Health and ageing in a hostile environment:

Understanding older asylum applicants’ narratives of life, health and ageing in the UK

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# Table of Contents

List of abbreviations ........................................................................................................ 6
Abstract ............................................................................................................................... 7
Declaration ........................................................................................................................... 9
Copyright Statement ......................................................................................................... 9
Acknowledgements .......................................................................................................... 10

Chapter One ....................................................................................................................... 11
Asylum in the UK: Hostility and austerity ........................................................................ 11
  1.1 Introduction ............................................................................................................... 11
  1.2 Thesis outline ............................................................................................................ 14
  1.3 Applying for asylum: The criticality of credibility ................................................... 19
  1.4 Crimmigration and the border spectacle ................................................................. 26
  1.5 Conclusion ............................................................................................................... 36

Chapter Two ...................................................................................................................... 37
The health of older refugees and asylum seekers: A critical overview of contemporary academic debates ................................................................................................................................. 37
  2.1 Introduction ............................................................................................................... 37
  2.2. Explanatory models of health .................................................................................. 39
      2.2.1 Asylum applicants’ explanatory models of health ............................................ 40
      2.2.2 Dominant tropes in biomedical migrant health research .................................. 43
      2.2.3 Dominant tropes in biomedical gerontology: The emergence and utilisation of frailty ................................................................................................................................. 53
  2.3 Structural violence and intersectionality .................................................................. 56
      2.3.1 Intersectionality ............................................................................................... 60
  2.4 Biopower ................................................................................................................... 63
      2.4.1 Governmentality, biopower and immigration .................................................... 63
      2.4.2 Biopower and biomedicine .............................................................................. 66
  2.5 Identity politics and biological citizenship .............................................................. 67
      2.5.1 Identity politics and migration ....................................................................... 67
      2.5.2 Identity politics and ageing in the UK ............................................................. 72
2.5.3 Biological citizenship and biolegitimacy .................................................. 75

2.6. Conclusion .................................................................................................... 78

Chapter Three ..................................................................................................... 81

Methodology and methods .................................................................................. 81

3.1 Introduction .................................................................................................... 81

3.2 Shifting epistemologies and resultant disciplinary orientation.................... 82

3.3 Quantitative methods: The question of measured frailty in older asylum seekers and refugees ................................................................. 87

3.4 Research questions ......................................................................................... 91

3.5 Qualitative methods ....................................................................................... 91

3.5.1 Making contact with a hard-to-reach population ...................................... 91

3.5.2 Obtaining consent ...................................................................................... 100

3.5.3 The research interview .............................................................................. 103

Table 1: Research participants ............................................................................. 104

3.5.4 Linguistic and cultural interpretation ......................................................... 110

3.6 Data processing and narrative analysis ......................................................... 114

Table 2: The steps of data analysis ...................................................................... 118

3.7 Conclusion ..................................................................................................... 119

Chapter Four ....................................................................................................... 121

Intersectionality and ageing in exile .................................................................. 121

4.1 Introduction .................................................................................................... 121

4.2 Participants’ explanatory models of ageing .................................................. 122

4.2.1 Ageing as a social process ......................................................................... 122

4.2.2 Migration as a determinant of ageing ....................................................... 130

4.3 Ageing and intersecting identity politics ....................................................... 133

4.3.1 The identity politics of immigration categorisation .................................. 134

4.3.2 Gendered experiences of ageing in exile .................................................. 138

Table 3: Number of main asylum applicants to UK in 2016 by age .................. 140

4.3.3 Racism ....................................................................................................... 150

4.4 Discussion ..................................................................................................... 152
Chapter Five .......................................................................................... 156

Explanatory models of health, ill-health and frailty .......................... 156

5.1 Introduction ..................................................................................... 156

5.2 The multiple dimensions of health ............................................. 157

5.3 Protracted liminality....................................................................... 165

Table 4: Date of arrival in UK and countries of origin of refused asylum
seekers interviewed ............................................................................. 167

5.4 Bi-directional narrative co-construction: Pathographies and liminal
experience .............................................................................................. 171

5.5 Participants’ explanatory models and experiences of frailty ...... 180

5.6 Discussion ........................................................................................ 188

Chapter Six ............................................................................................ 192

Biocredibility and the apparatus of asylum ..................................... 192

6.1 Introduction ..................................................................................... 192

6.2 Journeys to the UK ......................................................................... 194

6.3 Biocredibility and encounters with the Home Office .............. 199

6.3.1 Interrogative interviews: Credibility in question................. 202

6.3.2 Strategies of surveillance: Crimmigration in practice .......... 209

6.3.3 Using illness in the asylum appeal ......................................... 218

6.4 Discussion ....................................................................................... 223

Chapter Seven ....................................................................................... 231

Discussion: Research contributions and impact ............................ 231

7.1 Introduction ..................................................................................... 231

7.2 Methodological reflections: Invisibility begets invisibility .... 231

7.3 Intersecting structural violences and biopower ...................... 234

7.4 Explanatory models of ageing, frailty and health ................. 238

7.5 Identity politics: Biocredibility ..................................................... 242

7.5.1 The impact of biocredibility: Problematising somatoform
disorder .............................................................................................. 244

7.5.2 The impact of biocredibility on practice, policy and research... 247
7.6 Conclusion ........................................................................................................ 250

Bibliography ............................................................................................................. 255

Appendices .................................................................................................................. 335

Appendix 1: Definitions of categories of migrants used in the thesis 335
Appendix 2: Strategy used to identify literature for review .................. 336
Appendix 3: CPRD research protocol ................................................................. 337
Appendix 4: List of research outputs and collaborative projects ...... 350
  Peer-reviewed journal outputs ................................................................. 350
  Research reports ...................................................................................... 350
  Book chapters ......................................................................................... 351
  Short articles ......................................................................................... 351
  Media ...................................................................................................... 352
  Abstracts ................................................................................................. 352
  Oral presentations .................................................................................. 353
  National conferences .............................................................................. 354
  Leadership and management ................................................................. 355
  Voluntary work .................................................................................... 355
  Local network involvement ................................................................. 356

Appendix 5: Email sent to potential Voluntary Community Organisations ................................................................. 357
Appendix 6: Participant information sheet ................................................ 359
Appendix 7: Consent form .................................................................................. 364
Appendix 8: Interview topic guide ............................................................... 366
Appendix 9: Translator Confidentiality Agreement .................................. 368

Word Count

71,853
**List of abbreviations**

AIDS – Acquired Immune Deficiency Syndrome  
CMA – Critical Medical Anthropology  
CD – Communicable Disease  
DRC – Democratic Republic of Congo  
ECHR – European Convention on Human Rights  
EU – European Union  
FM – Forced Migrants  
HIV – Human Immunodeficiency Virus  
ICD-10 – International Classification of Diseases 10  
IPA – Interpretative Phenomenological Analysis  
IRC – Immigration Removal Centre  
MoU – Memorandum of Understanding  
NHS – National Health Service  
NCD – Non-Communicable Disease  
PIS – Participant Information Sheet  
PTSD – Post Traumatic Stress Disorder  
SD – Somatoform Disorder  
UK – United Kingdom  
VCO – Voluntary Community Organisation
Abstract

This thesis sits at the nexus of three important contemporary issues: health, migration and ageing. A growing literature problematises the UK’s current restrictive approach to immigration, whilst concurrent health research increasingly recognises that exile environments determine long-term health for displaced people. This thesis, with its theoretical roots in critical medical anthropology, asks how older asylum applicants narrate their health in relation to their lived experiences. 21 semi-structured interviews, conducted between August 2017 and March 2018 with older asylum applicants in Greater Manchester, were analysed using narrative analysis.

The asylum applicants interviewed faced multiple intersecting structural violences, placing them in unique positions of disadvantage. The majority felt their health was poor and told of the difficulties of life in the UK. Stories of homelessness, poverty and exclusion dominated, underpinned by the erosion of their perceived trustworthiness and credibility through encounters with the Home Office. They narrated particular personal experiences of social, political and economic strife in exile and correlated them with narratives of illness. The thesis proposes biocredibility as a novel theoretical concept to analyse this. Biocredibility describes how visceral descriptions of biological suffering can function as a narrative tool by adding credibility to accounts of experienced adversity. It does this, firstly, by allowing the narrator to ascribe culpability for illness. Secondly, by interjecting experiences of illness into life narratives, the significance of such experiences is effectively communicated. Finally, describing disease and disability provides narrative evidence of individuals’ autobiographical testimony. For discredited and marginalised asylum applicants, biocredibility represents a strategy used to re-negotiate credibility. Rather than proffering to make inferences about the aetiology of the health episodes described, or suggest health rememberings are consciously
exploited for personal gain, biocredibility urges a critical consideration of the socio-political contexts in which it is observed. In doing so, this research raises questions about the drivers and consequences of the narrative biologisation of complex human life in global yet austere contemporary times.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other University or other institute of learning.

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Chapter One

Asylum in the UK: Hostility and austerity

‘If we are to understand the causal processes whereby social conditions shape health, we need to examine how social conditions are experienced, perceived and handled, and how they constrain the freedom of people to act in such a way that those conditions could be transformed, adapted or avoided in different ways.’

Williams, 2004, p. 280

1.1 Introduction

Contemporary society is stratified along dimensions of global mobility; for those high up, borders are worn down to facilitate freedom of travel for enrichment, consumption and commodification. For those low down, travel is approached clandestinely and at great risk; borders are considerable and prohibitive, consisting of immigration control and exclusion from welfare (Bauman, 1998). Over the last 50 years across Europe, economic and political logic has interacted with social fears and ideological manipulation to produce often-radical changes to immigration legislation (Andreas and Snyder, 2001; Fassin, 2011). Although asylum applicants constitute only 6% of all migrants in the UK¹, the British government takes a penurious approach to the provision of assistance to those applying for protection as refugees (Squire, 2009; Geddes and Scholten, 2016; The Migration Observatory, 2017a). In 2012, as Home Secretary, Teresa May promised to decrease migration from the ‘hundreds of thousands to the tens of thousands’ by creating a ‘really hostile

¹ There has been an increase in the number of people migrating to the UK in the last two decades. Between 2004 and 2017 the population of foreign-born nearly doubled from 5.3 million (8.9%) to 9.4 million (14.4%) (The Migration Observatory, 2017a). There were 30,700 main asylum applicants in 2016. When dependents are included - family members accompanying the principal person making the application - the number of individuals seeking asylum is higher: 39,400 in 2016 (The Migration Observatory, 2017b).
environment’ for those classified as irregular migrants, including those refused asylum (Travis, 2013). As a result, the Immigration Acts of 2014 and 2016 adopted a punitive approach to immigration and shifted the enactment of border control practices to everyday state and non-state actors (Guentner et al., 2016).

This parsimonious stratified neo-liberal globalisation results in a paradox: the cross-border movement of goods for consumption is permitted, whilst the migration of the majority of the world’s people into high-income countries is restricted (Fassin, 2011; Leon and Overbeek, 2015). This paradox should be critically considered against the post-colonial geopolitical position of Britain. Often-brutal colonial rule resulted in Britain’s profitable acquisition of natural and human resources from across the globe, on which the UK’s current prosperity is built (Drayton, 2012; Anderson, 2017). Colonialism also laid the foundations for much-needed labour migration in the mid 19th century and enduring post-colonial ties still shape migratory patterns to the UK economically, linguistically and logistically today (Hatton, 2005; Turner, 2015; Vezzoli and Flahaux, 2017). In 2016, the top asylum-sending countries were Iran, Pakistan, Iraq, Bangladesh and Afghanistan: three of these five are former British colonies (Home Office, 2017; Bales and Mayblin, 2018).

This stratified parsimony forms the backdrop for this thesis, which sits at the nexus of three important contemporary issues: transnational migration to the UK, health inequalities, and ageing. The research seeks to explore how older asylum applicants narrate their health in relation to their lived experiences.2 From a population perspective, this is an imperative enquiry. The number of people forcibly displaced from their homes globally is among the highest on record; the population-proportion of older people is

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2 The classification of those interviewed, and thus the terminology used to describe them, is, in itself, a research finding. This will be made evident as the thesis progresses. However, for the purposes of clarity, Appendix 1 displays and qualifies the terminology used to describe the research subjects in the thesis.
increasing in all regions of the world; and inequalities in health and wealth between population strata in the UK have been growing since the 1970s and 1980s (Shaw et al. 1999; Shaw et al. 2005; Wilkinson and Pickett 2009; Bennett et al. 2015; Office for National Statistics, 2018; UNHCR, 2019). Despite these demographic trends, existing research into the health of asylum seekers and refugees in the UK is scarce. Where it does exist, the social and political determinants of health are overlooked, older people are neglected, and individuals’ experiences of illness in the context of migration are not addressed (Calvi-Parisetti, 2011; Hynie, 2018). Although only 1% of people seeking asylum in the UK are over the age of 65, the number of older 3 asylum seekers and refugees is increasing (Hatzidimitriadou, 2010; Calvi-Parisetti, 2011; Centre for Policy on Ageing, 2016; Refugee Council, 2018a).4

This thesis asks how older asylum applicants understand and narrate the associations between lived experience and their experiences of ageing, health, ill-health and frailty. As well as being of demographic significance, this research is academically and ideologically important. Approaching the older forced migrant as a research subject provides an opportunity to embark on a rich analysis of the drivers of health inequalities accumulated across the life course. Centralising the particular health and life experiences of this marginalised minority group challenges their invisibility, thus contests their exclusion from academic and policy conversations.

These academic and ideological concerns considered, this thesis adopts a critical perspective on the contemporary dynamics surrounding migration

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3 In the UK, older people are often defined as those over 60 or over 65, owing to this age’s correspondence to pensionable age. However, there is consensus from experts that in the forced migrant population, the threshold for being considered older is lower. Most researchers and policy makers regard forced migrants over the age of 50 as ‘older’ (Knapp and Kremla, 2002; Connelly et al., 2006).

4 Scholars suggest this is both due to ageing populations globally and the increase in number of complex and protracted humanitarian crises which are not conducive with refugees’ return (Hatzidimitriadou, 2010; Calvi-Parisetti, 2011; Centre for Policy on Ageing, 2016; Refugee Council, 2018a).
to the UK, with a view to confronting the structural drivers of health inequalities. Empirically, the analysis shows how hostile and austere material, social and political conditions can produce suffering.

Methodologically, narrative analysis is used to both attend to the idiosyncrasy of older asylum applicants’ lived experiences, whilst critically exploring the broader social context. Theoretically, the thesis aligns itself with ideas from medical anthropology to disrupt the hegemonic disciplinary approach of biomedicine. In particular, the work of Didier Fassin and his concept of biolegitimacy is important. Advancing Fassin’s ideas through the narrative analysis of older asylum applicants’ pathographies, the thesis makes a novel theoretical contribution: biocredibility. Biocredibility describes how, in a hostile and austere environment, biological narratives can add credibility to accounts of lived experience.

1.2 Thesis outline

Such an interdisciplinary and geopolitically situated enquiry necessitates an understanding of the research context. This chapter, the first of seven, introduces the political climate surrounding migration to the UK, drawing on sociological and political science scholarship. After the legal frameworks underpinning asylum applications are introduced, the processes of how the Home Office makes decisions about asylum cases is critiqued. It is shown

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5 Debate exists over the conceptualisation and definition of suffering, with philosophical, sociological and medical perspectives (for an overview see Bueno-Gómez, 2017). For the purposes of this thesis, suffering is not considered in the abstract, rather it understood to be an unpleasant experience with the potential to profoundly affect an individual. Although Kleinman’s concept of social suffering and evidenced-based notions of physical pain tend to dominate existing literature, this thesis rejects the idea that suffering can be delineated along the lines of along mind/body dualisms (Kleinman, Das and Lock, 1997; Bueno-Gómez, 2017). Instead suffering is a negative experience which affects individuals along psychological, physical and functional dimensions.

6 Pathographies are autobiographical accounts of illness experience. Pathographies can provide a rich insight into people’s ‘attitudes and assumptions regarding all aspects of illness’ and place the individual at the centre of the illness experience (see Hawkins, 1999a p. 127; Hawkins, 1999b; Sakalys, 2000).
that the perceived credibility of asylum applicants is central. Finally, the UK’s contemporary bordering practices and asylum apparatus⁷ are explored, with a focus on crimmigration and the border spectacle.

Chapter Two provides a critical overview of the relevant literature, framing the contemporary academic debates about the health of older asylum applicants within a critical theoretical framework. The framework draws on four theoretical concepts from the discipline of Critical Medical Anthropology (CMA) suggested by Carroll (2013; 2014): explanatory models; structural violence; biopower; and identity politics and biological citizenship. These four theoretical concepts were selected to frame the literature review as they provide a critical skeleton on which all of the necessarily broad literatures can be explored. This framework is revisited in the final chapter, where the four themes are re-examined in light of the empirical, methodological and theoretical contributions of the thesis. As well as providing a synopsis of current academic thinking, Chapter Two illustrates the theoretical assumptions and epistemological foundations of the thesis. Within the critical overview of the literature, the following assertions are made. First, the hegemony of biomedicine in academic considerations of health is problematised. Second, attention is drawn to the myriad and intersecting social, political and economic structural violences⁸ older asylum seekers and refugees are subject to. This is so that the empirical contribution of the thesis, which illustrates how these structural violences are experienced in the UK, is contextualised. Of

⁷ In Marxist theory, the Repressive State Apparatus describes the government, police, courts and prisons which operative through direct or administrative violence and oppression. Building on Marxist theory, Althusser described the Ideological State Apparatus, which denotes institutions such as education, families, media, and law (Althusser, 2014). Although formally outside state control, Althusser suggests these institutions propagate the values of the state and maintain a capitalist social order. Informed by Gill’s understanding of the state as diffuse and Guentner et al’s observations about everyday bordering, the term asylum apparatus is employed in this thesis as a way of describing both the repressive and ideological frameworks and machinery used to regulate asylum applicants in the UK (Gill, 2010; Guentner et al., 2016).

⁸ The term structural ‘violences’, rather than structural violence, is used as a purposeful plural in the thesis with the aim of highlighting the multiple forms of structural violence facing the participants.
particular importance is the exploration of the social uses of illness identities; specifically, the concepts of biological citizenship and biolegitimacy. This scholarship provides the conceptual tools needed for the development of the main theoretical contribution of the thesis: biocredibility.

The third chapter describes the research methodology and methods. Although the preliminary research design included quantitative biomedical measurements, the thesis evolved into a qualitative study. The drivers of this evolution are explored, as is the associated intellectual discomfort, disruption and reconstitution of the self. The chapter documents the narrative analysis of 21 interviews with older asylum applicants conducted over an eight-month period at voluntary community organisations (VCOs). Manchester, a metropolitan city in the North-West of England and the setting for this thesis, has been the recipient of large-scale immigration since the industrial revolution in the early 1800s (Bullen, 2015). The varied patterns and drivers of migration since have created a diverse city (Gopal et al., 2013). However there are also great inequalities in wealth and health in the region; even within Manchester’s local authorities, those in the wealthiest quintile can expect to live ten years longer than those in the most deprived (Rubery et al., 2017). Ethical conundrums and issues of positionality embedded within this inequality are reflected on throughout this chapter.

Chapter Four is the first of three empirical chapters. It introduces some of the individuals interviewed through an exploration of their narratives of ageing. The chapter shows that participants construct articulations of their explanatory models and experiences of ageing alongside narratives of lived experiences of migration and social roles. In these narratives, migration is seen as a challenge to ageing, and ageing a challenge to life in the UK. However, the research participants are a heterogeneous group, diverse across multiple social dimensions. Rather than essentialising them, this
Chapter draws on the concept of intersectionality to facilitate an exploration of how structural violences operate differentially across dimensions of gender, race, immigration status, employment and poverty. As a consequence, the chapter highlights both the particularities and the commonalities of ageing in exile.910

Chapter Five analyses participants’ explanatory models of health, ill-health and frailty. As most felt their health was poor, rather than discussing health as an abstraction, participants spoke about particular personal experiences of ill-health. Pathographies, or illness narratives, represent individuals’ illness experiences and in doing so can provide ‘powerful means for communicating and giving meaning to experience’ (Mattingly and Garro; 1994 p. 771; Sakalys, 2000). As with their stories of ageing in Chapter Four, participants intertwined pathographies with narratives of social, political and economic strife. Despite the heterogeneous nature of the sample, and the multiple and varied intersecting axes of oppression operating on them, participants’ narratives are unified by the concept of liminality; this liminality is underpinned by immigration categories that set the parameter for everyday lives. This chapter also makes an observation about narrative structure that emerges as central to the thesis; participants construct and narrate ideas of health and ill-health in relation to personal lived experiences bi-directionally. On the one hand, health stories are used as a vehicle to describe significant and often-negative life experiences. On the other, during discussion of important life events, participants draw on accounts of biological dysfunction. The narrative association between bodily suffering and lived experience centralises the significance of the hostile exile environment. As a result, health stories emerge as a narrative tool.

9 The term exile is used by migration scholars to describe the ‘state of forced emigration, displacement and social and political marginalisation’ (Baumann, 2013, p. 17).
10 The three empirical chapters have a discussion that brings together the main analytical points of the chapters and situates them within existing literature. The non-empirical chapters - one, two, three and seven – instead finish with a short conclusion.
Chapter Six, the final empirical chapter, develops the idea of health stories as a narrative tool through a critical exploration of participants’ encounters with the Home Office during their asylum application. Participants’ journeys to the UK place them in perilous positions and the desire to evade state authorities en route lays the foundations for an ongoing relationship of mutual distrust and suspicion with the Home Office on arrival. Further, specific encounters with the Home Office erode credibility. The asylum interview is remembered as interrogative; asylum housing is seen as an extension of state surveillance apparatus; and the process of reporting to the Home Office is feared, owing to its association with arbitrary detention and deportation. In this context, stories of biological dysfunction can be understood to renegotiate credibility. Consequently, Chapter Six proposes a novel theoretical concept though which these pathographies can be understood: biocredibility. Biocredibility refers to the way accounts of visceral biological dysfunction can serve to reclaim integrity and renegotiate credibility in the context of the profound impoverishment of social, political and economic resources. This is realised in two main ways. First, recounting pathographies provides narrative evidence of experiencing ill treatment. Second, accounts of illness convey the significance and import of particular experiences.

The final chapter draws together the objectives, methodology and findings of the thesis. The chapter is structured around the theoretical milieu described in Chapter Two: explanatory models; structural violence; biopower; and identity politics and biological citizenship. Through this thematic approach, the main empirical findings are revisited. Illustrating how biocredibility might problematise the hegemonic tendency to biomedicalise social distress further refines the central theoretical contribution of the thesis. Importantly, implications of the research for policy, practice, and future research are considered.
1.3 Applying for asylum: The criticality of credibility

Asylum applications in the UK are supported by three pieces of international law. The first is the 1951 Geneva Convention, which defines a refugee as one who:

‘Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it’ (UNHCR, 2011).

The convention is forward looking; that is, it focuses on the ongoing and future risk to the claimant should they return to their country of origin, rather than necessarily focusing on any previous ill treatment.

The second piece of legislation is the 1950 European Convention on Human Rights (ECHR), which documents articles of protected rights. Asylum claims based on the ECHR are often referred to as human rights claims, which can stand alone, or be combined with claims under the Geneva Convention (Council of Europe, 2010). The Geneva Convention only provides limited protection for asylum seekers awaiting an outcome decision.11 Under UK law there is a chasm between the rights of UK citizens and the rights of foreign nationals; here the ECHR’s Human Rights Act 1998 has been used to safeguard the rights of asylum seekers (Equality and Human Rights Commission, 2019). The final piece of legislation is the European Union Asylum Qualification Directive, which the UK has adopted alongside a

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11 By way of example, Article 31 of the Geneva Convention prohibits states penalising refugees who enter illegally.
number of EU member states. This aims to clarify and regulate the grounds for international protection, as well as the minimum level of support offered to those seeking asylum (European Parliament, 2011).

However, nation states interpret and apply the Geneva Convention in ways that reflect dynamic national interests (Sweeney, 2009; Scherschel, 2011; Jubany, 2017; Crawley and Skleparis, 2018). The British state’s current drive to decrease net immigration has led scholars and activists to question the ability of current asylum procedures to identify those in need of protection. The Home Office manages asylum applications, appeals and deportations in the UK. Asylum applicants can make asylum claims to the Home Office at an airport or port on arrival to the UK, or once inside the UK at the Home Office in Croydon, London (Home Office, 2019a). Next, an initial screening interview is performed where personal details of the applicant and their journey to the UK are documented. Following this, the applicant undergoes a substantive asylum interview. Here applicants are asked to explain ‘how you were persecuted in your country [and] why you’re afraid to go back’, to allow Home Office caseworkers to make the delineation between those who qualify for protection under the Geneva convention, and those who do not (Home Office, 2019a). In order to be eligible for refugee status, asylum seekers must demonstrate a ‘well-founded fear of persecution’ (UNHCR, 2011).

When deciding whether individuals meet the criteria for refugee status, caseworkers consider the asylum seeker’s autobiographical testimony of persecution and any supporting evidence, such as personal documentation. In contrast with other legal procedures, asylum

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12 The UK Home Office, part of central British government, is responsible for the regulation of immigration, and is supported by the Border Force, UK Visas and Immigration, and Immigration Enforcement. These departments will be referred to as the Home Office throughout the thesis for the purposes of consistency and simplicity.

13 In addition to individuals’ testimonies, the Home Office operates bilateral agreements between states and considers ‘country policy and information guidance’ when weighing up an individual’s ongoing risk of persecution (European Commission, 2017; Crawley and Skleparis, 2018; Home Office, 2019b).
applications often involve no witnesses and have little corroborating documentary evidence to draw on. Thus caseworkers’ decisions often depend on whether they find the applicant’s account to be credible (Sweeney, 2009). The Home Office issues guidance for caseworkers on ‘Assessing credibility and refugee status’ and frequently refuses asylum applications due to concerns over applicants’ credibility (Sweeney, 2009; Home Office, 2015a). Perceived credibility is said to be the most important factor in determining refugee status; thus asylum outcome decisions rest on ‘what [applicants] say and how they say it’ (Bohmer and Shuman, 2007; Sweeney, 2009, p. 700; Rogers et al., 2015; Clayton, 2016; Jubany, 2017).

Scholars describe a culture of disbelief in many European asylum systems (Jubany, 2011; Lawrance and Ruffer, 2015; Tinti and Reitano, 2016). Of the French context, Fassin states: ‘There was a time, not so long ago, when the relationship between the administration and the claimants was one of trust. It has reversed into mistrust’ (Fassin, 2013, p. 48). Research shows that the UK Home Office, too, has a pervasively embedded institutional culture of disbelief towards asylum applicants. Exploring Home Office policy makers’ imaginings of asylum seekers, Mayblin (2017a) found the dominant institutional discourse was one which focussed on Britain as having a particular place in the world, and of economic migrants posing as asylum seekers in order to exploit economic pull factors:

‘You become that kind of, the prison guard as it were, who’s [sic] view on, well they’re [asylum seekers] all liars … And that genuinely is an attitude that no-one’s shy about that actually. It’s not something that we see as an embarrassing thing that you don’t want to admit that you’ve become racist, or you’ve become whatever. It’s probably not racist. But it’s certainly something with a nasty taste to it. (Civil servant B)’ (Mayblin, 2017a, p. 12)
This institutional culture, which erodes migrants’ credibility and constructs them as a threat, appears widespread, from the level of Home Office policy-makers through to caseworkers (Mayblin, 2016; Jubany, 2017). Recently, mainstream media outlets have provided a platform for Home Office caseworker whistle-blowers to highlight issues within the Home Office, including understaffing, target driven performance, and a culture of disbelief (Lyons, 2018; Lyons and Brewer, 2018). As the weight of responsibility lies with the individual applicant to prove their well-founded fear and demonstrate their credibility, delegitimising asylum seekers by questioning their credibility provides caseworkers with an easy route to refuse asylum applications.\footnote{In 2012, the Home Office introduced a new policy that prospective students looking to study in UK Higher Education institutions would undergo ‘Credibility Interviews’. Should the prospective student be deemed not credible by an Home Office Entry Clearance Officer, their student visa is refused. Universities have criticised this policy for being subjective, and have provided prospective international students with guidance for these interviews (UK Council for International Student Affairs, 2013). Although this policy does not directly concern asylum applications, it illustrates the institutional discourse around the centrality of credibility in delineating between types of genuine and bogus migrants.}

Credible, from the latin *credere*, refers to the quality of being trustworthy or believable. The centrality of credibility in asylum applications is problematic. Legally, credibility is ‘conceptually elusive [yet] adjudicatively influential’ (Coffey, 2003, p. 377). The Home Office has been criticised for exaggerating the significance of credibility on decisions over asylum cases, as an over reliance on caseworkers’ perceptions of claimants’ credibility is both subjective and inconsistent (Independent Asylum Commission, 2008; Sweeney, 2009; Herlihy et al., 2010). Qualitative research shows that caseworkers’ perceptions of applicants’ credibility is influenced by: the provision of inconsistent information or late disclosures of information relevant to the claim to be at risk of persecution; the behaviour and demeanour of the asylum applicant, including criminal convictions or delayed application for asylum; the use of falsified travel documentation; and the failure to claim asylum in the first safe country arrived in, known as...
third country cases (Cohen, 2001; Noll, 2005; Herlihy et al., 2010, 2012; Clayton, 2016; Jubany, 2017; Smith-Khan, 2017).15

The barriers to asylum applicants’ provision of a consistent and linear autobiographical account seen as credible by caseworkers are complex and multiple. Bio-psychological studies show that heightened emotion inhibits the encoding and retrieval of autobiographical memories; this results in the impaired recall of profound and intimate ill-treatment (Herlihy et al., 2012). Bögner et al. (2010) showed that the interpersonal qualities of the Home Office caseworkers influence applicants’ ability to disclose difficult personal information; yet the approach of many caseworkers has been described as hostile (Bögner et al., 2010). Should an applicant not disclose ill treatment at a Home Office interview, but later make a disclosure to an immigration lawyer, doctor or other advocate, the Home Office can consider this testimony inconsistent and questions the applicant’s credibility (Cohen, 2001).

Caseworkers’ assessments of applicants’ credibility relies on the problematic interpretation of both verbal and non-verbal communication across a heavily bureaucratised, cross-cultural, cross-linguistic interchange. Credibility is a culturally located concept; what would be seen as credible in one culture would not be seen as credible in another. For some African and Asian cultures, direct eye-contact is seen to be intrusive, rude and hostile, whilst others, such as the Canadians described by Brant (1988), see ‘people who do not provide direct eye contact ... as being shifty, devious, dishonest, crooks, slippery, untrustworthy’ (Brant, 1988, p. 261; Vrij et al., 2010). The content of autobiographies are also heavily culturally mediated.

15 The Dublin Regulation is a EU law covering 32 countries that aims to establish the EU member state which has the responsibility for processing individuals’ claims for asylum. Under the Dublin Regulation asylum seekers should make themselves known to authorities and begin an application for asylum at the first Dublin-EU country they arrive in. If asylum seekers are documented as passing through safe countries and later applying for asylum in a third country, they can be returned to the arrival country. This policy, aimed at reducing asylum shopping by EU states, has been criticised for eroding the rights of asylum seekers (Brouwer, 2013; Brekke and Brochmann, 2015).
Linear notions of past, future and present are not relevant in many cultures; those from more collectivist societies tend to narrate happenings in relation to the roles of, and interactions with, others (Mbiti, 1971; Parratt, 1977; Herlihy et al., 2012).

Drawing on anthropological fieldwork with asylum seekers in the UK, Griffiths (2012) shows how, for some asylum applicants, the provision of even basic demographic information requires knowledge, translation, and often the reduction of nuance, across multiple cultural and linguistic domains:

‘In response, people may guess or invent identifiers rather than admit ignorance or risk producing discrepancies. In so doing, they adapt their narratives and identities to fit the system – to meet decision-makers’ requirements, expectations and assumptions. Although highly evident in the asylum system, given that it is a space of extreme cultural diversity and one imbued with a moralistic prioritization of truth-telling, most bureaucracies encourage at least a massaging of the truth.’ (Griffiths, 2012, p. 10).

The Home Office necessarily but reductively categorises the messy complexity of cross-cultural life- and migration-histories into binary immigration categories (Mayblin, 2017a). However, Home Office policy-makers and civil servants demonstrate a ‘bureaucratic inability to manage complexity or doubt’; this, paradoxically, ‘may discourage full truthfulness, if not explicit lie-telling’ (Griffiths, 2012, p. 10).

If an asylum claimant is considered to have a current ‘well-founded fear of persecution’ the Home Office provides refugee status. This lasts for up to
five years, though can be reviewed at any time.\textsuperscript{16} If after this time the well-founded fear persists, refugees can apply for indefinite leave to remain in the UK. However the majority of initial asylum applications are refused – 68% in 2016 (Home Office, 2017; Refugee Council, 2018a). Claimants then have a right to appeal the decision. However the legal structures are complex\textsuperscript{17} and, owing to cuts in legal aid in 2012, many asylum seekers do not receive adequate legal advice (York, 2015).\textsuperscript{18} During the appeal tribunal, a judge sitting in the immigration and asylum appeal chamber hears the case and makes a decision; in 2016 42% of appeals against initial refusals were upheld in the appeal process.

In the UK, the legal precedent can change through common law, or case law, decisions. Where there is disagreement on what the law is, previous precedential decisions can be synthesised, and the reasoning followed and applied to the current case, in a principle is known as stare decisis. If no previous precedential decisions are applicable, the case is considered to be a matter of first impression and judges must resolve the issue. In this way, judicial systems have a major role in shaping the legal landscape in the UK. This is in contrast with continental Europe, where Civil Law is used and judicial reasoning is less influential (Garner, 2001). Where new evidence to support an asylum claim emerges, or if the law changes due to new legal

\textsuperscript{16} Humanitarian protection is usually granted for five years and is also subject to review. Family reunification also becomes possible for adults’ spouses and children under the age of 18. Children applying for asylum under the age of 18 are usually granted Discretionary Leave rather than refugee status, which is usually for 3 years or until they are 17 and a half years old. Children do not have the right to be joined by their parents or siblings (Home Office, 2013).

\textsuperscript{17} Asylum seekers have a right of appeal to the First-tier Tribunal and remain in the UK whilst this review is awaited, however some may only be allowed to make an appeal after being removed. This is most commonly in the case of applicants who have already claimed asylum in another country. Further appeals can be made to the Upper Tribunal on a point of law, with permission from the First-tier Tribunal. Upper Tribunal hearings are heard in open courts, which can be attended by members of the public, and must be attended by the applicant, who can be accompanied by a legal advisor. The Upper Tribunal can either uphold the First-tier Tribunal decision, ask the first tier tribunal to re-read the case, or overturn the First-tier Tribunal and make its own decision about the case (Clayton, 2016).

\textsuperscript{18} The Legal Aid, Sentencing and Punishment of Offenders Act 2012 declared the end of legal aid in immigration in England and Wales except for a few strictly specified exceptions (York, 2015). This leaves many asylum applicants with inadequate legal assistance.
precedents being set, a second asylum claim, or ‘fresh claim’, can be pursued. If no new evidence is brought forward by the claimant, refused asylum seekers are expected to make arrangements to leave the UK, or may be forcibly removed by the Home Office (Clayton, 2016).

1.4 Crimmigration and the border spectacle

The construction of borders is an ancient practice traceable to the earliest human societies (Grosby, 1995; Newman, 2006). However, the academic consideration of borders and bordering\(^{19}\) as socially constructed power strategies that assist in the territorialisation of difference and the organisation and sorting of lives has seen an exponential increase over the last 20 years (see Alvarez, 1995; Andreas, 2003; Agnew, 2008; Popescu, 2011; Paasi, 2012; Rumford, 2012; Mezzadra and Neilson, 2013; Svirsky, 2016; Jubany, 2017). Bordering around social rights and welfare provision by retrenching migrants’ entitlements creates points of closure through society and produces a ‘hierarchy of citizenship’ (Castles, 2005, p. 203; 2007). The UK has used these restrictive bordering practices long before Teresa May’s 2012 promise to create a ‘really hostile environment’ for irregular migrants (Travis, 2013). The 1998 white paper *Fairer, Faster and Firmer: A Modern Approach to Immigration and Asylum* referred to minimising ‘the attraction of the UK’ for asylum seekers not seen to be ‘genuine’:

> ‘those who are genuinely fleeing persecution are looking for a safe and secure environment which offers a basic level of support while their applications are being considered. Such people will not be

\(^{19}\)Bordering is a contemporary term used to describe border making. Bordering practices are measures taken by institutions, either at a frontier or within state territory, to delineate categories of people in order to include some and exclude others in a particular social order (Guentner et al., 2016). Thus bordering practices are ‘world-configuring’ (Balibar, 2002, p. 76), ‘bestowing on that order both its form and its rationale’ (Guentner et al., 2016, p. 392).
overly concerned about whether that support is provided in cash or in kind, nor about the location in which they are supported’ (Home Office, 1998, p. 3).

This exclusionary rationale reflects a system with inbuilt notions of deterrence, and lays the foundations for contemporary policies which seek to make the life of asylum applicants uncomfortable: ‘partly to discourage others and partly to pacify those who accused the government of being a “soft touch”’ (Winder, 2004, p. 419; Hynes, 2011).

In the past two decades, immigration administration and criminal law have converged through the criminalisation of immigration offenses and ‘broadly imposing immigration consequences for criminal acts’ (Stumpf, 2006, 2010, 2012, pp. 48-49; Bowling and Westenra, 2018). Stumpf described the hybridisation of these two legal domains as crimmigration (Stumpf, 2006). Recognising crimmigration highlights the way in which certain forms of migration are considered in public, legal, and political agendas. Moreover, it enables new approaches to academic analysis; namely, drawing links between multiple disciplines to question the impact of the criminalisation of migration on both host societies and migrants themselves (Hartry, 2012; Beckett and Evans, 2015; Armenta, 2017).

The UK’s expansion of crimmigration policy is paralleled by an ideology of austerity and the rationalisation of increasingly scarce public resources (United Nations, 2019). In this context, the figure of the fraudulent asylum applicant becomes both a target for displays of punitive state power and a ‘scapegoat for those members of the public who feel abandoned, powerless and fearful in the neoliberal globalised world’ (Bromley, 2015, p. 57). A pervasive anti-immigration sentiment from the media, government and general public underpins this, and naturalises this figure of the bogus asylum seeker in popular discourse, constructing them as a threat to the
order of society (Innes, 2010; Griffiths, 2012, 2015; Stewart and Mulvey, 2014).

The Immigration Acts of 2014 and 2016 endorsed crimmigration, expanded existing civil exclusions for migrants, and shifted the enactment of border control practices to everyday multiple non-state agents. Moreover, failure to comply with immigration enforcement is now criminalised. Private landlords who rent to tenants without proper immigration paperwork face fines of up to £10,000 and five years in prison (Home Office, 2015b). Those who employ migrants without permission to work in the UK face both civil and criminal charges (Bowling and Westenra, 2018). Banks are now legally obliged to conduct quarterly immigration checks on customers and freeze or close the accounts of those without appropriate immigration paperwork (Yeo, 2016). The result is a pervasive racialised hostility; a recent survey of landlords found that over half would be ‘less likely to rent to foreigners’ because of the legislation (Joint Council for Welfare of Immigrants, 2015).

Prior to January 2018, asylum applicants were granted temporary admission to the UK whilst they awaited their asylum decision; however immigration bail has now replaced temporary admission. This transition epitomises the language and practice of crimmigration. Although asylum applicants are entitled to remain in the UK on immigration bail whilst the Home Office consider their application, immigration bail outlines several conditions to asylum seekers’ presence in the UK and extends the power of the Home Office to detain and remove should these conditions not be met (Home Office, 2018a). Though less visible than physical borders at ports and airports, this more covert bordering is considered effective by states and reflects the strategic underpinnings of much contemporary British crimmigration policy (Parker and Vaughan-Williams, 2009; Guentner et al., 2016).
Those with refugee status are able to work and claim benefits in line with British citizens, but asylum seekers are not permitted to work whilst awaiting a decision on their asylum claim (Lewis et al., 2017; Home Office, 2019c). Eligibility for welfare support in the UK is dependent on the immigration status of the individual. Those who need welfare support can apply for this through the Home Office and are provided with £37.75 per week, loaded onto a debit card. Asylum applicants’ eligibility for financial welfare support is conditional, and depends on their decision to accept dispersal housing (Schuster, 2005). Since the 1999 Immigration and Asylum Act, asylum seekers have been distributed on a no-choice basis through the asylum dispersal pathway in housing outside of London and the South-East of England. Driven by a desire to relieve the burden on councils in London and the Southeast, this policy transformed a system where asylum seekers could live where they wished to a centralised arrangement of dispersal into particular accommodation in specific locations (Grayson, 2018). Darling argues this asylum accommodation acts to discipline asylum seekers, regulating them by placing them in discrete locations (Darling, 2011). In 2012, the government contracted the provision of asylum accommodation out to private companies. This depoliticises asylum housing and creates ‘a market-oriented transfer of responsibilities’ (Darling, 2016, p. 230).

This diffuse web of exclusion has also been embedded into health services. Although eligibility for free NHS treatment has never been truly universal20, the 2014 and 2016 Immigration Acts extended charging for those not ordinarily resident in the UK (Hiam et al., 2018). Refugees and people seeking asylum are eligible to free NHS healthcare whilst their claim is ongoing. Other migrants are subject to an annual National Health Service (NHS) surcharge, recently increased from £200 to £400 (Home Office, 2019c). Since its inception the NHS has been able to charge for some services. Entitlement for free NHS care based on ‘ordinary residence’ first entered the NHS in 1977. However, the Immigration acts of 2014 and 2016 placed a statutory requirement on NHS Trusts to identify and charge people not eligible for free NHS care. See Medact (2019) for further detail of the history of NHS charging regulations.

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Since October 2017\(^{21}\) those unable to prove their right to be in the UK, including refused asylum applicants, are ineligible for certain free NHS care. This includes secondary care, community midwifery, community mental health services, district nursing, support groups and drug and alcohol services (Department of Health and Social Care, 2018a). These individuals are now charged upfront, before they receive treatment. The Joint Committee On Human Rights accused the British Government of ‘practising a deliberate policy of destitution of [a] highly vulnerable group’ (Joint Committee On Human Rights, 2007, p. 41). More recently, the increasingly stringent approach to welfare support, including the healthcare, of migrants has faced critique from a number of actors, including doctors, academics and activists (Darling, 2011; Dehghan, 2017; Farrington et al., 2016b; Hiam and McKee, 2017; Tomkow, 2017a, 2017b, 2019a, 2019b).

When refused asylum applicants’ appeal rights are exhausted, individuals become ineligible for the majority of mainstream health and welfare support. Refused and destitute\(^{22}\) asylum seekers can be provided with minimal hard-case support under Section 4(2). This highly conditional and restrictive form of welfare support consists of asylum accommodation and a debit payment card. Individuals’ eligibility for hard-case support is dependent on them meeting stringent criteria, including ‘taking all reasonable steps ... or place[ing] themselves in a position in which they can leave the UK’. Alternatively, individuals can be eligible for Section 4(2) support if they are ‘unable to leave the UK by reason of a physical impediment to travel or for some other medical reason’ (Home Office, 2018b, p. 9).

\(^{21}\) The amendment in October 2017 both increased the number of chargeable services and requires hospital trusts to charge individuals upfront, before receiving care (Department of Health and Social Care, 2018a).

\(^{22}\) ‘A person is destitute if they: do not have adequate accommodation or any means of obtaining it (whether their other essential living needs are met), have adequate accommodation or the means of obtaining it, but cannot meet their other essential living needs.’ (Home Office, 2018b, p. 9)
The Section 4(2) hard-case guidance is of interest to this research in that it clearly elucidates the Home Office’s moral position on illness and asylum: ‘A person should only be supported under this provision [Section 4] if they are physically unable to travel (usually by air) and not because they are receiving medical treatment in the UK that does not prevent travel, or because there is a possibility that the treatment might no longer be available after departure from the UK’ (Home Office, 2018b, p. 11). In addition, the individual must comply with particular behavioural requirements:

‘specified standards of behaviour … such conditions must be set out in writing. The person should also be given notice that they must reside at the accommodation provided to them and not absent from it, unless given permission, for more than 7 consecutive nights or for more than 14 nights in any 6 month period.’ (Home Office, 2018b, p. 7)

Given these restrictive criteria, scholars have estimated that only a quarter of those with refused asylum applications accept Section 4(2) support; more often, refused asylum seekers have no recourse to public funds (Lewis, 2007; Lewis et al., 2017). The Home Office does not keep records of the number of refused asylum seekers with no recourse to public funds who remain in the UK, although it is estimated at around 800,000 (York, 2015). Many of these individuals count on their invisibility as a survival strategy; in combination with the active statistical neglect of the Home Office, this makes refused and destitute asylum seekers a hidden group (York and Fancott, 2008).

As well as these overt policies of civil exclusion, are more covert methods of surveillance that allow the Home Office to instrumentalise public services to identify individuals deemed irregular. In 2016 a Memorandum
of Understanding (MoU) allowed NHS Digital to share individuals’ demographic and healthcare billing data with the Home Office: ‘The Home Office can then use that data to deny any future immigration application to enter or remain in the UK that the person with the debt might make’ (Department of Health and Social Care, 2018b, p. 98). Following criticism from myriad actors, including professional medical bodies, politicians and activists who cited multiple concerns, the government recently suspended the MoU (Dehghan, 2017; Doctors of the World, 2017a; Farrington et al., 2016; House of Lords, 2017; Worthington, 2017). Nevertheless, the MoU illustrates the state’s drive to embed diffuse points of closure and surveillance around migrants’ everyday social encounters in the UK.

Although the dominant conceptualisation of the state in migration literature is of an essential entity, distinct from society and operating on the social sphere from a distance, these contemporary dynamics in the UK question the reification of a state-society divide. Empirical evidence highlights the readiness of citizens to perform exclusionary practices towards migrant communities in other contexts (Lahav and Guiraudon, 2000; Weber, 2003). Thus, depicting the state as a deliberate actor with ‘competences and capacities that are independent from, and ontologically prior to, [society]’ overlooks how both state and non-state actors put the state ‘to work’ (Gill, 2010, p. 628). Consequently, Gill urges a critical consideration of the notion of the state, which acknowledges variant forms of state power, the importance of individual state actors’ positionality, and the context of policy deployment (Gill, 2010). The Home Office’s governance of private corporations in the management of asylum in the UK highlights both the non-essential nature of the state’s asylum apparatus and the diffuseness and neo-liberalisation of contemporary borders. In response to Gill’s work, and in order to reflect this, this thesis considers the

23 The distinction between state and society is seen across multiple domains of academic enquiry from questions about: How states should respond to refugees (Gibney, 2004; Ruhs and Chang, 2004; Schuster, 2005a): national interests (Stewart, 2003; Van Hear et al., 2014); and the effectiveness of migration policies (Neumayer, 2006; Samers, 2004).
state a diffuse entity, embedded within and performed by multiple facets of civil society (see also footnotes 7 and 12).

In addition to these diffuse everyday bordering practices are more visible tactics used to criminalise certain migrants. The processes and practices that constitute the enactment of immigration law at international borders are described as the border spectacle (De Genova, 2013). The border spectacle embodies socio-political processes of ‘illegalisation’, where scenes of exclusion are enacted and the criminalisation of migration is visualised (De Genova, 2002, p. 419). This enactment and visualisation of migrant illegality legitimises immigration law, affording it ‘the commonsensical air of a “natural fact” which enfranchises the dehumanising rationale underpinning it’ (De Genova, 2002, p. 436).

Asylum seekers with ongoing or refused claims must report regularly to the Home Office in the UK. In 2016 around 60,000 migrants were regularly reporting, at a cost to the state of £8.6 million per year (The Migration Observatory, 2018a). This mode of surveillance is suggested by the Home Office to be a way to monitor the location of refused asylum seekers. Reporting facilities are either located in existing Home Office buildings or at police stations, locations which are also used to detain individuals before they are transported to Immigration Removal Centres (IRC), or detention facilities (Bosworth, 2011). The visibility of this surveillance of asylum seekers normalises and legitimises the construction of those seeking asylum as a threat. This galvanises momentum for restrictive migration-management strategies, and further undermines the credibility of those seeking asylum (Bosworth, 2011).

The detention of migrants in prison-like conditions in IRCs for the purposes of immigration control is a punitive practice of the border spectacle that epitomises crimmigration and propagates its discourse (De Genova, 2013; Bowling and Westenra, 2018). The UK has one of the largest immigration
detention systems in Europe and asylum applicants make up around 50% of those held in detention (The Migration Observatory, 2018a). Further, unlike other European states, in the UK there is no upper time limit for periods of immigration detention; a policy which has been criticised by multiple actors including the HM Chief Inspector of Prisons (2017) and the Joint Committee on Human Rights (2019). According to the UK Border Agency, immigration detention is used ‘whilst identity and basis of claim are established, where there is a risk of absconding, as part of fast-track asylum procedures ... and in support of the removal of failed asylum seekers’ (Migration Observatory, 2018). However, academic scholarship suggests the decision to detain under the Immigration Act can be arbitrary, irrational and difficult to justify (Weber, 2003, 2013; Weber and Bowling, 2004, 2008; Cornelisse, 2010; Bosworth, 2011, 2014).

Eight of the ten IRCs in the UK are run by private companies for-profit; as with asylum accommodation, this privatisation provides a form of corporate distance, which performs as a mode of risk management when tragedies and scandals occur (Bosworth, 2014; Bales and Mayblin, 2018). Although immigration law prohibits refused asylum seekers from working outside of immigration detention, the government introduced paid activities into UK IRCs in 2006 (Bales and Mayblin, 2018). This work is excluded from the National Minimum Wage Act of 1998; consequently immigration detainees undertake paid work, such as cleaning, cooking and decorating, for £1 or £1.25 per hour in IRCs, whilst the national minimum wage stands at £7.83 per hour (gov.co.uk, 2018a). Paid activities in IRCs epitomise Bauman’s notions of the paradoxes of the contemporary global neoliberal stratified society (Bauman, 1998). Detainees’ paid roles both

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24 27,300 migrants entered immigration detention in 2017 and at any given time, there are 2,000 to 3,500 migrants in immigration detention facilities. Immigration detainees are also held in UK prisons; on 31st March 2018, 358 individuals were held in prison in England and Wales under the Immigration Act (The Migration Observatory, 2018a).

25 Conditions inside IRCs have been criticised. 2017 was the most deadly in the UK for immigration detention, with 9 deaths of detainees held under immigration charges (Inquest, 2019). There have been claims of verbal, physical and sexual abuse from staff towards detainees (Joint Committee on Human Rights, 2019).
contribute to the maintenance of the institution that imprisons them, and provides private corporations running IRCs with cheap labour. Detainees’ immigration status and deportability positions them in a highly vulnerable position; Bales and Mayblin (2018) argue that the vulnerability of those detained means such work is exploitative, coercive and ‘unfree’ (Bales and Mayblin, 2018, p. 191).

