of the informants in France had sought asylum in the country because of their ability to speak French and also because of their faith in France being a country that respected *"the rights of man"*, few expressed confidence in opportunities available to them in France, many claiming discrimination, particularly in the field of employment. The inability to find suitable work means that refugees and asylum seekers are not achieving their potential, something that contributes to health.

The cost of living and lack of money were raised as concerns. Once refugee status is acquired, in both Britain and France, individuals are at the mercy of the employment market and social security system in the same way as nationals of the two countries. Informants in both countries experienced the adverse effects of poverty. Added to the material effects of poverty were the psycho-social effects, best expressed by the informant in France whose right to financial support from the state had been exhausted, when he declared himself *"finished"*. Likewise, in Britain, informants who were receiving vouchers to exchange for food described the lack of dignity attached to this, likening the whole process of exchange at the checkout to the immigration process and clearly perceiving themselves in a stigmatized position. These situations have arisen in both countries as a result of civic stratification that derives from exclusionary policy making that further serves to reinforce the view in the public's minds of who belongs and who does not. By ceasing to support asylum seekers after one year in France, or denying asylum seekers the dignity of using cash and supporting them at a level which is 70% of the income support afforded to others, the state sends a message to the public that these people are of a lesser value. The message of relative status is thus reinforced for both the recipients of the policy, i.e. the asylum seekers, and also for the general public.

Civic stratification, and again exclusionary policies, serves to affect refugees and asylum seekers in terms of housing. Housing that is made available to them, either via local authorities, housing associations or private landlords, tends to be sub-standard. This again serves to further remind refugees and asylum seekers of their relative status in society. However, the perception of the public is not always sympathetic to refugees and asylum seekers. When refugees and asylum seekers are housed in deprived areas, the perception of the people already living in those areas is often that refugees and asylum seekers are being given preferential treatment and 'jumping the queue' for housing. This in turn leads to racism and abuse, fuelled by beliefs about them 'not belonging', which then leads to further social exclusion and fear.

- ***Citizenship as a sense of belonging***

The integration of an individual into a given group can be measured through the study of his or her participation in the various activities of that group (Noiriel, 1996). Refugees and asylum seekers are, by definition, excluded from political participation in their host countries. Any political activities that my informants did engage in tended to be attached to their respective community groups. Labour market participation is important to the settlement of refugees and asylum seekers in host countries (Bloch, 2000), and thus to a sense of belonging. Such participation was denied to most asylum seekers in both countries. However, a sense of belonging is also facilitated by the relationship between the individual and the state, and is further grounded in formal rights and entitlements. The universal welfare benefits provided by the British state, and described by Marshall (1964), were crucial in facilitating a sense of solidarity, and assisting individuals to feel that they were fully respected members of society (Oliver and Heater, 1994). The shift from universal to selective benefits, together with differential eligibility for welfare rights for asylum seekers, detract from a sense of belonging. Further, Bloch and Schuster (2002) note a low uptake of welfare provision by minority groups in general, due to a lack of knowledge of their existence, or how to access them.

Refugees and asylum seekers may also feel excluded by government policies and media reporting that reinforces their 'otherness'. For example, since 11th September 2001, there has been a tendency for refugees to be portrayed as being synonymous with terrorism, even though none of the 'Twin Towers' terrorists were refugees or asylum seekers. Thus, refugees and asylum seekers have increasingly been considered threats to national security, an approach that has reinforced any sense of them 'not belonging' in the minds of the general public (Castles, 2003).

Assessment of 'health-related quality of life'

In both Britain and France changes have been made in social assistance for both citizens and non-citizens in periods of generosity and contraction (Turner, 1986; Fassin, 2000). During the initial period after entry, and while awaiting decisions on their applications for asylum, asylum seekers face restrictions on their activities and have to rely on basic and meagre resources (Sales 2002a). A safe environment, adequate housing and a guaranteed income contribute to an individual's quality of life (Patrick and Erickson, 1993) and it is apparent from this study that many refugees and asylum seekers are denied these. Most of the informants in both countries did not feel safe in their environments. Many were living in inadequate housing and many did not have a guaranteed income; for those whose income was guaranteed, it was deemed insufficient. Factors also considered to be essential to quality of life are work and the ability to contribute to community life. Both of these are, again, often denied to refugees and asylum seekers. Relationships with family and their relatives have been found to be important determinants of quality of life (Bowling, 1995a). This has implications for refugees and asylum seekers who often have difficulty achieving family reunion.

Health-related quality of life is a concept that can be used to assist thinking about ways to enhance the lives of particular communities in a democratic and inclusive way (Rapley, 2003). It is important, therefore, that attention is paid to the above trends in policy towards refugees and asylum seekers, notably that social inclusion is stronger for refugees, who meet the criteria of the Geneva Convention or have desired skills and are thus seen as 'deserving' (Sales, 2005). In contrast, asylum seekers face increasing social exclusion, fostered by the increasing separation of asylum seekers from mainstream services and society (Sales, 2005).

For the informants in this study formal status, whether in terms of citizenship or immigration status, was a key determinant of their health-related quality of life. Yet, instruments that measure health-related quality of life do not include questions about immigration status. There are many disease-specific and generic scales that purport to measure quality of life or health-related quality of life. For example, the Nottingham Health Profile, a widely used instrument based on lay perceptions of health status, but not intended to measure 'health-related quality of life', explores how people feel when they are experiencing various states of ill health (Bowling, 2005). The Short Form-36 Health Survey Questionnaire measures subjective generic health status (Bowling, 2005). While both of these instruments include questions on important aspects of health-related quality of life, for example, physical and social functioning, role performance, general health perception, they do not assess the more sensitive but importance aspects of the refugee experience. The same applies to the WHOQOL. Mooney (2006) gives further support to the need for qualitative exploration of the attributes of the concept of health-related quality of life by arguing that it *"should include whatever a patient sees as appropriate to include in the context of interactions with health care professionals"* (p338). The findings from this study suggest that, for refugees and asylum seekers from the DRC, important attributes of health-related quality of life include immigration status, location of family members, financial situation, political situation in the DRC, including any history of persecution, ability to communicate in the language of the host society, proximity to a community group, patterns of socialisation, and expectations of health professionals and health care systems. It is only once there is some understanding of these aspects of the refugee experience that health professionals might engage in some meaningful dialogue with refugees and asylum seekers concerning their health problems (Ahearn, 2000b).

Conclusion

Bestowing equal rights does not guarantee their realisation (Kabeer, 2000). Citizenship concerns the relationship between the individual and the state and thus is influenced by the structural arrangements instituted by the state. While none of the informants in this study, either in Britain or in France, had acquired citizenship status in the respective countries, there was a distinct difference in terms of their immigration status, that is, between those in the category of asylum seeker awaiting a decision on their application for refugee status, and those who had been granted the status. Arguably, the progression from the status of asylum seeker to refugee could be viewed as a step towards citizenship; at the very least it is a much more secure status affording the right of residence and also many of the rights that are normally accorded to citizens of the two countries being considered in this study.

The informants in this study had entered a stratified system whereby, using Cole's (2000) analysis, they had crossed the first two borders; asylum seekers had crossed the border into the state territory of the two respective countries, and refugees had acquired access to residency within the state. In doing so, the informants had entered a stratified system which conferred certain rights in their respective host countries (Morris, 2002). Civic inclusion or exclusion operates to deny both refugees and asylum seekers the full rights of citizenship but to further confer some rights on recognized refugees that cannot be realised by asylum seekers. Refugees are thus relatively more included in society than asylum seekers in both Britain and France. This is an important distinction that needs to be drawn between the two groups and this study has shown that the differing statuses have implications for the health-related quality of life of these two groups. Any attempts that seek to gain information on the health of refugees and asylum seekers really need to ascertain the immigration status of informants. This needs to undertaken with sensitivity as informants may become suspicious that answers to such questions may be used inappropriately and that those posing the questions may be working on behalf of immigration authorities. This, of course, could place a barrier between the health professional and the client. However, a health professional needs to be aware of the overwhelming importance that an asylum seeker attaches to immigration status.