Removal and deportation in the UK is legally complex, and a comprehensive overview of this is beyond the scope of this thesis. However, it is important to note that, although the branding of IRCs implies that the job of detention is to facilitate enforced removal from the UK, in 2017 only 44% of individuals held in immigration detention were removed. The undeportability of such high proportion of detainees is referred to as the deportation gap. The inadequacy of Home Office data makes the drivers of this gap difficult to explore, but causes are likely to include: individuals’ insufficient personal identification and travel documentation; non-cooperation from the country of origin or third countries; dynamism of immigration legislation; and the financial and logistical constraints of the Home Office (Paoletti, 2010). The ability of the state to enact removal is a central facet to the crimmigration paradigm; the spectacle of migrant deportability offers citizens the assurance of state authority within national borders (Walters, 2004). Increasing numbers of detainees are released into the community, which undermines detention’s stated purpose to expedite removal, the cost of immigration detention is high, and detention causes physical, psychological and social harm. Despite this the British state continues to detain and attempt to remove migrants to assure public opinion of its authority within national borders (Gibney and Hansen, 2005).

26 Removal is the term used to describe the enforced departure of an individual without legal status in the UK, and deportation is used to describe the same process for those with legal status. Removals and deportations are enacted if felt by the Secretary of State to be in the public good. Deportation orders prevent the deportee from ‘returning to the UK until the order is revoked. Although removal, supervised and voluntary departure will affect the ability of the individual to return to the UK, unlike a deportation order they do not have any continuing legal force beyond the departure date’ (Clayton, 2016, pp. 544–545).
1.5 Conclusion

This chapter has introduced the research context by providing a critical overview of the current climate of migration and asylum in the UK. The chapter has shown that, for asylum applicants, the contemporary political environment in Britain is both hostile and austere (Guentner et al., 2016; Jubany, 2017; United Nations, 2019). A web of immigration controls is embedded within both public services and private enterprises. As a result, citizens execute bordering practices and migrants must prove their credibility and demonstrate their eligibility in order to access services such as housing, banks and healthcare. Simultaneously, the border spectacle, made up of reporting procedures and detention practices, makes visible the criminalisation of certain migrants. The result is a migration regime that normalises questions about ‘who belongs and what kinds of rights they deserve’ as well as ‘decisions to expel and deny entry’ (Aas, 2013, p. 23; Bales and Mayblin, 2018).

Making these dynamics particularly problematic is the inherent assumption that delineating between deserving refugees and bogus asylum seekers is natural and possible. As the thesis will show, this reflects reductionist assumptions about the dynamics of migration and displacement, which are especially morally questionable when considered against post-colonial dynamics and contemporary neo-liberal globalisation (Bauman, 1998). By stating the research question in relation to the research context, this chapter has begun an outline of the epistemological and theoretical assumptions of the research. Chapter Two takes this geopolitical context as its point of departure and critically explores the literature on migration, ageing and health. Here, gaps in the academic landscape will be identified and the key debates in which the thesis will intervene will be established.
Chapter Two

The health of older refugees and asylum seekers: A critical overview of contemporary academic debates

‘*Medicine is a social science, and politics is nothing more than medicine on a grand scale*’

Rudolf Virchow, unknown date, (in Ashton, 2006)

2.1 Introduction

In order to develop an understanding of how migration determines health in later life, this chapter situates an overview of the contemporary academic debates about older asylum applicants’ health within a critical theoretical framework. The framework draws on four theoretical concepts from the discipline of CMA suggested by Carroll (2013; 2014): explanatory models; structural violence; biopower; and identity politics and biological citizenship. As well as providing an overview of the literature, the chapter illustrates the theoretical assumptions and epistemological foundations of the thesis. The approach is critical in that it understands knowledge about health and migration as both situated within, and determined by, contemporary social, political and economic environments. This chapter seeks to recognise that power relations structure the funding of research, guide research questions, methods and analysis, and thus influence research conclusions and impact (Leatherman and Goodman, 2011). Consequently, the types of data collected and the research and knowledge production that ensues are inherently political processes.

The chapter strives to consider academic literature on the particular experiences of older asylum applicants’ health; however scholarly attention to this is scarce. Consequently, in order to situate the thesis
within the existing academic landscape, it draws on debates about migration and health more broadly. These debates have been approached from a range of disciplinary and epistemological perspectives; as such a review of relevant literature is necessarily broad. Appendix 2 details the method used to identify literature.

The chapter can be divided into four sections and is structured as follows. The first and largest section will explore explanatory models of health. Here, tensions between asylum applicants’ models of health and dominant biomedical explanatory models are highlighted, before dominant tropes from biomedical health literature on migration and ageing are critiqued. The epistemological assertions made in this section, specifically, the critique of biomedicine, are developed further as the thesis progresses, through both the empirical data and the theoretical contribution. The second theme is structural violence. Here, attention is drawn to the myriad social, political and economic inequalities older asylum seekers and refugees are subject to. The concept of intersectionality is introduced to help understand the way in which multiple disadvantage performs. These theories of intersectional structural violence are later used in the analysis of the narrative data.

The third theoretical concept is biopower. Emerging from multiple critical contemporary scholarly works on both migration and health, biopower assists in understanding the techniques used to know and control populations and their constituent biological lives. This section discusses literature considering how biopower operates in both migration and biomedicine, thus it builds on the first two sections. The final section explores the concepts of identity politics and biological citizenship. These theoretical concepts are applied both to migration and ageing; the contemporary approach to immigration categorisation is critiqued, and social gerontologists’ thinking about ageing in the UK is discussed. The chapter finishes with an exploration of the ways in which individuals use
health to align themselves with certain social identities to negotiate access to resources, thus bringing together ideas of explanatory models, structural violence, biopower and identity politics.

These particular concepts were selected as they provide a critical skeleton on which all of the necessarily broad literatures can be explored. Although the four key theories introduced in this chapter are presented separately, they should not be understood as disparate entities. Rather, each theory builds on the last, adding nuance and entrenching the critical approach that will be taken in the analysis chapters. Of note is how the ideas provide a way of (re)conceptualising migration, ageing and biomedical health. Identity politics and biological citizenship are the key concepts that this thesis contributes to theoretically. However, empirical and methodological contributions are also made to the other literatures detailed. By identifying the gaps in existing academic work throughout all four concepts, the chapter outlines the diverse academic landscape to which this research will contribute, as well as setting out the key theories that will be used to do so. The four themes are re-examined in Chapter Seven in light of the empirical, methodological and theoretical contributions of the thesis.

2.2. Explanatory models of health

Kleinman, a medical anthropologist, suggested the term ‘explanatory model’ to describe individuals’ situated logic of disease (1978). Explanatory models shape reactions to illness and justify health and illness behaviours, thus it is crucial to engage with individuals’ explanatory models of health when exploring how health and lived experience are narrated. Explanatory models are frequently examined through narratives of socially constructed and culturally organised causes, experiences and expectations of health and illness. One example of an explanatory model is the biomedical approach, which functions to instruct and justify actions in response to
illness. The biomedical approach is rooted in a positivist epistemology. It holds that illness represents individuals’ physical or biochemical failure; consequently it directs treatment to the individual organism.

Sociologists have highlighted how, despite medicine’s inability to treat a wide range of chronic conditions and its persistent iatrogenic side effects, it has amassed power (Clarke et al., 2010). Over the past 50 years, increasing aspects of social life have been viewed through the scientific frame of physical and mental disease; over half of Americans are now diagnosed with a mental illness in their lifetime (Allen, 2013). Frequently termed medicalisation, these expanding boundaries of medicine are driven by specific cultural and social conditions both inside and outside of medicine (van Dijk, 2016). Critics of medicalisation suggest it results in a culture of dependency and erodes autonomy by permitting medical professionals to dictate individuals’ behaviour (Lupton, 1997). More recently, clinicians have observed how biomedicalisation intersects with neoliberal economies and technological development, resulting in the expansion of the boundaries of pathology in order to expand markets for novel medical products (Moynihan et al., 2002; Clarke et al., 2010). The next sections draw on Kleinman’s idea of explanatory models to facilitate a critical consideration of the dominant tropes from academic literature on the health of asylum seekers and refugees.

2.2.1 Asylum applicants’ explanatory models of health

Social scientists urge clinicians to be attentive to the importance of identifying and resolving potential conflicts in explanatory models of health, as it may assist therapeutically (Goldberg and Huxley, 1992; Watters, 2001; Palinkas et al., 2003). Literature highlights a tension between asylum seekers’ and refugees’ explanatory models of health and dominant biomedical approaches. However, the majority of these studies
are written from a biomedical epistemological perspective. Consequently they construct migrant populations as imprudent, with a low health literacy, evidenced by their lack of education, knowledge and awareness of biomedical health (see Zarcadoolas et al., 2009; Shaw et al., 2009; de Anstiss and Ziaian, 2010; Lee et al., 2010; Heidi et al., 2011; Jorm, 2012; Geltman et al., 2013; Slewa-Younan et al., 2014; Wångdahl et al., 2014; May et al., 2014; Owiti et al., 2015; Shannon et al., 2015). Where refugees’ spiritual, supernatural and magical health beliefs are described, scholars problematise them as a challenge to compliance with biomedical therapy (see Eisenbruch and Handleman, 1989; Fung and Wong, 2007).

Traditionally considered the domain of anthropologists and sociologists, the concepts of culture and acculturation are often cited in contemporary migrant health literature, particularly when older migrants are the focus. This research shows that migrants’ culture influences health beliefs; dietary preferences; recreational alcohol, smoking and illicit drug use; weight management, based on gendered ideals; and access to and compliance with medical treatment (Choudhry et al., 2002; Eshiett and Parry, 2003; Povlsen et al., 2005; Zaman and Mangtani, 2007; Karikari-Martin, 2010; Delavari et al., 2013; Parveen et al., 2013). However, this fixation on culture is problematic. At best this biomedical literature defines its central assumptions about culture poorly; at worst, it promulgates ethnic stereotypes (Salant and Lauderdale, 2003; Hunt, Schneider and Comer, 2004; Abraido-Lanza et al., 2006; Jayaweera and Quigley, 2010). Ahmad highlights how ‘instead of talking about “structure, power and racism” in health research, we instead talk about “culture, ethnicity, and difference”’ (Ahmad, 1996, p. 198). Exploring migrants’ health through the lens of culture ignores historical and social contexts and their effect on power and agency. Consequently, biomedical researchers’ fixation on individuals’

27 Acculturation refers to migrants’ adoption of the host societies’ normative values and behaviour (Jayaweera and Quigley, 2010a). A commonly cited example of acculturation is migrants’ adoption of high-sugar high-fat diets, and smoking (Zaman and Mangtani, 2007).
culture obscures the impact of modifiable social determinants of health, such as poor housing, hazardous working conditions, and inadequate food and healthcare access on health inequalities.

There are notable exceptions to this reductionist scholarship: Martin’s more nuanced analysis highlights how some asylum seekers and refugees favour a holistic understanding of health and disease, which centralises balance and the role of the social, emotional and spiritual aspects of illness (Martin, 2009). Even more insightful is work from Coker, which explores the associations of illness with the social, economic and political aspects of displacement (Coker, 2004). Drawing on ethnographic research in a medical clinic in an Egyptian refugee camp she describes how, despite cultural heterogeneity, refugees narratively situate their illness symptoms within the social context that produced them. Building on Kugelmann’s (1997) descriptions of how pain narratives are interwoven with stories of various aspects of the social world, from identity to economics, Coker suggests:

‘[Health] stories, whether they reflect a measurable “disease” or not, provide a glimpse into the ways in which illness becomes an avenue for discourse about the refugee trajectory ... the refugees in the present study “remembered” their illness stories with direct reference to their flight experience ... [medical histories were] immersed in a web of significance that addressed the realities of their traumatic and ongoing experiences as refugees.’ (Coker, 2004, p. 19)

Coker postulates that this phenomenon is emblematic of how refugees cope with the loss of society.

Research on older migrants’ explanatory models of health is extremely scarce and is often too particular to be generalisable to the experiences of asylum applicants in the UK (see Martin, 2009; Victor and Zubair, 2016;
A noteworthy exception is Emami and Torres (2005) who use stories of healthcare encounters as empirical evidence to starkly problematise biomedical academics’ and health care providers’ preoccupation with the cultural unusualness of asylum seekers and refugees. Like Coker, Emami and Torres subvert the dominance of cultural difference and successfully draw attention to how, for older migrants, health meanings are often rooted in lived experiences of the social disruption of migration.

2.2.2 Dominant tropes in biomedical migrant health research

The biomedical explanatory model is the prevailing approach in the academic literature on migration and health. Within this literature, a number of dominant tropes can be observed. First, there is a lack of data on asylum seekers’ and refugees’ morbidity and mortality, thus establishing epidemiological trends for this group is difficult. Second, despite the high rates of non-communicable disease in asylum seekers and refugees found in small-scale studies, there is an academic and policy preoccupation with their communicable disease burden. Thirdly, a significant body of scholarship describes the prevalence of psychiatric morbidity, specifically Post Traumatic Stress Disorder (PTSD), in asylum seekers and refugees. Finally there is an often-reductionist focus on how migrants use and misuse host states’ healthcare systems. Throughout this literature there is scarce attention to older asylum seekers and refugees. This next section critically considers these tropes in turn. Drawing on literature from social sciences and medical anthropology, it suggests that medical research constructs migrants as hazardous vectors of disease; psychiatrically impaired through trauma; and a burden on host states, evidenced by their misuse of health service access.
2.2.2.1 Measuring migrants’ mortality: Methodological challenges

Epidemiological researchers have attempted to answer questions about the health of migrants by examining mortality rates. Recent systematic reviews suggest migrants have a mortality advantage when compared with host populations, both in the UK and internationally (Wallace and Kulu, 2014; Aldridge et al., 2018). This advantage is observable for both men and women and across most International Classification of Diseases (ICD-10) disease categories, with the exception of infectious diseases and external causes, such as homicide and assault (Aldridge et al., 2018). Authors suggest this supports the healthy migrant hypothesis and the salmon bias. Moreover, it represents an epidemiological paradox, as migrants face disadvantage associated with the migration process, such as poverty and discrimination, which would be expected to negatively impact health (Borhade and Dey, 2018).

However, the methodological limitations of the studies included in Aldridge et al.’s review make generalisations about the health of migrants problematic. There is no international consensus of what a migrant is; variation exists both between and within countries and the included studies define and identify the population of interest variably (Rechel, 2011). The term migrant masks vast heterogeneity. One such example of this diversity is socioeconomic status. Statistical modelling for socioeconomic status is imperfect, with measurements often taken as a snapshot thus neglecting variation over migrants’ life-course. Nevertheless, data suggests wealthier migrants have better health outcomes than their poorer counterparts (Jayaweera and Quigley, 2010; Williams et al., 2010).

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28 The healthy migrant hypothesis refers to the idea that migrants are a healthy group who have the capacity to succeed in and benefit from international migration (Lu, 2008). The salmon bias, observed in Indonesia and China, suggests migrants tend to return to their countries of origin when in poor health before death (Hesketh et al., 2008).

29 For example in the UK, the Annual Population Survey collects data by country of birth, National Insurance number applications use nationality, and the Office of National Statistics cites the length of stay in the UK (Anderson and Blinder, 2017). The definition used in this thesis is of anyone born outside the UK.
The authors are careful to point out that the mortality advantage is representative of migrants who are studying or working legally in high income countries (Aldridge et al., 2018). Smaller analyses suggest multimorbidity is more prevalent in refugees than those migrating for work and education (Raphaely and O’Moore, 2010). However, larger epidemiological studies persistently fail to capture and measure health outcomes of the most vulnerable migrants, resulting in the exclusion or underrepresentation of asylum seekers, refugees and undocumented migrants in most biomedical research (Jayaweera and Quigley, 2010; Rechel, 2011; Anderson and Blinder, 2017).

Lack of available data contributes to the absence of asylum seekers, refugees and undocumented migrants from biomedical studies (Aspinal, 2007). Although the UK government collects statistics on the number of asylum applications and their outcome decisions, there are no records of the number of refugees, refused asylum seekers and undocumented migrants living in the UK (Correa-Velez and Gifford, 2007; Paoletti, 2010). British health records and disease registries record ethnicity rather than country of birth or migration status.30 As a result, social and medical research instead focusses on the relationship between ethnicity and health in the UK, drawing attention to ethnic health inequalities, which appear to increase with age (see Feder et al., 2002; Nazroo, 2003; Nazroo et al., 2007; Lip et al., 2007; Espinoza and Hazuda, 2008; Bhopal, 2012a; Bécares and Priest, 2015; Wallace et al., 2016; Das-Munshi et al., 2016; Vlachantoni et al., 2017; Katikireddi et al., 2018).

Obtaining data on migration status and health presents logistical challenges; maintaining a register of such capricious demographics would

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30 Large independent health datasets, such as the English Longitudinal Study on Ageing, also do not collect information on country of birth or migration status (Aspinal, 2007). Leading health surveys, such as the Health Survey for England, exclude individuals not in private accommodation (NatCen Social Research and UCL, 2017). Biobank records country of birth, but not migration status (Biobank, 2019).
be resource intensive. However, the absence of such data offers the political advantage of overlooking health inequalities, rendering population vulnerabilities invisible, and obfuscating the drivers of health inequalities and maintaining the status quo (Correa-Velez and Gifford, 2007). Consequently the data deficiency represents a challenge to researchers exploring health and migration and limits the capacity to improve asylum seekers’ and refugees’ health (Rechel, 2011; Matthews et al., 2012).

2.2.2.2 The asylum seeker as a vector of communicable disease

The concept of the migrant as a source of disease is an ancient and entrenched notion, yet one which persists (Kraut, 1994). Health globally is seeing a shift in disease burden from communicable (CD) to non-communicable conditions (NCD), yet academic literature on the health of migrants in the UK fails to reflect this (Jayaweera, 2014; Moraga-Serrano, 2018). Scarce literature exploring NCD in asylum seekers and refugees suggests a high burden of disease. One study analysed the health complaints of 397 asylum seekers in the North East of England and found only 25% reported no symptoms, despite the mean age of the sample being only 29 (Blackwell et al., 2002). Musculoskeletal complaints were most common and over 68.5% reported needing to see a dentist. Similar results are described in Switzerland: of 979 asylum seekers with a mean age of 22, 75% reported health complaints and only 6.3% of this was infectious in nature. The majority of the disease burden represented chronic NCD such as musculoskeletal pain and respiratory disease (Bischoff et al., 2008). The results of these small-scale studies, coupled with a scarcity of epidemiological data, increase the urgency of qualitative and quantitative research exploring NCD in migrants generally, and asylum seekers and refugees specifically. Multiple medical and social researchers have drawn attention to this gap in the literature (see Bhopal, 2012b; Jayaweera, 2014; Schouler-Ocak et al., 2016; Aldridge et al., 2018). Despite
this, literature on asylum seekers’ and refugees’ physical health tends to be focused on infectious disease (Clark and Mytton, 2007; Seedat et al., 2014; Wagner et al., 2014; Crawshaw et al., 2018; Gibson and Evennett, 2018). There are a number of possible reasons for this. First is the availability of data. Unlike NCD, certain infectious diseases, including TB, are statutorily notifiable in the UK; consequently the disease registers that capture TB patients’ data also routinely document country of birth and health outcomes. This makes epidemiological research exploring migration and infectious disease possible. The second is the distribution of communicable disease. Prevalence rates of infectious diseases vary greatly depending on country of origin and migration history, and in the UK 71% of all TB cases are in migrants (Public Health England, 2018). However, the prevalence of TB in UK asylum applicants is low. A 2007 review suggested rates of 1.33, 2.41 and 10.42 per 1000; and pre-entry screening of 18,418 refugees between 2013 and 2017 detected only 9 cases (Clark and Mytton, 2007; Crawshaw et al., 2018). The average time between migrants’ arrival in the UK and diagnosis of TB has been increasing year on year in recent years. In 2017, 63% of migrants with TB had resided in the UK for over six years (Public Health England, 2018). This diagnostic delay is likely to be indicative of the increasing barriers to NHS healthcare, and migrants’ poor living conditions in the UK, which both increases TB transmission and contributes to the reactivation of latent TB (HPA, 2006; Robinson, 2010; Abubakar et al., 2013; Jayaweera, 2014; Kang et al., 2019). Older migrants are especially likely to experience a delay between symptom onset and treatment initiation (Public Health England, 2018).

31 This literature concentrates on communicable, or infectious, disease such as tuberculosis, HIV and hepatitis B and C.
32 Suspected cases of certain infectious diseases must be reported to Public Health England in order to facilitate rapid detection of possible outbreaks of disease and epidemics (Public Health England, 2010).
Aldridge at al. (2016) showed that the potential for migrants with TB for onward transmission is negligible. Despite this, there remains an academic and governmental preoccupation with the infectious nature of asylum seekers, paralleled by a media fixation on the biological threat migrants pose (Tondo, 2018). This infers something broader about the moral economy and priorities of the UK state. As Horner suggests of TB screening in Australia, it illuminates the state’s moral positioning on ‘who “matters,”’ as well as dilemmas about what constitutes adequate care for the “Other,” both of which go to the heart of the political economy of migration’ (Horner, 2016, p. 65). Solely pursuing correlations between TB prevalence and country of birth overlooks the identification and modification of material and social conditions of asylum in the UK (Offer et al., 2016). Furthermore, this imperialistic academic investigation propagates the racialised stigmatising narrative of the asylum seeker as a vector of disease. The evidence considered here shows that only a small minority of asylum seekers have CD, whereas many more are in need of basic care for chronic NCD and dental conditions.

2.2.2.3 Mad migrants: The psychological impairment of asylum seekers and refugees

A further dominant trope is that of mental health, specifically PTSD. An extensive body of psychiatric, psychological, epidemiological and biomedical literature focuses on asylum seekers’ and refugees’ propensity for mental illness; some studies report rates of PTSD ten times higher than age-matched native controls (Fazel et al., 2005; Crumlish and O’Rourke, 2010). A consensus emerges from this literature that asylum seekers and refugees are more vulnerable to mental illness than voluntary migrants (Silove et al., 1997; Turrini et al., 2017). Often, studies seek to establish an association between psychiatric diagnoses, particularly PTSD, and stressors experienced across the life course including: torture (Steel et al., 1999; Van Ommeren et al., 2001); sexual violence (Boersma, 2003; Rogstad and Dale,
2004; Bradley and Tawfiq, 2006); and exposure to armed conflict (Steel et al., 1999; Silove et al., 2007; Bovic et al., 2015). Asylum seekers and refugees have also been shown to have high rates of anxiety and depression, however this receives less academic attention. There is also a lack of evidence exploring the efficacy of psychosocial interventions in this population (Turrini et al., 2017). Research into the specific mental health needs of older asylum seekers and refugees in the UK is scarce; one report suggests older refugees may be especially vulnerable to mental health problems, which contributes towards a cyclical social isolation (Home Office, 2004).

There are tensions between different disciplines’ approaches to PTSD. Critical medical anthropologists draw attention to the politicisation of PTSD. Initially used to describe the psychological consequences of the Vietnam war in American soldiers, when diagnosing PTSD clinicians seek to directly connect specific experiences with psychiatric symptoms (Hiley-Young et al., 1995). The application of PTSD has rapidly expanded and it is now used in varied contexts (Fassin and Rechtman, 2009; Taithe, 2016). Crucially, the diagnosis performs in multiple mainstream, legislative and clinical domains to ‘identify victims, explain their actions, and justify official responses’ in a scientifically legitimate way (Desjarlais et al., 1995; Breslau, 2004, p. 113; Fassin and Rechtman, 2009). This makes it politically useful. Some suggest it is this political utility, rather than any clinical or therapeutic significance, that has driven PTSD’s widespread popularity (Aretxaga, 2003). In some settings a diagnosis of PTSD can afford asylum seekers political recognition. Fassin critiques the nosology of PTSD as a proof of ill treatment: ‘Psychic trauma thus says less about a refugee’s “truth” than about the “truth” of political asylum in France’ (Fassin and d’Halluin, 2007, p. 325; Fassin, 2012). Section 2.5 provides a more detailed problematisation of this and begins an exploration of the social and political uses of illness.
Transcultural psychiatrists and psychologists are becoming increasingly concerned about PTSD’s ethnocentricity and impaired cultural translation (Ancis, 2004; Mattar, 2010; Adeponle et al., 2012; Kirmayer, 2012; Kirmayer, Gone and Moses, 2014; Tay et al., 2015). Social scientists have critiqued PTSD’s historical and singular consideration of adversity:

‘...what is of note is how easily we tend to use the refugee trauma hypothesis as the possible main cause and how we tend to discard and assign a back-ground noise status to other considerations, regardless of their apparent relevance. Trauma seems to offer tangible and clear ‘evidence’ which is most welcome in situations of unclarity, unbearable suffering and messy feelings and situations.’ (Papadopoulos, 2001, p. 412).

In striving to identify high-risk pre-migration events, much of the medical literature overlooks the modifiable structural violence faced by asylum seekers and refugees in exile (Gorst-Unsworth and Goldenberg, 1998; Lie, 2002; Laban et al., 2004; Steel et al., 2006; Ryan et al., 2008; Ryan, et al., 2009; Carswell et al., 2011; Schweitzer et al., 2011). A recent review found that, despite having symptoms of pre-migratory traumatic stress, refugees describe being more troubled by current stressors (Tempany, 2009; Nicolas et al, 2015). Thus the on-going harshness of life in exile renders the post in PTSD redundant. More broadly, this pervasive pathologisation discursively reduces asylum applicants to being necessarily psychiatrically deficient, which neglects current and ongoing basic needs (Ryan et al., 2008).

2.2.2.4 Migrants’ (mis)use of host countries’ healthcare systems

There is a political and academic drive to establish population patterns of healthcare utilisation in the UK’s contemporary political climate of ‘economic austerity, cuts to public services and rationalisation of health resources’ (Green et al., 2017; Iacobucci, 2014; Tomkow, 2018, p. 1; United
Nations, 2019). Over the last twenty years a growing body of literature has explored migrants’ utilisation of healthcare services (for a systematic review, see Credé et al., 2018; also Feldman, 2006; Jayaweera and Quigley, 2010; Norredam et al., 2010). As well as gauging the burden on host countries’ health care systems, researchers have used these enquiries as a way of attempting morbidity estimations and facilitating an assessment of health behaviour within migrant populations. Unscheduled care is used more frequently by migrants, for lower acuity conditions, and at higher rates during unsociable hours (Hargreaves et al., 2006; Solé-Auró et al., 2012; Norredam et al., 2010; Credé et al., 2018). These differential patterns of healthcare use between migrants and non-migrants are only partially explained by differences in health status (Credé et al., 2018). Some data suggests these differences are more pronounced in older migrants and those who are new arrivals to the UK (Solé-Auró et al., 2012).

Although an assessment of populations’ utilisation of services is of value to health care providers, policy makers and economists, there are limitations to the ability of this work to make conclusions about migrants’ health. As with other epidemiological studies, this literature defines migrant variably and fails to capture the most vulnerable migrant groups (Grassino et al., 2009; Credé et al., 2018). Extensive evidence documents the barriers to accessing primary care in host countries, and the multiple dimensions across which inequalities in healthcare access function, including: ethnicity (Katikireddi et al., 2018); gender (Annandale et al., 2007); poverty (Aberle et al., 2010); age (Clark et al., 2009); and immigration category (Bhatia and Wallace, 2007; O’Donnell et al., 2007; Palmer and Ward, 2007; Papadopoulos et al., 2004; Kang et al., 2019). Moreover, estimations of the acuity of conditions are not without bias; racism amongst health care professionals in communication, diagnosis and management of ethnic minority patients has been well documented (Trevino, 1999; Sheifer et al., 2000; Nazroo, 2003). Older migrants present additional challenges to existing services which are shaped around younger clients, leading to an
invisibility of the social and health needs of older refugees (Connelly et al., 2006).

In addition to these technical limitations are epistemological pitfalls. Epidemiological studies tend to speculate on the causes of population differences in healthcare utilisation without empirical data or critical consideration of geopolitical dynamics. In increasingly intolerant political environments, states’ approaches to migration determine migrants’ eligibility for welfare and healthcare.33 Small qualitative studies show that asylum applicants face multiple and intersecting barriers to accessing safe appropriate care in the UK, including racism, language barriers, and poverty (Kang et al., 2019). Critical health scholars are increasingly recognising the risks of this structural hostility, and are drawing on political, social and epidemiological sources to call for universal health care access (Keith and Van Ginneken, 2015; Britz and McKee, 2016; Farrington et al., 2016; Dehghan, 2017; Hiam and McKee, 2017; Nezafat Maldonado et al., 2017; Tomkow, 2017a, 2017b, 2019a, 2019b; Puchner et al., 2018).

The dominant biomedical tropes of migrants as unmeasureable subjects who are outside the scientific realm, vectors of infection, psychologically impaired and burden to the host’s healthcare system, dominate the biomedical academic landscape. Much of this work fails to capture older migrants. Although they rarely overlap, parallels can be drawn between this scholarship and geriatric medical literature. Particular explanatory models dominate the biomedical scholarship on ageing, and much of this work excludes migrants. The next section considers the dominant tropes in biomedical gerontology.

33 In the UK undocumented migrants and refused asylum seekers are charged 150% of the cost of certain services prospectively; if medical bills remain unpaid for two months individuals’ demographic information is shared with the Home Office, policies which deter vulnerable migrants from accessing care (Doctors of the World UK, 2017a).
2.2.3 Dominant tropes in biomedical gerontology: The emergence and utilisation of frailty

Government, media and popular discourse constructs older people as a challenge to states’ existing welfare and healthcare (Laurence, 2002; Press Association, 2005; Silcock and Sinclair, 2012; Campbell, 2015; Thompson, 2015). Paralleling contemporary governmental and academic interest in migrants’ use of healthcare systems is an attention to the fiscal threat posed by the UK’s ageing population and an interest in identifying those most likely to utilise costly health services (Campbell, 2018). In the past 20 years, geriatric medicine has applied its long-established tradition of delineating between individuals’ normal and abnormal ageing to the ageing of populations (Rowe and Kahn, 1997; Depp and Jeste, 2006). The geriatric concept of frailty, first conceptualised biomedically in the 1990s, now forms a dominant biomedical geriatric paradigm (Pickard, 2014). Frailty, as a syndrome, predicts death and dependency better than chronological age and epitomises the trend to theorise variable ageing (Mitnitski et al., 2001). It is commonly conceptualised as a ‘medical syndrome with multiple causes and contributors that is characterised by diminished strength, endurance, and reduced physiologic function that increases an individual’s vulnerability for developing increased dependency and/or death’ (Morley et al., 2013, p. 392).

Biomedical researchers’ numerous approaches to measuring frailty are broadly divisible into two dominant paradigms from the early 2000s: the frailty phenotype and the deficit accumulation model. Through the phenotype, frailty is understood as an observable clinical syndrome with five characteristics: self-reported unintentional weight loss, self-reported exhaustion, weakness (measured by a grip-strength dynamometer), slow walking speed and self-reported low physical activity (Fried et al., 2001). The deficit accumulation model, operationalised though the Frailty Index (FI), understands frailty as the product of accumulating physical,
psychological and social losses (Mitnitski et al., 2001; Rockwood et al., 2007). Both the phenotype and the deficit accumulation model are independently predictive of often-costly adverse outcomes, such as unplanned hospital admission and mortality (Fried et al., 2001; Mitnitski et al., 2001; Boyd et al., 2005; Fugate Woods et al., 2005; Bandeen-Roche et al., 2006; Cawthon et al., 2007).

Biomedical studies have shown frailty to be associated with a number of factors across the life course. It increases with age, is associated with morbidity and has differential distribution and trajectory according to gender (Mitnitski, et al., 2004; Kuh et al., 2005; Crimmins, Kim and Seeman, 2009; Yang and Lee, 2010; Brown et al., 2012; Marshall et al., 2015). Although a vast biomedical and epidemiological literature explores frailty in populations of Europe, America and North America, there is a scarcity of research on frailty in low-income countries (Pathai et al., 2013; Teguo et al, 2015; Payne et al., 2017).

Only two identified studies explore frailty in migrants in Europe and both drew on data from the SHARE health survey, which excluded forced or undocumented migrants. Brothers et al. (2014) found an association between levels of migrants’ frailty and both country of birth and current country of residence. Migrants from low- and middle-income countries were more frail than migrants from high-income countries. Building on this, Walkden et al. (2018) showed migrants tend to be frailer in countries where healthcare eligibility and access was more restricted. Conversely, migrants’ citizenship status in their destination country is associated with frailty levels; citizenship appears to be protective against frailty, particularly for those from low- and middle-income countries. This study uses epidemiological data to draw attention to the fundamental importance of immigration policy on health outcomes, refute the healthy migrant hypothesis and show that environmental factors across the lifespan determine health in later life (Alvarado et al 2008; Birnie et al.,
This quantitative enquiry raises questions about why and how immigration status impacts health outcomes.

However the concept of frailty is facing increasing resistance from health care providers and older people (Shaw et al. 2018). The lay perception of frailty is of a negative state of existence. The English dictionary describes frailty as: ‘wanting in power ... unable to resist temptation; habitually falling into transgression... perishableness ... a spot, a flaw ... a “weakness”’ (Simpson and Weiner, 1989). Social gerontologists assert that frailty ‘links with the negative social imaginary of a feared old age’, thus it connects with powerlessness and an implication of blame, which inherently causes social devaluation (Grenier, 2007; Gilleard and Higgs, 2011, p. 478). Warmoth et al. (2016) showed that being diagnosed as frail leads to disengagement with social and physical activities, which causes marginalisation. Empirical qualitative data suggests older people in the UK and US resist frailty as a diagnosis and identity, despite describing experiences of feeling frail (Grenier, 2006; Nicholson et al., 2012; BritainThinks, 2015). Although older migrants in the UK are subject to the diagnosis of frailty routinely, there is no research on migrants’ experiences or perceptions of frailty. This research will address this gap in the literature by exploring forced migrants’ explanatory models of frailty.

This first section has outlined the literature on migrants’ health and ageing. In doing so, it has shown the following. First, the tensions between dominant biomedical approaches to health and individuals’ explanatory models of health have been highlighted. Literature suggests this tension is observed in both migrants and in older people. In addition, a critical overview of the dominant biomedical tropes in migration and ageing research has been provided. This functioned to disrupt the normative academic narratives about migrants and older people, which too often see these groups constructed as ‘other’. Moreover, the section has drawn attention to the social and political reasons for particular gaps in the
literature, and shows these areas worthy of investigation. The social determinants of health emerged as important throughout; the next section builds on this, and explores these determinants through the frame of structural violence.

### 2.3 Structural violence and intersectionality

The second theoretical theme, structural violence, emerged from the 1960s writings of peace scholar John Galtung and describes the unequal power distribution built into social structures which results, in a broad sense, in harm (Galtung, 1969; Carroll, 2014). Structural violence is a way of describing ‘social arrangements that put individuals and populations in harm’s way. The arrangements are structural because they are embedded in the political and economic organisation of our social world; they are violent because they cause injury to people’ (Farmer et al., 2006, p. 1686). Structural violence is dynamic; it is both structured, through the social and political apparatus, and structuring, in the way it determines how resources are allocated and experienced (Farmer, 2004). Applying the concept of structural violence to health research illuminates the social drivers of illness and results in more effective health improvement strategies, which strive to address unequal power relations (Bourgois, 2004; Carroll, 2013). Thinking on structural violence’s relationship to health is rooted in Marxist philosophy about the social origins of disease, and in the writings of Virchow, a physician who argued that the 1848 Prussian typhoid epidemic was caused by social and economic oppression, and that socio-political change was needed to prevent recurrence (Taylor and Rieger, 1984).

Numerous biomedical studies reify the association between social disadvantage and ill-health. Since the introduction of social policies in the 1970s and 80s, inequalities in both wealth and health are increasing in the
UK (Shaw et al., 1999; Shaw, et al., 2005; Wilkinson and Pickett, 2009; Office for National Statistics, 2013; Bennett et al., 2015; Cooper, 2018; United Nations, 2019). More recently, austerity deficit reduction policies have impacted health through cuts to healthcare services, and by the worsening socioeconomic determinants of health (United Nations, 2019). Men and women born in the most deprived areas will live 9.4 years and 7.4 years less respectively than those born in the most affluent areas, and those living in the most affluent areas live disability-free for 15 years longer than their poorest counterparts (Office for National Statistics, 2018).

Structural violence operates across myriad social dimensions and manifests as unequal life opportunities and health outcomes. Structural violence’s impact on health is evidenced over multiple domains, including: race and racism (see Krieger, 1990; Kessler et al., 1999; Williams et al., 2003; Viruell-Fuentes et al., 2012; Lewis et al., 2015; Wallace et al., 2016; Bastos et al., 2018;); and gender and sexuality (Matthews et al., 1999; Denton et al., 2004; Gates, 2013). Frailty can be understood as a manifestation of structural violence. Not only do poorer groups become frailer at a younger age, poverty is associated with faster decline and worse subjective wellbeing when compared with equally frail but wealthier groups (Yang and Lee, 2010; Brown et al., 2012; Hubbard et al., 2014; Marshall et al., 2015; Warmoth et al., 2018).

A small collection of work considers questions of migration and health through the frame of structural violence (Zwi and Ugalde, 1991; Pedersen, 2002; Walter, Bourgois and Margarita Loinaz, 2004; Miller and Rasmussen, 2010; Quesada et al., 2011; Larchanché, 2012). These largely North American texts draw attention to the multiple and complex axes on which structural violence operates towards migrants generally, and refugees particularly. This includes gender, race, poverty, immigration status, labour
market access and pre-migration personal violence. The concept of structural violence is adopted less frequently by European scholars; nevertheless, there is a growing recognition that migration is a determinant of health (Davies et al., 2006; Kirmayer et al., 2011; Fleischman et al., 2015). Zimmerman et al., (2011) proffer a framework on which to explore the multiple potential structural violences faced by migrants at each phase of migration: pre-departure, travel, destination, interception and return phase. The next paragraphs summarise the existing evidence concerning migration-related determinants of health within this framework. Importantly, asylum seekers and refugees appear to face additional structural violences when compared with other migrants at all stages of migration (Burnett and Peel, 2001).

Pre-departure structural violence can impact health as a result of poverty, food security and local healthcare quality, access and policy (Peters et al., 2008). Torture is common, up to 86% in some cohorts of asylum seekers and refugees, and frequently has health consequences (Laban et al., 2008; Kalt et al, 2013). Of a cohort of tortured Kurdish refugees in the UK: 18% had scars; 29% had fractures; 12% had chronic disability; and 22% had chronic pain which interfered with activities of daily living (Bradley and Tawfiq, 2006). Asylum seekers also face significant risk of sexual violence during all migration phases; prevalence was 76.2% among females and 13.6% among males in one UK Genito-Urinary Medicine clinic (Rogstad and Dale, 2004). The structural violence of states’ restrictive border practices impacts asylum seekers’ health during the travel phase; the scarcity of legal and safe routes means many embark on irregular journeys (Laczko et al., 2016). Perilous sea journeys are a direct threat to migrants’ lives and

34 Galtung differentiated personal violence from structural violence. In personal violence harm can be traced to individuals as actors; in structural violence, violence manifests as unequal power and consequent unequal opportunity (Galtung, 1969).

35 The return phase is beyond the scope of this thesis and will not be considered further.

36 This framework may not reflect all contemporary migration flows; migrants may live in a number of countries for significant time periods without seeing each as their destination (Zetter, 2007).
certain migrants, such as women and those with a disability, face additional disadvantages (Pisani and Grech, 2015; Freedman, 2016; Galis et al., 2016). There are no identified studies specifically exploring older migrants’ travel experiences.

As Chapter One suggested, the UK’s current immigration apparatus positions asylum applicants at the border indefinitely and the destination phase subjects asylum applicants to multiple structural violences. Many social scientists conceptualise this social positioning as a state of liminality (Darling, 2009, 2011; Hynes, 2011; Mountz, 2011; Rainbird, 2014; Guentner et al., 2016; Yuval-Davis, Wemyss and Cassidy, 2018). Liminality, from the Latin limen, or threshold, represents the state of ambiguity at the transition between two stable states of being. A limina persona, or transitional-being, is structurally invisible as a result of being both not yet classified and no longer classified (Menjívar, 2006; Rapport, 2014). Liminality represents a rite of passage following the rite of separation and before the rite of incorporation; as a consequence, the individual is neither here nor there, instead they occupy a socio-cultural space of non-existence (Thomassen, 2009). Although the health impacts of the asylum system in the UK have not been researched, length of asylum procedure and immigration status is associated with poor health outcomes elsewhere (Gerritsen et al., 2004; Laban et al., 2004, 2008; Toar, O’Brien and Fahey, 2009; Juárez et al., 2019).

The interception phase, characterised by the detention of migrants by immigration control, is a practice that has increased exponentially over the past 15 years (Global Detention Project, 2016). States use detention techniques to deter prospective migrants, process asylum claims and enforce deportations (Kotsioni, 2016). Detention can be experienced during the pre-departure phase, as part of state sponsored torture, and

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37 Liminality was first used in the early 20th Century by French ethnographer van Gennep, and was later reworked by Turner in the 1960s (Rapport, 2014)
during the travel and destination phases. The arbitrary detention of new arrivals is commonplace in Southern Europe, particularly in Greece and Italy (Mountz, 2011; Rozakou, 2012; Bosworth, 2014). The UK’s immigration detention facilities are among the largest in Europe (The Migration Observatory, 2018a). An extensive evidence base documents the long-term, irreversible mental, physical and social harm caused by immigration internment (Koutroulis, 2003; Steel et al., 2004, 2011; Robjant, Hassan and Katona, 2009; Kalt et al., 2013).

2.3.1 Intersectionality

Zimmerman et al.’s framework provides an approach for systematically identifying particular structural violences that operate on migrants. However, older asylum applicants may be subject to multiple interlocking forms of disadvantage across the life course (Zimmerman et al., 2011). Intersectionality, a concept described by critical race theorist Kimberle Crenshaw, strives to understand and explain multiple connected systems of oppression (Crenshaw, 1989; Kimberle Crenshaw, 1991; Nash, 2008). Crenshaw used intersectionality to draw attention to, and thus challenge, structural power relations and oppressive social hierarchies. She showed that the dominance of white feminists, who failed to acknowledge issues of race, and the sexism of black anti-racism campaigners, left black women at a crossroad of unique disadvantage (Collins, 1990). Intersectionality holds that at the nexus of two axes of oppression is a unique position of social privation; the concept looks to acknowledge the multidimensionality of the lived experiences of the oppressed (Crenshaw, 1989, p. 139).

Since the 1980s, intersectionality has spread, both geographically and theoretically; it now has global uptake in feminist and antiracist scholarship, liberal activism and popular culture. This malleability and unrefined uptake has attracted critique (Nash, 2008; Byrne, 2015). Though
some have attempted to provide epistemological models of intersectionality, many who cite the concept fail to be precise about their epistemological position (McCall, 2005). Nash (2008) highlights the paradox between intersectionality’s insistence on the complex and multiply-burdened nature of individuals, and Crenshaw’s creation of the quintessentially intersectional figure as solely defined by her race and gender. Byrne (2015) suggests that by failing to be precise about epistemological foundations, intersectionality can be a non-performative concept that substitutes thorough critical analysis by simply being named as an analytical method. Instead, she suggests it should be viewed as a useful metaphor.

These critiques highlight the potential pitfalls of doing research and calling it intersectional whilst paying insufficient attention to epistemology; moreover, Nash highlights an important point about unspoken, and therefore neglected, social categories. In addition to these critiques, accepting and adopting often-oppressive social categories, such as age, gender and immigration status, to identify and describe participants can serve to unintentionally reinforce and reproduce existing power dynamics. However, these social categories provide labels through which structural violence can occur, a phenomenon epitomised by the exclusionary bordering practices described in Chapter One. Crenshaw’s original understanding of intersectionality is as a description of the co-construction and consequent performativity of multiple social identities. This epistemological approach makes intersectionality a useful analytical tool when looking to examine the interplay of the multiple structural violences

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McCall suggests three ontological perspectives from which intersectional phenomena can be considered and organises these on a spectrum based on how social categories are considered (McCall, 2005). Post-structuralist antcategorical intersectionality rejects the categorisation of identities, in order to dismantle normative assumptions and disrupt inequalities. At the opposite end of the spectrum, intercategorical intersectionality uses existing imperfect social categories as an analytical tool for delineating inequalities. Positioned between these two extremes, intracategorical intersectionality examines the lived experiences of an often multiply-oppressed single social group. McCall suggests researchers may traverse the spectrum; nevertheless her modeling provides some clarity and organisation of this broad and pliable concept.
facing older asylum seekers and refugees, particularly when understood in combination with structural violence.

Although academic literature exploring the particular structural violences faced by older asylum seekers and refugees is scarce, where it does exist, it describes multiple axes of oppression functioning across several domains. These axes include poverty due to lack of employment and adequate pension; language difficulties, due to late life migration; social isolation, due to loss of social status and social role; and racism, and associated problematic stereotypes that ethnic minority communities ‘look after their own’ (Wilson, 2001, p. 45; Knapp and Kremla, 2002; Connelly et al., 2006; Dwyer and Papadimitriou, 2006; Centre for Policy on Ageing, 2016). This is in addition to the aforementioned oppressions facing migrants of all ages. Drawing on intersectionality works to identify commonalities within and across the structural violences older migrants face. This balances ‘the efficiency of working “as women” or “as blacks” with the necessary attention to variation and diversity within “women” and “blacks” to organise across and beyond difference’ (Nash, 2008, p. 4). Crenshaw’s idea highlights how common and particular structural violences overlap, are lived by, and impact the health of older asylum applicants in the UK.

This section has introduced the theoretical concepts of structural violence and intersectionality, and has used this introduction as a way of exploring the literature concerned with the harms older asylum applicants face across the life course. These two theoretical ideas will be used in the analysis chapters to acknowledge and analyse the heterogeneity of older migrants from myriad backgrounds. The next section grounds the exploration of structural violence as a determinant of health in theoretical idea of biopower. Doing so illuminates how governmental strategies of distinction and division perform to provide a way for structural violence to operate with legitimacy.
2.4 Biopower

2.4.1 Governmentality, biopower and immigration

The third theoretical theme of this critical literature review is that of biopower. This section will provide a critical overview of the concept, before exploring how it has been applied to thinking about both immigration and health. Critical scholars exploring both migration and health frequently draw on the theoretical work of Michel Foucault. Of particular relevance to this thesis is the concept of biopower, rooted in Foucault’s work on governmentality. Governmentality concentrates on how governmental rationality is produced in a variety of spaces, and describes a contemporary change in the focus of government towards the welfare of the economy and population (Foucault, 1991).

‘Governmentality includes the institutions, procedures, actions, and reflections that have populations as object. It exceeds the issue of sovereignty and complicates the question of control. It relates the power and administration of the state to the subjugation and subjectivation of individuals. It relies on political economy and policing technologies.’ (Fassin, 2011, p. 214).

The governmentality of liberal states centralise ideas of welfare promotion for both population and economy, hence the aforementioned drive to explore costly healthcare use and infectiveness of migrants. The concept demands a shift of focus away from the study of policies’ robustness, towards a critique of how reason operates in the governing of particular happenings (Dean, 2010). The governmentality of immigration and health refers not just to the processes and practices surrounding immigration and health policy, but to a critical consideration of the effects of policy, and what this says about how societies understand immigration, health and illness (Rajas, 2014). Thus a consideration of governmentality enhances the
understanding of the complex and nuanced games of a ‘biopolitics of otherness’ (Fassin, 2001, p. 3; 2011).

Foucault used the term biopower to refer to the tactics used to govern lives within contemporary states. Biopower is defined as ‘the ways historically entrenched institutionalised forms of social control discipline bodies’ and power over the way life is lived (Bourgois, 2000, p. 167; Rajas, 2014). Biopolitics describes the particular strategies within the field of biopower that make lives knowable and governable. Together biopower and biopolitics refer to a set of diverse techniques that create ways of knowing and controlling populations and their constituent biological lives (Foucault, 1998). In an attempt to provide conceptual clarification, and in critique of others who have used the concept too broadly, Rabinow and Rose (2003) suggest that the term biopower should be applied to processes which: involve the knowledge of vital life processes; invoke power relations that take humans as living beings as their object; and apply modes of subjectification, through which subjects work on themselves.

Foucault held that modern liberal states use biopower paradoxically to foster life, whilst concurrently disallowing life to the point of death. He contrasted this with more traditional sovereignty, which he conceptualised as able to ‘take life or let live ... The old power of death that symbolized sovereign power...was now carefully supplanted by the administration of bodies and the calculated management of life’ (Foucault, 1998, pp. 139-140). Although Foucault did not explicitly apply the concepts of biopower and governmentality to immigration, a number of critical migration scholars have since used these as analytical frames (see Conlon, 2010; Walters, 2010; Rozakou, 2012; Estévez, 2013; Bulley, 2014; Holmes and Casteñada, 2016; Peim, 2016). Dominant academic discourse holds that, contemporarily, British immigration governmentality centralises ideas of categorisation and uses biopolitics and biopower to organise lives for the purposes of distinction and division (Walters, 2004). Darling suggests that
these systems of knowledge and classification represent a ‘politics of discomfort’ which positions the asylum seeker as the other who is ‘forever at the border’ (Darling, 2011, p. 268; p. 264).

The theoretical work of Giorgio Agamben also influences this biopower and immigration scholarship (Agamben, 1998; 2005). Through the character Homo Sacer, Agamben illustrates how individuals can be excluded from citizenship rights, yet still under the rule of law: ‘Human life ... included in the juridical order solely in the form of its exclusion (that is, of its capacity to be killed)’ (Agamben, 1998, p. 12). Agamben asserts that biopower results in bare life. Bare life refers to the notion of life that prioritises the biology of living over the way life is lived, or the political potential of an individual. Agamben observed that the Ancient Greek conceptualisations of zoë, meaning humans as basic biological lives, and bios, meaning humans as potential political beings, had been obfuscated within modern sovereignty. Life now equals zoë and offers no assurances about quality of life. Darling (2009) explored the analogy of the figure of the asylum seeker as emblematic of bare life, the apolitical other whose immigration status mean they are often ineligible for citizen rights, yet who must report to the Home Office.

There are tensions between Agamben and Foucault’s understanding of biopower. Foucault sees biopower as a contemporary and generalised form of power. In contrast, Agamben understands biopower as the covert rationale for all power, and asserts that all power rests on the ability of one to take life from another, which contradicts Foucault’s notion of contemporary making live yet letting die (Rabinow and Rose, 2003; Foucault, 2004; Genel, 2006; Owens, 2009). However the writings of both Foucault and Agamben provide useful theories on which to consider

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39 *Homo Sacer* is a figure in Roman law who had his citizen rights revoked after committing a crime. As a consequence, *Homo Sacer* can be killed legally without the killer being regarded a murderer, though he is unable to be sacrificed in a religious ceremony (Agamben, 1998).
questions of health, ageing and forced migration. Foucault’s thoughts on biopower as a way of managing populations by creating knowable biosocial divisions for the purposes of governmental control provides a critical framework for considering how the British state enacts immigration policies. Through *Homo Sacer*, Agamben draws attention to how governmental mechanisms, which include populations in the jurisdiction solely by their exclusion, might reduce socio-political beings to ‘bare life’.