Beyond this legal structure, civic gain or deficit serves to further include or exclude refugees and asylum seekers by virtue of the processes that misinterpret entitlements, for example in terms of access to health care, or promote civic deficit by adverse media reports that serve to fuel public mistrust and misunderstanding of refugees and asylum seekers. The increasing difficulties faced by asylum seekers, in acquiring refugee status in western European states, are a consequence of a process of civic contraction, as harmonisation of immigration policies serves to increasingly exclude applicants from access to refugee status.

Lack of citizenship status in a stratified society poses threats to health. Wilkinson's (1996) work has essentially argued that relative status in societies, where there are large inequalities in the distribution of income, has deleterious effects on health that exacerbate material deprivation and contribute to psycho-social stress. The results of this study extend Wilkinson's argument to the situation of refugees and asylum seekers and argue that their relative status in terms of lack of citizenship, and resultant civic stratification, has an effect on their health-related quality of life, an effect that results in part from material deprivation, but also from the psycho-social effects of their location in the social hierarchy and subsequent lack of control over their lives.

As stated in chapter 2, citizenship encompasses the notion of participation in public life (Steenbergen, 1994) and the relationship of the citizen with society as a whole. It is in this sphere that, perhaps, the lack of the formal status of citizenship had the most marked impact in this study. No difference was detected, in terms of feeling a sense of belonging to either British or French society, between those informants who were seeking asylum and those who had been granted asylum in the form of refugee status, as none of the informants felt they belonged to their respective host societies. Consequently, there was little participation in wider society and public life. An overwhelming sense of 'otherness' prevails, something that is reinforced by the nation-state definition of insiders and outsiders (Turner, 1986), and results in most refugees and asylum seekers from the DRC 'retreating' into the security and familiarity of their community groups. Better integration into a network of social relations is known to benefit health (Wilkinson, 1997). According to Levine (1995), an individual's health-related quality of life is concerned with social context and the presence of a supportive community to which an individual can turn. There is abundant literature that demonstrates that social supports and social integration are important factors affecting health status (Wilkinson, 1996). It is clear from this study that refugees and asylum seekers are very dependent on their own communities for such support. However, policies such as dispersal can deny some asylum seekers that support.

Elstad (1998, p40) summarises the psycho-social perspective on inequalities in health in terms of three core assumptions:

1. the distribution of psychological stress is an important determinant of health inequalities in present-day affluent societies;
2. psychological stress is strongly influenced by the quality of social and interpersonal relations, and
3. the latter are determined to a large extent by the magnitude of society's inequalities.

Psychological stress is the product of despairing circumstances, such as those experienced by refugees and asylum seekers, and can have effects on the body that can lead to physical and mental illness. Informants in this study demonstrated high levels of psycho-social stress; asylum seekers experiencing greater stress than refugees. This, in part, resulted from interpersonal relations, for example, family disruption, encounters with health care professionals, communication problems, and/or discrimination. Wilkinson (1997) contends that although material deprivation contributes to inequalities in health, the importance of relative status implies that psychosocial influences are also playing their part. In this study this can be seen particularly in relation to income. Informants in both countries were experiencing the direct effects of material deprivation in terms of reduced income and inadequate housing but were also very troubled by the psychosocial effects of not having those things that other people around them had.

Enormous worry was caused by not having sufficient income in individualistic societies. The social position of refugees and asylum seekers, that is, where they stand in relation to others, is clearly diminished and evidenced in several areas; in terms of their civil rights, political rights and social rights. The psychosocial effects of this diminished status result in behaviours that pose risks for psychological and physical health through the medium of chronic mental and emotional stress. Research shows that emotional distress creates susceptibility to physical illness; social and emotional support can protect against premature mortality, prevent illness and aid recovery (Stewart-Brown, 1998). Ill health is associated with prolonged exposure to psychological demands when possibilities to control the situation are perceived to be limited (Bosma et al, 1997). The location of refugees and asylum seekers in the social hierarchy results in social exclusion, whether in terms of relative poverty, or a subjective sense of 'otherness', or powerlessness. Such social exclusion results in loss of control over their lives, and it can be seen from this study that refugees and asylum seekers face many and varied stressors.