### 2.4.2 Biopower and biomedicine

Although Foucault’s development of biopower remains unfinished, it has been widely applied, both by Foucault and others, to the theorisation of the production of individuals as subjects by medical institutions and dominant biomedical cultures (Foucault, 1994). Biomedicine’s dominant knowledge makes it a prolific disciplinary power (Carroll, 2013). The adoption of biomedical discourse in mainstream policy and governance illustrates this; the drive to identify and mitigate risk and disorder through medical prevention strategies represents forms of social control (Fischer and Poland, 1998). Simultaneously, population health data is the principal mode of knowledge production in the age of public health and health promotion (Lupton, 1995). Lupton argues health statistics and resultant public health projects, such as hygiene and vaccination, are strategies to control unruly populations (Lupton, 1995). The propensity of British governmental data collection and knowledge production to construct asylum seekers as infected and a potential threat to the native population’s welfare illustrates this. Simultaneously, migrants’ non-communicable disease burden in the UK is neglected, and the ability to explore the health impacts of governmental structural violence is impaired.

Biopower has also provided an analytical framework on which to explore the governmental use of particular diagnoses, such as the geriatric
syndrome frailty (Tomkow, 2018). Despite ambiguities around the definition of this emerging concept, governmental and academic discourse presents frailty as a biomedical truth, owing to its ability to predict individuals’ risk of utilising costly adverse outcomes (Pickard, 2014). There is a governmental drive to routinely delineate between frail and robust older people, a practice which objectifies and disempowers individuals, yet proffers those making the diagnosis with ways of knowing and controlling populations (Grenier, 2007; Richardson et al., 2011; Clegg et al., 2016; NHS England, 2017). Frailty reflects structural violence across the life course (Tomkow, in press). Despite this, the management of frailty suggested by experts focuses on individual lifestyle modification (Turner and Clegg, 2014; Marshall et al., 2015). This overlooks modifiable structural inequalities, and encourages the subjectification of disadvantaged older individuals (Tomkow, 2018).

In summary, this section has shown how using biopower as an analytical frame facilitates a critical analysis of the rationale that underpins both immigration policy and biomedicine. Such analysis reveals how both can perform to manage the perceived risk posed by migrant bodies and older bodies for the economic benefit and welfare of the population as a whole. The next and final section will build on this, exploring the moral and social consequences of biopolitical categorisation though ideas of identity politics and biological citizenship.

2.5 Identity politics and biological citizenship

2.5.1 Identity politics and migration

The final theme is identity politics and biological citizenship. Although all of the four of the themes described in this chapter are important concepts that thread throughout the empirical findings, theoretically, ideas of identity politics and biological citizenship are particularly fundamental. This
section explores the critical literature around contemporary identity politics, both with reference to migrants and older people. The ideas of identity politics and biological citizenship allow a consideration of how the aforementioned ideas of explanatory models, structural violence and biopower can come to be negotiated. Moreover, they support the main theoretical contribution of the thesis: biocredibility.

Rooted in Foucault’s theories of subjectivity and biopower, identity politics and biological citizenship explore the moral, social and political conflicts surrounding the formation of social subjects. The concepts provide different theorisations of how individuals negotiate social structures and capitalise on social and material resources (Carroll, 2014). Intimately connected to social justice activism, the analysis of structural violence, and biopower, identity politics refers to ‘the revaluation of difference: the assertion of a difference that has been disvalued, the witnessing of discrimination, and the struggle for rights and social justice’ (Whyte, 2009, p. 7).

The lived experiences of asylum seekers and refugees are necessarily bound to identity politics. Identity politics, whether ethnic, religious, national or political, are frequently an inherent part of war and conflict: ‘refugees are commonly the casualties of identity clashes ... When a group of people is persecuted, tortured, killed, raped and driven out of their homes by another group of people, we witness the stark outcomes [when identity] turns the merely different into the absolutely other’ (Allen, 1998, p. 58). In addition to the identity politics in refugees’ countries of origin, applicants are subject to the imposition of immigration categories in exile. In the UK, this classification has profound social, economic, political consequences (see Chapter One).

In order to meet the biopolitical objective of ascribing an identity, such as ‘refugee’, human lives must be grouped and categorised (Zetter, 2007;
Scherschel, 2011). Categorisation, a subjective process, facilitates our political and social construction of the world. The Home Office’s categorisation of migrants performs particular social and political functions (Bowker and Star, 2000; Moncrieffe and Eyben, 2007; Bakewell, 2008). Immigration categories are associated with a ‘hierarchical systems of rights’ and shape ‘perceptions of how people fit into different spaces in the social order, and of the terms on which society should engage with them in varying contexts and at different points in time’ (Moncrieffe and Eyben, 2007, p. 2; Crawley and Skleparis, 2018, p. 51). Delineating migrants into certain categories produces groups of foreigners who are seen as genuinely deserving of hospitality and welfare, such as refugees, and groups who are not, such as bogus asylum seekers, economic migrants and illegal immigrants (Holmes and Casteñeda, 2016; Potter, 2018).

Contemporarily, the processes and terminology surrounding the classification of those who cross international borders seeking resettlement has received much legal, political, academic and media attention (Edwards, 2015). The UNHCR suggests refugees face particular predicaments and so seeks to delineate them, with the aim of offering protection, from other migrants who ‘choose to move not because of a direct threat of persecution or death, but mainly to improve their lives by finding work, or in some cases for education, family reunion, or other reasons’ (Edwards, 2015). Academics, too, argue vehemently that differentiating refugees from other migrants is essential for legislation, welfare and research purposes (see Hathaway, 2007).

This categorisation is problematic. It epitomises the tendency for categories of migrant to be constructed along rigid dichotomies: legal vs. illegal; forced vs. voluntary; skilled vs. unskilled (King, 2010). Socio-political categories homogenise heterogeneous individuals and fail to reflect real-world processes and contemporary migratory patterns (Bloch, 2014; Lewis, et al., 2017). In response, novel immigration categories have been
suggested, such as transit migration, mixed motivations and mixed flows (Collyer and de Haas, 2012; Koser, 2011; Moncrieffe and Eyben, 2007). However these additional categories too fail to encompass the complexities of experience of new arrivals to Europe. Many journeys are fragmented temporally and geographically; many new arrivals to Europe have lived in countries other than that of their birth, often for prolonged periods, before moving on (Cwerner, 2001; Collyer, 2010; Collyer and de Haas, 2012; Crawley and Skleparis, 2017). This, coupled with climate change, protracted complex humanitarian crises and rising global inequality, challenges the existing normative and legislative frameworks designed to identify those in need of protection as refugees (Zetter, 2007).

Thus, empirically, there is a slipperiness and overlap between irregular migration, economic migration and the search for asylum. Individuals move between seemingly-fixed immigration categories: an individual may arrive with an appropriate visa but if they fail to renew it they become illegal and undocumented; the socio-political situation in countries of origin may mean a migrant from Syria who arrived before the conflict is unable to return, thus they go from being a voluntary to a forced migrant (Potter, 2018).

Hacking suggests that classification is linked to ‘medico-forensic-political ... individual and social control’, a notion evocative of biopower (Hacking, 1986, p. 75). Interested in how classification affects those classified, and how in turn this changes the classification, Hacking suggests: ‘Social change creates new categories of people, but the counting is no mere report of developments. It elaborately, often philanthropically, creates new ways for people to be.’ (Hacking, 1986, p. 170; Hacking, 2007). In this way, classification ‘makes people up’ (Hacking, 1986, p. 161). This paradigm raises the question of how immigration classification systems create ways of certain categories of migrant to be. Hacking’s ‘new ways to be’ are inherently linked to possibility; categorisation creates and ascribes dual realities which structure opportunity through modifying the parameters of
possibility (Hacking, 2007; Jones, 2014; Allegories on ‘Race’ and Racism: Camara Jones, 2014). Classification makes people up by ‘changing the space of possibilities for personhood’ (Hacking, 1986, p. 79).

These dynamics raise questions about researchers adopting immigration categories; by aligning themselves with reductionist oppressive governmental ideology, researchers risk limiting research participants, methodologies, and results (Bakewell, 2008). However, a critical exploration of how the structural violence and biopower of the UK asylum system is understood and narrated in relation to health is central to this thesis. Consequently, rather than overlooking the structural violence and identity politics of immigration categorisation, the processes and practices of categorisation will be a focus of critique. Appendix 1 displays and qualifies the terminology used in the thesis.

Interestingly, classification, and the oppressive identity politics of asylum in the UK, can be negotiated and resisted by those classified. Cuthill's (2017) recent ethnography focused on destitute asylum seekers and described the social terrain facing those with undermined legitimacy and credibility. Being categorised as refused asylum seekers meant individuals had lost the ‘right to have rights’ (Arendt, 1951, p. 273) and so were reduced to a ‘bare life’ (Agamben, 1998). Their ascribed immigration category meant they were without citizenship, shelter, access to the labour market or fiscal welfare, and thus were in conflict with embedded governmental and social structures which sought to exclude them. In response, through performative and discursive actions, they re-shaped their identity into students, thus reconstructing themselves as legitimate subjects. Through claiming this social identity, Cuthill suggests they found meaning and exercised resilience (Cuthill, 2017).
2.5.2 Identity politics and ageing in the UK

Older people are also the subject of identity politics. Social gerontologists have drawn attention to the changing nature of the identity politics of older people in Britain.\(^{40}\) Borrowing from Laslett’s (1987) seminal paper, Gillett et al. (2005) suggest there has been a:

‘cultural demise of the old age pensioner as emblematic of old age and its replacement by a “third ager” defined by a focus on self-realisation and an on-going engagement with lifestyle, shopping, vacations, and lifelong learning. What determines the degree and nature of that participation is both the level of economic resources that members of particular cohorts of retirees command and the extent of their socialisation into the cultural practices of a mass consumer society’ (Gillett et al., 2005, p. 306).

Identity politics represents a way of constructing oneself as a specific type of moral subject within structural power relations (Phillips, 2011; Carroll, 2014). This is achieved both by controlling the social production of knowledge about oneself, and asserting difference with others. In a capitalist society, the Third Age epitomises a culture of identity politics where older people’s consumption performs as a resistance to the oppressive ascribed identity of being old (Twigg, 2010; Marshall and Rahman, 2015). Third Agers gain recognition and value from their identity as aspirational consumers, rooted in ideas of successful ageing (Jones et al., 2009). The Third Age is defined in its contrast to the more sinister Fourth Age, which is often equivocated to frailty:

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\(^{40}\) The social gerontology literature is extensive; a review is beyond the scope of this thesis. Instead, dominant paradigms are discussed within the frame of identity politics and with attention drawn to how this evidence base neglects marginalised groups.
'The social imaginary of the fourth age, a stage of life or state of being that is represented within the collective consciousness as one bereft of agency, autonomy and desire; dominated by frailty and failure; constituting part of a new ‘abject’ class whose social realisation is enacted by the institutions of welfare and welfare rationing’ (Gilleard and Higgs, 2018, p. 61 in Westwood 2018).

These theories have underpinned a large body of social gerontological literature over the past 20 years (see Blaikie, 1999; Gilleard and Higgs, 2000, 2005, 2010, 2010; Weiss and Bass, 2002; Gilleard et al., 2005; Katz, 2005; Higgs et al., 2009; Featherstone, 2010).

However Laslett’s ideas have also faced criticism. Arguably, the binary division between Third and Fourth ages identities is reductionist. Empirically, individuals often fluctuate between the two (Midwinter, 2005). Moreover, this binary has the potential to exacerbate ageism41; though the attractiveness of the Third Age may negate some aspects of ageism, this is dependent on transferring negative features of ageing to the feared Fourth Age. Thus, the categorisation of certain older people as ‘Fourth Age’ causes othering and devaluation, which leads to the dehumanisation and homogenisation of frail older people in need of social support (Grenier, 2006; Gilleard and Higgs, 2011; Grenier et al., 2017). Finally, although the paradigm has provided a theoretical basis for exploring the processes of ageing in Britain in an era of economic neoliberalism, it rests on classist and out-dated assumptions about the nature of populations in an age of globalisation. The ability to capitalise on the freedoms of a Third Age are doubtlessly spatially and socially situated, as well as gendered, classed and racialised. However, the contemporary nuances of these dynamics remain underexplored (Adams et al., 2000; Gilleard and Higgs, 2007).

41 ‘Ageism allows the younger generation to see older people as different from themselves, thus they subtly cease to identify with their elders as human beings’ (Butler and Lewis, 1973, p. 35).
Although social gerontology has been criticised by its tendency to remain ‘deeply embedded in normative assumptions which serve[s] to exclude a wide range of older people’, there is a growing body of work at the intersection of ageing and migration (Karl and Torres, 2016; Westwood, 2018, p. 2). This focuses both on older migrants and older people left behind in the context of population migration: Bastia focuses on the effect of family migration on older Bolivians in Bolivia (Bastia, 2009); Vullnetari and King explore the impact of mass emigration on older people in rural Albania (Vullnetari and King, 2008); Victor and Zubair explore notions of home in transnational migrants (Victor and Zubair, 2016); Hussain explores Turkish migrants’ experiences of social inclusion in London (Oglak and Hussein, 2016); and Cook draws attention to the myriad challenges facing older migrants attempting to access welfare citizenship rights and services in the UK (Cook, 2010). This research draws attention to how meanings of ageing vary both across, and between, culture, gender and class; migrants’ imaginaries of growing older are highly contextual, ranging from being a symbol of wisdom, to the feared imaginary of dependency and burden. Yet the dominant narrative within this scholarship is that migration poses challenges to older people, and that those who migrate can face a double jeopardy, in that they are both older and migrants.

King et al. (2017) and challenge this idea, by exploring how some older migrants resist vulnerability and enhance wellbeing (see also Lulle and King, 2016). Nevertheless, the authors acknowledge that the experiences of growing older are socially and politically located. Especially important are issues of citizenship and welfare rights, factors that limit the translation of existing research to the experiences of those applying for asylum in the UK. Despite King et al.’s (2017) reference to the ‘entwined trajectories’ of being both older and a migrant, an intersectional analysis of the differential experiences of older asylum seekers and refugees is not yet described (King et al., 2017, p. 183). In exploring the experiences of transnational care,
Baldassar problematises the category of economic migrant by showing how migrancy can be triggered by the need to provide or receive care (Baldassar, 2007); this work questions how the situated identity politics described by Cuthill (2017) and Laslett (1987) might translate to ageing in different contexts. However, of particular interest to this thesis is how governmental strategies of biopower and the resultant identity politics of immigration might be narrated in reference to experiences of health and ageing in exile.

2.5.3 Biological citizenship and biolegitimacy

The term biological citizenship was introduced by Petryna (2004), who described the victims of the Chernobyl disaster’s overwhelming demand for, yet limited access to, social welfare; a scenario of resource scarcity that parallels asylum claimants’ lives in the UK. In order to rationalise this welfare, Ukrainian state policies stipulated specific medico-legal criteria that acknowledged and compensated for biological injury; as a result, individuals already unwell because of the disaster, yet not unwell enough to qualify for welfare, exposed themselves to further radiation to enhance their chances of compensation (Petryna, 2002, p. 6). The ways in which identity, medicalisation and the state interacted resulted in health emerging as a form of negotiation for basic economic resources. Whilst citizenship is a legal category, Stillo importantly highlights that within the biological citizenship literature, citizenship refers to basic social recognition and associated rights and entitlements, rather than legal citizenship (Stillo, 2015).

The concept of biological citizenship has been applied in other contexts (see Biehl and Eskerod, 2007; Phillips, 2011). Medical anthropologist and physician Nguyen described the use of illness narratives as part of a negotiation for access to lifesaving treatment in a post-colonial Ivory Coast with scarce lifesaving antiretroviral medication. Here, well-meaning
international aid agencies unintentionally nurtured an environment in which the individuals most able to tell their story of contracting and living with HIV effectively were most successful at accessing medication. Thus the ability to convincingly articulate illness became a matter of life or death (Nguyen, 2010). By problematising the logic of medical stratification as a form of colonial classification, Nguyen argues that in resource scarce environments, enacting decisions about who will live through triage constitutes a form of therapeutic sovereignty. This concept, inspired by Karl Schmitt, equates sovereignty with the ability to decide who and what is an exception (see Nguyen). Biological citizenship is a facet of identity politics, where individuals align themselves with a certain social identity in order to negotiate access to resources; in this way biological citizens are the epitome of the product of biopower in the way they subjectify, or work on, themselves (Rabinow and Rose, 2003).

French medical anthropologist Didier Fassin explores the moral implications of using the medicalised body as a source of legitimacy. Arguing that Foucault’s conceptualisation of biopolitics overlooks ideas of values and meanings, both to the processes of governmental biopolitics and on the end effect on individuals’ lives, Fassin suggests that an alternative, albeit not exclusive, way of considering the politics of life might be that of biolegitimacy (Fassin, 2009). Whilst the concepts of biopower and biopolitics refer to the power over life, biolegitimacy refers to the power of life. Fassin illustrates this phenomena using three real-world examples. The first draws on the lives of three individuals, Pinochet, Papon and Barth, who were all convicted of abuses of power, yet were spared punishment, owing to their lawyers’ appeals on the grounds of ill-health. The second highlights the humanitarian illness clause in the French asylum system, which allows asylum seekers who can prove they are suffering a serious illness legal recognition as refugees. The third is the case of biological citizenship described in Ukraine by Petryna (2004). Biolegitimacy describes how, in contemporary political moral economies, biological life
can, in some way, take precedence over political life. In this context, the medicalisation of complex social experience positions the biologically impaired body as a political resource (Maluf, 2015).

Ticktin suggests that, in France, the humanitarian illness clause makes the domain of biomedical authority an important site of power, where medical professionals become the gatekeepers of citizenship (Ticktin, 2006). Asylum applicants present their suffering to biomedical authorities who then make delineations between those deserving and undeserving of legal status: ‘The immigrant searches in his/her history and his/her symptoms for something that will help obtain the hoped-for legal authorization, at the risk of hearing the doctor say that the pathology offered is not “serious enough” to back up the claim’ (Fassin, 2001, p. 5). This renders physical and psychiatric sickness a necessity. In order to be considered a political subject with rights, impairment is required (Ticktin, 2006). The practice ‘gives rise to highly consequential assessments that shape immigrants’ lives, the implementation of immigration law, and the notion of citizenship itself’ (Lakhani and Timmermans, 2014, p. 361). As a result of biolegitimacy, individuals exist only as a result of their suffering diseased bodies or damaged minds, and asylum applicants are left with ‘a limited version of what it means to be human’ (Ticktin, 2006, p. 33; Fassin, 2009).

When described by Fassin and others, biolegitimate subjects are produced by overt policies that legislate for the recognition of physical impairment as a way of obtaining access to rights or resources (see Bessire, 2012; Young, 2013; Maluf, 2015; McMullin, 2016; Premkumar et al., 2016). As a result, individuals’ biological capacity to live is valued, whilst their political capacity is neglected: ‘the extortion of “truth” from bodies and minds to attest experiences of suffering has become a predominant way of exerting power in contemporary societies’ (Fassin and d’Halluin, 2007, p. 325). The UK’s approach is in contrast with France. The humanitarian illness clause does not exist in British law. Both section 4(2) and common law illustrate
how life-limiting illness is disregarded in decision-making on UK asylum applications; unless the applicant is at risk of dying on the plane, removal orders are served (UKUT445, 2017). Refused and destitute asylum seekers who are too unwell to fly are offered hard-case support. However, rather than illness proffering any real legitimacy as Fassin understands it, this policy simply affords a parsimonious reprieve from the most restrictive and punitive policies: destitution and removal. No identified literature explores biological citizenship and biolegitimacy in the UK immigration context. Through the narrative analysis of older asylum applicants in the UK, this thesis considers the utility of these theoretical ideas in a contrasting context. In doing so, it advances this scholarship by proffering biocredibility as a novel theoretical contribution.

2.6. Conclusion

Rather than generating neat conclusions, this critical overview of the academic literature on migration, ageing and health has elicited different perspectives, drawn attention to the social, political, and fiscal construction of biomedical facts, and problematised the dominance of biomedicine in knowledge production. Data about older asylum seekers’ and refugees’ health is lacking. Although there are logistical reasons for this, it has epistemological implications, determining what research is funded, what questions are asked and about whom, and whether they are answerable. The consequence is a dearth of work at the intersection of aging, forced migration and health, and the exclusion of vulnerable migrants from most biomedical studies of migrant health. Instead, the majority of existing biomedical literature explores migrants’ tendency to behave as vectors of infection, their vulnerability to PTSD and their propensity to misuse host states’ healthcare. In parallel, older people are also constructed as a risk to themselves, and a threat to the current configuration of NHS health care (Tomkow, 2018).
There are tensions between asylum seekers’ and refugees’ and biomedical explanatory models of health. Although literature exploring the perspective of older individuals is lacking, studies suggest health meanings are often rooted in the lived experiences of the structural oppressions and the social disruption of migratory experiences. This problematises the hegemonic academic fixation with culture and difference. Instead, it foregrounds the urgency of an exploration of intersectional structural violences, and how these might influence migrants’ health experiences.

Migration scholars and critical medical anthropologists have readily utilised the theoretical concept of biopower. More recently, the critical exploration of emergent biomedical gerontological concepts, such as frailty as a form of biopower, has demonstrated how governmentality and biomedicine can converge to create new ways of knowing and controlling older populations. In addition, scholars’ explorations of the dominant tropes of identity politics echo Foucauldian thinking on biopower. In doing so, parallels are drawn between the reductive binary divisions in immigration categorisation and in the sociology of ageing in the UK. Although the policy contexts in France and the UK suggest contrasting moral landscapes regarding asylum and illness, the concept of biological citizenship has initiated a consideration of how illness might function to resist biopower, re-negotiate categorisation and circumvent intersecting structural violences.

Many researchers habitually call for further critical exploration of the nuances of ageing in the context of migration, yet there is a gulf between migration and gerontology throughout the literature, and an invisibility of older asylum seekers and refugees. Academic considerations of ageing in the context of diversity can be deficient, owing to a preoccupation with economic resources; a tendency to focus on a small number of minority populations; and the under-development of theoretical analyses
(Westwood, 2018). No identified studies have explored health experiences of older asylum seekers and refugees in the UK. The particular and intersecting structural violences, as well as the strategies of biopower and identity politics they are subject to, make research into how forced migration determines health in later life pertinent. This thesis will address this gap in the literature. Drawing on critical theory, it will explore how the social and material conditions of asylum are narrated in relation to health by middle aged and older asylum applicants in the UK.
Chapter Three

Methodology and methods

‘Working across the boundaries of disciplines “unsettles certainty”’
Scott, 2012, p. 21, cited in Potter, 2018

3.1 Introduction

This chapter describes the research methodology and methods. As well as providing a critical account of how the research was done, \(^{42}\) reflect on my positionality, and the rationale for my decisions. This chapter builds on Chapter Two and shows how working to address gaps in the literature both across disciplinary borders and with critical theory fosters reflexivity. This reflexivity has permeated both my individual positionality and my disciplinary foundations to facilitate an approach that prioritises an examination of social and political context. Although the initial intention was to employ mixed methods and use the biomedical conceptualisation of frailty to explore the impact of forced migration on the health of older asylum seekers and refugees, the thesis evolved into a qualitative project that critically considers the social dynamics surrounding health and forced migration.

The first section of the chapter describes this evolution. I start with an experiential account that reifies the political nature of data, and thus knowledge production, discussed in the previous chapter. As a medical professional, my previous education and vocational experience taught a positivist approach to knowledge and practice. I now understand that research questions can be answered through varied methodologies and I

\(^{42}\) In order to foreground my research experience, locate myself in the research and facilitate an open, detailed and reflexive description of how this research was done, the first person will be used in this chapter. It is the only chapter of the thesis which does so.
believe that, for this research context, a qualitative approach fosters much-needed criticality. However, to arrive at this point, the evolution of this thesis involved a challenging disruption and reconstitution of the self: an epistemological shift. I describe the intellectual discomfort this shift caused and how, by embedding my epistemology in a critical disciplinary orientation, I capitalised on the benefits of a new perspective.

The second section describes the research methods. Older asylum applicants were recruited through VCOs. Semi-structured interviews were analysed using narrative analysis. Research with vulnerable groups can replicate existing social hierarchies and my positionality affected multiple dimensions of the research process (Hesse-Biber and Yaiser, 2004; Ali, 2015). Consequently, I critically examine the power and perils of particular aspects of my positionality: doctor, citizen and activist. I describe some of the difficult ethical scenarios, many of which remain intellectually and morally unresolved. In particular, I highlight how I grappled with balancing the responsibility to not abuse my relative privilege, whilst using these same social assets to enhance the validity and impact of the research.

3.2 Shifting epistemologies and resultant disciplinary orientation

During my undergraduate medical education and eight years postgraduate professional work as a doctor I had unwittingly and unquestioningly

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Positionality refers both to individuals’ specific structural societal position, as well as the actions, practices and meanings associated with such positioning; it encompasses both identities - age, class, gender - and dynamic qualities - ideologies, skills and disposition (Anthias, 2008; Okely, 2012). Reflexivity, defined as the ‘thoughtful, self-aware analysis of intersubjective dynamics between the researcher and researched’ encourages researchers to actively consider their positionality and the impact it may have on their research (Finlay and Gough, 2003, p. 4).

Ethical approval was provided by the University of Manchester Research Ethics Committee and took the form of an online application form and a face-to-face review panel. Following minor amendments, the project was approved in July 2017 application number 2017-1934-3154.
adopted a purely positivist view of the world. Until the year prior to commencing this thesis, I had encountered no exposure to a critical approach to understanding knowledge and its production; my first introduction to the concepts of ontology and epistemology\(^{45}\) was during the completion of a research methodology module whilst undertaking a Masters in Humanitarianism and Conflict Response. The initial research proposal for this PhD was that of a mixed methods study, the quantitative component of which looked to explore how forced migration impacted the health of older migrants by utilising frailty measurements. The qualitative and quantitative enquiries were planned to run parallel; whilst the quantitative enquiry faced significant issues (see 3.3), the richness and depth of qualitative data collected, as well as the socio-political complexity of the research context, was revealed.

As the PhD progressed, I became more engaged with the social sciences, both through immersion in critical theoretical scholarship and engagement with an academic community. Consequently, the way I thought about research shifted and evolved. I began to move away from positivism towards a more interpretivist understanding of the world. This shift produced significant intellectual discomfort; it forced me to question my most basic epistemological assumptions and undermined the central dominant biomedical concepts of the thesis. Embedding myself in the literature of disciplines with a more interpretivist epistemology helped me overcome this discomfort and ground my new perspective. I wrote critically about how the biomedicine of frailty could be considered a form of biopower (Tomkow, 2018). Combined with the logistical problems

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\(^{45}\) Knowledge production can be considered on a continuous spectrum, with idealism and constructivism at one end, and realism and positivism at the other. Realism and idealism are ontological positions; that is, they depict how we understand reality. Positivism and constructivism are epistemological positions, describing the nature, scope and structure of knowledge (O'Reilly and Kiyimba, 2015). Positivism holds that knowledge is fixed and knowable, thus lends itself well to hypothesis-based natural science research. Conversely, social constructivism understands all knowledge to be socially constructed and knowledge not to exist beyond the individual.
described in Section 3.3, this informed my decision to terminate the quantitative component of the thesis.

As a result of this epistemological shift, this thesis sits at the intersection of CMA, migration studies and critical gerontology. CMA, as a disciplinary approach, considers health to be a political issue and relations around health to be embedded within power dynamics:

‘A theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction between the macro level of political economy, the national level of political and class structure, the institutional level of the healthcare system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behaviour and meaning, human physiology and environmental factors’ (Singer, 1995, p. 81).

By examining the social conditions that pre-dispose individuals to ill-health, CMA seeks to examine how multi-level factors intersect and perform to produce health outcomes (Page-Reeves et al., 2013). CMA encourages a research orientation that seeks to understand populations’ felt needs through engagement; examine the interactions between health associations; explore the relationship between structure and agency in producing health outcomes; and undermine, rather than reinforce, inequalities in power (Singer, 1995; Page-Reeves et al., 2013).

Critical gerontology is an approach concerned that there is insufficient attention paid to ‘the degree to which age and aging are socially constituted and to the ways in which both age and aging are currently being transformed as a result of the set of social forces surrounding processes of globalisation’ (Baars et al., 2006). Like CMA, critical gerontology is driven by an exploration of inequalities and strives to guide
a radical scholarly approach into the field of ageing, whilst simultaneously introducing issues of ageing into other fields. Critical gerontology focuses on the everyday subjective aspects, and meanings, of growing older. Close attention to narratives of the ordinary is felt to be important when drawing links between the self and society. In order to foster an approach that challenges the normalised order of things, critical gerontologists work to problematise dominant cultural discourses and instead pay heed to marginalised voices (Katz, 2014).

Both disciplines have roots in notions of social justice, and strive to challenge inequalities through exploring individuals’ experiences; values that speak directly to my personal drive to undertake this research. Both encourage researchers to explore how structural social happenings are expressed on the individual level. Thus, by drawing on the approaches of CMA and critical gerontology when considering older asylum seeker and refugees’ health, the thesis seeks to be grounded in marginalised individuals’ lived experiences and to be critical of structural power relations.

Rather than endorsing a single constructivist research paradigm, the thesis draws on a number of philosophical and epistemological considerations as learning devices and research guides, as suggested by Ormston et al. (2014). One such device is phenomenology, a philosophical approach interested in human experience, which holds that this is best explored through the examination of meaning-making. Although I endorse phenomenology’s focus on meanings, I found it deficient in its concern with the examination of immediate experience as the basis of meaning, 

46 Heidegger, perhaps the most prominent phenomenologist, suggested that there is no such thing as the world as separate from our experience of it. Because we are ‘in-the-world’ our understanding of truth depends on our individual perspectives, which are in-turn based on culture, language, history and politics (Dreyfus, 1991). Furthermore, Heidegger suggested that one of the functions of truth is to conceal things, and that every truth we see conceals other possible truths, akin to looking around a darkened room with a torch. Heidegger holds that truth evolves as a process of revealing and concealing, rather than a binary delineation between truths and untruths.
which paid insufficient attention to the social processes that drive and shape meaning-making (Crotty, 1996).

As suggested in Chapter Two, this thesis is socially constructivist in that it holds that knowledge claims reflect power relations (Cruickshank, 2012). Like social constructivist researchers, I seek to:

‘replace fixed, universalistic, and socio-historically invariant conceptions of things with more fluid, particularistic, and socio-historically embedded conceptions ... specifically [seek to demonstrate], how certain states of affairs that others have taken to be beyond the reach of social influence are actually products of specific socio-historically and/or social interactional processes’ (Weinberg, 2008, p. 14).

Social constructivism facilitates the exploration of meaning whilst paying attention to the social forces that drive these meanings. However, the paradigm should not be endorsed without critique. If taken as absolute, social constructivism considers all knowledge to have equal validity (Cruickshank, 2012). As such, the opportunity to critically examine structural social phenomenon can be overlooked. Obrist et al. (2003) usefully propose a modified social constructivist perspective, which borrows from the critical realist’s approach to urge a consideration of individuals’ accounts within a broader framework of social structures. Whilst rejecting extreme relativism, I have drawn on social constructivism as my primary epistemology: I am concerned with how social processes drive meaning-making in the narrative construction of stories of life, health, and ageing. I also use ideas from phenomenology: as suggested by Heidegger I hold that every form of human awareness, including that of description, is always already interpretive (Dreyfus, 1991). Finally, borrowing from critical realism, participants’ narratives have been
considered within the frame of their wider social dynamics, which exist outside of participants’ constructions of them.

3.3 Quantitative methods: The question of measured frailty in older asylum seekers and refugees

Looking to address the absence of asylum seekers and refugees in academic research on frailty the initial PhD proposal outlined a mixed methods study. This included a plan to measure and compare the prevalence of frailty in asylum seekers and refugees with the UK born population, alongside qualitative semi-structured interviews. It was postulated that asylum seekers and refugees would be frailer at a younger age, owing to their exposure to multiple stressors across the life-course. Section 2.2.3 describes the two main approaches to the conceptualisation, and therefore operationalisation, of frailty. As the frailty phenotype paradigm necessitates face-to-face clinical assessments, time and resource constraints made this impossible to employ (Fried et al., 2001). The frailty index counts deficits as a measure of frailty and relies on the interrogation of large health data sets, thus represented a potential avenue of enquiry (Mitnitski et al., 2001; Rockwood et al., 2007).

Multiple meetings with public health and migration researchers were undertaken, with a view to accessing the health data of older asylum seekers and refugees. It became evident that quantitative research into the health and frailty of asylum seekers and refugees has not previously been undertaken due to the lack of data30. One exception to this data scarcity is
read codes.\textsuperscript{47} The read-code ‘asylum seeker’ (13ZN) and ‘refugee’ (13ZB) can be documented in the patient’s digital general practice health record, and thus facilitates identification of a sample population. A promising potential avenue of enquiry emerged from a collaboration with the Division of Population Health, Health Services Research and Primary Care at the University of Manchester. This department has access to, and expertise in, the Clinical Practice Research Datalink (CPRD).\textsuperscript{48} Over a number of months, a retrospective comparative cohort study was designed and an application for formal access to CPRD data was developed. This research protocol is detailed in Appendix 3.

However, during a scoping search\textsuperscript{49} of the CPRD database a number of factors emerged which jeopardised the feasibility of the study. Asylum seekers and refugees were found to have fewer coded comorbidities than would be expected of UK nationals of their age; findings in contrast with the hypothesis. There are two potential explanations. First, the scoping results were a true positive; asylum seekers and refugees really were less frail than their age and gender matched UK counterparts. However this would contradict existing knowledge about the health of asylum seekers

\textsuperscript{47} ‘Read Codes are a coded thesaurus of clinical terms which have been used in the NHS since 1985. They aim to provide a standard vocabulary for clinicians to record patient findings and procedures, in health and social care IT systems across primary and secondary care.’ (NHS Digital, 2018). Arguably, read codes do not represent the world of disease, rather they facilitate the statistical and fiscal use of health data (Grenon, Smith and Goldberg, 2004). Read codes are used in the UK for payment of healthcare services and elsewhere for heath insurance processes. Code V31.22 illustrates well how read codes are framed ontologically by economics rather than disease ‘occupant of three-wheeled motor vehicle, non-traffic accident, while working for income’. Clearly, this code classifies the mechanism of acquisition of an injury rather than a disease process, a focus with limited usefulness for the clinician.

\textsuperscript{48} CPRD is a governmental, not-for-profit research service, jointly funded by the NHS National Institute for Health Research (NIHR) and the Medicines and Healthcare products Regulatory Agency (MHRA), a part of the Department of Health (CPRD, 2018). CPRD provides anonymised primary care records for public health research.

\textsuperscript{49} A researcher from the Centre for Primary Care extracted the health data for those with the read codes ‘asylum seeker’ (13ZN) and ‘refugee’ (13ZB) over the age of 50. This yielded around 300 health records of asylum seekers and refugees in the UK. It is important to note that this was an informal and unapproved scoping ’look’ at the data and thus is not considered to represent an empirical finding, rather it was a step in the research design.
and refugees. The second is that of a false negative; digital general practice records were not representative of the true health status of asylum seekers and refugees. A number of factors make this likely. Asylum seekers and refugees have been shown to face multiple barriers when accessing primary healthcare, and therefore utilise NHS care differently than the native population (Annandale et al., 2007; Bhatia and Wallace, 2007; Credé et al., 2018; Kang et al., 2019). Moreover, recent analysis revealed a strong association between eFI and length of registration with a GP, implying an under-estimation of frailty levels by the eFI for short medical records of less than 10 years (Reeves et al., 2019). Further, the reliability of using read codes 13ZN and 13ZB to identify the variable of interest – being an asylum seeker or refugee – is questionable. Application of these read codes, unlike many other clinical read codes, is not incentivised by payment, thus they are used variably. In some cases, codes may be applied incorrectly, and in others, they may not be applied at all.

These dynamics raise questions about the extent to which the healthcare records of those who have applied for asylum reflect their actual morbidity burden. In turn, this questions the validity of frailty measurements based on digital health records, such as the eFI, in this group. Exploration of this is deserving of further academic enquiry, however, as well as being beyond the scope of this thesis, there are financial implications. Frailty measurements are validated through predicting risk of morbidity and mortality, thus in order to answer questions about the validity of the eFI in asylum seekers and refugees, it is necessary to link to CPRD data to Hospital Episode Statistics and mortality data, which comes at a cost upwards of £20,000, making it unfeasible (University of Bristol, 2018).

\footnote{Deficits are assumed to be non-resolvable by the eFI. Consequently conditions coded years earlier but not since, including acute and resolved events, are all counted by the eFI and contribute towards the current frailty score (Reeves et al, 2019).}
There are increasing calls within academic research to make digital data more readily accessible. Although there are legitimate reasons why health data may not be publicly available, concerns over confidentiality can be addressed by removing patient identifiable information (National Research Council, 1999). Failure to share data has a number of implications in addition to the aforementioned fiscal ones. Scarcity of data can perform as a barrier to innovation, interdisciplinary cooperation, and education, all of which incur a cost to broader society. It can also function to block the verification of concepts, as in the case of frailty measurements in asylum seekers and refugees. Finally, data sharing draws attention to the issue of equity in research, and shows how researchers in poorly resourced settings are at a structural disadvantage. This stifles not just research capacity and knowledge production, it impairs public health and contributes to structural and cyclical economic stratification (National Academy of Sciences, 2009).

These forms of bias contributed to my decision to put the quantitative component of this research project aside, yet their existence facilitated my exploration of new ways of answering research questions. Although the primary aim of this chapter is to document the research orientation and process, the epistemological shift I experienced reveals how the research process itself can be understood as a form of empirical data that highlights how structural barriers operate across multiple dimensions to further exclude already-marginalised populations. My attempts, as a geriatric medicine physician with an interest in health inequalities, to access high quality quantitative data about individuals’ immigration status and health outcomes were thwarted by a number of factors. The collection and recording of immigration status is poor and asylum seekers and refugees face multiple barriers to accessing healthcare, meaning their records are less likely to reflect actual morbidity than those of their UK-born counterparts. Any attempts to validate the widely-used frailty tools are made difficult by the costs associated with accessing data. These
problematic dynamics are highly political, and raise questions about the drivers of what demographic and health data is collected, for what purpose and for whose benefit. This process draws attention to the political dynamics of biomedical research itself. The availability of, and access to, data and funding guides research and thus shapes knowledge production.

3.4 Research questions

This PhD explores how older asylum applicants narrate the associations between life stressors (pre, during and post exile) and the experiences of ageing, health, ill-health and frailty in exile, and how intersecting structural violences are spoken about. By exploring the meanings and associations of health and ageing through the accounts of older asylum applicants, the research looks to gain an insight into the multiple structural violences faced by older asylum seekers and refugees and how these axes of oppression are understood in relation to health. This enquiry was largely driven by my ideas of social justice; namely a desire to challenge the drivers of health inequalities. Further, in foregrounding the stories of older asylum seekers and refugees, who are often presumed a hard-to-reach group, I strove to challenge the invisibility of older people in both knowledge production and consequent policy focus.

3.5 Qualitative methods

3.5.1 Making contact with a hard-to-reach population

The process of recruiting participants for interview commenced in August 2017. Criterion-based sampling was used to identify individuals meeting
two inclusion criteria: being over the age of 45 and having applied for asylum in the UK. Criterion-based selection can be defined as a strategy where particular people are selected deliberately so as to collect information which would be otherwise difficult to obtain (Maxwell, 2012, p. 88). Older asylum applicants are said to be a hidden or hard-to-reach social group. Whilst planning the research, academics, practitioners and activists advised that identifying and accessing participants would be challenging, owing to both the low numbers and invisibility of older migrants (Livingston et al., 2001; Knapp and Kremla, 2002; Centre for Policy on Ageing, 2016). Consequently, to enhance recruitment, several avenues of access were pursued, including meeting professional informants, recruiting through local VCOs and onward snowball sampling after interviewing participants.

Open-source internet searches and personal and professional contacts were drawn on to identify and arrange face-to-face meetings with individuals who worked in migrant health locally. These individuals are referred to as professional informants henceforth. The vocations of these professional informants varied and included General Practitioners, local councillors, social workers and activists. In some cases, these meetings represented the beginning of on-going collaborative professional relationships, involvement in local advocacy and policy networks, and academic and activist opportunities (see Appendix 4).

Local VCOs across Greater Manchester were identified through the meetings with professional informants and open source internet searches. Contact was either initiated by an introductory email from the professional

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51 Typically, gerontological enquiries are concerned with participants over 65, however in populations facing extreme deprivation and adversity, geriatric syndromes have been observed at much younger ages (Brown et al., 2013). This, coupled with a desire to collect a sufficient amount of data from a large enough number of subjects, led to the inclusion age being decided at 45.
informant to the gatekeeper, or by a direct email from myself, an excerpt of which is presented below:

‘I am a medical doctor (Geriatric Registrar) currently undertaking a PhD looking at the long-term health effects of forced migration ... During interviews I would draw on my communication skills and experiences from my medical career, as well as my experiences volunteering with Freedom from Torture, being mindful that topics discussed at interview may be traumatic.’

Excerpt from recruitment email (Appendix 5)

The dynamics surrounding this are important to consider: ‘Being positioned as a medically authorised observant participant’ can offer researchers a privileged access, both to the individuals themselves, and to their stories’ (Sufrin, 2015, p. 625). I still grapple with the ethical implications of using my medical credentials as part of my recruitment strategy; it is discussed in more detail throughout this chapter. On the one hand it represents an immodest exploitation of my privileged experience, aimed solely at enhancing recruitment to the study; on the other, failing to disclose my vocational background could be considered dishonest.

VCOs were the main conduit for recruiting interview participants. Staff at VCOs acted as gatekeepers.\footnote{Gatekeepers are individuals or groups with the power to grant or withhold access to research participants (Holloway and Wheeler, 1995). Emmel et al., (2007) describe the multiple levels at which gatekeepers function. For the purposes of this research, gatekeepers were either organisations who provide support services to asylum seekers and refugees in Greater Manchester, or individuals working for these organisations who had personal contacts with older asylum seekers and refugees.} Two participants were recruited via professional informants directly. Of the 24 organisations emailed, 16 responded. One VCO declined to participate at this stage, after discussion with the board of trustees:
'Those who were not keen about involving the asylum seekers were worried that for them to relive their experiences could be very traumatic and there would be no follow up to support them. We asked one of our refugee helpers what she felt and she thought it could be cathartic but another woman said she had been interviewed recently (I think by another researcher from Cambridge) and had found it a very difficult and upsetting experience. Some people thought we should give them the opportunity to decide for themselves. Others were quite against it.'

Email excerpt from VCO volunteer

The potential for the research interview to be cathartic and/or traumatic was a dominant and persistent ethical conundrum throughout the research process. For traumatised individuals, revisiting difficult experiences in a research interview risks creating renewed emotional distress. The consequences of this re-traumatisation include the de-stabilisation of existing mental health issues, self harm and suicide (Krysinska, Lester and Martin, 2009). The issue of scarcity of mental health support services augments this risk of harm following retraumatisation (Maltsberger et al., 2011). The VCO who opted out of the project had recently lost funding and had consequently reduced its support services, thus they decided to protect their clients from a potentially harmful encounter with a researcher. However, a significant evidence base also suggests disclosing traumatic events has a positive impact on psychological and physical health (Petrie et al., 1995; Hemenover, 2003; Frisina et al., 2004; Frattaroli, 2006). Most studies describing the benefits of traumatic event disclosure do so in physically and psychologically healthy subjects; there is insufficient evidence to predict the outcome in those with mental health consequences of trauma, and thus quantifying the risk of harm in this group is impossible (Batten et al., 2002; Newman and Kaloupek, 2004).

53 VCO and asylum advocacy groups use the term ‘client’ to describe the individuals who attend their services for support.
However, in making the decision to be included in research on behalf of their clients, it could be argued that the board of trustees infantalised these older people, removing their agency and excluding their voice.

In reply to recruitment emails, many local refugee organisations cited a concern that they would not be able to identify many, or any, clients over the age of 45. The following are experts from email correspondence:

‘If you can come at 11.50 we can chat for 15 minutes and then I can introduce you to another volunteer ... However, I am very doubtful that we can find a client of 45 ... I don’t think we have contact with someone over 45. I really don't want you to waste your time! You are very welcome to come and see us and we will tell you what we know, but if you feel that you can find a project in Manchester that can help you, that is fine!’

‘I've just checked, and out of the 60+ people we're currently accommodating only 5 are over 45 years old, and they are all refused asylum seekers.’

‘I'm sure Rethink Rebuild Society would be happy to help, although the ‘above 45’ bit might make it a bit difficult because most of the refugees coming from Syria are young.’

Face-to-face meetings with staff from the remaining 15 VCOs ensued. Although meetings varied in time, place, length and format, they were most often conducted at the organisations’ community centres, though on occasion we met in coffee shops or University buildings. Being primarily concerned with first-hand experiences of migration, meetings with VCO staff and professional informants were not audio recorded, nor formally analysed. However, many of these individuals had years of experience working with asylum applicants. Consequently, meetings represented
fruitful research encounters, providing an understanding of the intricacies of the asylum system, knowledge of the structure and function of support services, and an introduction to the structural violences faced by asylum applicants in Greater Manchester. Issues such as poverty, homelessness, mental health and the frustration of waiting for asylum decisions dominated the discussions; these later emerged as important themes from the analysis of asylum applicants’ lived experiences.\textsuperscript{54}

Gatekeepers used this initial meeting to enquire about my background, motivations and the research rationale. Often after discussion with other VCO staff, a decision would be made about the VCO’s involvement in the research. Although all 15 VCOs agreed to be involved, not all were able to identify participants who met the inclusion criteria. The final participants were identified through connections with six organisations: Leigh Asylum Seekers and Refugees Support (LASARS), Oldham Unity, Rainbow Haven, Befriending Refugees and Asylum seekers (BRASS), Boaz Trust and the Growing Together Allotment Project.

LASARS, Oldham Unity and Rainbow Haven are all community-based organisations run by volunteers operating drop-in sessions for asylum seekers and refugees. The exact focus of the support provided by these groups varied, though all hold drop-in sessions in community spaces, such as church halls, either weekly or bi-weekly. At the drop-in sessions hot meals are provided, as well as English language classes and volunteer-led support with signposting to local services. Oldham Unity focused on a ‘Destitution Food Project’, which takes the form of a food bank for migrants in need (Oldham Council, 2017). LASARS provide informal support and signposting by Methodist Church volunteers and a safe space for

\textsuperscript{54} This correlation can be understood as a form of triangulation, and a demonstration of the reliability of the empirical findings of the thesis. Other forms of triangulation were used, including engagement with grey literature, official governmental policy documents, peer-reviewed academic papers, and attendance at local policy and advocacy meetings (see Appendix 4).
socialising (Wigan Council, 2017). Rainbow Haven offer a more formalised support service, as well as hosting the Red Cross family reunification project (Rainbow Haven, 2017).

I was invited by the staff at Rainbow Haven, LASARS and Oldham Unity to attend these sessions to identify potential participants. I found the drop-ins chaotic.\textsuperscript{55} It was noisy: adults shouting to each other in various languages; children screeching and crying; and the sound of slamming doors and pots and pans banging in the kitchen area. It was busy: varied activities occupied any available space in the halls, the local food bank was giving away food tins and bread; English classes were being led by volunteers; children’s play areas spilled over into any free space; and second-hand clothes piled up on tables, many being sold for under £1. Having no specific role in the running of the drop-in service, I felt like an extra burden on the already-busy VCO staff. Despite my discomfort, the staff were keen to be involved with the process of identifying individuals who might be interested in participating. They either introduced me to people who they thought would be willing and able to be interviewed, or dissuaded me from approaching certain particularly vulnerable individuals. I felt welcomed by all, yet I often left a half-day session feeling exhausted, albeit satiated with rich data and volunteer-made vegetable curries.

BRASS and Boaz Trust are based in office spaces, open daily, and offer more specific and focused services. BRASS offers a formal immigration legal service alongside a library for book exchange, discounted second-hand clothing, English language classes, and support service signposting (BRASS, 2016). Boaz Trust provides accommodation for destitute asylum seekers as well as advocacy, pastoral support, food and clothing (Boaz Trust, 2018).

\textsuperscript{55} The gendered nature of the drop-in sessions is discussed further in Chapter Four, suffice to say they tended to be dominated by younger men. Although gender-specific organisations exist in Greater Manchester, and one all-female organisation was approached to participate in the research, access was not obtained to their clients to discuss recruitment. This is likely due to their ongoing existing partnerships with the University and legitimate concerns about research fatigue of their clients.
Staff from BRASS and Boaz Trust contacted clients meeting the inclusion criteria directly, and facilitated a face-to-face meeting with me at a time convenient to the client. On one occasion, a gatekeeper copied me into email correspondence with a client who no longer attended the drop-in, after checking they were willing to discuss participation.

The weekly Growing Together Allotment Project differs from these drop-in based VCOs. Based in an urban community allotment in Levenshulme, the project aims to provide asylum seekers, refugees and anyone who has difficulty with their right to live in the UK with a safe space and the skills to grow food (Lovell, 2017). The sole activities are gardening and cooking the allotment-grown vegan produce. The client group was significantly older and the atmosphere was calm. Each session would start with a circle; clients and volunteers stood outside in the garden amongst the vegetables, introduced themselves and announced any important news. I, too, introduced myself and briefly stated my research aims. Interested clients then approached me throughout the day. It was at the allotment I first noticed the dynamics surrounding the reimbursement of travel expenses. Many VCOs reimbursed clients’ travel expenses by providing them with £5 cash each time they attended a session. Participants later told me that this sum would be saved, combined with travel expenses from attendance at other VCOs, and often used to purchase a weekly bus pass. On one occasion the staff at the allotment had insufficient funds to reimburse all of the clients; the heated arguments between clients that ensued were the only time the allotment’s serenity dissipated.

This research was conducted in the city where I grew up, live and work. When I left the drop-ins I remained geographically close to the participants. Although the proximity offered logistical advantages, it also produced significant discomfort, aspects of which have been described by other scholars (Gilbert, 1994). In particular, whilst attending the VCOs, I was exposed to levels of desperation and poverty I had only previously
witnessed whilst traveling and working abroad in India and Malawi. The contrast between my own social position and that of the clients at Growing Together, panicked and arguing over the loss of £5, felt starkly visible and profoundly uncomfortable.

Scholars have highlighted the relational nature of vulnerability. That is, vulnerability has been shown to be dependent on the production of power relations between non-marginalised and marginalised people across society (Pells, 2012). My house and lifestyle, a mile or so away from the VCOs, seemed suddenly luxurious. At its most productive, my discomfort at this contrast motivated me, galvanising my anger about, and interest in, structural inequalities. At worst, it led me to feel frustrated with my family, friends and colleagues, who often seemed disinterested in the subject.

Perhaps as a consequence of my perceptions of clients’ vulnerability and the guilt over my relative privilege, I became increasingly involved with the VCOs and their clients in philanthropic ways. Initially this involved donating clothes, and then giving cash when there were insufficient funds to reimburse people for travel. Later I gave clients lifts to and from the drop-ins in my car and provided informal telephone support in the evenings when a negative asylum decision had been received, or a change of accommodation was threatened. During one such phone call, one refused asylum seeker who had received an eviction notice described how she ‘just wanted someone to know’ about her housing, in case she faced removal from the country. In this way, my role extended beyond that of a researcher conducting semi-structured interviews; instead, at times, and albeit peripherally, I bore witness to the harshness and anxieties of participants’ everyday lives.

Swartz (2011) describes the complex, messy and, paradoxically, additional ethical challenges raised by doing research that strives to address power imbalances between researcher and participant. At the beginning of the
research I felt aware that my actions could be understood as extractive: I was taking experiences from delegitimised non-citizens and, through my interpretation as a citizen pursuing a postgraduate qualification through an elite institution, re-constructing and thus validating their accounts. My philanthropic donations were also problematic. Although giving away cash and clothes may have gone some way to alleviate my guilt, it did little to challenge structural power inequalities. Instead donations arguably reify the inevitable transactional nature of research.

Nevertheless, in order to create ‘personally engaged and politically committed’ research, CMA encourages involvement with research participants in order to understand their felt needs, and challenge inequalities in power rather than re-enforcing them (Singer 1995; Schepers-Hughes, 1995 p. 419; Page-Reeves et al., 2013). By allowing myself to befriend and support some of the people I interviewed, our dialogue extended beyond the research encounter. This enhanced my understanding of their daily lives, which enriched the research process and product. Moreover, in some instances, it facilitated a transition away from a researcher-led interaction, towards one where participants chose to initiate additional interactions in order to share particular and challenging aspects of their life with me. This, with the view that I, through my research, might affect a change in their circumstances.

3.5.2 Obtaining consent

Individuals expressing an interest in taking part in the research were provided with a Participant Information Sheet (PIS) (Appendix 6). Translated documents were offered; several participants were provided with PIS in Arabic. 56 Participants were then given time to read the document and ask questions about the research. If happy to be involved,

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56 PIS were translated into Arabic by the translator used for all of the interviews
an interview appointment was arranged at a time and location convenient to the participants, either on the same day, or on another day. Participants were asked to sign a written consent form prior to commencing the interview (Appendix 7).

Before commencing the interview, the most salient points in the PIS and consent form were discussed verbally with participants, with an interpreter if needed. It was made clear that participants were under no obligation to take part, and that participation would not affect on-going asylum claims, access to health care, charity services, legal assistance, or housing support. Participants were informed that the topics of discussion might be upsetting; they were encouraged to choose not to answer certain interview questions if they felt uncomfortable, and were reminded of the option to stop the interview and withdraw from the research altogether at any point. On occasion, participants discussed certain aspects of their lives, such as their previous vocation or health conditions, and specified that they did not want these details to be included in the research. In these cases, these details were not transcribed.

When given the opportunity to ask questions about the research, participants often instead asked about my background, job and family. Whilst obtaining consent prior to interview, I would inform participants about my professional background, using phraseology such as: ‘my background is in medicine’ or ‘I am a medical doctor, studying for a PhD’. I rationalised this disclosure as it being representative of open engagement; being a doctor is a core feature of my positionality and thus shaped the research questions, the analysis and potential research outputs.

I made certain to tell participants that I was interviewing them as a researcher, not as a clinician, clearly stating that I was unable to offer treatment or medical advice. On reflection, this disclosure was problematic. I capitalised on my professional credentials by proclaiming my
dual identities, then asked participants to disregard my profession. The cultural norms in many of the countries of origin, where doctors are held in high social esteem, coupled with the multiply-marginalised social position of many of the participants in the UK, may have augmented the existing power imbalances between researcher and participant. Consequently the implicit pressure of being asked to do something by a doctor, or by a gatekeeper on behalf of a doctor, is likely to be significant. Moreover, whilst offering no medical therapy, I inferred participants were invited to share in-depth details of their life history and medical issues with the implicit assurance of medical ethics: ‘Trust me, I am a doctor’. The dynamics of this should not be neglected, especially given that participation in the research was not without risk of harm (Merriam et al., 2001; Sufrin, 2015).

Involving gatekeepers in the recruitment process may also amplify unequal power relations between researcher and participant, as well as risk the disclosure of participants’ identities to people outside the research team (Emmel et al., 2007). Clients may feel especially obliged to comply with a request to participate in research when such a request comes from a gatekeeper who provides a support service philanthropically. I was not witness to all research-related gatekeeper-participant interactions. However, during my conversations with gatekeepers they demonstrated insight into the potential for research interviews to do harm. They tended to be cautious, presenting a conversation with myself about the research as an option. Furthermore, a number of steps were taken to protect participants’ identities. Gatekeepers were aware that the identity of participants should not be shared, and after an introduction to potential participants, gatekeepers were not routinely informed whether an interview took place. Pseudonyms\textsuperscript{57} have been allocated in this thesis, and identifiable features have been removed.

\textsuperscript{57} Pseudonyms have been chosen based on the most popular gender-specific names in the participant’s country of origin.
3.5.3 The research interview

Individual face-to-face interviews were conducted in English. An Arabic interpreter, Hina\textsuperscript{58}, was used for nine of the 21 interviews. A summary of the key demographics of the sample can be found in Table 1.

\textsuperscript{58} A pseudonym has also been given to the interpreter in order to protect her identity. In later chapters Hina emerges as a key informant.
### Table 1: Research participants

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Sex</th>
<th>Country of origin</th>
<th>Immigration status</th>
<th>Year of arrival in UK</th>
<th>Interpreter</th>
<th>Date of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amraz</td>
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<td>Iraq</td>
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<td>2003</td>
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<td>2010</td>
<td>-</td>
<td>11.9.17</td>
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<tr>
<td>Farhad</td>
<td>?</td>
<td>Male</td>
<td>Iran</td>
<td>Refused Asylum Seeker</td>
<td>2008</td>
<td>-</td>
<td>11.9.17</td>
</tr>
<tr>
<td>Bondeko</td>
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<td>Male</td>
<td>DRC</td>
<td>Asylum Seeker</td>
<td>2014</td>
<td>-</td>
<td>8.9.17</td>
</tr>
<tr>
<td>Hafiz</td>
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<td>Syria</td>
<td>Refugee</td>
<td>2015</td>
<td>Arabic</td>
<td>12.9.17</td>
</tr>
<tr>
<td>Mahmood</td>
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<td>Male</td>
<td>Eritrea</td>
<td>Refugee</td>
<td>2014</td>
<td>Arabic</td>
<td>12.9.17</td>
</tr>
<tr>
<td>Rohat</td>
<td>65</td>
<td>Male</td>
<td>Syria</td>
<td>Refugee</td>
<td>2007</td>
<td>Arabic</td>
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<td>2015</td>
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<tr>
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<td>Refugee</td>
<td>2014</td>
<td>Arabic</td>
<td>14.9.17</td>
</tr>
<tr>
<td>Abdo</td>
<td>60</td>
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<td>Refugee</td>
<td>2016</td>
<td>Arabic</td>
<td>19.9.17</td>
</tr>
<tr>
<td>Masimab</td>
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<td>Zimbabwe</td>
<td>Asylum Seeker</td>
<td>2015</td>
<td>-</td>
<td>2.11.17</td>
</tr>
<tr>
<td>Dikembe</td>
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<td>DRC</td>
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<td>2003</td>
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<td>9.11.17</td>
</tr>
<tr>
<td>Garian</td>
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<td>Male</td>
<td>Liberia</td>
<td>Refused</td>
<td>2002</td>
<td>-</td>
<td>9.11.17</td>
</tr>
<tr>
<td>Name</td>
<td>Gender</td>
<td>Nationality</td>
<td>Status</td>
<td>Year</td>
<td>Age</td>
<td>Language</td>
<td>Date</td>
</tr>
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</tr>
<tr>
<td>Nyasha</td>
<td>Female</td>
<td>Zimbabwe</td>
<td>Refused Asylum Seeker</td>
<td>2002</td>
<td>-</td>
<td>-</td>
<td>14.11.17</td>
</tr>
<tr>
<td>Aneni</td>
<td>54</td>
<td>Female</td>
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<td>Refused Asylum Seeker</td>
<td>2002</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ahmed</td>
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<td>Kuwait</td>
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<td>2008</td>
<td>Arabic</td>
<td>19.12.17</td>
</tr>
<tr>
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<td>1998</td>
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<td>-</td>
</tr>
<tr>
<td>Aran</td>
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<td>Kuwait</td>
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<td>2011</td>
<td>Arabic</td>
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</tr>
<tr>
<td>Tala</td>
<td>57</td>
<td>Female</td>
<td>Kuwait</td>
<td>Refugee</td>
<td>2011</td>
<td>Arabic</td>
<td>5.1.18</td>
</tr>
<tr>
<td>Julie</td>
<td>49</td>
<td>Female</td>
<td>Malawi</td>
<td>Refused Asylum Seeker</td>
<td>2004</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kamal</td>
<td>50</td>
<td>Male</td>
<td>Sudan</td>
<td>Refused Asylum Seeker</td>
<td>2013</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The majority of those interviewed were male. This gender balance reflects the gendered nature of the recruitment spaces, where the majority of clients were male. Two VCOs provided gendered data about their clients; one saw 69% male and the other 90% male. Reasons for this are multiple. Statistical data shows that the journey to the UK is a gender sieve, with the concentration of males increasing as distance from home country increases. Men represent 50% of those forcibly displaced from their homes worldwide, 68% of Mediterranean sea arrivals and 75% of asylum
applications in the UK (Migration Observatory, 2017; UNHCR, 2018).
Gender is further discussed in Chapter Four.

Interview length ranged from an hour to two and a half hours; participants were offered a break every 30 minutes. The interview location depended on the availability and preference of the participant, and most often took place in a private space at the VCO. Often this was a small office, borrowed from a staff member busy elsewhere. A reflective diary, detailing my emotions, thoughts, feelings and research ideas, was maintained throughout the period of data collection. Interviews were audio recorded with a Dictaphone and written notes were taken.

An interview topic guide was developed after a literature review on migration and health, and was adapted after conversations with the professionals, activists and gatekeepers described above (Appendix 8). Interviews were semi-structured, allowing participants to share a biography whilst I loosely guided the discussion by asking open questions around key themes in the interview guide. Pre-migration, migratory and post-migration life experiences were explored, however I was keen to foreground the perspectives of the participants. I planned time so that interviews could take place at a relaxed pace, allowing time and space for the participants to develop detailed descriptions and have control over their narratives (Weiss, 1994; Galletta, 2013). At the time, I felt a lot of the interview was taken up by participants’ tangential accounts; however in retrospect I believe this assisted with building rapport and, as the analysis shows, provided a richness to the data.

I offered no payment for participating in the research in order to avoid incentivising a potentially traumatic encounter. The majority of participants seemed positive about their experience of being involved in the research, and thanked me for my time:
'You are the only person I talk to about these things. You know I feel like you give me treatment by listening to me, because in this country I have nobody. I have my sick wife, she’s laying in bed all the time, tired, and I have my children – this is not a story for children. So now I feel good, so thank you.’

Amraz

Nevertheless, participants frequently became emotional during the interview; many cried or become angry when narrating their lives. On one occasion, a research interview was stopped because the participant, Mahmood, was too upset to continue. Below is an extract from my reflective research diary:

‘I’ve just got home from an interview with an elderly refugee. I asked a question about how he found the process of dealing with the Home Office and he became upset, started to cry and asked if he could come back later on, or at another time. It was clear that he wasn’t comfortable with the interview and so we decided to terminate it. Seeing, well making, him cry right in front of me gave me such a shock. My palms got sweaty, I felt my heart racing and blood rushed to my face. Suddenly the gravity of what I am doing, what I am putting the participants through, became so real and so tangible. For me it’s easy. I am just collecting stories. But the participants are being asked to re-live the most traumatic and dehumanising experiences of their lives, so that I can make an academic judgement about the impact of this on their health. Why am I doing this, asking these intrusive questions? For my own benefit and career? For my own personal interests? This is academic voyeurism, and I am the primary beneficiary. I feel sick. I am used to seeing people in extreme emotional distress in a clinical setting, both in the NHS and at Freedom from Torture – it is par for the therapeutic course. This feels different. In this new role of PhD
researcher I am offering nothing and taking everything. I am rubbing salt into the wounds caused by my country’s policies of systematic dehumanisation and neglect.’

Following this research encounter, I grappled with issues of positionality and power in research with vulnerable groups. I reflected critically on my decision to disclose my job, considering whether this had coerced Mahmood to participate. By inviting individuals to share in-depth details of their life history with the implicit assurance of medical ethics, whilst offering no medical treatment, I feared that as a doctor-researcher I had appropriated and exploited the doctor-patient relationship. In particular, my moral reasoning centred around contrasting the risk of re-traumatisation in a research setting with a clinical one. I fixated on, what at the time I perceived to be, the inertia and impotence of my new researcher role; I could offer no medical therapy, nor could I directly access psychological support for Mahmood.\(^{59}\)

In addition to the risk of direct harm from the research encounter, I became concerned about the broader social implications of the medical gaze. Uncritical medical enquiries into the health of asylum seekers and refugees can result in the discursive construction of this population as necessarily diseased and vulnerable. Even if driven by notions of social justice, this is problematic as it propagates the narrative of refugees as impaired and in need of professional management (Pupavac, 2008). As a British citizen, doctor and PhD researcher, my positionality makes my research susceptible to the unintentional propagation of ‘old colonialist views of an essentialised and exoticised’ other (Dennison, 2013, p. 185). Adopting a critical perspective of the dominant discourses around

\(^{59}\) Hina, the interpreter, took the lead following the termination of the interview. She spoke to Mahmood at length in Arabic, using her experience of working with asylum seekers in Greater Manchester to signpost him to relevant support services.
migration and health, I believe, goes some way in mitigating this exoticisation.

Nevertheless, many of the participants interviewed were keen to have their story heard. Francis, a refused asylum seeker from Cameroon, epitomised this. During the interview he described feeling suicidal and hearing voices, and having sensed a change in his affect, I checked he felt comfortable enough to continue with the interview:

‘Oh yes. It is important and I feel comfortable because when you meet me it is about positive things, because you are going to help many people. I share my experience and you are going to use my experience to help people - that is good that is not bad. The thing that is bad is to make bomb to kill people. (Laughs). You are going to use my experience to help more and more and more people. I’m free to talk to you.’

Francis

In this excerpt, Francis eludes to feeling compelled to continue the interview in order to improve the lives of others who tread his path after him. As Harris points out ‘people living through the cyclical deprivations of displacement … seldom have the opportunity of a meaningful say in shaping the decisions and factors affecting their lives’ (Harris, 2000, p. 20).

Schepers-Hughes (1995) suggests that research can result in works of recognition. In parallel to this period of critical self-reflection, my moral convictions and discontent about the social (in)justice of contemporary migration and asylum in the UK became more acute, driven by the augmentation of the structural inequalities that motivated the research in the first place. The extension of the NHS charging regulations galvanised my medical activism and I became increasingly involved with Medact’s campaign to resist the policy (Medact, 2019). In this activism, my medical
title represented a form of social capital. I was invited to write blogs for mainstream media, I drew on my medical contacts to conduct and present academic-activist research, and with a group of other doctors I took direct action, picketing on the streets outside a Manchester hospital (Tomkow, 2017a; 2017b; 2019a; 2019b) (Appendix 4). Barton (2011), a teacher-researcher, considers the duality of her responsibilities paradoxical; ‘the responsibility not to abuse my power as an educator warring with my responsibility to the overall project validity and the [participants] I interviewed’ (Barton, 2011, p. 11). This notion is paralleled in my research. Despite being a source of uneven power relations throughout the research, my positionality has afforded both a privileged access to people’s lives in my clinical work, and a relatively powerful voice to draw attention to the inequalities I have witnessed the effects of.

### 3.5.4 Linguistic and cultural interpretation

Prior to commencing this research, my clinical work as an English-only speaking doctor in Greater Manchester, a region with over 150 languages spoken, had provided me with experience of working with a range of interpreters. This included professional translators, telephone services and family members (Gopal et al., 2013). Moreover, through my work with Freedom from Torture

\[60\] I received additional training on working with interpreters with potentially distressed asylum seekers. As such I understood the significance of good quality interpretation on health outcomes. During the interviews I chose to work with a single interpreter, Hina, who I identified from a cohort of specially trained interpreters who

\[60\] Established in 1985, Freedom from Torture is a British charity that provides support for victims of torture. This can be in the form of psychological therapy, practical assistance or medicolegal reports. I have volunteered as a medicolegal report writer since 2016 (Freedom from Torture, 2019).
work for Freedom from Torture. Freedom from Torture’s translators undergo specialist training, focusing on difficult life experiences. Originally from Libya, Hina had extensive experience translating for migrants in Greater Manchester including with Freedom from Torture, the NHS and legal appointments. Although as a non-Arabic speaker it is difficult to reliably verify the quality of Hina’s interpretations, in contrast with some of the interpreters I have worked with previously in healthcare settings, I had no concerns about the quality of the service provided.

Working with an interpreter presents logistical challenges, such as cost, time and availability. However, issues of language and interpretation require additional consideration when conducting research with its roots in CMA. Language is central to the construction of reality, ontologically and epistemologically (Temple and Young, 2004). In this thesis, where none of the sample of participants used English as their first language, issues of translation influenced the construction of the narrative data, and the interpretation of its meaning. Introducing a third party into the process of data collection adds a further layer of interpretation (Temple, 1997). As a result, using an interpreter introduces fundamental shifts in the research dynamics.

Researchers often strive to obtain interpreter neutrality, which phenomenologically is impossible (Temple, 1997). In a Heideggerian sense, Hina is an individual whose perspective is shaped by her experiences of

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61 I was aware of power dynamics that can occur between researcher and translator and strove to establish a relationship of working ‘with’ Hina, rather than her working for me (Berman and Tyyskä, 2011). Co-incidentally, I had worked with Hina’s husband, also an interpreter, with an Arabic-speaking client at Freedom from Torture. We had fostered a positive working relationship. We lived in a similar area in Manchester, and I would often share transport to the interviews. We had a number of shared interests and values, and would chat about these on the car journeys and before and after interviews. Because of this relationship, which felt collaborative, as well as the quality of the interpretation service Hina provided, I chose to use her for all of the interviews. Using a single translator can enhance the reliability of qualitative interviews (Katz, 2014).

62 Additional funding for translation services was provided by the Economic and Social Research Council
being in the world. This influences how she interacted with the participants and the choices she made about the language and form used to translate their accounts. Baker argues that, from a constructivist perspective, translation can be understood as a form of re-narration. This re-narration ‘constructs rather than represents events and characters … [Translators] are embedded in the narratives that circulate and simultaneously contribute to the elaboration, mutation, transformation and dissemination of these narratives through their translation choices’ (Baker and House, 2014, p. 159). No two languages are directly interchangeable, therefore pursuing absolute equivalence in translation is futile (Baker, 1993). Meanings for words are often encoded within one language and may not be directly accessible by another (Tribe and Keefe, 2009). This was realised on a number of occasions during the interviews; here Hina behaved as a cultural interpreter, as well as a linguistic one (see Section 5.5).

The presence of an interpreter also raises ethical issues of confidentiality and representation. Refugees can be hesitant to make sensitive disclosures to an individual from the same diaspora (Tribe, 1999). Although Hina signed a confidentiality assurance policy, participants were required to depend on her to convey their accounts accurately in English, a language they did not understand, whilst respecting their privacy (Appendix 9). On occasion, participants recognised Hina from previous translation work; here they seemed pleased to see her, with one hugging her and proclaiming: ‘This made my day, I feel comfortable’. Academic literature suggests the effects of using interpreters are mixed; some refugees report interpreters left them feeling infantalised, whilst others felt empowered (Tribe and Keefe, 2009). In parallel, the work involved potential risks to Hina, including vicarious trauma, enhanced by shared migratory experiences and ‘making the community look bad and or looking bad in front of the community’ (Salihovic, 2008; Berman and Tyyskä, 2011, p. 186). These dynamics are fluid and messy, and add complexity to the ethics
of this research. During the research process no specific evidence of these issues materialised, nevertheless they are important to consider.

Linguistic translation involves the identity politics of language. There are social, emotional and political connotations raised by being interviewed in a second language. Two of those interviewed in Arabic described themselves as Syrian Kurds. During the interviews, I did not consider this to be an issue; most Syrians are fluent in Arabic, the participants requested either an Arabic or Kurdish translator, and none reported communication problems during the interview. However, I later learned of how the Kurds have been persecuted for years in Syria, and Kurdish language banned, replaced by Arabic (Human Rights Watch, 2009). These power dynamics also apply to those interviewed in English; many of their countries of origin were previous British colonies or mandate territories. Whilst mother tongues are seen as intimate and close, second languages can be understood as more constraining or formal (Burck, 2004). This raises ethical as well as methodological issues; both Arabic and English can represent the language of oppression.

In line with my previous training, Hina and I set time aside for a discussion before the first interview and after each interview to ensure we had a shared understanding of the concepts central to the research, and to check on both of our wellbeing. This was particularly beneficial after the discontinuation of the interview with Mahmood. Discussion with Hina surrounding the meanings and specific understandings of particular words, phrases, and sayings continued throughout analysis and write up period, with email exchanges and telephone conversations. Although her presence during the interviews lengthened the interview time, it provided me with time for active reflection and detailed observation. She also identified and recruited two participants. Working alongside Hina was an informative and supportive collaborative process. Hina’s role extended beyond that of a linguistic translator to a cultural interpreter, an active participant for data
collection and co-construction of the data, and a personal support mechanism.

3.6 Data processing and narrative analysis

Narrative analysis is a qualitative research method concerned with capturing and analysing stories of human experience (Webster et al., 2007). There is debate within social science research surrounding what constitutes a narrative (Squire et al., 2013). However, for the purposes of this project, narratives are understood to be temporally and geographically situated, to have a perceived beginning and a projected end, and to embed protagonists who have configured relationships with the world around them (Baker and House, 2014). As a research method, narrative analysis endorses a constructivist approach in that it holds that we have no unmediated access to reality. Instead, narrative is our interface with the world and is one way of constructing reality (Baker and House, 2014). Stories do not exist in isolation; rather, they are shaped by experiences and interactions over the life course. Stories are constructed socially, through sharing and telling. Social narratives thus shape our culture and influence our understandings of reality (Riessman, 1993).

Before deciding on narrative analysis as the analytical approach, other qualitative research methods, such as interpretive phenomenological
analysis (IPA) were explored. IPA is useful for analysing small rich data sets and focuses on the study of particular happenings rather than general laws. Both IPA and narrative analysis are interested in how meaning is co-constructed by researcher and participant, often in the context of unequal power relations. However, some aspects of IPA were problematic. IPA holds that an authentic truth exists and explores how individuals make sense of their experiences in order to get as close as possible to this truth; notions which do not marry well with the research objectives or disciplinary roots (Seale, 2018). Compare this with narrative analysis, which is interested in the social aspects of stories and how critical experiences over the life-course are understood and spoken about. Narrative analysis suggests researchers should be attentive to how stories are told, as well as the content of what is told. In this way the method encourages a focus on the meaning, structure and content of stories, and the inferences these components can make about broader social processes (Riessman, 1993; Webster et al., 2007; Seale, 2018). Like Reissman (1993), I consider how the story is told to be as important as what is said; the use of sequencing, the order of events and insertion of enclaves into narratives is significant, as this guides the listener towards the teller’s point of view. This structural social focus, coupled with its attention to the co-construction of knowledge, meant narrative analysis was ideally suited to answer the research questions within the critical disciplinary orientation.

IPA is a research methodology with its philosophical roots in phenomenology and hermeneutics (Larkin and Thompson, 2012). IPA aims to explore the participant’s view of the phenomenon under study, with a focus on idiographic and on the importance of individuals’ meaning-making. This is with the ultimate aim of decoding the essence of the experience. Exploration of the IPA literature was useful. It is often used in health and psychology research, and its fixation with particularity and meaning-making facilitated my epistemological shift towards constructivism. However, the critiques of IPA centre around: ‘The identification of themes as analysis (in spite of arguments to locate their meanings), its take-up as codified practice (even though this was never intended), the limited consideration of its philosophical and theoretical background, and above all, [a lack of] discussion on how IPA is positioned, epistemologically and theoretically as phenomenological and hermeneutic in nature’ (Chamberlain, 2011, p. 53). Indeed, some of the guidance of how to do IPA makes it indistinguishable from other thematic analysis approaches.
Illness narratives represent more than the retelling of physical impairment. Pathographies can be understood to expose how ‘cultural and social meanings shape the illness experience and the identity of the sick, illuminating conflict between patient and health care cultures’ (Sakalys, 2000). Narrative researchers have demonstrated how individuals use biomedical disease to draw attention to their difficult lives (Scholes 1985; Heurtin-Roberts, 1993, p. 320; Sakalys, 2000; Strahl, 2003; Coker, 2004). Mattingly and Garro suggest that for unwell individuals, the meaning of illness can be more important than pathology’s effect on bodily functioning (Mattingly and Garro, 1994, p. 771). Sakalys (2000) suggests pathographies can perform as ‘cultural and political critiques’, making visible the intersection of power and weakness (p. 1470).

There is no consensus guidance of how to do narrative analysis (Seale, 2018). Atkinson (2009) draws attention to how uncritical and empathic appreciation of individuals’ accounts is analytically insufficient; instead narratives should be treated as ‘speech acts, based on socially shared resources’ (Atkinson, 2009, p. 1). Perhaps the most critical and nuanced narrative analyses come from scholars who use a dramatological perspective to understand human interaction (see Riessman, 1990, 1993; Strahl, 2003; Cuthill, 2017). These analyses are rooted in the ideas of Goffman (1959) who contended that individuals display a series of masks for each other and change these masks according to social context. However, although Goffman’s ideas usefully explore the sociological aspects of the performance of language, his assumptions are not without problems. This approach risks representing the narrator in a pejorative way, insinuating they are manipulative in their attempts to mask a genuine reality. This position arguably fosters the trivialisation of narrators’ accounts of disease, suffering and loss. In response to this, the methodological position of this study assumes narratives represent a spoken action within a social context (Bauman, 1986; Riessman, 1993, p. 1196). As well as looking to explore individuals’ experiences, I am
interested in what personal narratives can reveal about the larger social context, such as the political climate, the processes of immigration categorisation. That is, I recognise that, and am concerned with how, both structural forces and individuals’ agency impacts how a story is formed.

Drawing on my previous research experience analysing qualitative data, I recognised that re-listening to interview recordings and transcribing verbatim represented a valuable stage of analysis (Silverman, 2014). I listened to the audio recordings of interviews twice; the first time for transcription, and the second time whilst reading the transcript and making corrections. Although this took a considerable amount of time, it allowed me become grounded in the data. Interviews were conducted over an eight-month period. Whilst not spending time at the VCO centres, I began to transcribe and analyse the completed interviews. The 21 interviews resulted in over 100,000 words of text transcripts.

The analysis involved multiple steps, some of which were repeated as new concepts emerged from later transcripts (Table 2). In order to be systematic with the organisation of such a large quantity of data, whilst being detailed and nuanced in my exploration of the structure, content and meaning of participants’ stories, data analysis was necessarily a time-consuming process. Throughout this multi-stage process, emerging themes and theoretical ideas were shared with a number of parties. This included, but was not limited to: my local academic community during presentations, seminars, and more informal peer meetings; the supervisory team through formal and informal review arrangements and submission of written work; and the broader academic and practitioner community, through sharing written work and by presenting at conferences. These critically constructive interactions shaped and refined the analysis, as well as encouraging a continuous reflexive approach.
Table 2: The steps of data analysis

<table>
<thead>
<tr>
<th>Stage^64</th>
<th>Aim</th>
<th>How it was done</th>
<th>Why it was done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steps 1, 2 and 3 were performed in order, though step 2 was revisited and refined often</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Immersion in data</td>
<td>Listening to audio-recordings, Transcription, Re-listening to audio-recordings and re-reading transcripts, ‘Initial Note’ taking on content, language, context and researcher reflexivity</td>
<td>To ensure familiarisation and grounding in the data.</td>
</tr>
<tr>
<td>2</td>
<td>Macroscopic narrative analysis: Identification of emergent themes</td>
<td>I summarised my previous notes with concise but abstract concepts, whilst revisiting the original data to ensure these concepts remained grounded in original accounts.</td>
<td>To urge a focus on content of the stories.</td>
</tr>
<tr>
<td>3</td>
<td>Re-organisation of the data into themes</td>
<td>Collection and compilation of all data pertaining to a single theme in one document.</td>
<td>To organise data.</td>
</tr>
<tr>
<td>Steps A, B and C were performed simultaneously and were revisited during the analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Microscopic</td>
<td>Line-by-line examination of</td>
<td>To urge a focus on</td>
</tr>
</tbody>
</table>

^64 Stages that are undertaken in order are numbered 1, 2 and 3. Stages A, B and C were undertaken simultaneously.

^65 Although this approach is more often adopted by thematic analysis researchers than those doing narrative analysis, it was felt to be essential in this project in order to organise the data in a way which reflected how the findings would be presented in the thesis. For example one such document contained all of the data that referred to frailty.
<table>
<thead>
<tr>
<th></th>
<th>narrative analysis: content</th>
<th>what was being said with attention to language, meaning, associations, time, space, protagonists, emotion.</th>
<th>content of the stories.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Microscopic narrative analysis: structure</td>
<td>Line-by-line examination of how stories are told, with attention to temporality, associations, causality, word order, how ideas are structurally constructed and co-constructed.</td>
<td>To urge a focus on structure of the stories.</td>
</tr>
<tr>
<td>C</td>
<td>Macroscopic narrative analysis: Identification of conceptual connections between emergent themes</td>
<td>A matrix between the dominant emerging themes was developed.</td>
<td>To build a picture of how the structure and content of the stories relate to the geopolitical context.</td>
</tr>
</tbody>
</table>

### 3.7 Conclusion

This chapter details the research orientation and strategies in order to frame the empirical chapters that follow and increase academic rigour. More noteworthy, however, is how the logistical disruptions and moral challenges raised during the research altered both my disciplinary and epistemological orientation. Darling suggests that rather than simply generating data ‘fieldwork produces sensibilities and dispositions, it alters researchers and those they encounter in often unpredictable ways’ (Darling, 2014a, p. 201). As well as causing an alteration of self, the intellectual, political, social and moral encounters described resulted in the
unanticipated production of a piece of critical socio-political qualitative health research.

I am unable to proffer certain conclusions to many of the difficult dynamics of morality and power described; my discomfort with the privileges of my positionality and the unequal nature of this research persists. Doing politically-engaged and socially-responsible research with marginalised people in a hostile environment is morally complex. Engaging with, and attempting to address, the power relations this research evoked can augment this ethical complexity (Swartz, 2011). Nevertheless, though my clinical work and daily life I am exposed to the human cost of structural inequalities. I believe that bearing witness to, yet failing to engage with, these dynamics propagates the active neglect of marginalised individuals through complicity with the current socio-political status quo.

This chapter has highlighted how I attempted to negotiate the unequal power relations during the research process. Equally important is how the research altered my practice as a clinician. Alongside the research, I have published on migrants’ healthcare access, have undertaken medico-legal advocacy volunteer work with Freedom from Torture, and became more involved in medical activist networks. The impact of these experiences on my future clinical career as a geriatric medicine doctor is yet to be seen. However, the observations about power relations and the epistemological shift afforded by this educational opportunity has enhanced my knowledge and galvanised my drive to challenge health inequalities beyond the academy.
Chapter Four

Intersectionality and ageing in exile

‘If I was with people similar to my own age they could understand me, understand my hardships as well.’

Aneni

4.1 Introduction

This chapter is the first of three empirical chapters. It introduces some of the older asylum applicants interviewed, through an exploration of their experiences and explanatory models of ageing. The chapter demonstrates how participants’ articulations of ageing are constructed alongside narratives of lived experiences of migration. Broadly, participants see migration as a challenge to ageing, and ageing a challenge to life in the UK. However there is variation between the accounts and experiences of those interviewed; this exists across multiple social dimensions. Existing studies exploring ageing and migration more broadly tend to focus on theories of cumulative advantage and disadvantage, but this approach can fail to capture the diversity between and within migrant groups (Phillipson, 2015; Hussein, 2018). In response to this, this chapter uses the concept of intersectionality to facilitate an exploration of how structural violence operates differentially across dimensions of gender, race, immigration status, employment and poverty. As well as recognising the multidimensionality of these identities, using intersectionality allows this analysis to highlight both the particularities and the commonalities of ageing experienced by these older asylum applicants (Crenshaw, 1989, p. 139).
The chapter can be broadly considered in two parts; the first analyses participants' explanatory models of ageing, and demonstrates that ageing is conceptualised as a social construct. Participants remember homelands fondly; here, a critical consideration of the concept of nostalgia illuminates the potential drivers of this. Stories of the disruption caused by migration will be considered, as will the accounts of those who feel migration has accelerated the ageing process. The second part of the chapter adds layers to this analysis by using intersectionality to consider how particular dimensions of identity, including immigration status, gender and race, operate within participants’ differential experiences of ageing in exile. Rather than proffering to provide an exhaustive insight of every social characteristic at play, the chapter uses the narrative analysis of participants’ lived experience to introduce the idea that multiple interlocking axes of oppression perform to position older asylum applicants in inimitable social positions.

4.2 Participants’ explanatory models of ageing

4.2.1 Ageing as a social process

The sample of participants interviewed was heterogeneous across multiple social demographic dimensions, including age, gender, country of origin, immigration status, educational level and employment status. Although participants’ articulations of their individual agedness and ageing varied, they were united in their disregard for chronological age. Chronological age is the hegemonic explanatory model used to conceptualise and define age biomedically and bureaucratically. It is used both as a proxy measurement for individuals’ ageing and a way of modelling population health, through

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66 Education history and employment history are not presented routinely in order to protect the anonymity of participants; particular experiences of (un)employment are discussed throughout the empirical chapters if relevant to the analysis.
countries’ average life expectancies. Participants’ understanding of their own ageing was unrelated to the average life expectancy in their country of origin: Abdo from Sudan, where the life expectancy is 63, said he felt young at 60 and believed old age started at 80. Dikembe, 58, from the Democratic Republic of Congo where life expectancy is just 59, said he no longer felt young, but did not yet feel old. Instead, their narratives focussed on the social, cultural and financial aspects of age. Individuals’ experiences of ageing were communicated in relation to other dimensions of identity including gender, race and immigration status. Ageing, therefore, emerged from this empirical data as a socially constructed process.

Dikembe, 58, fled his native Democratic Republic of Congo (DRC) with his wife and three children. He arrived in the UK in 2003 as a refugee on the ‘Gateway’ pathway, having been selected for resettlement by the UNHCR whilst living in a refugee camp in Kampala (Refugee Council, 2018b). Now a British citizen, he explained:

‘In Africa [older people] are sociable. They have their own communities and they can interact in their own communities, they can do some dance, they can play, they can joke, they can share anything. But in Europe they don’t have anything to share. That is individualism. In Europe capitalism is more than communitism [sic]. That means everything that you have it’s for your own, but in Africa everything you have is for your community. That means in Africa if I am old everybody looks after me. It is a very big difference. A big big difference … here maybe there is a community centre where you can go and meet people, maybe you can talk to people for an hour or two hours. What’s in Africa? You can be all together for one day, if you have a beer, I have something to eat and we eat all together.'

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67 Average life expectancies varied widely across participants’ countries of origin across the African continent and the Middle East, from just 59 in the Democratic Republic of Congo, to 74 in Iran.
You feel that love. But here you don’t feel that. You are lonely ... It has affected me. For young people it’s fine, but for old people is terrible ... for old people they have grown up in that situation where they are in that community, so when you come to the UK you are in a small group of people. You don’t have any Auntie, you don’t have any brother, you don’t have any Uncle. In Africa you can have many people who are looking after you, or looking after your children, and you can go anywhere.’

Dikembe

Dikembe configures this narrative in a way that effectively contrasts the social experiences of ageing in Africa and in the UK, comparing the drivers, practices and effects of ageing in both places. He problematises the superficiality of local community initiatives in the UK and suggests loneliness is rooted in a culture of individualism. He also delineates between the issues faced by younger and older people living in an individualistic society, and suggests that age augments the loneliness this causes. Loneliness in older people in the UK is increasingly receiving academic and policy attention; biomedical research has drawn attention to the health impacts of loneliness, and in 2018 a minister for loneliness was appointed (Holt-Lunstad et al., 2015; gov.co.uk, 2018b). Although he considers himself neither young nor old, and speaks in the second person, Dikembe’s narrative evokes a sense of loss. His memories of the communality of life in Africa position the social experience of ageing in the UK as problematic (Makoni, 2008). Migration to the UK emerges from this excerpt as a disruption to the trajectory of later life through the dissolution of social networks and communal experiences.

Rather than speaking about ageing as a chronological or biological phenomenon, participants articulated their ideas about age and ageing in reference to the social and material conditions of their displacement. In this way, their experiences of being older and being a migrant intersected.
The idea of displacement broadly, and the environment in the UK in particular, as a hostile disruption to the social experience of ageing was central to many participants’ stories. Many remembered homelands fondly, and reflected on the contrasting societal status they occupied in the UK. For Syrians, the acuteness of the war and the country’s previous prosperity may explain this sentimentality. Interestingly though, nostalgic narratives were also expressed by people fleeing chronic hostility and poverty, such as those from Sudan, Cameroon or Zimbabwe:

‘I was an electronic technician. And a Christian first because I love God and I love Jesus. I was a preacher, then gospel and a technician and everything. This was my life. Let me tell you something - this is Africa. European people they have their attitude. You have lots of neighbour but no visit, do you understand? Neighbour cannot visit neighbour, this is European. But in Africa my neighbour I go to him he comes to me.’

Francis, 58, Cameroon

‘My experience in this country, it was hard a hard time. Because I had a good life in my country I have never been in this life before ... Being in a strange country, being away from your friends and your family also that affect your health, that affects your mental health. I felt like I lost my life, my lover, my friends, my colleagues, because in Arabic countries especially in Sudan we have very strong social relationships there. I’ve been alone for nine months. Sure it’s going to affect me.’

Abdo, 60, Sudan

‘Here the community in the society is less sociable. It's not like in the Arabic countries where we are much more sociable. I’m an old man. If I see somebody who needs help I will go quickly and help them,
especially children. Here they say: “Don’t touch the children, don’t help any children, don’t help out and don’t touch them.”

Ahmed, 52, Kuwait

Ahmed is a Bedoon and told of how he fled Kuwait after being persecuted by the government. Although he has lived in the UK for 10 years, he has had his application for refugee status refused multiple times. Like Dikembe he finds life in the UK less sociable than in Kuwait. Ahmed’s account suggests that he understands British social norms to challenge his ability to adopt the role he sees as appropriate for an ‘old man’. Abdo and Francis’ narratives also evoke ideas of loss of social value; this echoes existing literature on forced migrants’ loss of social networks (Warfa et al., 2006; Valentine et al., 2009).

Nostalgia is a ‘structure of feeling that invokes a positively evaluated past world in response to a deficient present world’ (Tannock, 1995, p. 454). From the Greek nostos, meaning ‘to return’, and algos, meaning ‘pain’, until the late 19th Century nostalgia was equivocated to homesickness and conceptualised as a psychiatric illness: ‘the state of moral decay arising from a forced separation, when an individual is torn from the social and geographic environment of his childhood and youth’ (de Diego and Ots, 2014, p. 405). Academic critiques of nostalgia have associated it with hegemonic conservative social forces (Tannock, 1995). The sentimentality of nostalgia has been contrasted to a feminist memory which aims to unpack and challenge historical voices and institutions (Greene 1991). Nostalgia has also been problematised by scholars who highlight its appropriation by reactionary strategies of governmentality, where it is used control behaviour and maintain established power dynamics (Combs, 1993).

Kuwait has been accused of practicing widespread discrimination against Bedoons, who are long-time inhabitants of Kuwait yet have been denied Kuwaiti citizenship and are thus rendered stateless. Bedoons are prohibited from employment and education and face arbitrary arrest and deportation (Human Rights Watch, 1995).
However these critiques overlook how an insistence that times were happier may be driven by an desire to affect social change, rather than a longing to reify historic happenings (Williams, 1973). Contemporary understandings have de-pathologised nostalgia; it is now considered a pervasive sense of sentimentality reflecting either ambivalent or positive emotions of sociality, redemption and selfhood (Sedikides et al., 2008). Nostalgia can perform in response to a personal need; psychoanalytical literature describes the role of nostalgia in refugees as therapeutic. Triggered by emotions of loneliness, it has been suggested that nostalgia provides key psychological functions, acting as a coping mechanism by providing individuals with a sense of continuity and meaning in times of existential threat, as well as magnifying perceptions of social support (Wildschut et al., 2006; Sedikides, et al., 2008a; Routledge, et al. 2011). Emotive connections to the past have been said to facilitate a private space for refugees’ growth and respite (Akhtar, 1999). Thus nostalgia represents a ‘psychological home’ for those living in exile (Volkan, 1999; Papadopoulos, 2002; Rosbrook and Schweitzer, 2010, p. 21).

Hafiz, 46, was a wealthy businessman in Syria and is recognised as a refugee in the UK. Although he is legally able to work, he speaks no English and is unable to find employment. He saw his quality of life in the UK as poor:

’[In Syria] I was more happy than Prince William. I had my car. I had a villa with a swimming pool. I had an airplane agency. I used to travel all the year. Here it is a big prison and I cannot do anything. About what happened to me, [in Syria] forget about it. It’s fine, it’s happened. What about this life that I’m living now? All that I need to feel respected to feel free, to feel happy, to do whatever I want. What I found was not what I expected from here. I have an Uncle. He has been living here for 30 years. He was a consultant surgeon
and he died now, but I didn't expect that he was living here in this life the way that I am living now.’

Hafiz

In this excerpt, Hafiz composes an impression of himself as a powerful man with an eminent social status in Syria. Like Dikembe he contrasts this against life in the UK. Hafiz associates his wealth and power in Syria with freedom and feels imprisoned in the UK as his expectations of life, based on his Uncle’s experiences, have failed to materialise. Throughout his interview Hafiz alluded to his dismay at life as a refugee in the UK. He recalled an Arabic proverb:

‘If you plant a tree away from its home you won't get anything from that tree.’

Hafiz

He then went on to associate feelings of youthfulness to his social position in Syria, again contrasting it with life in the UK:

‘When I was in my country I was feeling 20, 30 years old. To be honest when I was in my country I was very well respected. I had a value from people. I was very well known from the people and from the society. Since I came to this country it is like I am, we have a saying it's like you are a 0 on the left side. When you put 0.1 it means you are nothing, and am that 0.’

Hafiz

Hafiz projects a definition of himself as a highly regarded individual in Syria, which made him feel young. By narratively moving back and forward in time, he illustrates his contrasting social positions and guides the impression that this contrast augments the suffering he endures in exile.
Like Hafiz, many participants reflected warmly on their pre-migration social status, and the value they felt from being well known or well respected. Narratively, this value was often illustrated by vocation. Bondeko, 45, worked as a surgeon in his home country, the DRC. After speaking out against the Kabila regime, he was detained and tortured so fled the country, leaving his wife and three children behind:

‘But me I did work as a medical doctor, I live my life ... I miss it. Like I said from the start it is a vocation, it is something that it's not for money, but it's because of devotion. I like it. When I was 12 years old I took some worms and took some herbs and mixed and see if I could kill them. I remember when I'm 30 when I come out of the theatre I walk like a wrestler. I feel like it is a game ... For me it's the same way as when soccer players enjoy when they're playing when they dribble it's the same feeling I am feeling. And when I'm out doing any skin graft or any... I feel like I'm proud I feel like it makes me myself. I miss it. That's my hope. I really miss it. Walking along the corridor from theatre.’

Bondeko

For Bondeko being a doctor is inherently linked to self-worth and is narratively associated with youth, strength and masculinity. These apparently-nostalgic accounts of youthfulness and prestige may be driven by individuals’ return pains, or they may simply represent the nostalgia of ageing described in non-migrants (Lundgren, 2010; Draaisma, 2013). However, and importantly, considering the past as a source of stability and meaning can be indicative of an unstable present (Doane and Hodges, 1987). This considered, a critical engagement with participants’ readiness to draw on nostalgic narratives highlights the social deficiencies produced by current political conditions. In short, rather than dismissing nostalgic narratives as overly sentimental, they should be understood to be a political response, indicative of significant on-going suffering.
4.2.2 Migration as a determinant of ageing

Building on the idea of forced migration as a disruption of social expectations and experiences of ageing, participants often spoke about life in exile as a stressor. Some suggested that the suffering endured in the UK caused accelerated ageing:

‘I was born in 1965. But if you see me I don’t look like I was born in this year, you think I was born in 1956. Even everybody says I look much older than this. When I entered Britain all my hair was black and now it’s white. I have changed for the worse because of the Home Office. I like Britain. I like the society here. I respect the laws. I respect the administration, whatever they apply on me. Even the British people, they don’t like the asylum procedure.’

Ahmed

When asked how old he felt, Ahmed replied: ‘100 years in Britain’. By suggesting that he has undergone a rapid acceleration of the ageing process as a direct result of the stress caused by the Home Office, Ahmed narratively locates his ageing historically and geopolitically. This articulation can be understood to perform a narrative function. It serves to infer causation for his physical appearance and feelings of agedness; in doing so it allows him to attribute blame by positioning the Home Office as an oppressive force. Analysis of the narrative utility of participants’ accounts of ageing and illness is developed in the chapters that follow.

Others, too, described how they believed particular migratory experiences had accelerated the ageing process. When Abdo, a 60-year-old refugee
from Sudan, arrived in the UK alone on Christmas Eve 2016 he was unaware of how to claim asylum or where to access welfare support. He described shops and offices being closed and recounted how he was without accommodation for nine days. Throughout the interview he persistently described the horror he felt at this time. When asked about his age, he volunteered:

‘I think that those nine days made me much older. I was much, much younger before those nine days.’

Abdo

In making this statement, he suggests that time spent homeless in the UK caused a seismic shift in his ageing trajectory. Tala travelled with her husband Aran and children to escape Kuwait where, as Bedoos, they were being persecuted:

‘Before, in Kuwait my kids were around me. We were laughing together eating together, sitting together all of the time but here it is nothing like that. Once a week we used to go to our relatives and we would eat all together as a big family, we were laughing a lot and smiling. Here we eat, sleep, worried, scared, feeling low and thinking all the time. That’s it. I feel now that I really need a psychologist. I feel like I’m much older than before. Sometimes I compare my picture to a few years ago and now it’s much, much different.’

Tala

Despite her descriptions of years of persecution by Kuwaiti state officials and the marginalisation produced by living as stateless people throughout her interview, Tala reflects nostalgically on the sociality of life in Kuwait.

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69 Although Abdo did disclose his reasons for fleeing Sudan, he stated he did not want this information to be included in the final research
She uses the change in her appearance to visually depict her perceived accelerated ageing and support her claim that life in the UK has negatively impacted her. She also uses other approaches to vibrantly contrast the two parts of her life, namely, contrasting her daily activities and asserting that she needs professional psychological support.

Originally from Liberia, Garian is destitute and has had multiple asylum applications refused. He told of how he regularly sleeps on the street and, with no recourse to public funds, depends on local charitable organisations for food and shelter. He, too, recounts ideas of how harsh conditions in the UK have led to the physical signs of ageing. Specifically, he locates the origins of his distress in his precarious economic situation. By drawing on his linguistic skills, and the mismatch between his intelligence and income, he alludes to a sense of injustice, and recounts the feeling of desperation that this causes. Garian spoke at length about how his life in the UK represented a stressor:

‘When I show you my picture of when I came to this country you’re not going to believe it is me. With stress I have become old ... I did not come in this country like this. You can see yourself. (Garian holds up a picture of himself on arrival to the UK). Stress is making people become old. I’m an intelligent person. When today I go to the Home Office I speak three languages. I speak French, I speak Portuguese, I speak English. I’m an interpreter. I’m going to get money, look. But now I do interpreting for free in the community in Rochdale ... I don’t have money. I don’t have food. I do have stress. When I’m in this place it’s like I’ve already died. I’m already dead. I tell you I’m serious. Sometimes I think I’m going to kill myself. This place. What am I going to do? What is a life like that? For a person like me, my daughter asked me: “Daddy buy me chips.” Where am I going to get the money to buy chips? Look in my wallet it is empty, empty. An older person like me. It is not easy.’
During this account, Garian uses a number of strategies to create and project an impression of himself as being the victim of unfair treatment from the Home Office. During the interview he opened his wallet and handed it to me, demonstrating that it was empty aside from his ID, on which ‘EMPLOYMENT PROHIBITED’ went alongside a photograph of a more youthful-looking weightier man. Using the scarcity of his belongings as a prop, Garian visually highlights his destitution. By handing over the empty wallet, he connotes that his account is authentic – he has nothing to hide. Taken to its interpretive extreme, this action of physical engagement could also be understood to be making a symbolic moral demand for assistance.

Narratively, too, Garian’s geo-temporal historicisation of his ageing serves multiple functions. He attributes causation, blaming his destitution for his aged appearance, and uses the change in his physical form to evidence the distress that his poverty causes. He draws on his age in way that assists him in demonstrating the difficulties of his life. Thus ageing is constructed as part of a cycle of biosocial decline; destitution in exile has accelerated his ageing, and his agedness is an added burden to his impoverished life in the UK. In this way, age and poverty intersect and perform as symbiotic axes of oppression which co-produce vulnerability.

4.3 Ageing and intersecting identity politics

Analysis thus far has demonstrated that participants’ explanatory models of ageing are rooted in the social processes associated with migration, rather than chronological age. Despite the variety of cultural contexts of participants’ countries of origin, participants’ accounts are united by their tendency to juxtapose the sociality of ageing in homelands against the isolating individualism of life in the UK. This section will build on this. It will
be shown that the conceptualisation of ageing as a social phenomenon was seen across multiple domains of difference, including immigration status, gender and race. Importantly, the biopolitical identity politics associated with these social characteristics appear to contribute to differential experiences of ageing in exile. Exploring this through a frame of intersectionality facilitates observations about ageing and migration, whilst giving the necessary attention to the variation and diversity within these social categories. In this way the analysis is conducted ‘across and beyond difference’ (Nash, 2008, p. 4).

4.3.1 The identity politics of immigration categorisation

The material and social conditions of life in the UK, underpinned by often-insecure immigration status, were the central focus of many participants’ accounts. Participants’ immigration statuses at the time of interview are listed in Table 1; however, migration trajectories were complex and convoluted. Many described how their legal immigration status had changed. This section takes the identity politics of immigration categorisation as its point of departure and examines the narrative of a now-British citizen, Denis. Denis’ account describes the consequences of having his credibility questioned by the Home Office caseworkers, and illustrates the all-encompassing experience of being refused asylum, and thus being categorised as illegitimate. In doing so, this narrative problematises rigid immigration categories and highlights how the identity politics of immigration status sets the parameters for individuals’ everyday lives.

After being detained by the Congolese army for refusing to fight in the conflict, Denis fled his DRC home in 1998. His family paid an agent, who provided him with falsified documents and flew him to Europe.
‘I didn’t even know that I was coming to the UK. I would prefer to go to France because I was speaking French. The decision was made on my behalf by an agent. I was just asked to give photographs. You don’t ask where you’re going. You just keep quiet. The uncle has just managed to deal with the authorities and so on. So they just try and exfiltrate you and you keep quiet. I just assumed that I was going to France.’

Denis

Denis’ account of not being aware of his destination country is striking. This narrative both persuasively conveys the urgency of his escape from the DRC and effectively illustrates his voicelessness in the face of a decision that will have a profound impact on his future. Many people attempting to escape homelands use irregular migration mechanisms, paying agents to supply falsified travel documents that allow travel and entry to European countries. This is explored further in Chapter Six.