As well as lacking in material possessions, both these groups lack esteem and power, that is, they suffer from relative status.

> *"To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job and housing insecurity; to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure: these feelings can dominate people's whole experience of life colouring their experience of everything else."*
> (Wilkinson, 1996, p215)

Wilkinson (1996) argues that it is necessary to understand the determinants of the subjective quality of life in order to prevent ill-health, notably understanding the psychosocial effects of hierarchy and social position.

It is clear that the health-related quality of life of refugees and asylum seekers in Britain and France is affected by the attributes of my chosen definition. These in turn are influenced by legislation and policies that determine the relative statuses of refugees and asylum seekers. There is a profound difference in the health-related quality of life of refugees compared to asylum seekers, whether they are in Britain or France. The insecurity of status that asylum seekers experience has damaging effects on their psychological health. If instruments that purport to measure the health-related quality of life of refugees and asylum seekers they should include questions on concepts that are not currently included in such existing measures.

CHAPTER NINE

CONCLUSION

This chapter will address each of the four aims of the study.

1. To investigate the health-related quality of life of Congolese refugees and asylum seekers in Britain and France.

There is insufficient available evidence to claim that refugees and asylum seekers experience health inequalities relative to the white majority population in either Britain or France. However, this study has demonstrated that a range of factors do affect their health and health-related quality of life. Health is one component of health-related quality of life (Lerner and Levine, 1994). It is clear that refugees and asylum seekers do experience problems with their psychological health; as a consequence of their 'refugee experience' some have endured persecution and oppression in their countries of origin. It is also clear that refugees and asylum seekers experience a lot of anxiety while working their way through the immigration process. The insecurity engendered by the process of waiting for a decision on an application for refugee status generates problems with psychological health. While refugees have previously experienced relief when granted their secure status, in Britain, recent government policy has removed this security as individuals granted refugee status now run the risk of being returned to their countries of origin should the UK government decide that the situation that precipitated their flight has improved (Home Office, 2005). Further the 'refugee experience', together with a reduced 'bundle' of rights (Faist, 2000), relative to citizens of Britain and France, results in both a sense of, and realisation of, a lack of control over one's life, reinforced by a loss of reference points, and loss of financial independence. Loss of, and/or separation from, family members, and worry about the predicament of those remaining in the DRC, serve to increase strains on the psychological health of refugees and asylum seekers. Such stressors are known to affect psychological health and ultimately manifest in physical health problems, as stated by Wilkinson et al (1998, p579):

> *"... the growing body of epidemiological findings suggesting the importance of features of psychosocial life, such as sense of control, social affiliations and support, self-esteem, 'life events' and job security, is now coupled with a clearer understanding of the physiological pathways through which chronic psychosocial stress can have a wide range of health outcomes."*
> (Wilkinson, et al, 1998, p579)

These resultant health problems prompt refugees and asylum seekers to approach health services where they experience dissatisfaction and mistrust if they cannot speak the language of the host society, as demonstrated by my informants in Britain. Lack of awareness of the culture of Congolese refugees and asylum seekers, together with some apparent insensitivity towards the experiences of refugees and asylum seekers can serve to increase the perceived distance between the patient and health professional. The consequences of these encounters tend to be unsatisfactory in terms of solving or alleviating the presenting health problems. While refugees and asylum seekers share some health problems with members of low socio-economic classes, and members of minority ethnic groups, they also have problems that are specific to the 'refugee experience'. These problems pose a threat to the health-related quality of life of refugees and asylum seekers.

2. To identify factors that have an impact on the health-related quality of life of these two groups of people who lack citizenship status and have differing status in the civic stratification system.