On arrival to the UK, Denis applied for refugee status; thus he was initially categorised an asylum seeker. Denis recalled: ‘the Home Office did not believe me’. Because of questions over his credibility, his asylum application was refused. He recounted, in fluent English, how, at the time, he had little English language ability. He did not know anyone in the UK and he was unaware of his right to appeal the asylum refusal. As a result he became destitute and was thus categorised a ‘refused asylum seeker’ ‘irregular migrant’ or ‘illegal immigrant’:

‘I went underground. I was begging for food, especially hanging around Central London, I see a parking officer, I run away from him. I see a policeman - don’t even talk to me about policemen - I’m just hiding and using a travel card to sleep on the buses. I’m not talking about something that happened for one week or one month, [it was] for about 2 years until I found a cleaning job at Piccadilly
Circus in Central London. Normally you would get paid, I think the minimum was £3.75 but they would pay me £1.25. I’ll never forget that. Finally I found somewhere and I could sleep. It was a small room with 10 people inside with bunk beds. Mixed females and males. The smell, ugh it was horrible.’

Denis

Denis’ irregular immigration status left him fearful of authority. He was excluded from mainstream social structures, such as welfare, housing and legal employment. The susceptibility of undocumented migrants in the UK to exploitative or forced labour has been described elsewhere; Denis’ account echoes that literature (Bloch et al., 2014; Bloch and McKay, 2016; Dwyer, 2016; Lewis et al., 2017). The illegal nature of Denis’ employment meant he was vulnerable to multiple forms of exploitation. He told of how his new employer discovered he was street homeless and invited Denis to stay on his sofa. Denis described being in awe of the opulence of the man’s flat, in an affluent part of London, though recounted in horror how he awoke in the night to find his boss attempting to sexually assault him.

In parallel, access to the labour market exposes Denis to other irregular migrant workers. This network, a form of social capital, eventually led him to become aware of his right to legal aid. As a result, he entered into a lengthy legal process appealing the Home Office refusal. Nine years after he first arrived in the UK, Denis was recognised as a refugee by the British state. He described how immigration status provided a foundation on which he was able to begin to build his life in the UK:

‘Finally I was granted asylum in the UK. That was in 2007. Then life was definitely better, I was smiling ... I kept carrying my trauma but it was definitely better. Number one, being assured that nobody is going to stop you and put you on the next plane to Congo. That was my biggest fear. Isn’t it funny, even today I’ve applied for my
citizenship. I have gone through all of the citizenship tests and I'm now a British citizen, sometimes I still think “this is just on paper, it's just technical and I'm still like...” but it's become that much better. I feel much safer that no-one is going to put me back on a plane. So later on as I say socially and economically that I found that life was even more challenging and more difficult, but the basics were there. And the basics was having indefinite leave to remain in the UK ... like a strong foundation for everything else.”

Denis

Despite now being a British citizen, a Masters Graduate, a Father and a Husband, Denis still alludes to a persistent sense of vulnerability and fear, and refers to the portability of his trauma. This becomes particularly evident when his usually-free flowing, eloquent speech, tails off. Here, rather than what is verbalised, it is what is left unsaid that is important. Denis appears unable to describe the feeling of insecurity he lives with. Although he says he feels safer, he never states that he feels safe. The pervasiveness of his unease is likely rooted in the initial erosion of his credibility, and consequent protracted legal irregularity, on arrival to the UK.

This overview of Denis’ migration trajectory draws attention to the slippery nature of immigration categories. It disrupts normative assumptions about the neat delineations between those deserving and undeserving of support. This empirical data echoes existing literature and shows how individuals can move, and be moved, between immigration categories independently of their eligibility for protection under the Geneva Convention (Düvell and Jordan, 2002; Koser, 2010; Bloch, 2014). Thus it adds weight to academic arguments that suggest current immigration categories fail to reflect real-world contemporary migratory patterns (Moncrieffe and Eyben, 2007; Collyer and de Haas, 2012).
More broadly, this empirical data problematises the principle of categorising individuals for governmental purposes (Zetter, 2007; Scherschel, 2011). Denis’ account illustrates how identity politics result in the production of social, economic and sexual vulnerabilities. This is achieved through a biopolitical system of immigration categorisation based on the paradigm of crimmigration, which serves to include certain individuals only through their exclusion from particular rights and eligibilities. Thus, Denis’ experiences draw attention to how the asylum apparatus provides a vehicle through which structural violence both operates, and is legitimised.

Although immigration categorisation dominated many participants’ stories of ageing in exile, it was not the only social characteristic of importance. Gender, race and employment status were also significant. Understood though the paradigm of identity politics, these social categories can be considered as forms of differentiation, though which structural violence can operate. The following sections will consider these features in turn, and, through narrative analysis, will explore how intersecting structural violences perform to proffer unique privileges and disadvantages to older asylum seekers.

4.3.2 Gendered experiences of ageing in exile

Of the 21 participants interviewed, only five were women. Many of the participants described the gendered dimensions of migration. Rohat, a 65-year-old Kurdish Syrian refugee, fled Syria for the UK in 2007 after being detained by the Assad regime. He spoke about his son, who travelled alone from Syria:

‘Now he has got his status he has brought his wife so we are happy that they are here, she is like my daughter I can hug her and when I
hug him and he's like I'm hugging all of my children ... I'm so happy that he is here and with his wife that is a big change in my life.’

Rohat

Daran, a 46 year-old agricultural worker, fled Syria due to the conflict there:

‘[I came] by an agent, in a lorry, in a big boat. Italy, then from Italy to France. Then, from France to the UK ... my family help me to pay for it because it was very expensive, eleven to twelve thousand Euros ... One year after I came here I took my status. It took time ... After 1 year they have sent a letter. And after 8 months my family came to me here. I have done family reunion ... legally through the family reunion ... it took around two years until I have my wife and children here.’

Daran

These accounts typified the migration stories of participants from Syria, where men frequently risk the costly and perilous land and sea crossings alone then apply for family reunification for their wives after securing refugee status. The reunification process, however, is not always straightforward:

‘His family is still there. Hasn’t done family reunion for his family ... It needs a lot of money to get his family from Eritrea to Sudan and for them to provide the documents. He is from Eritrea. His wife must go out from Eritrea to Sudan to apply’

Hina, explaining a conversation she was having with Mohammed.

However, the gendered reality of asylum is more complex than the statistical data, described in Chapter Three, and these excerpts suggest.
Age- and gender-specific statistics from the Home Office suggest that as age increases, gender differences in asylum applications diminish.

Table 3: Number of main asylum applicants to UK in 2016 by age

<table>
<thead>
<tr>
<th>Age range</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-49</td>
<td>1994</td>
<td>912</td>
</tr>
<tr>
<td>50-59</td>
<td>593</td>
<td>388</td>
</tr>
<tr>
<td>60-64</td>
<td>131</td>
<td>107</td>
</tr>
<tr>
<td>65+</td>
<td>166</td>
<td>168</td>
</tr>
<tr>
<td>Total percentage</td>
<td>65%</td>
<td>35%</td>
</tr>
</tbody>
</table>

(adapted from The Migration Observatory, 2017)

Table 3 shows that although the total proportion of male asylum applicants is higher, after the age of 60 gender differences are minimal. Although some organisations in Greater Manchester specifically focus on female migrants, older women were less visible in the VCO spaces used for recruitment. Male participants suggested how patriarchal social norms encourage women to remain at home, whilst men attend the VCO:

‘In our country we say home is for wife … She stays all the time at home, so it is hers, so she has to be happy.’

Rohat

Research highlights the specific oppressions faced by migrant women, such as high rates of sexual violence (Boersma, 2003; Rogstad and Dale, 2004; Steel et al., 2004; Bradley and Tawfiq, 2006). Taken together, these dynamics may represent a cycle of exclusion and segregation, which maintains existing patriarchal dynamics and creates an invisibility of migrant women to some VCOs.
Rather than being solely a quantitative phenomenon, narrative analysis suggested gender identities resulted in differential experiences of ageing in exile. Men and women conceptualised their experiences of ageing based on gendered norms and expectations; this intersected with the identity politics of immigration categorisation. Some participants described how ageing masculinities offered social advantages. The excerpt below is taken from a longer discussion about Ahmed’s experiences socialising in VCOs and asylum accommodation in the UK:

‘If there is any problem between asylum seekers in the area or in the place, you know they are mentally unwell, they're angry. They have anger issues and anxious, but they respect me as an old man. At the garden [Allotment Project] there was a problem between two ladies. One young and one old, and because I am an old man I got involved because they respect me and respect my age. And I got involved in they stopped arguing. Another time I was living in a shared house in Hull. The people in the accommodation were applying for a fresh claim, and so they were sharing accommodation with me. It's like the people you have seen in the garden, different cultures, different countries you know. They have the right to drink alcohol and to eat non-halal food … they had girlfriends. One of them they were selling drugs, but it's not my problem. I'm not police because I can see British people they come and buy from them. They have been fighting once, and one of the girls she was pregnant. So I took her out because they do party in the living room but I’m away from this … And one of the young men said “if I give you one punch you will die, because you are an old man, but I respect you because you are an old man.”’

Ahmed
In this data, Ahmed’s convoluted narrative draws on two occasions where age and gender have intersected to afford him a sense of social capital. Ahmed articulates these stories using a narrative arc structure.\(^\text{70}\) In the exposition he creates a sense of chaos and lawlessness. This climaxes to conflict; although not directly involved in either conflict Ahmed was witness to them both. The narrative’s resolution is realised when Ahmed’s capabilities as a mediator result in the assistance of the women and the restoration of order. The excerpt ends with Ahmed describing the younger man’s reference to his physical vulnerability. Jaji (2009) describes how displacement disrupts certain African men’s ability to conform to gendered norms. She describes how male refugees discursively create new forms of masculinity. The respect proffered by his status of ‘old man’ means Ahmed is assured protection, which paradoxically illustrates the social capital his gendered age provides. Understood in the context of Jaji’s work, this paradox could be taken to represent a ‘new form’ of masculinity.

Dikembe also speaks about the benefits of being considered an ‘old man’:

“To feel old it is a privilege. Because not everybody will be old. To be old is an honour. Not everybody will be that age. Other people die young, and then when you are old for us, as a Christian we say thank you god ... I would like to look old ... it is the culture. In Africa when you say “old man” that means wise man. It is different because the people like to be called old man.”

Dikembe

Dikembe is thankful for his longevity, and although he does not yet consider himself old, he constructs ageing and agedness as desirable. Unlike others, who conceptualise aged appearances as a deficit and as

\(^{70}\) Typically, a narrative arc is made up of the following components: exposition, rising action, climax, falling action, and resolution (Ryan, 2009).
evidence of mistreatment, for Dikembe looking old is coveted, as this image confers wisdom.

Dikembe and Ahmed’s positive conceptualisations of aged masculinities may have roots in the patriarchal, and often-tribal, societal norms in the DRC and Kuwait, their countries of origin. Although there are no identified studies examining the gendered shape of ageing in Southern Africa or the Middle-East, societal patriarchy is well described in both regions. In conflict-ridden DRC, scholars interested in gender have focused, arguably to the point of preoccupation, on militarised masculinities and sexual violence (Baaz and Stern, 2009; Meger, 2010, 2012; Cudworth, 2013). Sexist attitudes to roles and rights of women and girls are also prevalent across North Africa and the Middle-East, particularly in older people; Ahmed’s Bedoon culture, which favours polygamy for men, is particularly patriarchal (T trereault and Al-Mughni, 1995; Al-Maseb and Julia, 2007; Moghadam, 2007; Feki et al., 2017). Interestingly, Ahmed feels the esteem towards his masculinity translated into migrant spaces in the UK.

Many of the participants living in shared Home Office accommodation expressed how being the only older resident made them stand out. Bondeko told of how younger male asylum seekers nicknamed him ‘boss man’ due to his age. A female-equivalent of this revered ‘old man’ did not emerge from the data. Instead, women’s narratives tended to centre on the difficulties of being an older female migrant:

‘[The accommodation] is just a room. The rest of them are young ladies. I am the old one because I’m 63, 64. I am old. I am 64 … I just look at my body and my body is like. The doctor is giving me cream. It is white stuff, because my skin is dry. I have dry skin … I don’t know. I feel like I don’t dress properly. Just now I just go to the shops even in nightmare. I just think I am useless; I am just waiting to die. When I came here I was 49 now I am 64.’
Nyasha, a refused asylum seeker from Zimbabwe, was often teary during the interview. Like Garian and Abdul, she describes her bodily signs of ageing. She suggests how these observable characteristics, such as dry skin, visibly differentiate her from the younger asylum seekers she lives with. She sees herself as old at 64, and her narrative associates agedness with hopelessness, desperation and a proximity to death.

Aneni, a 54 year-old refused and destitute asylum seeker, initially came to the UK on a working visa and then applied for asylum when her personal situation changed. She has appealed the Home Office refusal multiple times, but told of how her autobiographical testimony, which outlines the reasons she cannot return to her native Zimbabwe, has been discredited. Aneni’s age meant she felt isolated and unsupported by other asylum seekers:

“When you are over 50 you don’t see many in that age group. Most of them are in their 20s and it makes you not feel good being amongst young people. Young girls who were young enough to be your own daughter. Like in a shared accommodation I’m a 54 year old now, the rest are 25. If I was with people similar to my own age they could understand me, understand my hardships as well.’

Aneni

Unlike Bondeko, neither Nyasha nor Aneni report feeling valued by younger asylum seekers on account of their age. Age is instead constructed as a barrier between the females and appears to enhance the loneliness and isolation felt by the older women. Feelings of loss of utility and lack of

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71 Although Aneni did disclose her reasons for seeking asylum at interview, she stated she did not want this information to be included in the research
confidence were also reported by Aneni, rooted in gendered challenging life experiences, and associated with age:

‘It impacts as well, like me, I do not behave like a 54 year old because my confidence has been knocked off ... I have a different experience to the younger people. Most of them, like the young girls, they haven’t gone through a lot yet, apart from the whole asylum system, unlike me. I’ve been through a lot. Abusive marriages. I had so many abusive marriages. My first husband was abusive. My second one was abusive. Before I even came here I was already messed up. The young girls have no kids behind. When you are older you have much more priorities. Like thinking about the kids that you’ve left. I don’t even want to think about them, because I first start thinking of them ... to start with I don’t even know if they’re alive and I don’t want to start thinking about them... what if I hear that one is dead? How will I handle that? I'm already in a mess right now.’

Aneni

In this narrative arc, Aneni uses her age to differentiate herself from the younger women. She develops the exposition by suggesting her gender-specific experiences intersect with her agedness and exile to place her in a unique position of disadvantage. During the interview Aneni described not wanting to talk about her marriages and children; yet, in this arc, she pluralises her experiences of domestic violence. Despite its opaqueness, this pluralisation effectively cumulatively layers the particular challenges she has faced over her life-course, and shows how these are compounded by her estrangement from her children. At the climax of the arc, she speculates about their whereabouts and wellbeing. In the resolution she illustrates her vulnerability, suggesting she is unable to think about her children. Aneni’s description of her inability to mother narratively illustrates the profound incapacity caused by her difficult life experiences.
These narratives also suggest ageing in precarious exile can disrupt the ability to conform to age and gendered specific social expectations: ‘I do not behave like a 54 year old’ and ‘I feel like I don’t dress properly’. In this way, for some of the older women interviewed, exile threatens normative ideas of ageing femininities.

Although Dikembe and Ahmed suggest patriarchal social norms may offer men some mitigation for the stressors of ageing in exile, other accounts reify the feminist adage that patriarchy also oppresses men. Social imaginaries of displaced people often centre around ideas of vulnerability and femininity; deserving asylum seekers are often portrayed as women or children and dominant masculinities are in tension with normative assumptions of credible and legitimate asylum seekers (Griffiths, 2015; Stivens, 2018). Islamic extremism has provided a fertile ground on which younger male asylum seekers can be framed as a security threat by media and politicians; 89% of immigration detainees in the UK were men in 2017 (Crisp, 2017; Dearden, 2018; Refugee Council, 2018a). Foreign masculinities are also represented as a sexual threat; sexual harassment is a dominant theme in news articles about asylum seekers in the UK and Finland (Sumuvuori and Vahasoyrinki, 2016). Men are portrayed as an economic threat, with populist Nigel Farage declaring ‘most people aren’t refugees, they’re young males, effectively economic migrants’ (Slack and Ledwith, 2016; Worrall, 2017). In these discourses of security, sexuality and economics, demographics alone appear to undermine the credibility of asylum applicants. Consequently, patriarchal dynamics are subverted and dominant masculinities are weaponised against particular masculine subjects, so as to highlight their undesirability.

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72 This is an idea which is globally pervasive; Canada’s Prime Minister Justin Trudeau has been praised for accepting 25,000 Syrian refugees, however this programme excluded single males on the basis of security concerns (Barton, 2015).
Through his interview Denis regularly reflected on the time before his immigration status was secured:

‘I felt extremely powerless, extremely. To everybody, to anyone, to everything. At some point I was like “why did I come here?” Because the reasoning was that I would be safe, or at least safer here, but then I started questioning myself: “What was the point coming here?” Because I'm, well I’m not going to say was more frightened than the other side, but I was as frightened ... talking about this brings, I mean I like to think about myself as a mature person, and I'm very strong. Like in Africa we say a man is like a lion, he never cries. But inside of myself I cried quite a lot, and maybe after the interview when I leave you I might cry. But in front of Doctor Louise I need to compose myself. But it's not an African man’s DNA to start crying. It's still extremely difficult though.’

Denis

Denis describes the traditional expectations of a man to be ‘like a lion’, a dominant wild animal and contrasts this against his feelings of powerlessness and emotion. His reference to ‘an African man’s DNA’ can be understood to evoke notions of an imagined African-ness, and suggest that the vulnerability and powerlessness experienced in the UK challenges both his gender and his heritage.

Francis, 58, is originally from Cameroon. Following a period of detention and torture there, he fled in 2010 and has lived in the UK since. He has had claims, and subsequent appeals, for asylum refused by the Home Office multiple times, and is thus prohibited from employment. Like Denis, he associated notions of strength and power to masculinity:

‘I need to be strong to open the company. I need to open a company to prove to the Home Office here that I am a big man.’
Francis articulates a desire to demonstrate masculinity economically. Literature suggests African masculinities are often accomplished through social practices, particularly employment and financial independence (Mahalik et al., 2006; Mfecane, 2018). Francis’ exclusion from the labour market means he is unable to meet these patriarchal expectations, thus the identity politics of gender and asylum intersect to produce particular experiences, challenges and desperations.

At the time of Bondeko’s interview he had been awaiting the decision about his asylum application from the Home Office for over two years:

‘What I'm facing now I'm getting older and older. I came here I was 44. Soon I'll be 47. That means I'm losing youth and yeah I'm losing strength. I'm losing force. I can't stay like this for 5 years and 10 years and do nothing. That means I'm not going to build my future. I have nothing. That's my fear. It's a real fear.’

Bondeko

In this excerpt Bondeko describes how advancing age makes him feel that his time to create a secure financial future is running out. Bloch et al. (2014) describe how irregular immigration status can leave younger migrants ‘frozen in the present’ (p. 151). Bondeko’s account builds on this, suggesting that age intersects with gender and immigration status to create a sense of urgency to his waiting. In the context of exclusionary identity politics and intersecting structural violences, ageing was often narrated in reference to impending powerlessness and vulnerability, and was thus evocative of threats to masculine social practices. Six months after his interview Bondeko’s claim for asylum was refused.
Garian narrated his experiences of destitution around a discussion of his gendered family role:

‘I’m feeling bad because, me, I am a man. Just give me a chance for work. I have a daughter. She no go on holiday. She said “Daddy when I go on holiday?” I am here 15 years. No income support. No house. But I have a daughter. She is 10 years ... They keep me in this country for 15 years. People who live here need to have money, maybe transport. I am not working. Where am I going to get money from to come? It is not fair. I am feeling bad.’

Garian

Garian can be understood to utilise his masculinity and the traditional cultural norms of a man as a financial provider as part of his narrative negotiation of the unjustness of his socio-political marginalisation. Like Bondeko, age appeared to augment the gravity of Garian’s precariousness:

‘[Age] seriously it is important. Because when you are young people is working ... When you are older you lose your strong. This time for me I need to think for my daughter when I come old. Now I am strong, when I go to work, I will go to work. I will manage. But later I will not be able to manage. I’m worried about getting older. Because when I’m getting older I’m not going to be strong like today.’

Garian

In these narratives, economic resilience and financial stability emerges as a facet of strength. Power is associated with masculinity and is threatened by feared imaginaries of ageing. Makoni (2008) highlights how, in some African cultures, at increasing ages gender is not binary; instead multiple gendered identities are drawn on, which are constructed around social experiences of ageing, including father and grandfather. During the
interview, much of Garian’s narrative focussed on fatherhood. Specifically he articulated how he grappled with the social norms tethered to his role of father. For Garian his ageing fatherhood was associated with an expectation to financially support his daughter, yet his immigration status prevented him from doing so. Critical examination of media and popular narratives, as well as analysis of the lived experiences of the older men interviewed, demonstrates how hostile social environments can subvert patriarchal norms and intersect with ageing in exile to bring unique challenges to ageing dominant masculinities.

4.3.3 Racism

In addition to ageing, gender and immigration status, issues of race and racism emerged as an unanticipated yet important trope from the intersectional analysis. Racism is defined as ‘a system (consisting of structures, policies, practices, and norms) that structures opportunity and assigns value based on phenotype, or the way people look’ (Jones, 2002, p. 9). As a result, certain individuals and communities are afforded unfair advantage, whilst others are disadvantaged (Wallace et al., 2016). A small number73 of the participants described being racially abused in the UK:

‘I remember at some point I lived in Blackley in Manchester when I just arrived in Manchester because they kept moving us. They sent me to Salford, Eccles and so on and then I found a house in Blackley, and there was this young people these children who shouted “you smelly African. It is not because they call it Blackley that we want black Monkeys here. Go back to your country. Not because that we call it Blackley that we want black smelly Africans here.”’

Denis

73 Although stories of overt racism were not dominant in the data, their poignancy means they warrant attention in this analysis.
‘Sometimes when you are passing some naughty boy on the car is speeding just shout “black black” I say “yes”. Anyway I am black and I’m proud to be black ... I know many people hate immigration they put you all in the same package. And some people they can’t hold themselves, they show it. What is even worse, on the bus it is worse. The bus can be full and you will stay alone.’

Bondeko

Bondeko and Denis both remembered the emotional distress this abuse caused. Bondeko recounted how it made him ‘feel so down, it really touched me’. Denis described: ‘Okay I’m a smelly black African, I am stupid and I was sometimes crying and I thought “all of these sins that I’ve committed, the only thing is being black and being an asylum seeker.”

There have been recent increases in racially motivated hate crimes reported in the UK.74 In these xenophobic hostile contexts, race reifies Denis and Bondeko’s visibility as ‘other’ and racism amplifies their status as outsiders. In these narratives, experiences of racist abuse are articulated alongside feelings of isolation and powerlessness. As well as highlighting the emotional burden of this, their accounts illustrate how racism can intersect with the aforementioned structural violences to subject black asylum applicants to particular challenges and hostilities.75 This is further discussed in Chapter Five.

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74 There has been a 29% increase in police-recorded racially motivated hate crimes in 2016/17 compared with the previous year. Police and crime statisticians suggest this reflects both a real-world increase in racial hostility following the EU referendum and improvements in the way racially aggravated hate crimes are reported and recorded (O’Neill, 2017). Both of the incidents described above were unreported; recent migrants, especially those with insecure immigration status, are less likely to access police services (Bhatia, 2017).

75 An extensive evidence base documents that experiencing racism is associated with poor physical and mental health (Paradies, 2006; Barnes et al., 2008; Gee and Walsemann, 2009; Pascoe and Smart Richman, 2009; Lewis et al., 2013; Adam et al., 2015; Lewis et al., 2015). Exposure to racism cumulatively has been demonstrated to be associated with long term adverse mental health (Wallace at al., 2016).
4.4 Discussion

Older asylum seekers’ and refugees’ experiences of ageing in the UK have not been explored elsewhere in the academic literature. This chapter begins to address this gap through the analysis of participants’ narratives of ageing. The explanatory models of ageing of the older people interviewed were not based on chronological age; rather, ageing was articulated as a social process. Many of the stories of ageing were constructed in relation to accounts of displacement. Migration was seen as a disruption to ageing and homelands were remembered fondly. A mismatch between expectations of growing older in countries of origin and experiences of ageing in exile was evident. Some participants described how they felt life in the UK had resulted in a process of accelerated ageing. In these narratives, exile was constructed as challenging and hostile. Physical signs of agedness evidenced the harshness of the social and material conditions of asylum in the UK.

Dikembe’s observations about individualism and ageing in the UK echo social gerontologists’ commentary on Third Agers’ sociality and consumption (Gilleard and Higgs, 2002). As Gilleard et al. highlight, the degree to which individuals are able to engage with the Third Age as a cultural field is determined by ‘economic resources … and the extent of their socialisation into the cultural practices of a mass consumer society’ (Gilleard et al., 2005, p. 306). For the participants interviewed, the former negates any consideration of the latter. All are in precarious financial positions; the most financially secure relied on welfare support, but many had no recourse to public funds. This analysis highlights how, as well as being gendered, classed and racialised, the ability to capitalise on the liberties of a Third Age is underpinned by biopolitical identity politics. Despite their relatively often-young chronological age and potential to participate socially, participants’ social and economic precarity aligned them more with conceptualisations of the Fourth Age: an “abject” class
whose social realisation is enacted by the institutions of welfare and welfare rationing’ (Gilleard and Higgs, 2010; Gilleard and Higgs, 2018, p. 48). This contributes to an intersectional and cyclical devaluation and dehumanisation; a ‘biopolitics of otherness’ of both ageism and immigration categorisation (Fassin, 2001, 2011).

One of the most striking research findings was the degree to which participants focussed on post-migratory stressors. Although asylum seekers may obtain relative physical security in the UK, they do not necessarily experience ‘a sense of being settled and safe’ (Goldsmith Citizenship Review, 2008, p. 121; Stewart and Mulvey, 2014). In particular, legal immigration status was seen as central to people’s lives. Denis’ story of moving in and out of varying immigration categories problematised the existing normative and legislative frameworks that aim to neatly delineate between those who are in need of protection as refugees and those who are not (Zetter, 2007).76

Denis’ account also illustrated how immigration categorisation works to set the ‘terms on which society should engage with [migrants] in varying contexts and at different points in time’, as well as defining the ways in which migrants can engage with varying social contexts (Moncrieffe and Eyben, 2007, p. 2). Descriptions of life in London sleeping rough and working in exploitative conditions reifies Hacking’s and Jones’ contemplations of how categorisation structures opportunity by ‘changing the space of possibilities for personhood’ (Hacking, 1986, p. 79; Hacking, 2007; Allegories on ‘Race’ and Racism: Camara Jones, 2014). The categorisation of immigrants emerges from this analysis as a form of

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76 The notion that delineating between refugees and migrants is possible, natural and even simple neglects the dynamics of migration and displacement within contemporary geopolitical environments. Many new arrivals to Europe have lived in countries other than that of their birth, often for prolonged periods, before moving on (Crawley and Skleparis, 2017).
identity politics that bureaucratises, and so legitimises, the structural violence and active neglect of certain migrants.

Although undocumentedness as a social process has been described elsewhere, this scholarship has focused on youth (Bloch et al., 2014, Bloch and McKay 2016; Lewis et al., 2017). Using intersectionality as an analytical frame, the empirical data presented in this chapter suggests that the social process of ageing can intersect with precarious migration statuses to augment vulnerability, desperation and suffering. An intersectional framework also draws attention to dynamics of gender and race, and reveals the gendered aspects of social environments in exile to be complex. As well as presenting challenges to traditional social expectations of femininity, whilst revering in aged masculinities, the environment has emasculating tendencies that challenge male asylum seekers’ culturally-rooted normative gender roles. This creates a heightened sense of vulnerability.

Intersectional methodology encourages researchers to recognise neglected social categories, yet in order to begin examining the social world, prioritising certain issues and disregarding others is inevitable. Intersectional researchers are still grappling with these methodological dilemmas, so as to avoid reproducing existing power dynamics (McCall, 2005; Nash, 2008; Byrne, 2015). Intersectional analysis of such rich and complex data generates a chaotic mesh-like model of interlocking social categories and axes of privilege and oppression; the nuanced consideration of each would be an infinite task. Therefore it is not suggested that the structural violences identified in this chapter are the only factors at play77; rather, the dynamics described dominate the analysis, facilitate an

77 Whilst accounts of pre-migration conflict, detention, social class, post-migration diaspora support and family separation did not emerge as dominant ideas from the data, they were discussed by many, and so are likely to represent important additional determinants of participants’ wellbeing.
understanding of how structural violence operates intersectionally, and illustrate how this is lived.

In conclusion, this first empirical chapter has introduced some of the research participants through an exploration of their narratives of ageing in exile. Using the frame of intersectionality assisted in presenting the idiographic qualities of the individuals interviewed, whilst recognising some of their shared experiences. Ageing was both disrupted and accelerated by life in exile and can present particular and additional challenges in an already-precarious social environment. For the vast majority, these challenges were not constructed through fear of biological failure; instead, they were articulated in relation to the inability to occupy particular social roles. The next chapter builds on this analysis, exploring participants’ explanatory models of health, illness and frailty. Here, narratives illustrate how the biopolitical identity politics of immigration categorisation intersects with other structural violences to have a negative impact on health.
Chapter Five

Explanatory models of health, ill-health and frailty

‘I think my health is related to my asylum status.’

Kamal

5.1 Introduction

Existing literature suggests that there are tensions between migrants’ explanatory models of health and hegemonic biomedical models of health. No studies explore the explanatory models of health of asylum seekers and refugees in the UK. This chapter builds on the intersectional analysis in Chapter Four and explores older asylum seekers’ and refugees’ explanatory models of health, ill-health and frailty. Despite some variation between participants, narrative analysis reveals a number of commonalities across the data, both in content and structure. Participants conceptualise health as a multi-domain phenomenon; many describe physical, psychological, social and spiritual dimensions of health. The majority of those interviewed felt their health was poor. Rather than discussing health, ill-health and frailty as an abstraction, participants spoke about particular personal experiences of ill-health.

The analysis in this chapter draws attention to the bi-directional narrative co-construction of stories of health and life. Identifying and describing this bi-directional co-construction shows how narratives of corporeal experience and migratory experience are knitted together in both structure and content. Narratives are co-constructed in that stories about health and life are presented by participants interdependently and in parallel. The co-construction is bi-directional in the way that stories of health and ill-health are punctuated with narratives of lived experience and, equally, stories of
migration experiences are peppered with memories of biological dysfunction. As a result, health emerges as a narrative tool. The narrative phenomenon of bi-directional co-construction in not described in other literature. Narrative analysis shows how these pathographies can be understood to perform as cultural critiques and ‘political forces’, by representing the ‘places where power and weakness become visible’ (Scholes, 1985, p. 11; Sakalys, 2000, p. 1469). Thus, drawing attention to bodily suffering both centralises the significance of the hostile exile environment and illustrates how the biopolitical identity politics of immigration categorisation intersects with other structural violences to have a negative impact on health.

The chapter is divided into three sections. The first explores asylum applicants’ explanatory models of health. Chapter Four showed that the sample is heterogeneous and that participants face multiple and varied intersecting axes of oppression. Yet commonalities were observed across the data. This chapter builds on this idea; analysis suggests participants’ narratives can be understood through the frame of liminality. Building on ideas of illness in later-life, the second section focuses more closely on these stories of liminal lived experience and narratives of illness, critically analysing the content and structure of pathographies. The final section explores participants’ explanatory models of frailty. Despite an impaired cultural translation of the concept, some of the negative connotations of frailty are pervasive. Participants described moments of frailty that are historicised and, like aforementioned understandings of health, are experienced in relation to lived experience.

5.2 The multiple dimensions of health

Originally from Iran, Farhad has lived in the UK since 2008. He sought asylum after fleeing what he described as the ‘Mullah regime’, the Islamic
Republic of Iran. He converted to Christianity in the UK and is estranged from his Iranian wife and has no contact with his two, now adult, children. Farhad joked often throughout the interview, and regularly requested cigarette breaks. Despite being told he was in his mid-seventies by the gatekeeper, he refused to disclose his age, only laughing: ‘I am 21.’ Farhad reported drinking alcohol heavily, spoke passionately and at length about global politics, and called himself a socialist, declaring: ‘I love Jesus, because Jesus is a socialist.’ When asked about what he thought good health was, Farhad quoted a Persian proverb:

Farhad: ‘There is a proverb in my language that says: if your body is healthy then your brain is healthy too.’
LT: ‘Which do you think is more important, the body or the brain?’
Farhad: ‘I think they both depend on each other. Ok if you have a brain but no hand it is a problem. (Laughs).’

Through the proverb, and its more rudimentary interpretation, Farhad draws attention to the idea of a synchronicity between mind and body. This idea was central to many participants’ explanatory models of health. Bondeko too described how good health depended on coeval multi-dimensionality:

‘Good health I mean is two parts. Spiritual, you need to be mentally open and not stressful and not be down, and physically, I mean, you need to eat well and as an asylum seeker I get £35 and sometimes I don’t get what I want.’

Bondeko

Although he divides health into two parts, Bondeko can be understood to identify a number of interconnected health domains, including spiritual, emotional, and physical. Moreover, by stating how his current politico-economic situation limits his ability to achieve physical health, Bondeko
acknowledges the importance of structural environmental factors on his personal health, inferring that the poverty associated with being an asylum seeker limits his ability to achieve good health.

Drawing on his previous vocation, Francis uses metaphor to liken the synchronous relationship between environment, mind and body to a computer system and highlight the importance of these connections:

‘[To be healthy] means to be good. You see I have problem, I have hypertension, I have bipolar, I have leg problems. But all the problems are here (gesticulates towards head). Because when you have a problem with your head it affects everything ... if for one week I don’t take these tablets then I crease. I crease. I cannot sleep if I don’t take this tablet. So it’s very difficult when the Home Office don’t believe you. If the Home Office don’t believe you, but I can’t put my mind in ... The problem is all of this is synchronised. Once things happened here (gesticulates towards head) it’s going to affect here (gesticulates towards body). You know I am an electro-technician. If you have A, B, C, D, E, F, you know you have motherboard. If mother card, first information to A. A is going to communicate information to B. And this is a motherboard (gesticulates towards head). Can you get me now?’

Francis

When asked about what health meant to him, Francis responded by listing his physical complaints. However he clearly communicates, using repetition and metaphor, his belief that the root cause of his physical complaints is his psychological wellbeing. He then goes on to describe how being disbelieved by the Home Office influences this, and thus all, domains of his health. Both the structure and content of Francis’ and Bondeko’s narratives locate the determinants of their multi-domain health in their social and political environment.
Kamal, a 50-year-old Sudanese man, fled conflict in Sudan and arrived in the UK in 2013. He has since had his asylum claim refused and remains estranged from his family, who are still in Sudan. His account of what good health meant to him echoed many of Bondeko, Farhad and Francis’ ideas:

‘I think the body is one. There is no separation between body and mind. All my body is controlled by my mind, all the functioning in my body. I think my health is related to my asylum status, because sometimes you feel like you have no right to live in this country. You have no right to work in this country. You have a family and you are away from your family and this makes you worried, and this affects your life. When I think about my family and I think about my life here, I cannot work, I cannot go to education, I don’t have any right in this country, it makes me very stressed.’

Kamal

Kamal’s account positions the social and political environment at centre stage in the determination of his health. Specifically, he implicates being prohibited from working and family separation for his poor mental health, and suggests that this in turn impacts physical health.

These accounts can be understood to illustrate how the multiple structural violences embedded into the regime of asylum and immigration categorisation can intersect to limit individuals’ ability to fulfil their desired social roles. This enforced impairment of function in turn limits capacity for health. Health was commonly conceptualised by participants with reference to a variety of functions, from the ability to perform and enjoy basic biological functions, such as eating and sleeping; cognitive functions, such as concentration and memory; and the fulfilment of more complex social roles, such as involvement in the labour market and family life. This was articulated bi-directionally. On the one hand, Kamal highlights how
exclusionary asylum policies impose limitations on social functionality, which in turn impairs his health. He thus demonstrates how function can determine health. On the other hand, Denis described health as the ability to ‘fully enjoy your body without limitations’, suggesting that health can explained as an ability to utilise and obtain pleasure from the body as desired. Here, health is a determinant of function.

This bi-directional narrative co-construction between health and function is further illustrated by the narrative of 54 year-old engineer Amraz. Amraz initially came to the UK on a student visa to escape harsh conditions in Iraq following the fall of Saddam Hussain. After the relationship with his academic supervisor broke down, he claimed asylum:

‘Good health means human feeling happily inside. When you eat, you like it, when I eat I don't like it, I only eat because I can't move. When you sleep you like it you enjoy, but when I sleep my eyes are just closed. When I sleep even for a few minutes I see these bad things, it's not healthy. Also means that when you see someone from your country because first, when I saw someone from Iraq I think he knows about my problems, he can help me, but unfortunately no. Now when I see anyone from that country, from that group I can't trust him. I don't like him actually I don't like Arabic countries. I don't like Shia. I don't like Muslims. It means I’m not healthy. But healthy means it when I see and I meet any person it means that I have to love him and respect him. I was famous in my country, kind man helpful, respected, respect others but now I’ve changed to another person. I was healthy, but now I’m not healthy.’

Amraz

Amraz narrates stories of his health in close association to accounts of his lived experiences. He uses an enquiry into health as an avenue through which he describes the interpersonal religious conflicts experienced both in
the UK and in Iraq. He articulates how these conflicts have negatively impacted his health. Despite the particularities of his experiences, Amraz, too, focuses on multiple domains of health, and associates health to function. He suggests that his ill-health results in impaired biological function. Many of the participants described a loss of appetite and sleeplessness, thus stories of biological dysfunction are seen throughout the analysis.

Throughout his interview, Amraz described the social isolation he experienced in the UK. He attributed this both to language difficulties and to the location of his allocated asylum housing on the periphery of Greater Manchester. In this excerpt, Amraz articulates his inability to socialise as both a determinant and reflection of poor health. He stresses the significance of this by contrasting his current social position with his life in Iraq, where his fame and respect meant he was healthy. This narration of the contrast and transformation of migration evokes ideas of nostalgia described in Chapter Four.

The occupation of social roles and social status was a common trope discussed by participants. Bondeko described the difficulties of waiting for nearly three years for his immigration decision, as being categorised an asylum seeker entailed enforced unemployment and consequent poverty. He spoke often about how he missed working as a surgeon:

LT: ‘What are your hopes for the future?’
Bondeko: ‘My dream is to go back to my work. That’s my first dream ... I like my duty. I like helping people. I can’t see being in another job apart from being in the medical field ... I miss it. Like I said from the start it is a vocation it is something that it’s not for money but it’s because of devotion.’
This impacted his emotional health, which in turn caused functional impairment:

‘As a human being waiting desperately it is not easy ... You can start to study but you feel like your mind is not there, you start to think twice ... I feel like not studying. I can cry. They can feel my performance is going down ... I get the news from the British Medical Association every week I will show you, I've not even opened it ... I'm supposed to study to refresh myself but I don't feel like it. I don't even feel like having friends. I feel like being isolated to stay by myself ... I feel withdrawn from the society, because I am stressful and I prefer to stay myself. I know it is not good but even you know if you're a medical doctor, say you are sick, you should not treat yourself. I know it’s not nice to withdrawing myself but that's what I do.’

Bondeo

Although he was enrolled in a professional course aimed at finding employment for medical professionals seeking asylum in the UK, Bondeo described how the uncertainty of his future causes significant psychological distress. As well as impairing his ability to concentrate on vocational learning materials, he suggests this makes him socially withdrawn. This illustrates how the restrictive hostility of the identity politics of immigration in the UK can impact individuals’ health and wellbeing, and thus social and vocational function.

Not all of the participants centralised environmental stressors in their initial discussions on health, however questioning about the barriers to good health often resulted in a discussion about difficult social, political and economic environments. Rohat, 65, a Kurdish Syrian refugee, fled Syria for the UK in 2007:
'I had a problem with the government. They detained me there [Syria]. They tortured me so I ended up at the hospital. Because I had a good relationship with many people in the country, I arranged with the doctor to keep me in the hospital. They kept me, and they put a security guard at the door. I gave them a bribe and I left the hospital, then I ran away from the country and came to the UK.’

Rohat

When asked what good health meant to him, Rohat gave an account underpinned by ideas of spirituality that acknowledged the importance of emotional wellbeing, individual health behaviours, and medical therapy:

‘First of all health is from God. It is the happiest person who has good health. So we have to look after ourselves. Like me for example I am diabetic, so I can’t eat sweet for example otherwise that will affect my health, like I can’t walk a lot, because I can’t. I can’t. So I have to look after my food. I have to follow my doctor’s prescriptions as well, and that’s it.’

Rohat

Rohat appears to believe that god gives health, whilst simultaneously suggesting that health is linked to happiness and self-care. He infers that by regulating his diet and complying with medical treatment, he is honouring god. Moreover, through his description of his physical limitations as a proxy for ill-health, Rohat echoes Amraz and Bondeko’s earlier ideas of functional ability as a proxy for health status. When asked about the factors that prevented him achieving good health, Rohat became teary:

LT: ‘Is there anything getting in the way of your good health?’
Rohat: ‘For example I can’t go to Syria, my kids are there. I talk to them on the telephone. (Starts to cry). Three days ago one of my grandsons, he said: “Please please please Grandpa I want to see
you. Just to see you.” What do you think about your health in this situation? What can I tell this child? He is 14. He needs his Grandad. When I left he was four or five. I haven’t seen him since then. I didn’t hug him as a Grandpa.’

Here, Rohat builds on his earlier explanatory model of health. He emotively articulates how his suffering is intractably linked to his exile and family separation. As with Garian’s ideas about fatherhood, for Rohat, the social role of ‘grandfather’ emerges as a central determinant of his wellbeing.

5.3 Protracted liminality

As has been described, the participants interviewed were diverse; their varied countries of origin, migration trajectories and ages meant they were subject to myriad intersecting structural oppressions. However the majority felt their health was poor. When asked about the meaning of health, rather than referring to health as an abstraction, participants spoke about particular personal experiences of ill-health. Specifically, pathographies were intertwined with narratives of social, political and economic life in the UK; the extent to which participants focused on post-migratory stressors was striking. Despite the often-varied subject matter, many of the stories told evoked the idea of liminality. Accounts illustrate how life in exile is precarious, suspended and uncertain, underpinned by often-insecure immigration statuses. New arrivals applying for asylum in the UK are facing increasingly protracted waiting times for Home Office decisions on asylum applications. In 2017, nearly half (10,552) waited over 6 months, an increase of 39% per cent on 2016 (Home Office, 2017). Many of the participants waited much longer:

‘Soon it is 3 years and I don’t have an answer … I thought they maybe have forgotten me, but they move me house to another
house, which means that they still know that I’m here. I went to my lawyer and ask for work permit. Until now I don’t have an answer. I went to my MP twice and he write to them and they answered, which means that they know that I am here. They never say no that means they ignore me. That means that I am one of those whose papers fall on the floor. And as a human being waiting desperately it is not easy ... we want to work and we are still living with £35 a week. I’m someone who is an active person. I like moving and really, sitting, not knowing what is going to come to you, really it's like a punishment to me. It's a real punishment. I'm feeling like I am in a prison.’

Bondeko

Bondeko’s account suggests that occupying the social category of asylum seeker for such a prolonged period of time causes him to feel ignored and forgotten. He spoke about his uncertain future passively, giving the impression that the lack of agency and the unknown temporality makes him feel as if he is being punished and imprisoned. Bondeko refers to the Home Office as ‘they’. By using the third-person personal pronoun, he humanises the Home Office. This allows him to speculate about the state’s moral reasoning and rationality, and attempt to make sense of his accommodation change and protracted waiting time. Despite taking steps to expedite the decision-making process, he still receives no response from the Home Office; this appears to augment his frustration at being left in in limbo. Six months after his interview, Bondeko’s asylum claim was refused. 8 of the 20 other participants were also categorised refused asylum seekers. Of those, the average (mean) time spent in the UK without refugee status was 12 years. This quantitative data illustrates the protracted nature of this form of liminality (Table 4).
Table 4: Date of arrival in UK and countries of origin of refused asylum seekers interviewed

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Arrival</th>
<th>Country of origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Francis</td>
<td>2010</td>
<td>Cameroon</td>
</tr>
<tr>
<td>Farhad</td>
<td>2008</td>
<td>Iran</td>
</tr>
<tr>
<td>Garian</td>
<td>2002</td>
<td>Liberia</td>
</tr>
<tr>
<td>Nyasha</td>
<td>2002</td>
<td>Zimbabwe</td>
</tr>
<tr>
<td>Aneni</td>
<td>2002</td>
<td>Zimbabwe</td>
</tr>
<tr>
<td>Ahmed</td>
<td>2008</td>
<td>Kuwait</td>
</tr>
<tr>
<td>Julie</td>
<td>2004</td>
<td>Malawi</td>
</tr>
<tr>
<td>Kamal</td>
<td>2014</td>
<td>Sudan</td>
</tr>
</tbody>
</table>

Kamal told of how his immigration status impacted his daily life:

‘It affects you day to day because your life now it has stopped. Now your life is on pause. Your life is not going on. You cannot work, I can't work. I need money for me and my family and I can't work. I need to go to education, I need to educate myself. I need to have skills, to acquire new skills. I need to have a bank account, I need to have a car licence, I need to have anything, so I can't. I can't do that.’

Kamal

Kamal’s story echoes Denis’ descriptions of his time spent as a refused asylum seeker before being recognised as a refugee. He describes his life as being on pause; despite fleeing from persecution in his native Sudan, Kamal’s insecure immigration status limits his access to basic entitlements and means he is unable to begin to build a new life in the UK. By setting the parameters for his possibilities, the apparatus of borders in everyday life includes Kamal only by his exclusion (Agamben, 1998). As a result, Kamal is suspended in a social space of ambiguity.
Although immigration status emerged as a dominant theme when considering how identity politics operates, it was not the only characteristic through which structural violence can be understood to be exercised. Unemployment and associated poverty was not solely an issue faced by those without access to legal employment; none of the participants interviewed were involved in the regular labour market. Many of those interviewed expressed frustrations surrounding their unemployment:

‘I don’t know how to start my life in this country. How can I start? What can I do? I wish I can have a job or do something. Nothing. Whenever I ask anyone to do a business or a project or whatever, they say: “Have you got English? No? Sorry we can’t”’

Hafiz

‘I've worked a lot in my life, I feel really tired. You know agriculture is a very hard job. Here I cannot find a job that matches my job in Syria. Here they don't look at your qualification to match you with your work, they just say go and work anywhere.’

Daran

‘Maybe they don't give me a job because of my age.’

Dikembe

‘Being older changes things, I think now they can say: “you cannot work here anymore”. I was working before. I was doing care before and I really enjoyed it ... I used to love it they were so interesting they were fun they were nice people.’

Nyasha
In these narratives, unemployment intersects with age, immigration status, language, class, and gender, and emerges as a further dimension through which individuals are positioned in a liminal space. This builds on the findings in Chapter Four; social characteristics appear to provide a way for structural violence to operate intersectionally.

Although the time and location of the study recruitment likely excluded employed individuals, high unemployment amongst refugees has been described elsewhere. This has been attributed to English language ability, the scarcity of UK-based work experience and the failure of many institutions to recognise qualifications from abroad (Lewis et al., 2017). However, this literature frequently overlooks issues of structural racism. Dikembe graduated from a British University with a Masters in social work. He has applied for jobs for a number of years and spoke at length about the difficulties of finding employment. He suggested racism played a significant part in this struggle:

‘I have a problem with employment. I have waited for years, applying, applying. My children have all finished University and they don’t get a job. If they do get a job then it’s not in the course that they did, it’s not in their field ... Sometimes when I apply for a job they say “okay then we can do an interview on the phone” and then when they hear my accent is not a English one that automatically they means there is a discrimination ... don’t think because I’m black I can’t do anything. I was helping many people at University, I remember even white people! I was helping them to do assignments or whatever but now everybody has got a job and me I cannot get a job, that’s discrimination ... It affects me a lot because now I’m thinking the England is my home, and I think and I feel that this is my home, but if it is my home they don’t treat me like it is my home ... in England they make that difference they talk about refugee even if I’m here for 20 years or 30 years. They are still calling me a
refugee. Why are they still calling me a refugee when I refuse my nationality and I have chosen to be British? Even if I go to apply for a job, the first question that they ask somebody if I'm black: “Are you a refugee?”... Me I am talking as a black. It can be 3 or 4. Security are black. Cleaners are black. Carers are black, or support workers are black. Did you see someone just sitting in an office? No all of the office is for white people. Maybe if you see a black than that black is an underdog ... they say in Africa we have dictators but here this is a slavery ... there is many racism but you can't just say that is particularly that.’

Dikembe

This excerpt is taken from a longer narrative about the racial discrimination Dikembe is subject to in the UK, and his resultant unemployment. By describing how ‘in England they make that difference’ he alludes to the artificial ascription of difference despite capabilities. Although he is legally able to work, his narrative highlights the paradoxically pervasive yet intangible nature of both racism and the identity politics of immigration categorisation. For Dikembe, the two intersect and position him liminally, despite his status as a British Citizen.

Dikembe felt strongly that racism impacted his ability to find employment as a social worker. A large evidence base supports his assertions about structural and institutional racism. In the UK, evidence from Rooth (2010) suggested that applicants with foreign-sounding names are less likely to be invited to interview than their white-sounding counterparts; the Department for Work and Pensions (2017) showed that black people are more likely to be unemployed than white; and data from the Office for National Statistics (2016) shows black households tend to be the poorest in the UK and proportionately few black people occupy top positions within UK organisations. These trends disproportionately affect women of colour, in a phenomenon that can be understood as quantitative evidence of
intersectionality (Booth, Leigh and Varganova, 2012). This section has demonstrated how experiences of liminality are experienced across multiple domains. The next section shows how these narratives of liminality are intertwined with pathographies.

5.4 Bi-directional narrative co-construction: Pathographies and liminal experience

Pathographies, or illness stories, can provide ‘powerful means for communicating and giving meaning to experience’ (Mattingly and Garro, 1994, p. 771; Sakalys, 2000). Many of the participants shared pathographies in which accounts of liminality dominated; illness stories drew attention to the deficiencies of the social and political world. Hassan, a 76 year-old Syrian refugee, fled his home with his 74 year-old wife after war broke out in 2015. When speaking about his life in Syria, he reflected nostalgically on his previous career and a time of prosperity, disrupted by conflict. Hassan travelled to the UK on a tourist visa to stay with his daughter and was told that he should apply for asylum in order to secure his immigration status in the UK:

‘[In Syria] I have been on a pension. I studied at the School of Education. I have finished there. I studied Arabic literature ... My situation in Syria was very good. We were living a very quiet life, a very calm life. But because of the war, and because of the killing in Syria, we started the process you know as asylum seekers. And then we started to have problems, like torture, you know mental torture.’