The investigation of the health-related quality of life of refugees and asylum seekers from the DRC has revealed that access to citizenship is seen as an important first step towards incorporation into British or French society, and that in the absence of this secure status, refugees and asylum seekers live in a hierarchical society, characterized by civic stratification. This stratification attaches different degrees of political, civil and social rights to the distinct statuses of refugee and asylum seeker. The denial of political rights for both refugees and asylum seekers is important as it represents a lack of voice and confers a sense of being unable to register complaints about immigration and welfare services. In the light of these findings it is not certain that the argument that national citizenship is no longer important can be sustained. Immigration and asylum policies in Britain and France construct refugees and asylum seekers as "other" and thus shape their lives (Saraga, 2004). In Britain the sense of otherness is reinforced by my informants' varying abilities to communicate in English; in France the sense of otherness is fuelled by the emphasis placed on being either French or a 'foreigner'.

This study has also identified that location in the lower reaches of a stratified society has adverse effects on health, regardless of the philosophical approach to citizenship. The approach adopted, then, would appear to be less important than the granting of the secure status of citizenship, as neither the civic republican approach to citizenship entrenched in France, nor the liberal approach adopted in Britain, had protective effects in the absence of full citizenship status. The experiences of refugees and asylum seekers in the two countries, in terms of lack of security, were similar.

In terms of immigration and asylum policy, it is apparent that the relative statuses that are attached to stratification result in problems with psychological health and also create situations which make refugees and asylum seekers more dependent on the state and others than need be the case. Refugees and asylum seekers should not be viewed as victims, or placed in positions of 'less eligibility'. Rather, their resilience should be noted, rewarded and celebrated in terms of assisting them to independence. Many of my informants held prestigious professional positions in the DRC and they could be enabled to return to similar or related positions in Britain and France. Failure to recognise their qualifications and skills results in a waste of precious resources. Most of my informants want to work in their host societies, and contribute to these societies, and forge futures for themselves and their children.

Refugees and asylum seekers fall into those categories described by Rees (1995) as incomplete citizens and by Heater (1999) as partial citizens. Whatever the categorisation, this incomplete status renders refugees and asylum seekers incapable of self-determination, unable to compete with other members of society on equal terms (Heater, 1999). Without doubt, health-related quality of life is a political matter the findings of this thesis confirm Rees' (1995, p319) contention that:

> *"the uniqueness of social rights has been much exaggerated. Political rights are the core of citizenship and have been especially jealously guarded".*

3. To explore the above factors in terms of their relationship to policy concerning immigration and the granting of citizenship in two countries with different approaches.

In terms of citizenship, procedures for acquiring this status are similar in both countries, and the associated rights in both countries share similarities. It is in the philosophical approach concerning the integration of migrants that the differences lie.

The ideals of France's reputation of being a country of human rights did not live up to the expectations of refugees and asylum seekers from the DRC, and the commitment to individual assimilation of migrants did not appear to confer any benefits on my informants, when compared with the informants in Britain, with the possible exception of access to health care. While there are profound differences between my informants in Britain and France in relation to their experiences of using health services, interpretations of these experiences are clouded by issues of language and modes of delivery of health care. Policies in terms of access to health care are similar in both countries. The differences between respondents in Britain and France relate to the modes of integration of migrants into the host societies. These differences are apparent in the comments relating to employment and aspirations for the future. Essentially, Britain's multi-cultural approach to integration appears to result in the perception, at least, of more opportunities for immigrants. In contrast, the perception of France's approach to the integration of individuals into the French polity and community is one of 'closed doors'. These are issues that are not specific to refugees and asylum seekers but to immigrants in general.

4. To identify the implications of the above factors for health policy and the health of refugees and asylum seekers.

The implications of the findings of this study for health policy are worthy of note. One of the most important aspects of a health policy for migrants is the promotion of understanding of the needs of diverse communities (International Organization for Migration (IOM), 2005). Successful integration of migrants into host societies requires health policies that understand the nature of migrants' health problems and for refugees and asylum seekers in particular, the human rights dimensions of health issues (IOM, 2005). This implies the inclusion of all members of the community, regardless of their citizenship status or civic stratification. It also implies awareness of the 'refugee experience', but without stereotyping refugees and asylum seekers and assuming that they all have the same experience and the same health problems. Successful health care for refugees and asylum seekers requires acknowledgement of their resilience and not casting them as victims of situations that are all beyond their control. Thus, it is important to concentrate on the capabilities of refugees and asylum seekers and not focus on their deficits.