Hassan

A few days prior to the interview Hassan had moved into a new flat, with which he was very happy. However the majority of Hassan’s narrative of his life in the UK focused on his housing and homelessness. Enquiries about
his health often led to stories about frequent enforced moves between sub-standard asylum accommodation across Greater Manchester and periods of time he and his wife spent street-homeless:

‘My health is worse. Much worse, because I have spent a long time unhappy here. From the first house to the hotel and then I was homeless ... Because of what happened to me here my health got affected. Before I had stroke. And now I started to feel like my body shake a lot and I still take medicines. I feel like my health has changed ... Because of the anxiety and stress, my body started to shake whilst walking in the street. My memory has become terrible. I can't even remember one word if I start to study. You know I’ve been a teacher, but I feel my body is very weak now. I told my kids yesterday I’ve lost 30% of my health. It's a drop down, that’s my feeling.’

Hassan

Hassan’s pathography functions as a ‘cultural and political critique’ (Sakalys, 2000, p. 1470). He both makes this explicit in the content of his narrative – ‘because of what happened to me here my health got affected’ - and allows it to be implied through the structure of the narrative. Although Hassan suffered a stroke whilst in Syria, he articulates the symptoms of his weakness in a way that temporally associates the stroke with his time in the UK. Specifically, he locates the change in his health with particular accommodation difficulties. He quantifies this numerically and, like Bondeko, alludes to a transformation in selfhood, realised through a loss of the cognitive functional capacity that underpinned his professional life. Hassan uses questions about health to describe the lived experiences he sees as significant and, as a result, draws attention to the harshness of life in exile in the UK. He continued:
'I went to the GP at the homeless place two days before I moved to that house ... When he examines me he said “I have to call the ambulance for you right now and you have to go to the hospital now”. So I stayed 10 days in the hospital.’

Hassan

Again Hassan narrates his hospitalisation, which resulted in the insertion of a cardiac pacemaker for a slow heart rate, against the timeline of a change in accommodation. Accounts of memory loss, biological dysfunction and healthcare encounters are intertwined with stories of housing, homelessness and immigration bureaucracy throughout his narrative:

LT: ‘So the main thing that affected your health is your accommodation?’

Hassan: ‘That’s it yeah, that’s right. I wasn’t stable, and so mentally I was really unwell, and my wife was crying all the time.’

LT: ‘How do you see good health? What do you think we need to have to have good health?’

Hassan: ‘I don’t want anything. I think that the accommodation is going to help me a lot and to be honest Britain help me a lot, a lot. The people are very nice here with me ... I’m very happy now with my new accommodation.’

Health is explicitly correlated to accommodation in Hassan’s narrative; not only does poor accommodation and homelessness result in poor health, good accommodation helps achieve good health.

Many of the participants described experiences of sub-standard accommodation, findings which are in keeping with concerns of asylum advocacy groups and academics alike (Papadopoulos et al., 2004; Palmer and Ward, 2007; Darling, 2009; 2011). When asked where he lived, Francis told me: ‘I live in Farnworth. It was raining inside but they took me off to
Blackpool and they repair it. No problem.’ Francis’ seeming indifference with this was exceptional amongst the narratives; more often participants were indignant about their housing. Housing entitlement is determined by immigration status. Although all migrant groups are at risk of homelessness, those with refused claims are more likely to experience street-homelessness (Allsopp et al., 2014). 10 of the 21 people interviewed had been street-homeless in the UK. As well as being a highly prevalent issue, homelessness as a social happening imbued a sense of profound desperation for the older participants interviewed. Insecure accommodation and homelessness is necessarily a liminal experience; in many ways, homelessness can be considered a materialisation of the sharpest end of social liminality (Baumohl, 1996; Hynes, 2011). Following several refused asylum applications Farhad spent years living in destitution, often street-homeless. When asked about his health, he described a recent eye infection:

‘I'm going to doctor last year, my eyes was infection, because I was living outside. I did not have a house or any benefits and so my eyes got an infection, and thanks to God and the doctor and the Royal Bolton Hospital they helped me.’

Farhad

Like Hassan, Farhad uses a pathography as an avenue to describe his homelessness. In this short excerpt ill-health and lived experience are bi-directionally co-constructed. Farhad states that his eyes were infected because he was street homeless, and that because he was street homeless he developed an eye infection. This bi-directionality, coupled with the use of repetition and emphasis, results in a narrative that makes the causal association between homelessness and infection clear. As a result, biological dysfunction and lived experience are closely bound within the narrative and Farhad clearly identifies the driver of his illness.
The bi-directional co-construction of narratives of illness and experiences of social marginalisation was seen throughout the interview data. As well as speaking about lived experiences when asked about health, many of the participants drew on narratives of illness when talking about difficult life experiences. These lived experiences were often linked to migration trajectories and centred around stories of prolonged liminality. Those with refugee status in the UK remembered how their time spent as asylum seekers carried a sense of precariousness and unknown futures:

‘I applied here as an asylum seeker. They kept me for three and a half years without status. This was like a mental torture a lot, a lot, a lot. You see I am disabled. My wife was with me and she was ill. After three and a half years they gave me the status. I am living here since then I have been here for 8 years now.’

Rohat

Rohat’s narrative evokes notions of restriction and suspension; he refers to his wife’s illness in addition to his own disability and tells of feeling ‘kept’ and ‘tortured’. Similar language was found in other participants’ accounts, specifically when describing time spent awaiting decisions about asylum applications. Later in the interview Rohat entered into a lengthy impassioned monologue about his difficult experiences with accommodation and homelessness during his three and a half years as an asylum seeker:

‘No one was helping me at all, at all, at all, no help! They moved me through 10 accommodations. Every 3 months in a different place they say: “you have to leave.” I asked them: “where do I have to go?” They said: “it’s not our problem you have to leave” … they brought me here to Rainbow Haven. They left me here, they took my name, and that’s it. I was ill. Very, very ill.’

Rohat
Rohat’s description temporally and geographically locates his experience of being ‘very, very ill’ at the point where he is ‘left’ in the care of charitable organisation, Rainbow Haven. His story continued with numerous other relocations into sub-standard accommodation, evictions, homelessness and charity support:

‘At the accommodation in Longsight my wife started to cry every day and she was mentally very unwell. She said she wanted to decide to go back to Syria. I told them that we have decided to go back to Syria. She said: “it is war, how are you going to go back there”. I said: “we want to die and we have decided to die there. Better to die there than this life” … She said: “They have refused to send you back to your country, you are not allowed to go back because there is war.” I said: “okay well either send us back or give us the status” … Whatever is going to happen it is going to be my fate, so what shall I do in this situation? I had to accept it. But it’s affected me to be honest. It mentally affected me a lot. You know my mental health was like when you feel you are powerless, nothing to do unless you accept your fate. Sitting all the time thinking what I’m going to do? What can I do? Nothing. It's useless. You can’t do anything. There was a lady she gave me that wheelchair and I can use it with someone pushing me in it. My wife could not push me. Even I had no energy or strength or power to push myself. I was diabetic. I do it 10 times and then I feel sweating and dry … after a month the solicitor called me and said we took the status. And they gave us accommodation but so you see it was a kind of torture to reach that point. A lot a lot.’

Rohat

Rohat punctuates his accounts of socio-political suspension with stories of mental and physical ill-health, which ensures that the causes of his
morbidity are clearly located in his liminality. Rohat’s immigration status, and resultant housing difficulties, means he is suspended. The doors behind him have closed, yet he is unable to begin to build a new life. He is powerless to control his environment, unable to return to Syria and unable to secure accommodation in the UK. He occupies the ‘spiritual, spatial, temporal and emotional equidistant no man’s land of midway-to-nowhere and the longer he remains there, the longer he becomes subject to its demoralising effects’ (Kunz, 1973, p. 133). Rohat describes these demoralising effects brutally, suggesting that life in exile is so difficult he would rather return to Syria and die.

Many of the narratives construct life in the UK as harsh and in contrast with old lives in countries of origin; however, for some, these difficulties compound existing psychological issues from homelands. Denis, a now-British citizen whose convoluted migration story was described in section 4.3.1, offers a nuanced and layered account of the causes of his distress:

‘They started moving people, so I was sent to Torquay, and then I was sent back to London, then they sent me to Newcastle, then they moved me to Sheffield … I didn’t like this, I found it very difficult because they would move you without your consent and you didn’t have any rights at all. I’m just like a goat that is tied, and I’ve got nothing I can do. They could just give you two days’ notice … they said: “just be ready, we’re coming,” … They would just tell you that you’re going, and they wouldn’t even tell you where you’re going. So psychologically, especially I mean I was traumatised. Losing sleep at night, linking backward what happened back in Africa, because that was still staying with me. I was having kind of panic attacks where you sort of wake up at night you’re very frightened and I noticed that I was losing weight as well. Because I have no appetite. Reflecting back I believe that it was due to the very difficult circumstances that I was living in so I had no appetite at all. We
lived in a big hostel in Newcastle and the manager would complain that I wasn't eating, but I had no appetite because I was constantly frightened that something might happen to me. So I wasn't sleeping at night time I felt extremely powerless, extremely. To everybody, to anyone, to everything. I was losing weight. At some point I was like: “Why did I come here?” Because the reasoning was that I would be safe or at least safer here, but then I started questioning myself. What was the point coming here? Because I'm, well I'm not going to say I was more frightened than the other side but I was as frightened.’

Denis’ story of asylum dispersal accommodation effectively conveys his lack of agency. He is moved, passively and blindly, around the UK by the asylum apparatus. In this way the dispersal strategy disorientates individuals and prevents them from developing local social capital (Hynes, 2011). This narrative echoes the earlier theme of suspension. Denis likens his position of powerlessness to a tethered animal, a simile which evokes the inhumanity of his treatment. As the excerpt progresses it, too, illustrates the bi-directional construction of ill-health and liminal experience. The story of his housing is peppered with descriptions of mental and physical dysfunction. Then, his accounts of weight loss and sleeplessness lead back to a consideration of his rationale for seeking asylum in the UK.

When asked about his housing in the UK, Abdo described the difficulties of his different accommodations. His account is also punctuated with references to his experiences of ill-health and hospitalisation:

‘They took me to a small camp in London. I stayed there two days and then they sent me to Liverpool. During my stay in Liverpool, in a sharing house, I was in a sharing house, a big sharing house. One
day I woke up as usual at 5 o’clock in the morning and I felt that I couldn't sit down because I was very dizzy. I felt like the room and my head was turning round and round ... I opened the door there was a Syrian guy next door to me, I knocked on the door and when he found me in this situation I said: “please call anyone call the ambulance quickly” ... When I was in the hospital I felt like my breath wasn’t well. I was sweating. They asked me lots of questions, they have taken lots of blood tests. I spent about 7 hours. Then the doctor said there is nothing wrong with you all of your results is good. But I told him I'm still feeling very dizzy how is there nothing ... He gave me tablets for the dizziness and I went back home to my room. I became better afterwards.’

Abdo

Abdo uses an enquiry about his life to speak about health. Following the thread of the conversation, an enquiry about the length of his episode of ill-health was made:

LT: ‘How long did it take for you to get better?’

Abdo: ‘Two days to three days. I spent time in Liverpool and then they moved me to Tameside. In Tameside after a month I had the same symptoms. But this time with lots of constipation. Took me to the hospital and they gave me the same tablets. And then I started to get depression, and worries, and anxiety. My family were calling me from Sudan a lot. They told me “it's normal what's going on with you, because you are in a different country a foreign country and it is the first time you have been away from us so it's normal.” I tried to cope with the situation ... They told me to organise my time, to go out, to watch TV to do something for myself. I got my status, my health was better and then they gave me a council house ... Now I'm in my house, my kids they are going to come soon hopefully. I have done a family reunion for them. My house is much better now.
Sometimes I feel really depressed, but comparing to the first days when I came here and in the airport I am much better now.’

In reply to a health-related enquiry, Abdo re-directs the conversation back towards a story about his accommodation, then back to his health. In this way he spatially and temporally locates his episode of ill-health around particular accommodation experiences. Describing the opinion of his family in Sudan can be understood as a way of adding validity to his explanatory model of health. In the last few sentences, Abdo’s bi-directional co-construction becomes more overt; his narrative jumps rapidly between health, accommodation and immigration status. Like Hassan, Abdo seems certain that his more stable immigration status, and resultant housing, means his health will inevitably improve. Rather than being considered the sole reason for ill-health, poor accommodation and homelessness can be understood as a dominant and pervasive manifestation of the precariousness, powerlessness and liminality faced by people in the asylum system. Both the structure and content of participants’ stories locate the causality of ill-health clearly in this socio-political liminality.

5.5 Participants’ explanatory models and experiences of frailty

In contrast to when asked about understandings of health, many of the participants did not recognise the term frail or frailty. Although Hina, the Arabic interpreter, has lived in the UK for 15 years and has extensive experience translating for patients in health care settings, she asked for further explanation about the term frailty:

Hina: ‘I think it’s a little bit unclear even to me what you mean.’

LT: ‘Is it that the translation doesn’t really work?’
Hina: ‘No. It's even culturally. I’m not sure what you mean by it. Can you give me an example? Is it like when he becomes very weak, and his hand can be broken easily? Like his muscles?’

Hina went on to explain that there is no direct translation for the word frailty in Arabic or Kurdish. An online translation tool translated frailty to *hashasha*, though this term is used to describe objects that are brittle or crisp, rather than to make reference to the human condition. This raises questions about the potential for objectification of older individuals when attempting to translate western biomedical concepts across language and culture. Similar words, which translate to ‘weakness’ or ‘sensitivity’, are occasionally used by medical professionals, however Hina stated: ‘But if you said it to a Bedoon, or someone without education, then they wouldn’t understand’.

The impaired translatability of frailty was pervasive, spanning educational levels, country of origin and language, also applying to those whose lingua Franca was English or French. Those who did not recognise the term included: Julie, an accountant from Malawi; Nyesha a cleaner from Zimbabwe; Kamal a businessman from Sudan; and Amraz an engineer from Iraq. Even Bondeko, who worked as a surgeon in the DRC, and has continuing access to medical educational materials in the UK, asked for clarification:

‘No I haven't heard of it. Maybe I can check it to see what you mean. (Reaches for his phone). Or maybe you can say it a different way?’

Bondeko

In order to facilitate participants’ understanding and progress discussions on frailty, the albeit vague contemporary biomedical understandings of the term was described, with a short explanation:
'It is a medical term for someone who may be vulnerable. It is often used in the context of older people. Someone who is frail can be seen as fragile.'

LT

Many participants then appeared to recognise the meaning of the word. Some used language that evoked ideas of frailty in the narratives that followed. Here physical connotations of the concept did not dominate; rather social or emotional ones did. When asked if he had any experience of feeling frail, Denis replied:

‘Yes. Especially during my, and even before, (pauses and sighs) I can see myself in that camp where they detained me. So moving back, and then coming from that time to the UK. Not today, until maybe when I got indefinite leave to remain. Maybe that [frailty] is the word that I was trying to find earlier, I strongly felt like that. Sometimes it comes back today ... I keep feeling that today to some extent ... it's very difficult. You need to be strong to kind of, yes you know. That's one of the reasons that I stopped working for [a refugee charity] because working in this context can be very difficult, especially for me because I can relate first-hand and if I'm supporting asylum seekers I found it extremely difficult ... When I'm teaching them, when I hear the stories, I look at them and I think “I can feel their pain”. I love human beings. I'm very soft natured.’

Denis

Like participants’ stories of ill-health, Denis constructs and narrates the social and emotional facets of frailty in relation to his experiences of liminality. His narrative moves back through time, and he makes sense of his feeling frail by interpreting his pain against his migratory experiences. Denis suggests that feelings of frailty persisted until he acquired leave to
remain in the UK. Although these feelings appear to be largely historicised, moments of frailty permeate through to the present. This materialises as an impairment in social function; he is unable to work for a refugee organisation in Manchester. Denis’ account of feeling frail does not reflect biomedical explanatory models of frailty. Instead it evokes notions of emotional vulnerability, highlighted by the poignant expression: ‘I can feel their pain’. Denis continued:

‘I think to some extent you have an element in that word [frailty] from being vulnerable, of being fragile and of being open to harm. That’s the way I see it. That’s my understanding of the word. It’s like somebody who had some security around him, but then everything collapsed to some extent, and he or she is then exposed, and the person is then vulnerable to any sort of harm, then anyone or anything can easily damaging, damage them.’

Denis

Biomedical explanatory models conceptualise frailty as a state of increased vulnerability to stressors due to lack of physiological reserve. Although Denis articulates ideas about vulnerability, he instead focuses on protective social and environmental factors. This shifts the focus away from a purely physiological notion of frailty and from a fixation on individuals’ resilience. Denis implies that experiences of feeling frail are socially determined and could be mitigated by modification of the social world.

Parallels can be drawn between the bidirectional narrative co-construction of ill-health and lived experience, and frailty and lived experience. Many of the participants recounted difficult life experiences in the UK when asked about frailty. Masimaba, 51, initially came to the UK to work as a nanny from Zimbabwe but left her job following an argument. She described how she found herself homeless and met a man who promised to help her;
instead she was held captive for a number of months and raped. When asked if she had ever felt frail, she spoke of feeling frail transiently:

‘Yes when I first escaped I felt like that, but now it is getting better every day.’

Masimaba

After her experiences of sexual abuse, Masimaba had felt frail. However, she rejected frailty as an all-encompassing identity; instead, our conversation focussed on the challenges of, and strategies for, rebuilding after this ordeal. Like Denis, Masimaba historicises her experiences of frailty, seeing them as temporary. This recovery from particular moments of feeling frail is, too, at odds with biomedical constructions of frailty. Moreover it may be in contrast with other illness identities. In Rohat’s earlier excerpt he volunteers his diabetes as a diagnostic identity: ‘Like me for example I am diabetic’.

Aneni, a 54 year-old refused and destitute asylum seeker, initially came to the UK on a working visa and then applied for asylum when her personal situation changed.78 Aneni, also described paroxysms of feeling frail and understood frailty as in relation to weakness: ‘Someone who is frail is weak’. When asked if she could identify with this personally, she responded by talking about social stressors, in particular her immigration status:

‘Yes. Always when I get a refusal I feel like I’m going to pass out and die. I feel all the breath is coming out. It can last maybe two days. But now I don’t want it to last two days because it’s no good, so I run here [to the Allotment Project]. And I get her (Aneni gesticulates towards a volunteer at the Allotment Project) to read

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78 Aneni specified that she did not want reasons for her asylum claim to be included in the research.
the letter. No one understands, you can ask any asylum seeker, no one understands. Maybe because our brains, we are too much torture, I don’t know, you don’t understand anything. But when you come here they will read it slowly slowly, because you need to read it like you reading to a 3 year old. Slowly slowly I take it in. And at the same time they sing calm down calm down. Also at least then you know that someone is knowing and someone is trying to comfort you as well that really helps. Even like when I go to Dallas Court I always go with somebody because I feel sick I’ll be scared.’

Aneni’s personal experiences of episodic moments of frailty are constructed around her interactions with the Home Office. She appears to use visceral79 descriptions of biological impairment, such as breathlessness and feeling like she might pass out, to illustrate the impact of these interactions. Although they describe psychological and physical symptoms, Aneni, Masibama and Denis locate their experiences of feeling frail to personal and emotional responses to social happenings of extreme adversity. These subjective experiences appear unrelated to the chronic impairment and accumulation of deficits proffered by the biomedical model. Instead, they draw attention to how adversarial social environments and structural inequalities determine experiences of weakness and vulnerability.

79 The word visceral has two main interpretations. The first refers to the viscus, the organs of the major biological systems in the body. The second refers to a sense of involuntariness, where emotions and feelings are the result of impulse instead of intellect. This iteration of the term comes from the notion that visceral organs, and the nerves which innervate them, are autonomic, or involuntary. Thus, the term visceral has been taken by some to be understood as being a proxy for a reflex-like reaction to an event. For the purposes of this writing, the term visceral will refer to its first interpretation; that is, in relation to the organs of the body and the vital function of such organs. Thus I am not inferring that these processes become embodied reflexively; rather, I am examining how health is spoken about in relation to basic biology. Rather than referring to deep reflexive feelings which are the result of impulse instead of intellect, the word visceral is used here in the biological sense; that is, in relation to the organs of the body and the function of such organs.
After seeking clarification of what the term frailty meant, Bondeko felt, somewhat emphatically, that he had experienced frailty:

‘I feel like I’m fragile, you know. I am a fighter. I am really a fighter but I feel weak now. When I say I’m a fighter I know that I can defend people. I know that I cannot stop defending people, but I feel like sometimes I can’t continue. I feel really fragile I feel like I am, like I don’t deserve to continue. Like other people are pushing me to stop. It’s that feeling that I’ve got since I’ve been here, it’s that feeling that I say that I feel like I’m in prison. They force me to struggle, to feel guilty, to feel weak, and not continue my purpose advocating for others ... I feel like I get punishment that’s my perception ... When you feel guilty yourself you will feel like you are not going forward. You feel like, I need to see my life. I feel guilty for leaving my children, but I feel guilty from losing my family ... because like I said I am a fighter. That’s the feeling.’

Bondeko

Despite being a medical professional, and seeking clarification of the term, Bondeko too understands frailty in relation to emotion; both in the emotional causes of feeling weak and frail, and in the emotional impact of feeling fragile. In this narrative, Bondeko constructs his natural character as a fighter and an advocate, notions that evoke ideas of both moral virtue and dominant masculinity. He contrasts his experiences of frailty against this, describing feelings of weakness, imprisonment and guilt, which he relates to his lived experiences in exile. Bondeko can be understood to imply that his current insecure immigration status, enforced unemployment and resultant emotional distress is, in some way, castigation for leaving his wife and children to flee from the DRC to the UK. Abdo’s description of the term also seems to infer a moral component:
‘[Frailty] means that if you don’t care about anything, it is easy to be broken.’

Abdo

These narratives imply that that for some, the meaning of frailty can be associated with a degree of individual culpability, carelessness and immorality. Rather than reflecting biomedical conceptualisations of frailty, these moral dimensions echo the traditional etymological ideas of a moral frailty: ‘wanting in power ... unable to resist temptation; habitually falling into transgression’ (Simpson and Weiner, 1989). Importantly, it highlights how frailty’s stigma appears to permeate, and even be augmented, across language and culture, despite the biomedical meanings being lost in translation.

Bondeko infers that his experiences of feeling frail are at odds with the strength that is expected of him. The previous chapter examined how the sociopolitical experiences of life in exile can challenge notions of dominant masculinities through the accounts of Denis, Bondeko and Garian. Denis’ earlier quote, which used a simile to compare an African man with a lion, also attempts to resist feelings of emotional vulnerability by suggesting that he needs to be strong (see 4.3.2). However these expectations are not solely a sub-Saharan African phenomenon. Hina described how notions of frailty might challenge culturally-rooted ideas of dominant masculinities for the Arabic participants:

‘In Arab society we depend on strong man, so if we say someone is weak, if we say he is frail, he is weak, we are saying his manhood is weak. This is how we bring our children up: be a man, don’t cry, don’t be weak.’

Hina
These excerpts draw attention to how the linguistic, social and cultural connotations of frailty challenge the expectations placed on some men and, as a result, raise questions about how being labelled frail may carry additional unwanted stigma for particular social groups.

5.6 Discussion

Older asylum seekers’ and refugees’ explanatory models of health, ill-health and frailty in the UK have not been explored elsewhere in the academic literature. Qualitative studies examining migrants’ ideas of health suggest it is understood as a highly value-driven concept, with spiritual, social and cultural components (Weerasinghe and Mitchell, 2007; Charlier et al., 2017). The findings described in this chapter echo and build on this literature. Narrative analysis shows that health is understood as a multi-domain phenomenon with psychological, social, physical and spiritual dimensions. Social functions, such as family roles and vocational positions, emerged as both a determinant of, and a proxy for, health. Pathographies thus revealed how social meanings shaped the experience of illness, as well as allowing participants to formulate and express a ‘cultural and political critique’ (Sakalys, 2000, p. 1470).

Participants’ explanatory models of health problematise the mind-body dualism of western medicine and challenge dominant academic definitions of health. Academic discourse has recently shifted its focus away from the 1948 World Health Organisation (WHO) focus on ‘complete physical, mental and social wellbeing’ (Larson, 1996, p. 182). Instead there is a drive to re-define health in relation to resilience, self-management and adaptation to adversity (Huber et al., 2011; Bircher and Kuruvilla, 2014; Bircher and Hahn, 2017). Using the concept of resilience implies good health can be achieved in the presence of chronic disease and at advancing
age, but is places the weight of responsibility on the individual to achieve health.

In contrast, the subjective experiences of these older asylum applicants suggest their health is determined by migratory experiences and the associated structural violences. This problematises the centralisation of individuals’ resilience in achieving health. At best, resilience neglects the role of structural violence in the determination of health outcomes; at worst, it enfranchises the notion that marginalised populations, such as forced migrants, must do more than privileged groups to resist adversities in order to achieve good health. In short, resilience places an expectation on disadvantaged individuals to ‘beat the odds’ when, in order to improve health, policy and practice should be looking to ‘change the odds’ (Seccombe, 2002, p. 384).

Many of the participants did not recognise the term frailty. This is likely due to the contemporary emergence of the concept, as well as its ethnocentrism. Until the late 1990s frailty referred to the social, rather than medical care needs of aged patients; frail older people were constructed as naturally decrepit and thus outside of the medical domain (Bridgen and Lewis, 1999; Pickard, 2014). The emerging dominance of biomedical understandings of frailty in research and practice over the last two decades has taken place almost exclusively in high-income countries with well-resourced accessible healthcare services (Pathai et al., 2013; Gray et al., 2016; Payne et al., 2017; Siriwardhana et al., 2018). For those who did recognise the term, or did so after a short explanation, frailty was loaded with negative connotations, inferring impaired morality and challenging ideas of dominant masculinities. Participants’ explanatory models of frailty mirrored their explanatory models of health; it was understood as a multi-domain phenomenon, where social and emotional dimensions dominated.
Importantly, experiences of frailty were largely momentary and historicised, and were constructed and narrated in relation to liminal lived experiences. These findings echo the work of Amanda Grenier. Although Grenier does not specifically examine frailty in the context of migration, she draws attention to the dichotomy between ‘medical–functional–corporeal understandings of bodies in decline’ and older people’s contextually and socially located moments of feeling frail (Grenier, 2005, p. 143). By locating their experiences of frailty in the past, these participants, too, reject frailty as an identity; instead, they can be understood to use the narrative co-construction of moments of frailty and experiences of liminality to draw attention to the harshness of their migration experiences.

Analysis of participants’ narrative structure showed how stories of liminality were frequently weaved into stories about health, ill-health and frailty. This phenomenon has been described elsewhere; Coker described how stories of illness can become ‘an avenue for discourse about the refugee trajectory’ (Coker, 2004, p. 19). Data from this study echoes these observations; when telling health stories, tales of lived experience emerge. However by showing that health and lived experience are co-constructed bi-directionally, both in the content and the construction of the narratives, this chapter builds on Coker’s work. Not only are health stories an avenue for narratives of lived liminal experiences, stories of difficult life experiences are punctuated with memories of biological dysfunction.

Participants’ pathographies can be understood to convey cultural criticism and political resistance. The bi-directional construction of health, ill-health and lived experience, which pervaded both the structure of the narratives as well as their content, positions pathographies as a narrative tool. Analysis has suggested that this allows participants to locate the blame for experiences of illness in their liminal social positioning, as well as drawing attention to the fundamentality of lived experience. The next chapter takes
the idea of health as a narrative tool as its point of departure, critically exploring this phenomenon with a specific focus on the socio-political context of asylum in the UK. It will be argued that the proximity between articulations of migratory experience and health serves a number of narrative functions. In doing so, it proposes a novel concept: biocredibility. Biocredibility refers to the way stories of visceral biological dysfunction can serve to reclaim integrity and renegotiate credibility in the context of the profound impoverishment of social, political and economic resources.
Chapter Six

Biocredibility and the apparatus of asylum

‘The Home Office can give you heart attacks’
Ahmed

6.1 Introduction

The previous empirical chapters have shown how participants’ narratives of ageing, health and ill-health intertwine with stories of lived migratory experience. Chapter Five demonstrated how this narrative proximity is constructed bi-directionally, in both structure and content. This narratively facilitates the imputation of meaning to experiences of illness, thus providing an avenue through which a social and political critique can be established and communed (Sakalys, 2000, p. 1470). This final empirical chapter takes the idea of pathographies as a narrative tool as its point of departure, critically exploring this phenomenon with a specific focus on the socio-political context of asylum in the UK. A novel concept is proposed, through which this can be better understood: biocredibility. Biocredibility is a narrative phenomenon whereby biological stories add credibility to narratives of lived experience.

The credibility of a narrative is dependent on both the plausibility of events and how events are corroborated (Ochs and Capps, 1997, p. 83). In recent years, the emergence of the ‘bogus asylum seeker’ in xenophobic popular and media discourse has made perceptions of credibility increasingly important for asylum applicants (Zimmermann, 2011; Griffiths, 2012). Moreover, asylum seekers’ autobiographical testimonies of persecution
have their veracity evaluated by decision makers\textsuperscript{80}, often in a highly speculative manner (Magalhaes, 2016; Holland, 2018). Many of the participants interviewed had their credibility questioned, and thus eroded, through their multiple interactions with the varied facets of the governmental asylum apparatus.\textsuperscript{7} Biocredibility refers to how, in the context of scoured credibility and profound impoverishment of social, political and economic resources, rememberings of visceral biological dysfunction can corroborate accounts of lived experience. As a consequence, pathographies can operate in a way that strives to reclaim integrity and renegotiate credibility. Narrative analysis of the empirical data suggests this is realised in two main ways. First, recounting stories of visceral biological dysfunction provides narrative evidence of experiencing ill treatment; second, pathographies convey the significance and import of particular experiences.

This chapter begins with an exploration of participants’ journeys to the UK. As well as placing them in perilous positions through physical danger, the desire to evade state authorities on the journey lays the foundations for an on-going relationship of mutual distrust and suspicion with the Home Office. Next, specific encounters with the multiple materialisations of the Home Office in asylum applicants’ everyday life will be examined. Here, the asylum interview is understood as hostile and interrogative; asylum housing is seen as an extension of the state’s surveillance apparatus; and the process of reporting to the Home Office is feared, owing to its association with arbitrary detention and deportation. It will be shown that these processes and practices persistently and pervasively undermine participants’ credibility, and that stories of biological dysfunction can be understood to renegotiate this. A final empirical section will analyse the accounts of two women who are using their HIV status to appeal their

\textsuperscript{80} Decision makers is a term used to describe any individual who makes a decision about the outcome of an asylum application including Home Office caseworkers and immigration tribunal judges.
asylum refusal. The chapter’s discussion embarks on a critical consideration of the particular identity politics and biopower embedded in the socio-political context in which biocredibility is observed. Drawing on Fassin’s and Petryna’s ideas of biolegitimacy and biological citizenship, the chapter concludes by refining and locating biocredibility within existing theoretical literature (Petryna, 2004; Fassin, 2009).

6.2 Journeys to the UK

As outlined in Chapter Four, the participants interviewed had travelled to the UK from a range of countries. Unsurprisingly then, the strategies and transport modalities used to reach the UK varied. Dikembe was selected for resettlement in the UK whilst living in a UNHCR refugee camp in Kampala, having fled his native DRC. He was the only participant to claim asylum in the UK through this official resettlement programme (Refugee Council, 2018b). This section will analyse participants’ descriptions of their journeys to the UK, and will suggest that the relationship of mutual distrust between asylum applicant and Home Office may emanate from the illegality of participants’ journeys.

The modes of transport used to journey to the UK by participants can broadly be divided into three: First are those who had legitimate visas and then applied for asylum in the UK when these expired. Second are those who travelled to the UK by air with the assistance of an agent and falsified identity documentation. Third are those who travelled to the UK over land and sea, often with falsified or no documentation at all. Those who obtained student or work visas for the UK from their countries of origin, and then applied for asylum in-country when these visas expired, citing changes in either personal circumstances or the security situation in their country of origin included Hafiz, Amraz, Aneni, Julie and Masimaba. Typically, these participants described travel to the UK as ‘easy’ or ‘no
problem’. In contrast, the narratives of those who used illegal strategies depict how illegality reduces agency and produces social vulnerability.

Those who flew to the UK employed agents, or smugglers, in their country of origin with the intention of claiming asylum on arrival. Agents charge fees in exchange for the provision of falsified identity documents, flight tickets and often a chaperone for the journey. Aran, a Bedoon from Kuwait, fled his home country with his wife, Tala, and children after being detained and tortured by Kuwaiti authorities:

‘We used an agent. We paid them lots of money to run away from Kuwait. Some people came to London some people went to other countries. It depends on the agent. They decide where you go … my story is that I took all of my family apart from one daughter. I left the daughter behind because my agent couldn’t get a passport for everybody (Aran begins to cry). There were seven of us and he could only get six passports. We have to decide that one of us would stay and it was my daughter. These passports are fake but they should be exactly like the original ones, because I don’t want to be in trouble in the airport, especially not in Kuwait’s airport. If we got out of Kuwait airport then any airport would accept us as an asylum seeker.’

Aran

Apart from his daughter, Aran’s family are now recognised as refugees in the UK. The reunification process to bring Aran’s daughter to the UK through official Home Office channels was proving difficult; the family were required to provide evidence to prove she was their biological relative. This separation was a central theme throughout Aran’s interview and he would frequently break down crying. His narrative about the journey to the UK clearly communicates the urgency with which he needed to leave Kuwait, and thus justifies the imperfect and illegal strategies he used to do so. His
account draws attention to the paradoxes and conundrums of irregular migration. Aran paid the agent expensive fees in exchange for a service, yet the illegality of such service means he was unable to stipulate crucial factors, such as where he sought asylum and which of his family members are able to accompany him. By emotively constructing the Kuwaiti state as a threat to his life, he conveys his desperation to escape in this way, and can be understood to attempt to rationalise his mode of travel, as well as his decision to leave his daughter behind.

Aran’s conundrum echoes the experiences of Denis, who flew to the UK using false documentation and the assistance of an agent. Denis’ story of not being aware of his destination country strikingly and persuasively conveyed the urgency of his escape from DRC (see 4.3.1). By specifying a preference to live in France, Denis effectively illustrates his voicelessness in the face of a decision that will have a profound impact on his future. Migration scholars describe the increasing influence of agents on asylum seekers’ destination countries (Gilbert and Koser, 2006; Crawley, 2010). For both Denis and Aran, invisibility and illegality are narrated as life-saving strategies; however, as a result of these strategies, neither are in the position to make even basic demands of the agents they commission.

The participants who travelled over land and sea, rather than on direct flights, employed multiple and varied strategies to reach the UK. However, all bypassed other European countries en route. The motivations for this ranged from concerns about language and social contacts, to imaginaries about educational and vocational prospects in the UK (Gilbert and Koser, 2006). These participants not only spoke about the journey to the UK as disempowering and uncertain, they described it as a physical threat to their lives. Daran, a 46 year-old agricultural worker, left his family in Syria due to the war and travelled to seek asylum in the UK, driven by the British education system and consequent English language skills that might be afforded to his children. He described his journey as dangerous:
‘I came by an agent in a lorry in a big boat. Italy. Then from Italy to France, then from France to the UK. [It took] around three months. My family help me to pay for it because it was very expensive, €11-€12,000. You are paying money, you might die. You take any risk, you are in a lorry, the lorry is in the middle of the sea, you don't know where you are, and you don't know where you are going. I tried hard to find a safe way but I couldn't. I had to accept this. I had no choice.’

Daran

Daran chooses not to discuss his reasoning for bypassing France and Italy. Instead, like Denis and Aran he guides the impression that he had limited options and no safe alternative. He, too, highlights the high financial cost of travel, and the high-risk nature of the journey, and describes a loss of control. However Daran measures the gravity of this risk in relation to his proximity to death. This narrative enclave expresses the peril of the journey.

Hafiz, like Denis, also travelled overland from Syria and inserted stories of death into the narrative of his journey to the UK:

‘We had one week in France and then we took a lorry, there were 36 persons in amongst potatoes ... There was no oxygen. People started to die ... We were dying for the last breath and that was it. They opened the lorry and then were in the UK.’

Hafiz

This narrative arc is taken from a longer story about Hafiz’s journey to the UK to illustrate how he creates a sense of jeopardy discursively. He builds tension to the climax of his story by making a visceral claim that he was ‘dying for the last breath’. By re-presenting his experience in this extreme
way Hafiz corroborates his account through articulations about death. Given migrants have recently died in this way, Hafiz can be understood to make a moral demand on the listener to find the narrative authentic.

In this resource-scarce context of invisibility and illegitimacy, narratives of health, ill-health and mortality emerge as an asset. Hafiz and Daran create narrative enclaves within the descriptions of their journeys to the UK and insert inferences about their proximity to death. As described in Chapter Five, intertwining stories of biological suffering with narratives of lived experience locates blame for ill-health experiences. Both men make it clear that they nearly died because of the journey. However, these visceral stories also highlight the jeopardy of their migration. This is a core feature of biocredibility; telling stories of morbidity and mortality quantifies the significance and peril of lived experience.

More broadly, these stories of feeling close to death whilst being transported across borders in a food container represent a sinister metaphor for the paradoxical dynamics of migration in the context of post-colonial globalisation. Here the transport of goods for consumption is encouraged, but the cross-border travel of certain human lives is prohibited (Bauman, 1998; Mayblin, 2017b). Should Hafiz have been documented by state authorities in Italy or France, the Dublin Regulation would have prevented him seeking asylum in the UK. Thus Aran, Denis, Daran and Hafiz all use invisibility as a strategy to avoid detection by particular authorities. In these transit spaces, the men are considered ‘illegal’. This illegality endangers Hafiz and Daran’s lives, and limits Denis and Aran’s agency. Their distrust of state authorities impairs their ability to seek assistance, information, and basic rights outside of the illegal network.

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81 In 2015 a lorry was found on the Hungarian border containing the dead bodies of 71 migrants (Harding, 2015)
82 The number of deaths of migrants crossing the Mediterranean sea have reached historical highs (UNHCR, 2018). The reported number of losses reached a record 5,082 in 2015, thought to likely be an underestimate (International Office For Migration, 2016).
(Geddes and Scholten, 2016). In parallel, the illegal strategies described propagate the construction of asylum seekers as ‘welfare cheats, asylum shoppers [and] bogus refugees’ in popular discourse (Griffiths, 2012; Jubany, 2017, p. 5). Those who enter the UK illegally are viewed by the Home Office as being deceptive, which sullies caseworkers’ perception of individuals’ integrity (Lawrance and Ruffer, 2015; Jubany, 2017; Mayblin, 2017a; Bohmer and Shuman, 2018). Thus a mutual relationship of distrust emerges. Asylum seekers are wary of state authorities, and the Home Office sees some asylum applicants as criminal and untrustworthy, and so questions their credibility.

6.3 Biocredibility and encounters with the Home Office

Asylum applicants must have regular contact with the UK Home Office. The interactions are both direct, through interviews, reporting procedures and court appearances, and indirect, through letters and third party organisations, such as housing providers. Much of the qualitative data focussed on participants’ negative encounters with the Home Office and alluded to how this eroded credibility. This section analyses narratives of encounters that dominated the empirical data: the asylum interview; having an asylum application refused; experiences of asylum dispersal accommodation; reporting to the Home Office; and appealing the Home Office decision. The result is a critical examination of the social and material conditions of asylum, and an exploration of how these conditions affect credibility. Biocredibility as a narrative phenomenon is observed throughout. Utilising the concept of biocredibility as a narrative frame highlights how, in this context, stories of biological dysfunction can be understood to renegotiate credibility through the biological corroboration of lived experience.
As described in Chapter Three, for Mahmood, an Eritrean refugee in his 70s, remembering the two and a half years spent applying for asylum in the UK resulted in profound emotional distress:

Mahmood: ‘I have been waiting two years two and a half to get my leave to remain. And then they considered me as a refugee after two years.’

LT: ‘How did that experience affect you?’

Mahmood: ‘I can’t talk about it. (Participant starts to cry, unable to talk, looks away). Mahmood: Can I come another time?’

LT: ‘You can, but you don’t have to take part.’

Mahmood: ‘I feel like I can’t. I am sorry.’

This difficult research encounter brought the fundamentality of the distress surrounding the asylum process to the fore (see Chapter Three). Mahmood fled Eritrea alone and arrived in the UK in 2014. Whilst his application for asylum was being considered, and without his family in the UK, he had a stroke that required a prolonged period of hospitalisation and inpatient rehabilitation. Mahmood was not interviewed further following the above exchange. Instead Hina signposted him to a family reunification service at Greater Manchester Immigration Aid.

The termination of Mahmood’s interview suggests the bureaucratic process of applying for asylum can cause significant emotional distress. Distress was also expressed by other participants. Ahmed, a refused asylum seeker from Kuwait, has lived in the UK for 10 years. Ahmed explained that he felt he had been unfairly refused refugee status; like others, he described the impact of this on his ability to work and support himself financially. He was relaxed and chatty throughout the interview until asked about his appeal of the Home Office’s refusal of his asylum claim. At this point his demeanour changed. He became sweaty and
tremulous and asked for a break. After having a cigarette outside, he returned:

‘I can’t properly talk about the Home Office. It makes me very angry. It makes my blood pressure go up. The Home Office can give you heart attacks, I don’t like to talk about it.’

Ahmed

Ahmed’s distain of the Home Office was typical of much of the narrative data, which constructed the department as a powerful and oppressive entity. Interestingly this was in contrast with other state organisations, such as the NHS, a notion which, owing to the diffuseness of borders in the UK, is potentially misplaced (see Chapter One). To illustrate the threat of the Home Office to his health and life, Ahmed inserts descriptions of visceral biological dysfunction, such as the feeling of high blood pressure and the fear of a heart attack, into his narrative. As well as blaming the Home Office for his hypertension, Ahmed’s biological language communicates the gravity of the threat posed by the governmental department. Like Hafiz and Daran, his stories of biological dysfunction can be understood to be a barometer, against which he measures the ill treatment he has endured in the UK.

It is difficult to deduce whether these statements are narrative devices aimed solely at conveying brutality, or whether they are rememberings of literal physical experiences. Importantly, however, the concept of biocredibility seeks not to explore the aetiology of the accounts, nor triangulate them through quantitative biomedical measurements. Instead biocredibility draws attention to the way in which recounting biological rememberings can add credibility to testimony. Regardless of whether these pathographies are narrative devices or narratives of experience, accounts of bodily dysfunction corroborate experiential stories and convey
the importance and urgency of hostile and austere social and material conditions.

6.3.1 Interrogative interviews: Credibility in question

For many, the expectation to engage with state authorities openly and proactively on arrival to the UK was in tension with the illegal strategies used to escape homelands and reach the UK. Tala (see 4.2.2) described how the agent offered she and her husband warnings about how to behave once they arrived in Britain and told of her resultant overwhelming fear when applying for asylum at the airport:

‘We were so worried and anxious during that day. We were so scared because people had said there are cameras, don’t talk they will monitor you. We were so scared that were being monitored. That’s what the agent told us. And don’t talk to anyone next to you he might tell you that he is an asylum seeker but really he is working for the Home Office. It was a very scary environment. The agent was making me feel very scared.’

Tala

Tala’s excerpt further illustrates how involvement with irregular migration networks can foster and augment fear and distrust towards state authorities in general, and the Home Office in particular. The agent’s speculations about the intrusiveness and extent of the surveillance technologies of the Home Office are likely to be a self-serving strategy; smugglers encourage migrants’ silence to ensure they can escape authorities undetected (Salt and Stein, 1997; Gilbert and Koser, 2006). However as a result, Tala is fearful and distrusting of the UK Home Office and, like others, constructs it as an oppressive authority.
Interviews elicited many accounts of experiences of the asylum interview; often this was unprompted. In the asylum interview applicants are asked to explain to Home Office caseworkers ‘how you were persecuted in your country [and] why you’re afraid to go back to your country’ (Home Office, 2019a). Based on applicants’ responses, caseworkers make the delineation between those with and without a well-founded fear of persecution. Experiences of ill treatment in Kuwait, and the aforementioned advice from the agent, taints Tala’s expectations of her interview and creates a feared imaginary:

‘We have been living a life [in Kuwait] like every minute the police and the security attack our house, they ask about us, they interrogate us, so we thought that’s what was going to happen here. So we were jumpy. Or to return us, and if they return us that means we are all going to go to prison, and it will be a disaster. We were so worried about our kids.’

Tala

By dwelling on the fear of her family’s incarceration, Tala highlights what is at stake and qualifies her anxiety about the interview. Her husband Aran also had low expectations of the Home Office interview:

‘So before that day of the interview my mental health was really bad … I was so scared because of this interview … I can’t explain to you how much I was living in fear, a big fear … I did the screening interview and I fainted … It had never happened to me before, it’s because of the anxiety because of the Home Office. From the first day in the UK my mental health was really low because of everything … I was so scared that I fainted … They give you lots of orders, it makes you very anxious and scared how they talk to you … outside they take everything off you, all of your jewellery. Everything out of your pockets … they called me I entered the room
with them I sat down, I was at the top of the fear. I cannot tell you how much I was scared … this security in our country is different from these people here. Here maybe they can interrogate you and be rude in their interrogation and in their interview, but they can’t hit you or touch you. There it’s all about beating you and hitting you.’

Aran intertwines stories of his asylum interview with rememberings of illness. Analysing this narrative through the concept of biocredibility draws attention to how he blames the interview for his anxiety and episode of fainting. After stating that he is unable to describe how scared the interview made him, Aran then goes on to explain that he was so fearful he fainted. The short pathography of a faint thus provides much needed support for his expression of fear; he articulates explicitly that he has no other way of describing it. Like Ahmed’s earlier excerpt, Aran’s use of biocredibility effectively elucidates and quantifies the severity of his ill treatment. In this way his pathography performs as a socio-political critique (Sakalys, 2000). Aran roots his fear in his previous experiences of physical abuse at the hands of the Kuwaiti state officials. Paradoxically, although the UK Home Office interrogation is not directly physically abusive, the asylum apparatus in the UK still results in physical harm.

Aran describes the Home Office asylum interview as an interrogation; this was echoed by other participants, as well as being referred to by asylum advocacy groups (Right to Remain, 2017). Hafiz became animated when he spoke about his asylum interview:

‘I was in a very bad situation when I did the interview in Liverpool. The Home Officer he was very tough with me. I thought that I was in front of someone from the Syrian intelligence. It was a very tough interrogation … In the end he said: “what do you think about this

204
“interview?” I told him the truth, I told him: “I felt like I am in front of the Syria intelligence, not a British person.”

Hafiz

Unlike Tala and Aran, who feared this encounter, Hafiz travelled to the UK having heard stories about the good quality of life from his uncle. Consequently he had high expectations of the British authorities, and was disappointed.

Aneni appealed her asylum refusal multiple times, however her autobiographical testimony, which outlined the reasons she cannot return to her native Zimbabwe, had been disbelieved. Like Hafiz, she became particularly impassioned when describing the ill treatment she felt she received from the Home Office at interview:

‘Before I came, I came in 2002, I was a healthy person. When I went to bed I would just sleep after what I’ve been doing all day. This thing just started when I started to apply for asylum … now, me I don’t sleep well … Early in February 2011 it all changed. I went to my screening interview. I still remember. And then the main asylum interview which was 250 questions, it was two weeks after. I think that one, that’s the one that changed me. It changed the old me into this now, because I had stopped my periods … but then this last night before this interview I bled a lot. I thought: “what has happened have I cut myself? I was like “what it is blood coming?” … So I rang this woman now and I said “I don’t know what’s going on with me I’ve stopped my periods but now I’m bleeding very heavily” and she said “this is what we call stress, you know this sort of thing can kill a person.” Now I don’t do that. I don’t bleed but I do get stomach cramps and diarrhoea. Because when I panic.’

Aneni
Aneni uses biocredibility to construct the Home Office as despotic and threatening, and position herself in opposition to the practices of the state. She stages the narrative by asserting that before she applied for asylum she was healthy, which assists in making the temporal relationship between the asylum interviews and her transformation certain. Her retelling of these consequential events is further aided by her inclusion of a third person into the narrative, who corroborates her claim that the asylum interview caused her to bleed. This excerpt illustrates all of the core features of biocredibility. She blames the Home Office for making her ill; her story of vaginal bleeding effectively conveys the significance of the event; and, by telling of her bleeding, she provides verification of her experience. As a result, her stark biological illustration adds credibility and authenticity to her narrative. Using biocredibility throughout experiential descriptions of state oppression, Aneni draws on visceral descriptions as a form of narrative resistance to the Home Office, thus her pathography functions as a form of political voice.

Aneni also alludes to a transformation of selfhood; throughout the interview she spoke about herself as ‘this person’. This creates narrative distance and implies she does not recognise the new version of herself:

‘These interviews and with the mental and physical torture from the Home Office, it has just changed me now. I used to be scared, but the way I get scared is too much now. The way I get scared now is not normal. I know it is not normal. Sometimes I will be walking and crying and I’ll be scared even to walk, which I know is excessive.’

Aneni

Aneni’s interview elicited myriad stories about the difficulties of life in the UK. She described how, as an older female refused asylum seeker, the asylum apparatus embedded into the everyday restricted every facet of her life. She struggled financially and during the interview asked for
donations of warm clothes for the winter; she shared stories of frequent accommodation moves and homelessness; and she feared detention and deportation back to her native Zimbabwe. Much like Kamal’s and Bondeko’s narratives in Section 5.3, Aneni’s interview illustrated how the identity politics of immigration categorisation produces ways for structural violence to operate under the guise of legitimate bordering practices. By describing the effects of the ‘mental and physical torture’ Aneni ensures that the listener understands, not just that the Home Office is bad, but just how bad. This raises questions about the pathogenicity of the Home Office. Although this thesis is does not seek to corroborate these assertions with quantitative biomedical measurements, many of the narratives of biocredibility imply that encounters with the Home Office cause illness.

As described in Chapter One, questions over claimants’ credibility are frequently used as grounds to refuse asylum applications; credibility is said to be the most important factor when determining refugee status, thus asylum decisions rely on ‘what they say and how they say it’ (Coffey, 2003; Sweeney, 2009, p. 700; Clayton, 2016). Denis’ convoluted migration trajectory was described in 4.5.1. He reflected on the psychological and practical difficulties he faced in his asylum interview:

‘Basically I was traumatised. I was somewhere that I’ve never been ... I was just on the street. I think I was traumatised from the beginning when I was around, and then with somebody questioning you, it’s like a police interrogation. They don’t mind about you. The interpreter wasn’t that good, it was a white person speaking French. But you have to put it into context. You’re trying your best but then the Home Office didn’t believe me, so finally they kicked me out and that was it.’

Denis
Denis’ narrative draws attention to the multiple factors influencing applicants’ ability to provide testimony considered credible. He perceived the Home Office caseworker as unsympathetic and interrogative. This, coupled with his previous torture, the newness of life in the UK, and the expectation to speak in his second language, results in difficulty making the rationale for seeking asylum understood. As a result, his testimony is disbelieved and his claim rejected (Bögner, Brewin, and Herlihy, 2010).

Many of the participants told of experiences of being disbelieved by the Home Office. Tala, the Kuwaiti refugee trying to coordinate reunification with her daughter, spoke about the difficulties of proving their biological relationship:

‘Still the Home Office do not believe that she is our daughter, so we are struggling.’