In terms of health policy, the findings suggest that Britain could learn lessons from France. The different degrees of satisfaction with health care in the two countries have been stressed. The lessons for Britain are to improve communication between refugees and asylum seekers from the DRC and health care providers/professionals. This could be achieved by more availability, and use, of interpreters and the provision of information concerning the functions of the NHS, both primary and secondary care, and the roles of the various professionals within it. This, together with better training of staff concerning the needs of refugees and asylum seekers, might help to reduce some of the mistrust that is currently so harmful to encounters with the NHS.

In conclusion, while several different themes have been identified in relation to the health related quality of life of Congolese refugees and asylum seekers, there are some unifying threads that run through these themes. One of these is lack of trust which has already been discussed extensively. Another is lack of control that is felt by refugees and asylum seekers over their lives. This lack of control extends from the early stages of asylum seeking, when there is a perceived lack of control over immigration status, through lack of control over income, housing, employment, to lack of control over the future. This lack of control also includes the lack of political rights afforded to refugees and asylum seekers and the consequent lack of voice. This lack of control is, in part, brought about by a reduced 'bundle' of rights in the country of asylum, be it Britain or France. It is in this area that similarities between informants in Britain and France are displayed. Asylum seekers in both countries have made similar comments about their status; refugees in both countries share similar concerns. This suggests that the relative status experienced by asylum seekers compared to refugees whose status can, in turn, be compared to that of citizens, contributes to their differing concerns and thus to their health-related quality of life. Differences exist between the informants in the two countries concerning their satisfaction, or otherwise, with health services. This was an unexpected finding and no doubt reflects the different degrees of satisfaction with the health services of the general populations of Britain and France. It is also very likely to be related to the ability to communicate in the language of the host society. As such, further exploration of reasons behind these differences would warrant another study, possibly asking questions concerning the nature of 'health citizenship', i.e., what citizens really do want from their health services. In the meantime the differences in satisfaction between these two groups of informants should provide 'food for thought' for policy makers concerned with reforming health service provision. This thesis also demonstrates that refugees and asylum seekers do have health needs that are specific to their experiences but that they also share a lot of needs in common with the host society. Certainly in Britain it may not be appropriate to continually draw attention to the needs of minority ethnic groups, as this may detract from the central problem of a poor service. Instead, it might be more instructive to work towards a health care system from which everyone can benefit.

An enormous amount of information exists concerning the health and illness experiences of people in lower social classes, there is a growing body of knowledge concerning that of members of minority ethnic groups. The effects of poverty on health are now beyond dispute. There is further evidence of the effects of relative status on health as a consequence of the psycho-social distress attached to it. This study has drawn heavily on these bodies knowledge and applied the theories to the situation of one particular group of refugees and asylum seekers. In doing so, this study has contributed to the body of knowledge concerning variations in health in general, but specifically, it has extended that knowledge to the situation of refugees and asylum seekers. This study has also made clear distinctions between the statuses of refugees and asylum seekers when investigating health-related quality of life. This is important as this study has revealed the profound distress caused by waiting for a decision on an application for asylum. There can be little doubt, then, that health-related quality of life has a political component, as political decisions determine procedures for asylum seeking and the granting of refugee status. Thus civic stratification and citizenship status make an important impact on health-related quality life. The results from this study support Ahmad's (1993) statement to the effect that health and ill health are mediated by a person's citizenship status. Health is affected by factors surrounding immigration status, which in turn derives from the structural arrangements of the society.