Tala

Similarly, others would often insist, unprompted, that the account they were giving during the research interview was authentic and truthful. Phrases such as: ‘Believe me’; ‘I am telling you the truth’; ‘I am being honest to you’; and ‘I swear’ appeared regularly in the interview transcripts. Francis, a refused asylum seeker, stopped multiple times during his interview and asked: ‘Do you believe me?’ This suggests that the effects of having credibility questioned is pervasive, and extends beyond encounters with state authorities. It is in this context that stories of biological dysfunction so readily emerge as a narrative tool:

‘I still have a case. It's still ongoing. My problem is I want to heal. If I start to concentrate on asylum, on Home Office, it was making me feel bad; forget that it would kill me. It's not so important. If I put more importance on the Home Office and asylum, then it would make me feel bad ... I cannot sleep if I don’t take the tablets. So it's
very difficult when the Home Office don't believe you. If the Home Office don't believe you, but I can't put my mind in.’

Francis associates having his story of detention and torture in Cameroon disbelieved by the Home Office, and therefore his credibility undermined, with ill-health and mortality. He constructs the Home Office as pathogenic, referring to sleeplessness, a lack of concentration and a dependence on medication as a result of the process; therefore like Aran and Aneni he employs narrative biocredibility. He uses stories of biological dysfunction to quantify the distress caused by the Home Office. Interestingly, in this narrative, Francis can be seen to use his ill-health to claim exemption from the responsibility of engaging with the intricacies of his asylum appeal. Similarities can be drawn between this and Ahmed’s earlier assertion that he cannot talk about the Home Office for fear of a heart attack. Both men use biocredibility to narratively construct versions of themselves as vulnerable and impaired, and appear to do so in direct response to the hostile and suspicious gaze of the Home Office.

6.3.2 Strategies of surveillance: Crimmigration in practice

As has been suggested thus far, the Home Office, realised both through individuals’ imaginaries and reified materialisations of the state, was narratively constructed as having a pervasive repressive influence in the everyday lives of participants. This was often expressed through stories of illness. Stories of encounters with the Home Office extended beyond descriptions of the asylum interview; many described the strategies of surveillance they were subject to, including asylum dispersal housing and attendance at Home Office reporting facilities. As was highlighted in Chapter One, refused asylum seekers’ eligibility for welfare support is linked to the acceptance of asylum dispersal housing. Refused asylum
seekers in receipt of Section 4(2) minimal hard-case support must comply with specific behavioural requirements, which include specifications about not being ‘absent’ from dispersal accommodation (Home Office, 2018b). Thus asylum housing represents a strategy used by the state to regulate migrants’ lives and produce discomfort (Schuster, 2005; Phillips, 2006; Darling, 2011, p. 268).

Aneni is in receipt of Section 4(2) support and lives in asylum dispersal accommodation with four other women. Aneni described her accommodation as a terraced house where she is allocated her own bedroom and has access to shared kitchen facilities. During the interview she told of finding out that a Housing Officer had entered her bedroom without her permission. In her absence, the Housing Officer had photographed the room, as she was suspicious that Aneni was not complying with the stipulated behavioural requirements:

‘I can’t relax and constantly since that Housing Officer called someone in my room and started taking photos, it’s made it worse. Constantly I’m asking my social worker ‘are you sure they haven’t put a camera in my room?’ My social worker says ‘no they cannot do that’. But I still think … the housing officer … after that incident she apologised. She sent me a text [Aneni holds up the text on her phone] … To me they are all the Home Office. Yes they pretend, but to me they are all bad. They make us… They have changed me, I get lost. I don’t know what I’m doing. All of a sudden my mind will just go. When I feel like that I get so emotional because I think ‘this is not right, what is going on with me? Why is my mind just going blank like that?’ So when it is like that I have to sit down take a deep breath.’

Aneni
The strategies of surveillance used by the Home Office to know and regulate the lives of asylum applicants are experienced as a violation by Aneni. Being subject to this form of biopower caused Aneni to imagine and fear the extent of the everyday surveillance capacities of the Home Office. She supports her moral objection of this practice and corroborates her narrative both by showing evidence of the Housing Officer’s apology, and by using narratives of biocredibility in her descriptions of cognitive impairment and breathing. Aneni builds on her previous conviction that the Home Office has changed her as a person, continuing:

‘The way they go around checking in your room. Am I a drug addict? Why are they going around checking in a woman's room, a poor woman's room, to look for what? I think that's part of it. They be telling you: “You think you are 54 but we see you as three years old.”’

Aneni

Aneni infers that the surveillance of her private space in the asylum dispersal accommodation is punitive and irrational. She feels criminalised despite committing no crime, and describes the sense of infantilisation this causes. She creates narrative enclaves and inserts certain social characteristics of herself, such as age, poverty and gender. This supports her claim and challenges the notion that she poses a threat. She continues:

‘When I say the mental and physical torture of the Home Office I mean I keep constantly thinking: “What is going to happen to me?” Even though I'm in their accommodation I do not feel relaxed. Like if you go to your home now from here, you go and relax. You put your boots up. Me I can't. My mind is constant. If you get a video of me for example ... My eyes go down to look for a letter behind the door. I check the back of the door to make sure that none of the letters have got stuck and haven’t dropped. Then I run to the kitchen
table there is a pile of letters and I will look for my name. Is there any letter for me? No. Let me go in my room. Is there any letter for me in my room? No. So what kind of life is this?’

Aneni

Letters are the main mode of communication used by the Home Office to contact asylum seekers (Darling, 2014b). Aneni uses a narrative arc to emphasise her preoccupation with receiving letters, and contrasts it against a life where one is able to relax in their home. Like Bondeko and others, she uses the third-person personal pronoun when referring to the Home Office. In other excerpts this implied the Home Office was constructed as a rational entity, capable of making (im)moral and strategic calculations. In this case, it functions to denote the Home Office’s possession of the accommodation Aneni is housed in.

The perturbed fixation with letters was described by others too. Julie, 49, a refused asylum seeker from Malawi, was destitute at the time of interview. With no recourse to public funds and no fixed abode, her personal address is registered at a local VCO. Staff at the VCO call Julie’s mobile when they receive a letter addressed to her. Julie uses biocredibility to communicate the experience of receiving post:

‘When they tell me to come and collect a letter, I am like (participant gasps) I’m just shaking and then I see that it’s just a hospital appointment letter and I think: “Thank God.”’

Julie

Nyasha is also a refused asylum seeker with an on-going appeal of her refusal. Her narrative illustrates how letters are can be loaded with the threat of deportation back to her native Zimbabwe, which she left in 2002:
‘I’m just scared like this time, it’s around Christmas and I’ve got a date to the 22nd of November [for asylum hearing]. They can even reply me at Christmas time and say: “Go away”. This is what I think about every day when I go in the house ... I was maybe going to be happy but everyday I am ... (participant starts crying). Everyday I am looking for letters (participant crying, incomprehensible sounds). Every day you just look out for the letter to say: “Go.”’

Nyasha

Letters containing decisions about asylum claims, appeals, and relocations have been said to embody the Home Office’s governmental authority and materialise the presence of the state in the everyday (Hull, 2012; Darling, 2014b). These accounts show how letters can arrive at any time, thus carry a temporal uncertainty, as well as spatially penetrating places of supposed sanctuary, such as charitable organisations. Nyasa, Aneni and Julie thus show how the threat of receiving letters makes the presence and power of the Home Office wide reaching. These women use biocredibility to convey this with certainty; by recounting stories of physical and psychological symptomatology, they quantify the distress letters cause physically.

Many of the participants described their experiences of ‘signing in’, or reporting to the Home Office. The local reporting centre in Manchester, Dallas Court, rapidly emerged as a particularly problematic feature of participants’ lives. Asylum applicants must report regularly to the Home Office, a biopolitical policy that can be understood as a punitive materialisation of crimmigration. For some, attendance was an unwanted logistical and fiscal burden. Garian, homeless and destitute, described the logistical challenges of attending for regular appointments across the city:

‘Home Office treat me bad. When I am sleeping outside I am complaining, no help ... they say: “You come to sign” ... there is no one to sign in Oldham so I have to go to Manchester ... I’ll tell you,
sometimes from Rochdale to Manchester I am walking ... it will take
maybe two to three hours to walk. When I go there I say: “Please
give me money for a ticket, and then maybe next time when I come I
can take the bus.” They say: “no” ... it was every two weeks but they
don’t give me any money for ticket. Where will I get the money? ...
the thing is bad. No money, no house. I think that is selfish. People
suffer. They tell me to come and sign every two weeks and they
don’t think about me suffering that is very selfish. It hurts me they
know I’m not allowed to work. This is selfish they’re not thinking
about other people.’

Garian

In this narrative Garian is the subject of a punitive form of biopower.
Reporting represents a strategy used by the Home Office to know and
regulate the lives of the foreign other. Garian’s indignation draws attention
to the hostile paradoxes facing destitute refused asylum seekers. Despite
having no recourse to public funds and being prohibited from working,
Garian remains under governmental surveillance, and is required to
present himself to the state authorities (Darling, 2009). This, a form of
subjectification where biopower encourages individuals to work on
themselves, results in Garian’s description of a paradoxical active neglect
(Rabinow and Rose, 2003). Garian is included solely by his exclusion; in this
way he represents the bare life described Agamben (Agamben, 1998). In
response to this form of crimmigration, Garian uses biocredibility to
corroborate his claim of injustice. Illustrating his vulnerability disrupts the
social imaginary of the asylum seeker as a threat who is in need of
supervision and regulation.

For participants with refused asylum claims, reporting to the Home Office
was understood to bring them dangerously close to detention and
deportation. Denis, a now British Citizen, reflected on a time when he was
asked to report:
‘I appealed again. I was refused again. Then at some point I was asked to go and sign in every week at a police station Sheffield, and I was just really frightened for my life ... because whenever you go there you don't know what's going to happen to you. They may keep you there for good. They may send you back to your country, and I definitely don't want to go back there.’

Denis

Following this excerpt, Denis’ narrative moved back in time to his life in the DRC. He described how, after being detained in by the Congolese army for refusing to fight in the on-going conflict, he witnessed the rape and torture of a young girl who was also being held in detention. He articulated how, should he be deported to the DRC, he would be killed:

‘I hate violence so it's just the idea of shooting a child I found it extremely difficult. They said: “You have to do it or you are the one that's going to lose your life.” And I said: “Well I better lose my life, I'm not going to do that.” So I'm traumatised ... And it's a bit funny because I dropped out again [of the asylum process]. I was afraid going to sign ... I didn't know what was going to happen to me there ... I'd say: “they are going to arrest me.”’

Denis

Denis uses a number of narrative strategies to justify his disengagement with the Home Office’s reporting system. First he creates proximity between reporting at a Sheffield police station and his experiences of death and torture in the DRC. Next he vividly depicts the political environment in the DRC as a risk, by re-presenting a piece of his life there. Finally he identifies himself as traumatised. This self-diagnosis allows Denis to self-identify as a victim; he then subverts his vulnerability and, by explaining his behaviour in a scientifically legitimate way, uses his
traumatisation as part of a resistance to the practices of crimmigration (Breslau, 2004; Fassin and Rechtman, 2009).

Aneni also fears detention and removal, but continues to present herself to the Home Office officials. She employs biocredibility in her narration of attending Dallas Court:

Aneni: ‘Even like when I go to Dallas Court I always go with somebody because I feel sick, I’ll be scared.’
LT: ‘Tell me about why it makes you scared.’
Aneni: ‘Because nobody knows. Any person will tell you. You’re not safe. You can go there even just thinking you’re going to report just for normal reporting, and then before you know it … mostly it happens when you’ve got a long time without any case pending … and there is no privacy, which is wrong … whatever the Home Officer is saying to me, all of these people can listen. They say: “you have no case” and I’ll say “why I am waiting for the evidence from my country”. Before you know it they can take you into a separate room and say: “Ok you’re going to detention today”. They do that in front of everybody listening. It makes everybody feel sick too … The detention process starts from there as well.’

Aneni had never been detained in the UK. However, as an active member of a local migrant organisation that campaigns against immigration detention, she had visited detention centres with others to protest their existence. She uses biocredibility to illustrate how the fear of detention affected her:

‘It affects even the people who are outside [detention] because you are just knowing that you could be there as well … you cannot say that you are safe … I have been to Yarl’s Wood twice. Even when the bus was around the grounds … you felt your tummy going up, it
wants to come out, but no it is just hanging. It's a land of nowhere. I don't know how to describe it ... it is so scary.’

Aneni

Like Aran’s earlier story about the asylum interview, Aneni says she does not know how to describe her fear, yet then goes on to recount a visceral experience of her stomach ‘going up’ and ‘hanging’ which effectively illustrates the effect being close to Yarl’s Wood had on her. Aran too used narrative biocredibility to describe the effect of reporting to the Home Office:

‘He told us to report at the Home Office... and when he said that I felt like my heart was going to stop.’

Aran

Despite this variability in individuals’ interpersonal encounters during reporting, fear of the process of signing in persisted, owing to concerns about being detained:

‘It depends on the officers. Sometimes you meet someone who is kind, but sometimes it is very horrible how they treat you and how they speak to you. It's so scary, because you don't know what it's going to be like there and whether I'm going to be detained. Me I am scared of detention. I haven't been detained but the experiences that people have told me about in detention, I just feel that I would just collapse if it happens to me. I will just collapse ... so I’m scared of that most of the time ... the way that they treat women in there, rape and the like, so that's another thing that scares me. If I go there, the things that have happened to other women, they have been raped by officers.’

Julie
Julie describes a violent imaginary of detention, based on what she has heard from others who have been detained. Accusations of sexual misconduct of immigration detention staff towards vulnerable detainees in UK detention centres have been described elsewhere (Townsend, 2013). Julie feels vulnerable to this harm. With few other resources available to her, Julie uses the threat of biological dysfunction to relay the weight of these fears and her vulnerability. She discursively constructs herself as physically vulnerable. However, she subverts this vulnerability, using stories of biological failure as part of a moral negotiation of why she could not, and therefore should not, be detained.

**6.3.3 Using illness in the asylum appeal**

Like other refused asylum seekers, Julie appealed the Home Office’s refusal of her asylum claim. She too described the harshness of life in the UK:

‘The only thing that would give me hope and that would boost me is if I could have my own accommodation, and I would go to work and I could feed myself, those things. I've lost hope that I can manage this ... I need just the acceptance of my application for asylum because I can't have my own home now, how can I pay for this? I can't go to work because I don't have work papers. If my application gets approved I can do anything, maybe cleaning, anything.’

Julie

Julie is prohibited from being able to provide for herself by her immigration status. Julie arrived in the UK from Malawi in 2004 on a student visa to study accountancy. In 2008 she became critically ill. During a three month hospitalisation, she was diagnosed with HIV and advanced AIDS with an
undetectable CD4 count. After being started on antiretroviral medication she recovered well, however during her hospitalisation her student visa expired and she became an illegal migrant. Julie’s migration trajectory challenges normative ideals of what constitutes an asylum seeker. She did not arrive to the UK fleeing persecution; instead her current asylum appeal is based on a medical need for antiretroviral drugs. This claim has been refused numerous times by the Home Office, who contest that there are HIV clinics in Malawi that could meet her medical needs. Julie’s HIV doctor has written a letter in support of her application, stipulating that she needs a particular medication regime that is unavailable in Malawi:

‘I just feel they [The Home Office] are harsh, that they don’t take time to understand your points of wanting to stay here. Like in my case my lawyer is pleading with them the way that Dr X raised concerns in my supportive letter: “If she goes back to Malawi and she doesn’t carry on with this treatment then she’s going to die” … That’s the argument that I have. And they don’t take time to reason with that. They just say that there is medication there. But when my lawyer gathered and did a survey, just like you’re doing research, they found that medication can be so scarce in Malawi, and it’s expensive - affordable for those who have money - so assuming I go there and I don’t have money and I stay for 5 or 6 days without medication that’s where the problems will begin … everywhere there are different issues. If I go to Malawi I will die, if I stay here I’ll just be stressed, stressed. It’s better maybe to die I think than to be harassed here. Because if you are dead you don’t know anything, you’re just down there, six feet under. I think there is hope somewhere though, that’s why they keep asking me to appeal, appeal, appeal.’

CD4 count is a measure of immune system competence, and can be said to represent a ‘snapshot’ of the immune system. In HIV, CD4 count represents the severity of HIV infection. A normal CD4 count is between 500-1500. AIDS is diagnosed when CD4 counts drops below 200.
Part of this narrative can be considered to represent biocredibility. In suggesting that the harassment she faces in the UK is so unbearable that she contemplates return to Malawi and premature death, she quantifies the distress caused by the Home Office by measuring it against her own mortality. However the broader dynamics of Julie using her HIV status as part of a bureaucratic negotiation for political recognition, represent biological citizenship, a part of Fassin’s biolegitimacy (Petryna, 2004; Fassin, 2009). Driven by her legal representative, she attempts, with futility, to base her asylum claim on her health condition.

This type of appeal was being used by a number of the participants interviewed; all were female. Nyasha had exhausted her appeal options and was preparing a fresh claim for asylum based on being HIV positive:

‘On the 22nd November I’m going to Liverpool. I’m going to submit some fresh evidence, a fresh claim. But they said, “If you’re bringing the doctors evidence, a human rights appeal on medical grounds we don’t want it.” But I’m just going to bring it to them. I have nothing else to give to them … if they take me to Zimbabwe there is no treatment, there is nothing. There’s nothing you can do. I will just die.’

Nyasha

Nyasha’s narrative infers that she realises her attempts at biological citizenship will be unsuccessful, yet both she and Julie are resigned to the

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84 None of the male participants disclosed that they were HIV positive, dynamics which draw attention to the gendered nature of HIV prevalence. Globally, women make up 51% of the HIV population (PEPAR, 2016). In Western countries where dominant modes of transmission are sexual in Men who have Sex with Men and intravenous drug use, HIV is more common in men. However, in sub-Saharan African countries, where the primary mode of transmission is heterosexual sex, women have a significantly higher burden of HIV; HIV prevalence rates are 12.8% in Malawian women compared to 8.2% in Malawian men (PEPAR, 2016).
fact they have no other ground for asylum, other than to attempt to use their HIV status as a resource with which to negotiate. In the UK, asylum applications based on health conditions are considered under Article 3 of the European Convention of Human Rights. However, common law does not favour these appeals. Judges have consistently applied the principle that a significant reduction in life expectancy caused by deportation is an insufficient justification for Humanitarian Protection. This principle has been waived under very exceptional circumstances, known as the ‘D exception’, where the appellant was critically ill, close to death or dying (Council of Europe, 2010; UKUT445, 2017).

As part of her appeal, Julie described attending immigration court. When asked how she found that experience, she gasped:

‘That one was even worse. If I just know today that I will have a hearing next month that means I will be sick until the day that I am going there. Heart palpitations, high blood pressure ... It means I will have high blood pressure and heart palpitations, you know that kind of nervous that I can’t even describe. Horrible. Because I don’t know what they’re going to say and how I’m going to take it ... They ask tricky questions it's just a trick you just go round and round like if you miss they will find a fault with you.’

Julie

Here Julie uses biocredibility, quantifying the severity of the ordeal biologically. Her story also describes attempts at biolegitimacy:

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85 Article 3 of the European Convention of Human Rights states that ‘No one shall be subjected to torture or inhuman or degrading treatment or punishment’ (Council of Europe, 2010)

86 The ‘D exception’ from 1997 case law D v United Kingdom refers to a case where an appellant had no family there willing or able to care for him or provide him with even a basic level of food, shelter or social support in his country of origin.
‘[Medical records] are the only thing that they are looking for. They are looking for the evidence. And I can’t hide; I’ve got no choice. It doesn’t feel good ... but if they can help to make my case successful, why not?’

Julie

Although she is willing to accept this strategy, it is troubling:

‘HIV was also mentioned in court. I didn’t like it ... me and my lawyer would be seated there, and then someone and his lawyer be seated there, and then someone else and her lawyer be seated there, so it’s intense. So then they had to talk about my [HIV] status ... when I was going out I could feel myself frozen ... everybody knew. Even then all the other lawyers knew ‘oh that lady is HIV positive’. They didn’t speak that but that is my feeling. I thought these people they know I’m HIV, I just felt like I don’t like this, I didn’t like this. But I didn’t say anything to my lawyer, what else can I do?’... I didn’t expect that I was finding another set of people in the court ... little did I know I would be exposed. I didn’t like it that time... But these are some things that happen in the courts and in the Home Office, but we just take it because what else can we do. There is nothing we can do. There are things we don’t like, but we have to take it because we have nowhere to go. Who are we to say anything.’

Julie

Julie’s account of having her personal medical information shared in a public forum reveals an unsettling interaction of biology, identity and the state. The assessment of patients’ medical information by non-medically trained immigration judges is a treacherous site of biopower, with potentially fatal consequences. There are considerable ethical concerns raised about both the drivers and impact of this heavily bureaucratised and
legally legitimised violation of medical confidentiality. As a result of this attempted biolegitimacy, Julie futilely seeks to be recognised as a refugee only as a result of her suffering and diseased body. Here, her appeal approach produces vulnerability. More broadly, the scenario of a Malawian HIV positive woman being denied humanitarian protection by a British immigration court brings Bauman’s notions of a stratified post-colonial globalisation into sharp focus (Bauman, 1998; Mayblin, 2017b).

6.4 Discussion

Chapter Five showed how participants’ pathographies can function as a vehicle through which stories of migration and exile can be articulated. Many of the stories of illness experiences attest, paradoxically, that although the biopolitical practices of the Home Office are not directly physically abusive, they still result in physical harm. This narrative phenomenon, previously described by medical anthropologists, allows the asylum applicants interviewed to attribute meaning to their illness experiences (Kleinman, 1983; Coker, 2004). Building on this, the analysis in this chapter shows how associating ill-health with ill-treatment allows illness narratives to perform as socio-political critiques (Sakalys, 2000). This chapter built on the observation that health and lived experience are narratively co-constructed bi-directionally, and pioneers the concept of biocredibility. Biocredibility refers to, and provides a way of understanding, participants’ propensity for creating narrative enclaves for pathographies in a way which might add credibility to narratives of lived experience.

Biocredibility tends to emerge during descriptions of difficult migratory experiences. Rather than pathographies taking centre stage, stories of

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87 Not only in Malawi a former British colony, but private British corporations and the UK government have recently been criticized for their approach to investment and aid in the country, which has been suggested to be exploitative of both individuals and natural resources (Mayblin, 2018b).
illness emphasise the social and material conditions of asylum, and support
descriptions of hostile and often-contentious encounters with the asylum
apparatus. The narrative phenomenon of biocredibility is observable
throughout all three empirical chapters, and is also seen in stories of age-
related physical decline. In Chapter Four, Ahmed, Abdo, Garian and Tala
used stories of physical ageing to verify their assertions about the
difficulties of life in the UK. Denis, Aneni and Bondeko drew on frailty
narratives to corroborate the suffering they endured whilst living as
refused asylum seekers. In Chapter Five Farhad’s infected eyes provided
physical evidence that his homelessness was harmful; Abdo’s hospital
admissions confirmed how poor his asylum accommodation was; and
Hassan’s 30% decline in health quantified the ill treatment he suffered as a
result of the asylum process. Biocredibility elucidates how stories of
physical afflictions can function as corroborative evidence to substantiate
autobiographical accounts, as well as conveying the magnitude of
particular social experiences.

Every individual who narrates an account of lived experience seeks to
create a story that sounds credible (Ochs and Capps, 1997, p. 83). Biocredibility shows how pathographies can enhance narrative
authenticity. However, and crucially, biocredibility does not make
inferences about the aetiology of the suffering described. This research is
unable to answer questions about the pathogenicity of the Home Office; in
narratives of biocredibility, illness can appear both as a narrative device as
well as a narrative of experience. However, biocredibility is not suggested
to simply represent a form of rhetoric; understanding biocredibility merely
as a form of creative verbal persuasion infers participants skilfully and
purposefully use their illness to prove a point whilst strategically masking
an authentic reality (Mattingly and Garro, 1994). These too-critical,
individualistic and simplistic assumptions risk undermining participants’
 experiential accounts (Riessman, 1990). Rather than inferring that stories
of morbidity are consciously exploited by individuals for personal gain,
biocredibility urges a critical consideration of the particular identity politics and biopower embedded in the socio-political context in which it is observed.

In considering what drives the criticality of credibility, a recognition that the current hostile socio-political environment in the UK constructs migrants as untrustworthy is fundamental. Questioning individuals’ integrity necessarily fosters uncertainty and consequently erodes credibility. As a result, a burden is placed on asylum applicants to demonstrate their authenticity and prove their credibility. It is widely accepted that, due to the erosion of their credibility, asylum seekers must be ‘excellent narrator[s] of their own story in order to gain refugee status’ (Farrier, 2012; Cuthill, 2017, p. 119). As the thesis thus far has illustrated, the increasingly diffuse asylum apparatus embeds the biopolitics of categorisation and the identity politics of eligibility into the everyday. Augmenting these dynamics is the jeopardy faced by migrants seen as not being credible. As the accounts of participants refused asylum have highlighted, criminalisation and the removal of social, political and economic recognition results in a highly precarious existence of prolonged liminality, desperation and despair. Thus the question of credibility is highly consequential; it follows that biological citizenship endeavors extend beyond the asylum interview into asylum applicants’ narratives of everyday life.

Parallels can be drawn between the concept of biocredibility and Fassin’s notion of biolegitimacy; both make inferences about contemporary political moral economies where biological life can, in some way, take precedence over political life. Both biolegitimacy and biocredibility elucidate the broader socio-political context, where complex social experiences are reductively biologised and medicalised (Maluf, 2015). Historically, the bodies of migrants were conferred legitimacy though work permits and labour (Weil, 1991). However today, with the need for
unskilled labour reduced and growing fears over workforce competition, immigrants’ productive bodies are considered threatening and undesirable (Fassin, 2001; The Migration Observatory, 2018b). In this context, society is now more prepared to recognise migrants’ suffering bodies:

‘Whether through traditional law or modern torture, the body has always been a privileged site on which to demonstrate the evidence of power. But for immigrants, the poor, and, more generally, the dominated—all of whom have to prove their eligibility to certain social rights—it has also become the place that displays the evidence of truth.’ (Fassin and D’Halluin, 2005)

However, there are fundamental differences between biocredibility and biolegitimacy. Whereas biocredibility describes a narrative device, the paradigm of biolegitimacy refers to a diffuse moral and social dynamic, enacted through overt policies that legislate for the recognition of disease as a way of obtaining access to rights or resources (see Bessire, 2012; Young, 2013; Maluf, 2015; McMullin, 2016; Premkumar et al., 2016). Fassin argues that biolegitimacy can produce political empowerment. In France the humanitarian illness clause allows asylum seekers with serious illnesses legal refugee status, thus they are legitimised through their suffering. This is in contrast with the British context where biocredibility fails to facilitate political recognition. With only a few exceptions, such as Section 4(2) hard-case support, in the UK borders are embedded into state welfare and healthcare systems, and migrants’ eligibility for assistance is based on immigration status rather than clinical need. Here, if an individual is considered illegal, both biological life and political capacity are disregarded. The analysis in this chapter demonstrates that, even in the absence of explicit biolegitimacy legislation, asylum applicants persistently draw on experiences of illness in order to negotiate credibility and recognition. This is realised both explicitly, through futile attempts at
biolegitimacy by using HIV for legal appeals of asylum refusals, and more commonly through more nuanced narrative biocredibility.

The drivers of this narrative biologisation can be found in the austere social and material conditions in which individuals seeking asylum in the UK live, coupled with the social and political gazes they are subject to. These objectifying gazes are polarised. On the one hand, a pervasive populist anti-immigration sentiment naturalises the figure of the bogus asylum seeker and sees asylum seekers as a multifaceted threat to the order of society (Innes, 2010; Zimmermann, 2011; Stewart and Mulvey, 2014; Griffiths, 2015). On the other, asylum applicants are the subject of a philanthropic humanitarian gaze, where they are constructed as diseased, damaged and dependent. More broadly, dominant social culture of medicalisation and the positionality of the researcher generates a medical gaze.

Biocredibility can be understood as the product of a combination of these problematic and contradictory socio-political gazes. Both the content and structure of participants’ narratives represent them as damaged as a direct result of the asylum apparatus in the UK. Stories of the body-in-failure and the body-in-decline can be understood to, at most, be produced by and, at least, be enhanced by the medical gaze. These pathographies facilitate the attribution of culpability, and stress the significance of the biopolitical hostile environment. In this way, biocredibility allows participants to define themselves in opposition to their constructions of the Home Office and

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88 The origins of the philosophical term ‘gaze’ can be found in the work of Sartre (1943) and describes the acts of seeing and being seen. In his explorations of the historical and epistemological foundations of objectification, Foucault described how shifting discourses encourage doctors to envision a case or disease rather than a human being; this phenomenon, so called the medical gaze, produces unwell individuals as subjects (Foucault, 1994). Social scientists have since expanded and widely applied the concept of gaze, to include: the post-colonial gaze, which positions the colonised as other and re-establishes the power of the conqueror (Beardsell, 2000); the male gaze, which draws attention to the objectification of women by hegemonic patriarchal norms (Mulvey, 1989); and the humanitarian gaze, which reinforces North-South power relations and normalises social, political, and economic inequalities (Mostafanezhad, 2014).
condemn the social and material conditions of asylum in a scientifically legitimate way. In addition, narrating illness evokes notions of vulnerability; biocredibility therefore allows asylum seekers to resist the hostile gaze that perceives them as an inevitable multifaceted threat. Thus, biocredibility can be used to subvert the suffering of social liminality by providing a narrative apparatus on which the oppressed can make personal and social attestations and engage in the political dialogue of resistance.

Simultaneously, biocredibility proffers a mechanism through which participants can resist the humanitarian gaze. This sympathetic gaze, which constructs asylum seekers as always vulnerable, risks reinforcing existing power relations and normalising structural inequalities. This objectifying imaginary is, albeit unintentionally, promulgated by both humanitarian and advocacy organisations that benefit economically from this discourse, and by critical academics who have challenged hostile approaches to migration by foregrounding accounts of migrants’ vulnerability (Rainbird, 2012). By clearly attributing impairments and agedness to particular experiences in the UK, those who employ biocredibility refute the assumption that they are always and already damaged and a burden. By attesting that their ill-health is the result of structural violence, participants make a powerful statement of attribution and resist the unwanted ascription of an identity of inevitable impairment. Instead, physical suffering is articulated as dynamic and preventable, and a moral decree of the treatment in exile is professed.

Biocredibility might also be understood as a form of self-governance, or subjectification. Subjectification, the engine of biopower, describes how individuals espouse debasing discursive norms, and work on themselves by narrating their lives accordingly (Rabinow and Rose, 2003). As well as providing a way to enhance credibility and resist certain undesirable gazes, biocredibility might allow the negotiation of social recognition through the demonstration of deservingness. Stories of illness and ageing can be
understood as a way to demonstrate deservingness of legal status, access to the labour market, and adequate housing. Conceptualising biocredibility through the frame of biological citizenship illustrates how pathographies might perform as moral articulations of negotiations for social justice.\(^{89}\) This draws attention to the ways in which identity, biology and the state interact to shape migrants’ understanding and articulations of suffering. However, self-pathologisation, a sullying form of subjectification, is likely to have denigrating effects. Julie’s story of attending an immigration tribunal shows how the appeal, based on her medical condition, produces vulnerability. Thus Ticktin’s concerns about the production of particular versions of humanity, limited and reduced to illness and infirmary, remain pertinent (Ticktin, 2011, p. 107; Premkumar et al., 2016, p. 17).

Fassin suggests that explicit policies and practices of biolegitimacy, such as the French humanitarian clause, assigns the body a privileged status and legitimises illness. However, biocredibility shows how the vilifying effects of biopower and identity politics transcend the explicit policies and practices of biolegitimacy named by Fassin. Instead, humiliation is fostered by the biopolitical immigration apparatus through the production of social circumstances of liminality, exclusion and resource deprivation. In this ascetic setting, the social and material conditions of asylum leave older asylum applicants with few other narrative resources on which they can draw to enhance credibility and exercise resistance. Consequently, stories of biological dysfunction emerge as a resource. Descriptions of biological pathology draw attention to shared humanity and human experience even between individuals who superficially appear to have very little in common. This encourages the listener to recognise human-ness, despite delegitimised status (Fassin, 2001; De Genova, 2002).

\(^{89}\) Stillo importantly highlights how, within the biological citizenship literature, citizenship refers to basic social recognition and associated rights and entitlements, rather than political citizenship (Stillo, 2015).
A small body of literature describes the social uses of illness narratives in other contexts, suggesting that bodily stories can be employed as a form of expression, and as a way to manipulate the relation of self to environment (see Riessman, 1990; Heurtin-Roberts, 1993; Strahl, 2003). In parallel, anthropologists have highlighted how asylum applicants negotiate issues of increasingly polarised representation, focusing on reshaped identity and resilience (see Kokanovic and Stone, 2010; Hilhorst and Jansen 2010; Clare et al, 2014; Cuthill 2017). The concept of biocredibility, introduced in this final empirical chapter, bridges and develops this scholarship. In spaces of extreme de-legitimisation and poverty of power and capital, stories of visceral biological dysfunction proffer a mechanism through which credibility might be negotiated and hostile and degrading depictions might be resisted. Although biocredibility has the potential to subvert the suffering of social liminality by providing the apparatus on which the oppressed can make personal and social attestations and engage in political dialogue, it also can be understood to represent a form of denigrating subjectification. Here, hostile social conditions cause suffering by producing subjects who narratively construct and inhabit pathological self-identities. The next and final chapter will summarise the thesis and explore the implications of these findings for practice, policy and research.
Chapter Seven

Discussion: Research contributions and impact

‘The first task of the doctor is therefore political: The struggle against disease must begin with a war against bad government.’

Foucault, 1994, p. 38.

7.1 Introduction

This final chapter outlines the implications of the research findings for policy, practice and future research. The chapter will begin by making some final methodological reflections, before drawing together the main research findings. These findings will be consolidated using the four theoretical concepts described in Chapter Two: intersectional structural violence; biopower; explanatory models of health; and identity politics. The empirical, methodological, and theoretical contributions of the thesis will be identified within this framework, as will the limitations of the work. Notably, it will be suggested that the empirical findings, which show how social conditions might produce suffering, and biocredibility, the central theoretical contribution of the thesis, challenge the medicalisation and psychologisation of complex human distress. This is illustrated through a critical consideration of somatoform disorder, a contemporary condition that epitomises the tendency to reductively medicalise complex suffering.

7.2 Methodological reflections: Invisibility begets invisibility

Chapter Three provided an account of the methodological processes used in this research. Rather than a repetitive summary, this section will provide a few short reflective conclusions. This research set out to explore how
asylum applicants narrate the associations between life stressors and the experiences of ageing, health, ill-health and frailty in exile, and how intersecting structural violences are spoken about. By foregrounding the experiences of an often-overlooked group, the research strives to understand the health and migration experiences, and thus challenge the invisibility, of older migrants; reflect upon the role played by therapeutic, institutional and legislative cultures; and re-evaluate the theoretical concepts outlined in Chapter Two.

Invisibility can be understood as a form of ageism (Clarke and Griffin, 2008). The perceived invisibility, and thus marginalisation, of older migrants was pervasive throughout the research process, from project planning to research dissemination. Governmental data shows that asylum seekers and refugees are a small minority of migrants to the UK and older asylum applicants are a minority within this minority. This rarity was posited as a challenge to the completion of the research by a number of parties. However, persistence in the recruitment stage of research revealed that, despite not being the most numerous age group, once in attendance at the VCOs older migrants became visible and were overwhelmingly keen and willing to participate in the research. Since data collection has been completed, further potential opportunities to recruit older asylum applicants have been identified. These observations about feasibility should encourage future researchers looking to explore the experiences of multiply marginalised individuals, given research that resists the invisibility of already-excluded social groups is so ideologically important.

However, the recruitment approach was not without limitations; although successful in accessing older people, it cannot claim to have done this intersectionally. The gendered nature of the study sample is more

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90 These parties include the local academic community, professional informants and VCOs.
reflective of the gendered recruitment spaces than the general population of older migrants, which is more or less equal. Future research should consider the issue of invisibility as a form of structural violence and strive to achieve more balanced representation of minority groups within minority groups. This is particularly important in light of the empirical findings of this thesis, which highlight how the multiple and intersecting axes of oppression impact the lives of the participants interviewed. More representative intersectional recruitment strategies might challenge and disrupt the absence of older women from mixed VCOs spaces, and thus should be of interest to policy makers and community workers assisting migrant communities.

The exclusion of migrants from large data sets inhibited the quantitative analysis of older asylum applicants’ health outcomes in this thesis. Chapters Two and Three drew attention to the absence of health data, and consequent biomedical literature, exploring the health of asylum seekers and refugees in the UK. In order to produce biomedical public health research, an accurate denominator is required; each member of the population of interest must be counted. In the absence of such data, researchers seeking to evidence population health inequalities are in conflict with governments who promote inequalities through austere and hostile policies that drive health disparities (Correa-Velez and Gifford, 2007). Thus this absence works to erase health inequalities; vulnerable populations are rendered academically invisible, which further contributes to their marginal social positioning. More broadly, these dynamics are illustrative of the position of certain migrants as paradoxically within the rule, yet outside the responsibility, of the state.

The current status quo legitimises the exclusion and invisibility of certain marginalised groups in biomedical, sociological and anthropological health research; academic work that disrupts these norms is needed. These methodological reflections also bring questions of power and knowledge
production to the fore, and highlight the resources and persistence required to challenge normative assumptions when researching marginalised populations. Consequently, important questions remain about migrants’ non-communicative disease burden, and the routine application of non-validated\(^{91}\) biopolitical concepts, such as frailty, to older migrant populations. Future research should be underpinned by critical theoretical approaches in order to illuminate the political nature of both health data and problematic emergent diagnoses.

### 7.3 Intersecting structural violences and biopower

Intersectional analysis of the empirical data both rejected the essentialisation of participants’ identities and revealed the multiple social domains through which structural violence operates. This included, but was not limited to, gender, age, employment status, and race. These factors co-existed and positioned individuals in unique social positions. Although a gendered analysis was not anticipated, the gendered nature of transnational migration, the male-dominated recruitment spaces and resultant study sample, and participants’ gendered narratives of ageing, meant that gender emerged as a key theme. Normative gendered social expectations combined with ageing and exile to produce particular challenges for older female migrants. For the older women, ageing was associated with social isolation, negative body image and hopelessness, findings which echo existing literature (Rutagumirwa and Bailey, 2017).

Examination of culturally-rooted patriarchal pre-migration and post-migration norms illustrated how, for some older men, presumed wisdom and esteemed social status in later life meant ageing was seen as a

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\(^{91}\) Routinely applied frailty scores are defined by individuals’ interaction with state healthcare systems, which in turn is dependent on multiple factors including: access and eligibility for healthcare, communication between practitioner and patient and explanatory models of health.
reverence. Simultaneously, however, discourses in the UK that position migrant men as a threat subvert ideas of male dominance. As a result, patriarchal norms exclude, and thus make vulnerable, particular categories of men. This was made evident through issues surrounding access to the labour market in the UK, which posed specific challenges to masculinities in exile, often through socially constructed ideas of male strength and responsibility for financial provision. A consideration of the barriers to employment for those with access to regular labour market identified some additional specific and intersecting axes of oppression faced by participants. Here, stories of racial abuse and discrimination were highlighted.

In particular though, participants attributed their suffering to their immigration status. Descriptions highlighted how the governmental categorisation of lives in the UK, for the purposes of distinction and division, impaired capacity for wellbeing. When describing biopower, Foucault refers to the administration of bodies and calculated management of life; ideas which are epitomised by reductionist immigration categorisation practices (Foucault, 2008). Analysis also demonstrated how this biopolitical oppression extends beyond the ascription of problematic labels. Rather, the biopolitical bordering practices were articulated through experiences of the everyday, through a nexus of surveillance, exclusion and destitution (Young, 1990). Life in exile, underpinned by often-insecure immigration status, was narrated as precarious, suspended and uncertain. By embedding the asylum apparatus into everyday life, the biopolitics of immigration categorisation creates a diffuse and hostile borderscape (Potter, 2018). Consequently, governmental immigration categories create new ways for people to be; they structure migrants’ dual realities by shaping the parameters of possibility.
Those with insecure immigration status inhabit a paradox. Despite being excluded from the protection and benefits of the state, they live under governmental rule. Narratives revealed how the diffuse machinery of the border operates to regulate these lives. Asylum applicants are the object of the processes and practices of contemporary crimmigration, subject to interrogation, surveillance and exclusion, often living in fear of detention and deportation. They are included merely through their exclusion, and epitomise the limina persona by being not yet and no longer (Menjívar, 2006). In this way those seeking asylum in the UK are positioned eternally at the border (Darling, 2011). This thesis suggests that this suspicious gaze, coupled with the protracted occupation of liminal social position, erodes individuals’ legitimacy and credibility.

This thesis makes an empirical contribution to a body of academic work that problematises the hostile and austere social and material conditions of asylum, much of which also uses the theoretical underpinnings of Foucault and Agamben. However, such work tends to explore one facet of hostility in isolation, for example Darling focuses on accommodation, Cuthill explores identity, and Bloch researches precarious labour. The intersectional framework used in this research is informed by this existing scholarship, yet builds on it by exploring the interplay of these multiple dimensions of lived experience. The intersectional analysis also makes epistemological assertions. By reifying how social categories, such as age and gender, are given meaning through social interactions, and how these lived identities vary across social landscapes, the analysis evidences social constructionism. For example, drawing attention to how dominant masculinities can be subverted and used to delegitimise and marginalise particular individuals rejects dichotomous additive thinking. By unpacking how individuals can simultaneously be both oppressed and oppressor, essentialised and binary imaginaries of oppression and deservingness are disrupted; instead, it has been shown that social characteristics are not experienced separately, despite them appearing oppositional (Windsong,
As well as broadening the research scope, the epistemological contribution facilitated by the use of intersectionality encourages a more nuanced and participant-led critical exploration of the social dynamics of asylum in the UK.

The analysis has wide-ranging and far-reaching implications for policy and practice. The current operationalisation of the UK’s asylum system has, unambiguously, been problematised. Denis’ account showed how the immigration categories ascribed to asylum applicants appear to represent the moral and political priorities of the host state more than the legitimacy of individual applicants’ claims of a fear of persecution. The campaign to keep migrants in a situation of prolonged discomfort is a strategic one, underpinned by a governmental drive to decrease net migration. However, many of the individuals interviewed were trapped in these liminal spaces indefinitely and, paradoxically, saw no option to leave the UK. The findings of this thesis illustrate how these governmental strategies of discomfort produce social, economic and personal vulnerabilities, thus it raises moral concerns. In addition, despite a desire to participate productively in social and economic life in the UK, many of the individuals interviewed were prohibited from doing so. Consequently, practical and fiscal concerns accompany the moral implications of this structural violence. This questions the logic of these malevolent policies and calls for a radical rethink on reductionist immigration categorisation. However, with the rise of popularism and uncertainty over Britain’s exit from the EU, an already overwhelmed Home Office is unlikely to give precedence to asylum seekers, thus these dynamics are likely to endure.

The thesis’ intersectional analysis also draws attention to the particular materialisations of these hostile dynamics, which offers pragmatic strategic guidance for further research and activism. Participants’ narratives highlight specific domains for improvement, such as: challenging indefinite immigration detention; a renewed approach to immigration interviews;
allowing those awaiting an asylum decision to work; and more appropriate financial support. This has steered involvement in several campaigns alongside the completion of this thesis (Appendix 4) (Tomkow, 2017a, 2017b, 2019a, 2019b; Kang et al., 2019). Of particular interest is the recent extension to the NHS charging regulations, which hardened existing legislation, making certain migrants chargeable for some NHS services prior to treatment if they are unable to prove their eligibility for free care. This policy raises urgent questions about how bordering within the NHS and other public services might determine health outcomes (Kang et al., 2019; Tomkow et al., under review). More broadly, exploration of the extent to which policies that foster pervasive hostility towards foreigners calcify existing biopolitical delineations and augment structural violence is warranted.\(^\text{92}\) Despite increasing opposition to these exclusionary policies\(^\text{93}\), researchers, practitioners and campaigners keen to resist these hostile dynamics have much work to do.

7.4 Explanatory models of ageing, frailty and health

As has been reiterated throughout the thesis, the asylum applicants interviewed were from diverse backgrounds and were not a culturally homogenous group. Unsurprisingly then, conceptualisations of ageing varied across the study sample. However some commonalities were observed. Rather than being based on chronological age, participants’ explanatory models of ageing were articulated socially. Stories of getting older were constructed in relation to migration and focused on displacement as a disruption to ageing. Expectations of later life were contrasted against the disappointing experiences of ageing in exile.

\(^{92}\) In early 2019, the High court ruled the ‘Right to Rent policy’, which made landlords check tenants immigration status, to be discriminatory and breach human rights (BBC, 2019).

\(^{93}\) Recent years have seen cross-party calls to end indefinite immigration detention, and to allow asylum applicants to work whilst awaiting their immigration decision (Bowcott, 2019)
Homelands were remembered warmly. Rather than dismissing nostalgic narratives as overly sentimental, these fond rememberings are understood as a political response to on-going social marginalisation. Participants’ readiness to draw on nostalgic narratives highlights the deficient social and political environment in exile.

Exile appears to place a strain on the very social processes used to construct ideas of old age, through disruption of social bonds, family estrangement, poverty, prolonged asylum processes and the spaces in which ageing in exile takes place. Some participants described a process of accelerated ageing as a result of life in the UK. These narratives echoed social gerontologists constructions of a Fourth Age: an “abject” class whose social realisation is enacted by the institutions of welfare and welfare rationing’ (Higgs and Gilleard, 2018, p. 48). Stories of the social and economic prosperity and consumption associated with the Third Age were absent. Further exploration of migrants’ precarious ageing in reference to existing theoretical social gerontological frameworks would be warranted, both to define the limitations of these hegemonic theories and facilitate more inclusive theoretical approaches to unequal ageing.

As Chapter Two demonstrated, literature exploring older migrants’ explanatory models of health is scarce. This analysis showed that participants conceptualised health as multi-domain, with psychological, social, physical and spiritual dimensions. Frailty, a now-dominant biomedical gerontological concept in the UK, was not a recognised by many of the participants. Those who did recognise the term articulated ideas of frailty as a multi-domain phenomenon, where social and emotional dimensions dominated. Frailty was often loaded with negative connotations, inferring impaired morality and challenging ideas of dominant masculinities. Participants’ experiences of frailty were momentary and historicised, constructed and narrated in relation to liminal lived experiences. Although they described psychological and physical
symptoms, participants located experiences of feeling frail in personal and emotional responses to social happenings of extreme adversity.

Participants’ subjective experiences appear unrelated both to the chronic impairment and accumulation of deficits proffered by the biomedical model of frailty and ideas of health based on resilience. Instead, attention is drawn to how adversarial social environments and structural inequalities determine experiences of feeling unwell and frail. There are no existing qualitative studies exploring frailty in migrants; these results suggest this is an avenue in urgent need of exploration. Alongside the quantitative validation of routine frailty measurements in asylum seeker and refugee populations is the necessity of an investigation into how these individuals might negotiate and rationalise being ascribed a diagnosis of frailty, given its often negative connotations and impaired cultural translation. By bringing the tensions between asylum applicants’ explanatory models of health and biomedical explanatory models of health to the fore, this analysis adds to the literature challenging the culture of increasing medicalisation. Specifically, the findings urge a reconsideration of models of health that centralise ideas of biomedicine and resilience.

The most salient finding however, was that health was narrated in close relation to lived experience. The extent to which participants focused on post-migratory stressors in their interviews generally, and health narratives specifically, was striking. The participants had varied countries of origin, migration trajectories, and ages, and consequently they faced myriad and intersecting structural oppressions. Nevertheless the majority felt their health was poor. Rather than referring to health in an abstract way, participants shared personal experiences of ill-health, intertwined with narratives of social, political and economic life in the UK. As with many other small qualitative studies, these accounts problematise the academic fixation with migrants’ mental health and infectious disease; instead pathographies located the determinants of health in experiences of
structural violence and the social disruption of migration.

The use of illness narratives as a vehicle for embarking on stories of displacement has been described by Coker, who suggested that the symptoms of refugees in an Egyptian medical clinic were inherently associated with their displacement: ‘part of the pain of losing their country, losing their relatives, and living constantly in fear of deportation, public harassment, or financial crisis’ (Coker, 2004, p. 34). She suggests that through illness narratives, refugees found ‘a common ground in which the role of the body becomes, for a time, explicit in a way that would never be seen in a society that remained more securely tied to its institutions, history, and geography’ (Coker, 2004, p. 34). In this study, too, participants introduced accounts of adversity into visceral descriptions of suffering, and so provided historical and geographical context for their deterioration in health. As a result, the UK asylum system emerges as a determinant of health. Participants’ narratives, which seamlessly interweave lived experience to health, suggest that, in order to really understand the causes of suffering, we should look to the social worlds in which we live.

Importantly, however, this thesis builds on Coker’s work. Using narrative analysis has demonstrated the bidirectional nature of the narrative co-construction of health and lived experience. This co-construction was bi-directional, both in the content of the narratives - what was said - and in the construction of the narratives - how it was said. Not only are health stories an avenue for narratives of lived liminal experiences, stories of difficult life experiences are punctuated with memories of biological dysfunction. As a result, stories of health and ill-health emerge as a narrative tool.

An awareness of this narrative co-construction between health and lived experience is of interest to practitioners, policy makers and researchers alike. Foremost, it problematises the pathologisation and medicalisation of
complex despair, and warns against the uncritical endorsement of biomedical models of health. Instead, practitioners and researchers should be encouraged to consider the wider social determinants of health when working with marginalised populations. Secondly, the narrative phenomenon may facilitate a more nuanced understanding of existing research, providing an explanation of why self-reported wellbeing has been shown to be so poor in similar populations (Gerritsen et al., 2006; Toar et al., 2009). Thirdly, the narrative proximity between physical suffering and experiences in exile shows how punitive policies, which hold individuals in liminal positions for prolonged periods of time, create and sustain ill-health. By viscerally illustrating the harms caused by the asylum system, the accounts of these potential citizens should be of interest to governmental policy makers.

7.5 Identity politics: Biocredibility

Building on the finding that narratives of health and lived experience are co-constructed bi-directionally, the thesis pioneers the conceptual idea of biocredibility. Biocredibility provides a way of understanding participants’ readiness to create narrative enclaves in their stories of lived experience and insert accounts of biological dysfunction. By interjecting pathographies into experiential life narratives, the significance and import of such experiences are communicated effectively and credible evidence of narrative testimony is provided. The concept of biocredibility describes this narrative phenomenon and cultivates a critical analysis of the drivers of the biologisation of complex human experience within hostile and austere environments.

Although in narratives of biocredibility illness can appear as a narrative device as well as a narrative of experience, biocredibility resists the perception of narrators as Machiavellian actors who use rhetoric to
strategically mask an authentic reality. As suggested in Chapter Three, performance, as a way of presenting the self in a Goffmanian sense, is problematic in that it can foster and propagate a pejorative gaze of marginalised individuals’ accounts (Riessman, 1990). Importantly, biocredibility does not proffer judgement on the aetiology of the health episodes described, nor does it infer participants exploit illness scrupulously for personal gain. Speculating that participants’ readiness to utilise pathographies is due to their fraudulent, neurotic or hypochondriac characters neglects an interrogation of the social context required to understand these tendencies (Crossley, 2004). Instead, biocredibility is epistemologically rooted in the consideration of narrative as a ‘verbal action in a social context’ (Bauman, 1986; Riessman, 1993, p. 1196). Thus it is interested in how and why pathographies are constructed alongside accounts of lived experience in this particular socio-political environment.

Chapter Six introduced, described and explored the idea of biocredibility, situating it within existing literature. The centrality of credibility was reiterated, as was the perilous exclusion faced by those who are seen as not believable. The chapter suggested narrative biologisation was a result of the austere context and particular social gazes asylum applicants are subject to. Immigration policies that produce deliberate destitution and discomfort leave asylum applicants few other resources with which to corroborate their stories. Simultaneously, the social and political gazes embedded in broader moral economies objectify asylum applicants in often-conflicting yet necessarily-undermining ways. Biocredibility can be understood as a form of resistance to these dynamics. Blaming the Home Office for illness undermines the humanitarian construction of asylum seekers as necessarily impaired and challenges dominant biomedical explanatory models of suffering. Simultaneously, using illustrations of vulnerability resists and destabilises the hostile gaze that posits asylum applicants as a threat. Here biocredibility is in a seemingly paradoxical position; individuals narrate themselves as having experiences of illness,
yet not necessarily being ill. Yet both of these seemingly-paradoxical dynamics illustrate how biocredibility can perform as a type of resistance. By using narratives of suffering to construct political voice, asylum applicants subvert their illness experiences, using them as a platform for socio-political critique (Sakalys, 2000).

Both biocredibility and biolegitimacy are reflective of a moral economy of increasing medicalisation and psychologisation where individuals’ political potential is subordinate to their physicality and pathology (Rose, 2007). Both concepts reflect the broader contemporary social and political environment in which medicalisation flourishes and a hostile austerity pervades. Fassin uses the case of the French humanitarian clause to show how biolegitimacy achieves political empowerment and it has been suggested that biocredibility might offer some narrative resistance to particular gazes. However, biocredibility should not be taken to simply represent a form of empowerment. In this way, it differs from biolegitimacy. In the context of the hostile asylum apparatus in the UK, narrative biocredibility fails to provide asylum applicants with political recognition. Instead, understood through the analytical frame of biological citizenship, biocredibility represents a mode of subjectification. Here, the social context fosters the necessary adoption and articulation of identities of disease and degradation. The sullying effects of this self-pathologisation are of cyclical suffering and despair. Thus the biopolitics of asylum in the UK produces impaired bodies that exist only with reference to their pathology. In this way, biocredibility denotes the narrative subjectification produced by a moral economy of medicalisation, the biopower of asylum, and deliberate austerity.

7.5.1 The impact of biocredibility: Problematising somatoform disorder
As has been discussed, the growing power and reach of biomedicine has led some practitioners to critically question whether the expansion of psychiatric diagnoses represents mental pathology, or justified social misery and resultant psychological distress (Goldhill, 2019). Somatoform disorder (SD) epitomises biomedicine’s tendency to intellectualise complex social distress, and root this intellectualisation in ethnocentric mind body dualisms (Becker, 1997; Coker, 2004; Al Busaidi, 2010). First introduced as a psychiatric diagnostic term in the 1980s and defined as the experiencing of psychological distress through physical symptoms, SD replaced the anachronistic and pejorative term ‘hysteria’ (Mai, 2004; Al Busaidi, 2010). Medical practitioners, who attribute meaning to symptomatology by associating experiences of suffering with organic disorders, can avoid diagnostic uncertainty by categorising individuals who describe symptomatology unexplained by biomedical models of health, with SD. However, the evidence base for SD’s diagnosis and treatment is deficient (Mai, 2004). Although medical anthropologists have criticised the medical imposition of other reductionist diagnostic categories, an academic critique of SD is lacking; instead, anthropologists, too, tend to regard somatisation as the physical expression of psychiatric distress (Kleinman, 1983; Hinton and Hinton, 2002; Coker, 2004).

The critical approach fostered by biocredibility problematises the ascription of psychiatric diagnoses such as SD to marginalised populations in austere and hostile environments. SD is a diagnosis of exclusion; that is, a clinician should be certain that symptomatology has no organic physical cause before attributing it to psychological dysfunction. However, migrants face myriad and multiple barriers to appropriate and quality physical

94 Biomedical researchers and clinicians define SD according to the Classification of Mental and Behavioural Disorders section of the International Classification of Diseases (ICD), which defines somatoform disorder as: ‘Repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient’ (WHO, 1992). In contrast with factitious disorder or malingering, the symptoms of SD are not thought to be intentional.
healthcare in the contemporary hostile environment in the UK (Kang et al., 2019). As a result, their chances of being appropriately investigated and diagnosed with a physical health condition are reduced. More worryingly, once diagnosed with a psychiatric condition, other physical symptoms may be inappropriately attributed to SD. In other words, those with SD may be less likely to have their physical complaints taken seriously, as clinicians may incorrectly use SD as an explanation. Resultantly, SD can be conceptualised as an exclusionary and silencing diagnosis, and both a reflection and determinant of impaired access to safe appropriate healthcare.

Underpinned by the idea that it materialises due to the stigma associated with mental illness, some medical anthropologists and western psychiatrists suggest SD is more prevalent in cultures they assume to be more primitive (Kleinman, 1977; Wierzbicka, 1992; Kirmayer et al, 2011). However, this diagnostic imperialism is ill-founded. High rates of SD have been observed across a range of cultural contexts; variation in the prevalence of SD is more associated with how it is defined, rather than geographical location (Simon et al., 1999). Despite this, SD remains a diagnosis more frequently ascribed to marginalised and minority communities (Lazaroff, 2006; So, 2008). This ethnocentrism contributes to the construction of migrant populations as somatisers; refugees’ physical complaints in the absence of diagnosed organic disease receives much academic attention and is often attributed to non-specific cultural difference (Lin et al., 1985; Westermeyer et al., 1989; Castillo et al., 1995; Waitzkin and Magana, 1997; Aragona et al., 2010; Rohlof et al., 2014). Coupled with the impaired access to appropriate physical healthcare, this ethnocentrism may increase migrants’ propensity for acquiring a diagnosis of SD.

The dominant discourse in medical anthropology holds that SD manifests when individuals are incapable of accepting, or unwilling to accept, the
psychological component of their distress (Kleinman, 1977; Wierzbicka, 1992). However, the participants in this research openly described their mental suffering and social difficulties. By constructing visceral narratives alongside stories of mental anguish and experiences of surveillance, hostility and austerity, they shrewdly recognised the interrelated nature of the social, mental and physical aspects of health. As biocredibility is observed across the varying cultural backgrounds of the participants, it resists the objectifying reduction of asylum applicants’ health experiences to either cultural difference or psychiatric disorder.

Moreover, biocredibility contests the isolation of psychological and physical pain from its environmental causes. Unlike SD, biocredibility seeks not to pathologise individuals, nor to diagnostically reduce narrative phenomenon into either medical or psychiatric categories. Thus biocredibility shows how SD can function as a silencing tool. By diagnosing the individual as mentally impaired, biomedicine neglects the fundamental role of social context, which participants’ stories of suffering so effectively draw attention to (Sandquist, 2014). Biocredibility rejects the idea that experiences of suffering must be externally validated by a medical professional, who determines whether the flaw is with the body or the mind. Instead, the concept shows how, when narratives of health are so closely interknitted into stories of life, close and critical attention should be paid to the socio-political environment in order to understand the drivers of suffering. In doing so, biocredibility draws attention to how pathologisation can overlook the social drivers of illness.

7.5.2 The impact of biocredibility on practice, policy and research

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95 The focus of this study was not to explore the biomedical aetiology of participants’ health experiences and there were no attempts to diagnose participants, thus aspersions about the clinical cause of bodily narratives would be inappropriate.
As well as making a contribution to theoretical thinking about the social nature of illness and the suffering body, the concept of biocredibility has the potential to shape medical practice, immigration policy, and future research. Biocredibility highlights how practitioners overlook, and thus fail to challenge, the social causes of suffering. Rather than suggesting individual practitioners are deficient in this, biocredibility foregrounds the influence of the broader environment of biomedicalisation. This medicalised culture produces practitioners who inadvertently accept the oppressive power dynamics that foster such suffering, both by disregarding the structural drivers of ill-health, and by overlooking potential therapeutic strategies to improve individuals’ lives. In its critique of the western medical duality of mind and body, biocredibility encourages practitioners to consider the broader structural determinants of health and drivers of suffering when patients talk about health experiences in close relation to their lived experience. This critical approach, which focuses on the meaning participants attribute to illnesses, urges questions around why this narrative co-construction dominates.

Taking a person-centred approach, and foregrounding the social world within which the individual exists, proffers a number of advantages. First it encourages practitioners to recognise the political nature of disease and the social determinants of suffering, and thus strives to encourage health care providers to be advocates. Medical advocacy can take multiple forms, from lobbying for change at population-level, leading on strategies to improve health at a local level, or advocating for patients at an individual level. Second, centralising the social world in medical consultations may be of therapeutic benefit for the patient. This strategy both has the potential to reduce over-diagnosis, which in Foucauldian thinking represents an objectifying practice, and decrease prescribing of pharmacological treatment, which is ineffective in addressing individuals’ social distress (van Dijk, 2016; Tomkow, 2018). Instead a meaningful therapeutic exchange is
stimulated, where patients’ social concerns and resultant misery are acknowledged, rather than disregarded.

Biocredibility as a concept is both worthy, and in need, of further academic exploration. The limitations of this research include the sample size and particularity of experiences described, which mean that findings of this thesis cannot be assumed to be applicable for all asylum applicants. Moreover, the narrative proximity between health and lived experience could be influenced by a social desirability bias, as a response to the perceived medical gaze and positionality of the researcher, coupled with the health-focussed research questions. This potential has been addressed in the analysis, by the consideration of biocredibility as a form of resistance, and of subjectification. Nevertheless, further exploration of this narrative phenomenon by non-health researchers would enhance the validity of the theoretical contribution.

Moreover, in the current political and economic climate of austerity, and the resultant rationalisation of welfare and healthcare, questions around biocredibility extend beyond the sphere of migration and into rights and entitlements of citizens. Here, critical enquiry into how stories of biological dysfunction can perform as a resource within the nation state would also be valuable, both through the renegotiation of credibility, as a form of resistance, and in the demonstration of deservingness. The relationship between the intersecting social demographics, described in Chapter Four, and biocredibility would also be valuable: although biocredibility was observed across the varied study sample, the impact of age, gender, education level and resource deprivation on this narrative phenomenon warrants further exploration.

The concept of biocredibility makes a methodological contribution by demonstrating how narrative analysis as a qualitative research method can both attend to the particularity of lived experience, whilst critically
commenting on broader social contexts. Sharing narratives allows individuals to make sense of disruptive life events (Riessman, 1990). Through detailed textual exploration, both the content and the construction of stories evidenced the fundamental degree to which health and lived experience are interwoven and co-constructed. Coupled with the critical epistemological focus fostered by CMA, narrative analysis allowed the richness of the empirical data to be both situated within broader social processes and to provide individuals an opportunity to speak for themselves. Although the harms precipitated by providing an outlet to share stores have been described, overwhelmingly participants were keen to speak out about their lives. Whilst describing the anonymisation of participants’ identities during the consent procedure, Rohat retorted: ‘I don’t care, share my story, put me on the news’. Although extreme, this sentiment was typical of most of the participants, who asked that their experiences of ill treatment be disseminated far and wide.

In observing the phenomenon of biocredibility, this thesis demonstrates how medicalisation collides and combines with the hostile and austere reality of life in the UK to foster the biologisation of complex social migration experiences. The role of biology and medicine in increasing the permeability of borders is a dynamic phenomenon; one which is especially pertinent given the continuously expanding power and reach of medicine, combined with the British legal system’s ability to evolve judicial landscape through common law. As the Home Office’s crimmigration strategies become ever more restrictive, migrants and their advocates may increasingly seek to capitalise on the medical and humanitarian gaze. The extent to which this succeeds, resulting in the reification of biolegitimacy into the UK context, will be an interesting research area in years to come.

7.6 Conclusion
Situated at the nexus of ageing, migration and health, this thesis has explored how older asylum applicants narrate their lived experiences in relation to their health. Motivated by a desire to disrupt the exclusionary rationale underpinning the hegemonic approaches to immigration and ageing, and challenge the invisibility of an often-overlooked group, a critical epistemology foregrounded the narratives of 21 older asylum applicants. The research process has involved an often-uncomfortable personal process of epistemological disruption and reconstitution, where positivist biomedical assumptions have been questioned and problematised, and a new critical position adopted. As a medical practitioner, narrative analysis has illuminated new dimensions of health and suffering. The result is a thesis that demonstrates the paramount importance of critical qualitative enquiry when answering questions about the drivers and experiences of health and illness.

The thesis has made clear how, underpinned by a drive to decrease net migration, the current socio-political environment in the UK embeds a web of immigration controls into public services and fosters a hostile and austere environment for migrants. Everyday bordering and the identity politics of immigration categories shape individuals’ parameters of possibility. The material and social realities of these policies are illustrated by the narrative data presented, where stories of regulation, surveillance and exclusion dominated. In these narratives, the asylum apparatus appears to augment the vulnerability of certain migrants, especially those who are considered ineligible for asylum in the UK, yet are unable to return home.

The process of categorising migrants is problematic and depends on subjective assessments of the credibility of claimants’ autobiographical testimony. Immigration categorisation can render asylum applicants prohibited from many aspects of social, political and economic life; this emerged central to participants’ narratives of health, ageing, frailty and
illness. Ageing and frailty were narrated as socially constructed, rather than biologically mediated. As a result, participants’ explanatory models of health were in tension with hegemonic biomedical thinking. This raises questions about the ascription of ethnocentric paradigms, such as frailty, to diverse populations (Tomkow, 2018).

The empirical data has drawn attention to the ways in which social conditions can produce health and ill-health. In the ascetic setting of extreme de-legitimisation and poverty of power and resources, the trustworthiness of asylum applicants is questioned through their encounters with the Home Office. As a result, the credibility of the asylum seeker is eroded and stories of biological dysfunction function as a necessary resource. Pathographies draw on shared features of human experience, even between individuals who superficially appear to have very little in common, and thus they perform as narrative corroboration. This phenomenon is described as biocredibility, and is the central theoretical contribution to knowledge of the thesis. The strive for narrative authenticity is inherently associated with the exclusionary identity politics of immigration categorisation, bordering practices, and crimmigration. Biocredibility transcends culture and instead is underpinned by the political environment in exile.

Rather than inferring that those who use illness to augment narrative believability are deceptive and strategic, biocredibility illustrates how the socio-political context encourages the reduction of complex social experiences into accounts of biological failure. Biocredibility should not be understood to represent an assemblage of ethically neutral reconstructions of illness, ageing and exile. Exploration of the moral dimension of biocredibility highlights the dynamics of identity politics at play. The use of pathographies to augment credibility and ascribe culpability can be understood as a form of resistance to: the medical gaze which posits asylum seekers as always impaired; the humanitarian gaze that constructs
migrants as necessarily vulnerable; and the hostile gaze which propagates the notion of a bogus asylum seeker as a multi-faceted threat. By narrating vulnerability, illness and impairment as an effect of harmful state practices, asylum applicants make a moral and political claim about the unjustness of their treatment in the UK. Simultaneously, biocredibility represents a form of subjectification. Here, pathologisation as a form of self-governance appears to produce vulnerability and imbue a spiralling sense of multifaceted decline: exclusion, impoverishment, ageing, impairment and suffering.

Biocredibility encourages the listener to look beyond individuals’ corporeal reality to the broader social environment in which the narrative phenomenon occurs. Here it provides a critique of the hegemonic tendency to pathologise individuals who suffer as a result of social marginalisation, a trend epitomised by psychiatric diagnoses such as Somatoform Disorder. Processes of psychologisation and pathologisation allow individuals’ complex suffering to be categorised and managed. Biocredibility resists this, instead urging an exploration of the social drivers of distress, with a view to identifying and challenging the social determinants of suffering. If embraced by clinicians, biocredibility might facilitate a more holistic therapeutic encounter, where the broader causes of health are acknowledged and addressed. Moreover, by contesting the medical gaze and seeing biocredibility as a renegotiation of social environment, this thesis goes some way in resisting the stigmatisation of refugees as necessarily vulnerable and mentally and physically impaired.

There is much work to be done in the policy and academic fields of migration, health and ageing. Biocredibility shows how bellicose biopolitical efforts to verify asylum applicants’ testimony and prove credibility intersect with the austerity and liminality of everyday lives to produce unanticipated dynamics. More work exploring the performativity of biocredibility in contrasting legislative and social environments and with
different populations is justified. Most urgent though is the reform of the UK’s approach to immigration and immigrants. This thesis in general, and biocredibility in particular, points to the causes of older asylum applicants’ distress and impairment. In doing so, it calls for a considerate and deliberate change to asylum policy. This reform must be attentive to the ways in which vulnerability and exclusion is produced, both by intersecting structural violences, and the social and material conditions of asylum.
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**Appendices**

**Appendix 1: Definitions of categories of migrants used in the thesis**

<table>
<thead>
<tr>
<th>Terminology</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee</td>
<td>An individual who is has been granted refugee status by the UK Home Office, according to the 1951 Geneva Convention or through Humanitarian Protection</td>
</tr>
<tr>
<td>Asylum seeker</td>
<td>An individual who has an active and on-going application for asylum with the UK Home Office</td>
</tr>
<tr>
<td>Refused asylum seeker</td>
<td>An individual who has had their application for asylum refused by the UK Home Office. They may have an on-going appeal with the Home Office or may have exhausted their right to appeal</td>
</tr>
<tr>
<td>Forced migrant</td>
<td>A descriptor for all participants including refugees, asylum seekers, and refused asylum seekers. The descriptor ‘forced migrant’ aims to draw commonalities across the participants, who have left their country of origin due to harsh, and what they perceive as unmanageable conditions and who had encountered the UK asylum system on arrival. It proffers ‘enhanced sociological accuracy and greater awareness of the varied nature of the displacement experience’ (Hathaway, 2007, p. 349).</td>
</tr>
<tr>
<td>Asylum applicant</td>
<td>A descriptor for all individuals who have, at any point in their migration, applied for asylum. Used to describe all participants including refugees, asylum seekers, and refused asylum seekers.</td>
</tr>
</tbody>
</table>
Appendix 2: Strategy used to identify literature for review

The literature search, which focussed on both academic and grey literature, started in 2016, and searches were repeated periodically over the years of thesis development. A number of methods were used to identify relevant literature:

- A series of search strings based on the research questions were developed; these were used to search leading databases: ‘SocIndex, Web of Science, Medline, Cinahl, Science Direct, and Google Scholar’.
- The bibliographies of relevant articles were searches for additional resources.
- The bibliographies of specific authors were explored. These scholars were identified either through previous research experience, conference attendance, or on recommendation from supervisors or academic community
- Social media was useful in identifying new publications during the research; twitter accounts for leading health and migration academics, journals and organisations often shared new studies and reports
- Grey literature was identified through hand searches of relevant organisations’ publications including: Doctors of the World; Refugee Council; United Nations.

Literature on older asylum seekers and refugees in the UK was often scarce; consequently literature from other migrant populations and other settings, such as Europe, North America and Australia, are drawn on.
### Appendix 3: CPRD research protocol

**Applicants must complete all sections listed below**

**Sections which do not apply should be completed as ‘Not Applicable’**

<table>
<thead>
<tr>
<th>A. Study Title§</th>
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<tbody>
<tr>
<td>§Please note: This information will be published on CPRD’s website as part of its transparency policy</td>
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</table>

Levels of frailty in asylum seekers and refugees in the UK: a comparative cohort study using the electronic Frailty Index

<table>
<thead>
<tr>
<th>B. Lay Summary (Max. 200 words)§</th>
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<tbody>
<tr>
<td>§Please note: This information will be published on CPRD’s website as part of its transparency policy</td>
</tr>
</tbody>
</table>

Frailty is a state of vulnerability to poor health outcomes, due to an impaired ability to respond to stress; no identified studies have examined frailty in older asylum seekers and refugees in the UK. Studies into the health of asylum seekers and refugees suggest that this population can often have different and additional physical and mental health needs to European populations. There is very little known about the health of older asylum seekers and refugees. This study will use electronic Frailty Index (eFI) scores from General Practice medical records to compare frailty scores in asylum seekers and refugees over the age of 50 to UK nationals over a period of time. The results will allow an understanding of the levels of frailty in asylum seekers and refugees compared to the native population. As it is the first study of its type, results are expected to raise questions about the associations of frailty to life events, how asylum seekers and refugees use health services in the UK, and the how useful
routinely-used frailty measures are in this population.

<table>
<thead>
<tr>
<th>c. Technical Summary (Max. 200 words)§</th>
</tr>
</thead>
</table>

§Please note: This information will be published on CPRD’s website as part of its transparency policy

Studies into the health of asylum seekers and refugees suggest that this population can often have different and additional physical and mental health needs to European populations. Frailty is a state of vulnerability to poor health outcomes, due to an impaired ability to respond to stress; no identified studies have examined frailty in older asylum seekers and refugees in the UK. This study will use electronic Frailty Index (eFI) scores from General Practice medical records to compare frailty scores in asylum seekers and refugees over the age of 50 to age- and sex-matched UK nationals over a period of time. The results will provide insight into comparative levels of frailty, as measured by the eFI. As it is the first study of its type, results are expected to raise questions about life-course associations of frailty, health care utilisation of asylum seekers and refugees, and the validity of the routinely-used eFI in this population.

<table>
<thead>
<tr>
<th>D. Objectives, Specific Aims and Rationale</th>
</tr>
</thead>
</table>

Specific Aims
This study aims to establish levels of frailty, as measured by the eFI, in asylum seekers and refugees in the UK as compared to UK nationals.

Objectives

Workstream 1 (W1): A demographic analysis.
- W1 will look to establish how the frailty scores of asylum seekers
and refugees, forced migrants (FM) compare to that of age- and gender-matched non-forced migrant controls (nFM).

Workstream 2 (W2) – will look to examine the validity of the eFl amongst FM. Specifically:

- How the eFl of the two groups change over two points in time.

- How the eFl is related to polypharmacy

Rationale

These aims are part of a larger project that seeks to gain a greater understanding into the effects of forced migration on health and ageing in older asylum seekers in the UK. Frailty is an extensively validated multi-domain assessment of vulnerability in older age and as such, frailty will be used as an outcome measure. The eFl uses routine GP data to identify frailty. It has been shown to have robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission in the general UK population. By comparing the frailty scores of age- and gender-matched FM and nFM, this study will explore whether being an asylum seeker or refugee is associated with higher levels of frailty, as measured by the eFl.

There is some evidence from qualitative literature that asylum seekers and refugees face barriers to accessing health services in the UK; however some quantitative studies suggest service utilisation in this population is higher than of the host population. The nature of the eFl means that it relies on accurate and up-to-date medical records to generate a frailty level, and so the eFl may perform differently in this population. By comparing frailty levels over time, and against polypharmacy, we hope to comment on the validity of the widely-used eFl in this population.
E. Study Background

Globally, levels of forced migration are at their highest in history (Stoddard, 2015). Asylum seekers and refugees are commonly perceived as amongst the most vulnerable in host societies, and face multiple potential adversities such as loss and trauma. Older asylum seekers and refugees are a minority (REF), although little research exists on their health needs. The dominant narrative in the FM health literature focuses on mental health, specifically PTSD. Studies indicate that FM appear to be more vulnerable to post-migration difficulties than voluntary migrants, and tend to be exposed to additional stressors over their life-course when compared to voluntary migrants or native populations (Silove et al., 1998).

Research into physical health of asylum seekers and refugees in the UK is sparse. Available literature focuses on communicable disease and mental health, with long-term non-communicable consequences of forced migration, and the complex relationship between physical and mental health, neglected (Cochrane, 2016). A handful of studies have attempted to explore associations between specific life stressors and physical health in FM. Bradley and Tawfiq (2006) found the physical consequences of torture were common amongst Kurdish refugees in the UK, with 12% having chronic disability as a result of torture injuries and 22% having chronic pain which interfered with activities of daily living (ADL). Qualitative research suggests asylum seekers and refugees face barriers to accessing health care in the UK (O'Donnell et al., 2007; Doctors of the World, 2015). However a recent systematic review suggested that the health service utilisation rates amongst FM are significantly higher than host populations (Hadgkiss and Renzaho, 2014).
Whilst these studies represent the beginnings of an important enquiry into the health of asylum seekers and refugees, there are many unanswered questions about the long-term sequelae of the stressors involved with forced migration and their effects on health and ageing. Frailty conceptualises variable ageing. Over the past two decades, academic and clinical interest in frailty has rapidly expanded. A consensus definition was developed by expert clinicians and researchers from the US and Europe in 2013: “A medical syndrome with multiple causes and contributors that is characterized by diminished strength, endurance, and reduced physiologic function that increases an individual’s vulnerability for developing increased dependency and/or death.” (Morley et al, 2013). Frailty finds its value in the imprecision of chronological age and attempts to explain heterogeneity in ageing between individuals. As a macroscopic variable, it reflects ageing at the level of the whole organism, rather than focusing on single functional deficiencies, making it an important concept for multiple reasons. For clinicians, it allows the identification of patients who may be in need of comprehensive geriatric assessment and holistic advanced care planning, whilst for patients, frailty and quality of life have been shown to have an inverse association, even after correcting for age, diabetes, macrovascular disease, renal impairment and depression (Kanauchi et al., 2008; Gale et al., 2014; Turner and Clegg, 2014; Kojima et al., 2016). Because of its predictive and macroscopic properties, it has been proposed that frailty be used as a proxy measure of ageing and as a marker of well-being (Mitnitski, 2001; Kiely, Cupples and Lipsitz, 2009). For researchers, examining frailty allows the exploration of its associations as well as trials of interventions to alter its trajectory. Lastly, on a population level, an understanding of population frailty prevalence can guide healthcare policy-makers’ appropriate allocation of resources. Many other health-status values lack the generality required to be valid single measures or are unfeasible because of lack of standards, availability, or
Frailty can be measured a number of ways and an overview of this is beyond the scope of this application; for this study, the electronic Frailty Index (eFI). The eFI uses routine GP data to identify frailty, with robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission in the general UK population (Clegg, 2016).

Extensive literature documents frailty’s inverse relationship with environmental stressors. Poorer socioeconomic class in Britain has even been linked to specific deficits, such as balance and chair rise times (Woo et al., 2004; Kuh et al., 2005; Alvarado et al., 2008; Lang et al., 2009; Szanton et al., 2010; Woo et al., 2010). Further, a recent study suggested that social and behavioural factors such as education, smoking and alcohol use are associated with different frailty trajectories (Chamberlain et al., 2016). Frailty has been examined in a small number of studies of younger vulnerable groups, such as the homeless, where it, amongst other geriatric syndromes, was shown to be significantly higher in the homeless population than non-homeless (Brown et al., 2012; Brown et al., 2013). Ethnic health disparities appear to translate to frailty; African-American ethnicity is independently associated with frailty after controlling for age, sex, comorbidity and socio-economic factors (Hirsch et al., 2006).

No identified studies examined frailty in asylum seekers and refugees, one identified study measured frailty scores in migrants over the age of 50 on mainland Europe (Brothers, Theo and Rockwood, 2014). Data from the SHARE health survey was used to compare immigrants born in low and middle-income countries (LMIC) with high-income countries (HIC) and native Europeans in North-Western Europe. LMIC immigrants demonstrated higher frailty index scores than HIC immigrants and native-born participants, after adjustment for age, gender and education, but in South-Eastern Europe, frailty index scores did not differ between groups.
Country of birth and current country of residence were each associated with frailty, supporting the idea that environment factors through one’s lifespan are important in the health of older adults (Alvarado et al 2008; Birnie et al., 2011). This study seeks to address this gap and explore levels of frailty in asylum seekers and refugees over the age of 50, compared with their age and gender match UK national counterparts. This will advance understanding of the health of older asylum seekers of refugees in the UK.

**F. Study Type**
Descriptive, retrospective comparative cohort observational study

**G. Study Design**
The study design must be clearly specified and appropriate for the research question to be addressed. Describe the overall research design, strategy, and reasons for choosing the proposed study design.

W1: A retrospective comparative cohort study. The exposure of interest is forced migration and the outcome is eFI score. A sample of forced migrants over the age of (40 or 50) will be identified through GP read codes of asylum seeker (13ZN) and refugee (13ZB). Age- and gender-matched controls will be identified. eFI will be compared between the two control groups and the FM group.

W2 will use the same sample as W1, and will examine the validity of the eFI in FM:
- How the eFI of the two groups change over two points in time.
- How the eFI is related to polypharmacy

The problems and bias posed by retrospective cohort design based on GP records are acknowledged, however due to nature of small sample which is difficult to access and identify, retrospective cohort offered advantages.
over other designs. Case-control design would have compared migration status in frail sample resulting in too small a FM group. Prospective design, or primary data collection through clinical assessments was thought to be too resource intensive, whilst higher quality studies, such as randomised control trials, are clearly not feasible. Case control not practicable due to small proportion of population who is a FM.

H. Feasibility counts

Sample size – Means

Compare the mean of a continuous measurement in two samples, using a z statistic to approximate the t statistic.

Instructions: Enter parameters in the red cells. Answers will appear in blue below.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \alpha ) (two-tailed)</td>
<td>0.050</td>
</tr>
<tr>
<td>( \beta )</td>
<td>0.200</td>
</tr>
<tr>
<td>( q_1 )</td>
<td>0.500</td>
</tr>
<tr>
<td>( q_0 )</td>
<td>0.500</td>
</tr>
<tr>
<td>( \mathbb{E} )</td>
<td>0.200</td>
</tr>
<tr>
<td>( \mathbb{S} )</td>
<td>0.900</td>
</tr>
</tbody>
</table>

The standard normal deviate for \( \alpha = Z_\alpha = 1.960 \)
The standard normal deviate for \( \beta = Z_\beta = 0.842 \)
\( A = (1/\mathbb{q}_1 + 1/\mathbb{q}_0) = 4.000 \)
\( B = (Z_\alpha-Z_\beta)^2 = 7.849 \)
Standardized effect size = \( (E/S) = 0.222 \)
Total group size = \( N = AB(\mathbb{E}/\mathbb{S})^2 = 636.76 \)

\( N_1 = 318 \)
\( N_2 = 318 \)
Total: 636

I. Sample size considerations

In consideration of the required sample size, a sample size calculation has been performed and suggests a total cohort of 318 per group – see below.
The estimated effect size of 0.2 has been taken from Brothers, Theou and Rockwood’s 2014 paper, which examined the difference in frailty scores between native Europeans and migrants from low- and middle-income countries. This is represents a likely underestimation of the expected effect size for this study, as asylum seekers and refugees have been shown to have additional health needs when compared with voluntary migrants.

Sample size – Means

Compare the mean of a continuous measurement in two samples, using a z-statistic to approximate the t-statistic.

Instructions: Enter parameters in the red cells. Answers will appear in blue below.

<table>
<thead>
<tr>
<th>α (two-tailed) =</th>
<th>0.050</th>
<th>Threshold probability for rejecting the null hypothesis. Type I error rate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>β =</td>
<td>0.200</td>
<td>Probability of failing to reject the null hypothesis under the alternative hypothesis. Type II error rate.</td>
</tr>
<tr>
<td>θ₁ =</td>
<td>0.500</td>
<td>Proportion of subjects that are in Group 1 (exposed)</td>
</tr>
<tr>
<td>θ₀ =</td>
<td>0.500</td>
<td>Proportion of subjects that are in Group 0 (unexposed); T₀₁</td>
</tr>
<tr>
<td>E =</td>
<td>0.200</td>
<td>Effect size</td>
</tr>
<tr>
<td>S =</td>
<td>0.900</td>
<td>Standard deviation of the outcome in the population</td>
</tr>
</tbody>
</table>

The standard normal deviate for α = Zₐ = 1.960
The standard normal deviate for β = Zₜ = 0.842
A = (√θ₁ + 1/θ₀) = 4.000
B = (Z₂₋₀₂)² = 7.840
Standardized Effect Size = (E/S) = 0.222
Total group size = N = AB(E/S)² = 635.76

N₁: 318
N₂: 318
Total: 636

J. Data Linkage Required (if applicable).⁵

⁵Please note that the data linkage/s requested in research protocols will be published by the CPRD as part of its transparency policy

K. Study population

Target population inclusion criteria: Any patients who received codes of asylum seeker (13ZN) and refugee (13ZB).
Over age of 40 or 50 (to be decided)

Study period: To be decided

L. Selection of comparison group(s) or controls
The control groups are not forced migrants.
Inclusions: Patients without read codes of asylum seeker or refugee over the age of 50.
Control group 1: age- and sex- matched 1:1

M. Exposures, Health Outcomes and Covariates

The exposure of interest is that of forced migration. This can be operationalized through the asylum seeker (13ZN) and refugee (13ZB) documented in the patient clinical or referral record. The primary outcome is the eFI. Data sources for this study are read codes within primary care clinical records.

Covariates:

- Socioeconomic status
- Number of medications

N. Data/ Statistical Analysis

WS1: Understanding the incidence and prevalence of frailty in FM and nFM.
WS1 will use the eFI with the CPRD to estimate rates of incidence and
prevalence of frailty in both FM and NFM groups. The study period will be 2005 to current. Patients enter the study on either the study start date or their current registration date, whichever is later; patients exit the study on their last collection date, date of death or the study end date, whichever is soonest. By focusing on a period post-introduction of the Quality and Outcomes Framework in Primary Care we will minimise changes in rates due to improved recording. Annual incidence and prevalence rates will be calculated for total frailty scores. Incidence and prevalence rates in relation to gender, age, residential deprivation and region will also be computed and described.

WS2. Understanding the progression over time of patient frailty and ability to predict falls, hospitalisation and death.

WS2 Existing work on the properties of the eFI has demonstrated an ability to predict outcomes including hospitalisation, nursing-home care and death, over and above what can be explained by age and sex, although this has not been examined in forced migrants (FM). We will duplicate these analyses with the CPRD (linked to ONS and HES data) – with the exception of nursing home care, where data are not available – using multivariate Cox regression to estimate hazard ratios for hospitalization and death at 1 and 3 years in relation to eFI score for both FM and nFM groups. The association between frailty and dropping out of CPRD for reasons other than death (transfer out of practice, last date of data collection or end of study date) will also be examined using Cox regression to examine the potential for bias due to informative censoring (e.g. if the frailest patients are more likely to ‘drop out’ by moving to residential care), and if necessary utilise more complex joint modelling approaches.

We will also examine how frailty scores change over time in individual FM patients. We will identify mathematical models for individual patient trajectories, such as quadratic or exponential functions, that best fit the
data using goodness of fit criteria such as the RMSEA and SRMR.

<table>
<thead>
<tr>
<th>O. Plan for addressing confounding</th>
</tr>
</thead>
<tbody>
<tr>
<td>When examining the relationship between forced migration and frailty, potential confounders such as patient characteristics, will be accounted for by including them as covariates in the analysis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P. Plans for addressing missing data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing data is an important consideration and we will investigate the extent of missing data for all variables in our analyses. Analysis of frailty in relation to deprivation, mortality and hospitalisation will be restricted to patients in whom this linked data is available. Where applicable we will use multiple imputation methods for longitudinal data and the twofold algorithm, as described by Welch et al (2014). We have considerable experience with applying these and other custom methods to account for missing completely at random and missing at random mechanisms in the data.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q. Patient or user group involvement (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is part of a larger mixed-methods PhD project which will explore frailty and ageing in asylum seekers and refugees. The development of this study design has involved numerous consultations with healthcare professionals and academics, including General Practitioners with a special interest in asylum seekers and refugee health. Although this quantitative study has not yet been discussed with the patient group to date, a qualitative phase of study will follow this enquire and will involve in depth interviews with asylum seekers and refugees, these interviews will explore their understanding and associations of frailty and forced migration, as well as the barriers to health care for forced migrants in the UK.</td>
</tr>
</tbody>
</table>
R. Plans for disseminating and communicating study results, including the presence or absence of any restrictions on the extent and timing of publication

This study is part of a PhD project and so will be included in the final thesis. Further, it is envisaged that study findings will produce at least one publication in a peer-reviewed journal. In addition, results will be disseminated at major conferences, in targeted presentations to policymakers and researchers focused on care for asylum seekers and refugees and elderly patients.
Appendix 4: List of research outputs and collaborative projects

Peer-reviewed journal outputs


Tomkow, L. (2019). Health and hostile hospitality: Understanding asylum applicants’ narratives of life and health in the UK. *Social Science and Medicine (Under review)*


Research reports


**Book chapters**


**Short articles**

NHS healthcare as a hostile environment

Tomkow, L.

*Public Sector Focus*, March-April 2019.

http://flickread.com/edition/html/5cc7fcde6dc3f#20

Is primary healthcare a hostile environment? The barriers facing asylum seekers and refugees accessing general practitioners in the UK

Tomkow, L and Farrington, R

*Policy at Manchester*, February 18, 2019

http://blog.policy.manchester.ac.uk/author/louise-tomkow/

Research off the beaten track - Profiling Dr Louise Tomkow

Tomkow, L.


Don’t Blame The Immigrants: We Want To See Patients Not Passports

Tomkow, L.

*Huffington Post*, 29 September 2017

http://www.huffingtonpost.co.uk/dr-louise-tomkow/dont-blame-the-immigrants_b_18136476.html?utm_hp_ref=uk

Doctor or Border Guard

Tomkow, L.

*Manchester Migration Lab*, University of Manchester, 17 October 2017

http://www.migrationlab.manchester.ac.uk/index.php/2017/10/17/doctor
The ethical implications of charging immigrants for healthcare

*Tomkow, L.*

Public Sector Focus, October 2017.


A call to action in research, practice and everyday life: Reflections on the 1st World Congress on Migration Ethnicity Race and Health.

*Tomkow, L.*

*Humanitarianism and Conflict Response ‘Student Blogs’,* May 2018-11-09


**Media**

‘The barriers facing asylum seekers and refugees accessing general practitioners in the UK’. *BBC news midday headlines*:

https://www.bbc.co.uk/sounds/play/p06z3313 at 2 minutes

‘NHS staff police patients’.

*Big Issue North.* No. 1278.18 – March 2019

‘Hostile Environment’ NHS policies are failing refugees and asylum seekers.

*University of Manchester News,* 12 February 2019


**Abstracts**


**Oral presentations**

*Health and hostile hospitality: Understanding older asylum applicants’ narratives of life and health in the UK*, British Society of Gerontologists Annual Meeting, University of Liverpool, July 2019

*Health, ageing and a hostile hospitality: Understanding asylum applicants’ narratives of life, health and ageing in the UK*, Thinking Ageing and Older Age MICRA PhD and Early Career Conference, University of Manchester, May 2019.

*The hostile environment and health*. Medical Humanities Symposium, April 2018.


*Young Professionals in Humanitarianism* and *Good Research and Research for Good*, Careers in Humanitarianism Day, University of Manchester, May 2019.


*Forced migration and health*. Humanitarian and Conflict Response
Institute, University of Manchester, Research Seminar, February 2018.

**OOP experience.** Guest lecture, Ashbourne Geriatric Medicine Conference. November 2016

**Ageing in a hostile environment.** Guest lecturer on Anthropology of Life-Course in Societies Affected by Violence, University of Manchester, November 2018.

**Immigration detention in the UK.** At ‘Get informed and take action: immigration detention in the UK’. Evening collaborative advocacy event at University of Manchester, October 2018

**Immigration categorisation.** Humanitarian and Conflict Response Institute, University of Manchester, Postgraduate Research Symposium, May 2018.

**Forced migration and health.** Humanitarian and Conflict Response Institute, University of Manchester, Research Seminar, February 2018.

**Health of forced migrants in the UK, Guest Lecture on War, Migration and Health, Intercalated BSc, Humanitarian and Conflict Response Institute, University of Manchester, October 2017; February 2018; February 2019.**

**National conferences**


Winner of ‘runner-up’ poster prize. Liverpool School of Tropical Medicine Humanitarian Conference, November 2017. The
instrumentalisation and distortion of humanitarianism: a grounded theory study of volunteers’ perspectives in Moria detention centre, Lesvos.

Leadership and management

Founded, organized and led the first HCRI Aid, Conflict and Peace; a collaborative research symposium, May 2017

Leads on organizing and running the HCRI PGR research seminars: 2018 to 2019

Voluntary work

I work as a volunteer medico-legal report writer for Freedom from Torture Northwest. I see and assess asylum seekers who have been tortured in their countries of origin and document the mental and physical evidence of this in a medico-legal report which is submitted alongside their asylum claim to support their claim for asylum. Often these individuals have been refused asylum by the Home Office and so the MLR supports their appeal.

In 2019 I helped to set up a service at Freedom from Torture Northwest which focussed on providing health assessments for clients. As part of this I worked collaboratively with other doctors, therapists, legal officers and physiotherapists. We established what the main objectives of the service were as well as the limits of what we could and should offer in the context of the legal and forensic work of the organisation.

I also volunteer for Medact Manchester. We are a group of healthcare professionals interested in issues of social justice. We are currently focusing our campaign on issues around migrant health. My activities with Medact include: developing, conducting and publishing a report of health
care professionals’ knowledge about asylum seekers’ entitlements to health care; writing blogs for the Huffington Post and other publications objecting to NHS charging regulations (Tomkow, 2017a, 2017b, 2019a, 2019b); organising a free evening lecture series focusing on social justice and health, including a recent anti-immigration detention event; and working alongside other medical activists such as ‘docs not cops’ to organise direct action objecting to the current ‘hostile environment’ policy.

Local network involvement

Greater Manchester Asylum and Refugee Health Advocacy Group

Vulnerable migrants group. Manchester Healthcare and Commissioning. A partnership between Manchester City council and NHS Manchester CCG.
Appendix 5: Email sent to potential Voluntary Community Organisations

Dear VCO,

I am a PhD researcher I am a medical doctor (Geriatric Registrar) currently undertaking a PhD looking at the long-term health effects of forced migration at the University of Manchester at the Humanitarianism and Conflict Response Institute. I am conducting primary research about the long-term health impacts of forced migration and am looking for asylum seekers and refugees who are willing to be interviewed.

I want to understand more about how the life events of asylum seekers and refugees impact on their health in later life. The interview will be semi-structured and will be a chance to explore the issues asylum seekers and refugees feel are most important. I will be conducting the interviews myself.

During interviews I would draw on my communication skills and experiences from my medical career, as well as my experiences volunteering with Freedom from Torture, being mindful that topics discussed at interview may be traumatic.

The conversation will be audio-recorded and transcribed. The interviews should take no longer than two hours. Responses will be anonymised and participants will be able to withdraw from the research at any point, up until September 2018.

I would be grateful you if your organisation would be able to help me identify and access participants for this project. Due to the potentially sensitive nature of the interview topics, the identities of potential participants should be kept confidential. If you feel your clients would be
willing to take part in this research, or would like to find out more, please get in touch on the email address below.

Many Thanks for your time

Louise Tomkow

louise.tomkow@manchester.ac.uk
Appendix 6: Participant information sheet

You are being invited to take part in a research study as part of a PhD research project. The overall aim of this research is to explore how migrating to the UK under difficult circumstances affects health. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?
Louise Tomkow. Louise is a student studying for a PhD at the Humanitarianism and Conflict Response Institute, University of Manchester.

What is the purpose of the research?
The purpose of the research is to gain a better understanding of how events in your life can impact long-term health. By conducting this research we hope increase our understanding of issues facing refugees and asylum seekers living in the UK. Long term, it is hoped that this research will used to inform policy decisions to improve peoples lives, including health care provision, housing and immigration procedures.

Why have I been chosen?
You have been chosen because your experiences migrating to the UK and the effect of this on your health is of interest to us.

What would I be asked to do if I took part?
You would be asked to take part in an interview with the lead researcher, Louise Tomkow. I would arrange to meet you somewhere convenient and
spend no more than two hours hearing your thoughts about your migration experiences and the effects of these experiences on your health. At times you may feel strongly about the issues you are discussing. Topics may include sensitive issues such as personal trauma, reasons why you left your country and family issues. If you feel you need a break at any time, or choose not to complete the interview you should let me know. The interview will be recorded on a Dictaphone (voice recorder) and the researcher will take notes. It is important that taking part in the research does not put you at any disadvantage. The interview should be at a time convenient to you. You should not take part in the research at a time where you would otherwise be at work, or at another appointment.

**What happens to the data collected?**
The information I obtain from our interview will be recorded on a Dictaphone. The recording will then be transcribed, and the interview will be turned into a written format. At this point, the voice recording will be securely deleted.

The information you give me, in its anonymous form, will be used in my PhD project; this will be read by academic tutors and University of Manchester students. It is hoped that the findings of the study will be published in an academic journal. If any direct quotations are used for this, they will be kept to a minimum and no identifiable information will be included.

**How is confidentiality maintained?**
All of the information collected will be anonymised, that is your name, date of birth, address and any other personal identifiable information will not be stored or used in the research. This will protect your right to confidentiality. All of the interview transcripts will be stored on a secure network at the University of Manchester.
If translators are needed for your interview, they will be required to sign a confidentiality agreement. This will be that they are not permitted to repeat any of the information that we discuss in the interview.

If at any point during the interview you tell the researcher information which causes significant concern about the safety of yourself or of other people, this may need to be disclosed as a way of keeping you or others around you safe.

**What happens if I do not want to take part or if I change my mind?**

It is up to you to decide whether or not to take part – participation is voluntary. Taking part in this research will not change or influence your access to health services, housing services or legal immigration services.

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw up to September 2018 without giving a reason and without detriment to yourself.

**Will I be paid for participating in the research?**

Unfortunately there is no payment for participation in this research.

**What is the duration of the research?**

The interview will last no more than 2 hours.

**Where will the research be conducted?**

The location should be easy for you to get to and should be a place where you feel comfortable talking about your experiences of moving to the UK and your health. This may be a public space such as a café or a park, or a charities space, or your home. You can decide.

**Will the outcomes of the research be published?**
We hope that the research will be published in at least one academic journal. Long term, it is hoped that this research will used to inform policy decisions to improve peoples lives, including health care provision, housing and immigration procedures. Remember all of the personal information collected about you will not be stored or used in the research. If any direct quotations are used, they will be kept to a minimum and no identifiable information will be included. This will protect your right to confidentiality.

**Who has reviewed the research project?**

This project has been reviewed by the University of Manchester Research Ethics Committee 2.

**What if something goes wrong?**

If you want any help or advice during the interview you should ask Louise Tomkow, the lead researcher. If you feel distressed we will stop the interview you should know that your wellbeing is the most important thing.

If you want any help or advice after the interview you can contact the lead researcher on louise.tomkow@manchester.ac.uk. If I am unable to address you concerns I can help to put you in touch with another service, if that is appropriate.

**What if I want to make a complaint?**

**Minor complaints**

If you have a minor complaint then you need to contact the researchers supervisor in the first instance: Rubina.Jasani@manchester.ac.uk

**Formal Complaints**

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact the Research Governance and Integrity Manager, Research
Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674 or 275 2046.

What Do I Do Now?
If you have any queries about the study or if you are interested in taking part then please contact the researcher
louise.tomkow@manchester.ac.uk

This Project Has Been Approved by the University of Manchester’s Research Ethics Committee 2017-1934-3154
**Appendix 7: Consent form**

If you are happy to participate please complete and sign the consent form below.

**Please initial box**

<table>
<thead>
<tr>
<th>I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.</th>
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<tbody>
<tr>
<td>I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to my treatment/service/self. If the participant cannot withdraw beyond a certain point this needs to be reflected in this section</td>
</tr>
<tr>
<td>I understand that my data will remain confidential. If there are any times when comments will be disclosed to others this needs to be outlined in the PIS and reflected here</td>
</tr>
<tr>
<td>I understand that the interviews will be audio-recorded.</td>
</tr>
<tr>
<td>I agree to the use of anonymous quotes.</td>
</tr>
</tbody>
</table>

This clause should only be used if the data is being retained for a further study by the research team when the comment should read along the lines of

I agree to my data being retained indefinitely for further research related to .....  
Or if the data is being archived for use as secondary data reading along the lines of
I agree that any data collected may be archived and used as anonymous data as part of a secondary data analysis process.

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Date</th>
<th>Signature</th>
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This Project Has Been Approved by the University of Manchester’s Research Ethics Committee 2017-1934-3154
Appendix 8: Interview topic guide

Research goals of the interviews:
The interviews will explore how the stressors associated with forced migration impact the health experiences of asylum seekers and refugees in later life.

Introduction: 10-15 minutes
- Introduction to researcher and translator
- Consent
- Participant information sheet to be discussed
- Outline structure of interview

Main body of interview: 90 minutes.
Semi-structured interview. Questions will focus on:
Life-history and migration narratives. E.g.
- Tell me about your life prior to coming to the UK
- Tell me about what brought you to the UK
- Tell me about your life here in the UK

Constructions of health
- How do you see your health?
- What does good health mean to you?
- Tell me about your experiences of the health care system here in the UK.
- If you needed help with a health problem, who would you see?
- What do you understand by the term ‘frailty’

Exploration of associations
- Do you think your life, and the stories you have told me about your migration to the UK, has affected your health?
• How do you think your life and the events in your country of birth affected your health?
• How do you think your journey to the UK affected your health?
• How do you think your life in the UK has affected your health?
• Is there anything here in the UK that limits your wellbeing?

Conclusion – about 5 minutes:
• Summarise up what has been discussed
• Is there anything important to you we haven't mentioned?
• If you want to follow any issues you have talked about, you can contact us (Participant information sheet has contact details)
• The participant will be told that if he or she wants to withdraw from the study, their data will not be used.
Appendix 9: Translator Confidentiality Agreement

I am aware that in the course of my involvement in this research project as a translator, I will have access to participants’ health, legal and other personal confidential information. Much of this information may be of a sensitive or traumatic nature. Any such information must be kept in confidence by me and used only in connection with the work assigned to me by Louise Tomkow, PhD researcher at the University of Manchester.

Therefore in consideration of my engagement as an interpreter/translator for the above research, I agree:

1. I will hold in strict confidence, and will not use, assist others to use, or disclose to anyone, any information from the interviews conducted as part of this research, except as such use or disclosure may be required in order to carry out any interpretation/translation assignment scheduled for me by Louise Tomkow.

2. That I shall not disclose the identity of the participants to anyone outside of the research team.

3. That translated documents remain the property of the owner of the original documents and/or the requester of my services at all times.

4. At the time I terminate my relationship with Louise Tomkow for any reason, I will deliver all documents related to the translation service to Louise Tomkow and I will not retain any such information for myself, including any and all means from which the information can be recovered or reproduced in any form.

5. Individually identifiable data is confidential.
6. That confidential data includes all personal information (e.g., name, birth date, social security number) which may, in any manner, identify the individual.

7. That any personal use of confidential data is strictly prohibited.

I certify that I have read and understand the foregoing agreement and I agree to take part in the above project.

Name of translator       Date       Signature

Name of researcher       Date       Signature

_________________________       ___________       _______________________

This Project Has Been Approved by the University of Manchester's
Research Ethics Committee 2017-1934-3154