> *"Being a refugee, with the associated upheaval and pre-migration experiences, is hard enough without policy in the host society diminishing opportunities for involvement".*
> (Bloch, 1999c, p128)

Bloch (1999c) argues that anything less than full citizenship status will impede settlement, which in turn will influence health. Citizenship, in terms of belonging, is often used by politicians to determine eligibility for services, entitlements and rights, but even when formal status is determined, refugees and asylum seekers may encounter barriers to the realisation of these rights.

This study brings together a variety of disciplines and sources of knowledge surrounding the issue of the health-related quality of life of refugees and asylum seekers. It is evident that a variety of factors, political, sociological, psychological, physical and policy-related, contribute to the health and illness experience of refugees and asylum seekers. This study is small in scale, with a limited number of informants, chosen purposively by community leaders, to participate in focus groups and individuals interviews. Qualitative research does not aim to generalise so the results remain unique to this particular group of informants, refugees and asylum seekers from the DRC, resident in Britain and France. However, repeated studies have revealed similar results and there are some common denominators: the distress that results from the process of seeking asylum, the worry about friends and family who remain in the country of origin, worry about money.

There is a growing acceptance that 'sterile' accounts of physical health status are now of limited value. As attention turns towards the holistic nature of the experience of health and illness, there is recognition in many quarters that it is now necessary to take account of wider psycho-social-economic experience. In the case of refugees and asylum seekers account must be taken of their status. This study further makes a contribution to another growing body of knowledge, that concerning health-related quality of life. Several authors (Hunt, 1995; Saxena et al, 2001) have commented on the fact that health-related quality of life is a subjective concept and thus lends itself to inquiry within the qualitative research paradigm. The results of this study provide insights into the health-related quality of life of one group of refugees and asylum seekers. It is apparent that some of the contributory factors raised by the informants do not appear in existing instruments that are used to measure the concept. Thus, these findings support those authors (e.g. Hunt, 1995) who cast doubt on the possibility of producing one instrument that is applicable for universal cross-cultural use. Qualitative methodologies can provide a complementary and often necessary additional insight into standardized assessment of outcomes using health related quality of life measures (Ebrahim, 1995). Qualitative research allows informants to 'tell their stories'.

Although refugees and asylum seekers are entitled to seek and receive health care in Britain and France, such rights are insufficient in terms of securing a good health-related quality of life. This thesis has demonstrated that there is a need for an elaboration of the concepts that constitute health-related quality of life. An illness or disease may be treated successfully or palliated, but in the absence of other rights, notably civil and political, refugees, and more importantly asylum seekers, can sometimes continue to live in insecurity. At a time of growing concerns about the rise of extremism and xenophobia across Western Europe, changes can be made in relation to the provision of health services that would benefit refugees and asylum seekers. Information can be provided in different languages, interpreters can be made available, staff can be trained in cultural awareness and sensitivity, and the 'refugee experience'. However, unless this is accompanied by different media approaches to the needs of refugees and asylum seekers, public opinion will not change and discrimination and racism will continue, with consequent detrimental effects on health. In order for this to happen, there is a need to move towards a more inclusive approach to citizenship that encourages and facilitates a sense of belonging to society. Access to formal citizenship is merely a step on the way to full membership of a society. Currently citizenship in western European countries has more to offer in its future potential than in its contemporary practice. Moves towards a transnational approach to citizenship, advocated by Bauböck (1994), based on universal human rights, rather than national citizenship, would have more to offer refugees and asylum seekers in terms of civil, political and social rights and a sense of belonging to a host society. In order to achieve this, states would need to accelerate the procedures that lead to the acquisition of citizenship and reduce the differences in rights attached to the different statuses of refugee and asylum seeker. In the absence of this visionary scenario, it is imperative that national governments review their immigration policies in order to make the experience of refugees and asylum seekers one of inclusion, rather than exclusion.

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APPENDIX

Topic guide for individual interviews

Age

Immigration status

Choice of destination – Britain or France

Family

Occupation in DRC

Present occupation

Language(s) spoken

Psychological health

Physical health

Access and use of health services

Relationship with health care providers/professionals

Accommodation

Safety

Socialising

Community organization

Aspirations for the future

Health-related quality of life