

# Our health and theirs: Forced migration, othering, and public health

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## Abstract

This paper uses ‘othering’ theory to explore how forced migrants are received in developed countries and considers the implications of this for public health. It identifies a variety of mechanisms by which refugees, asylum seekers and irregular migrants are positioned as ‘the other’ and are defined and treated as separate, distant and disconnected from the host communities in receiving countries. The paper examines how this process has the potential to affect health outcomes both for individuals and communities and concludes that public health must engage with and challenge this othering discourse. It argues that public health practitioners have a critical role to play in reframing thinking about health services and health policies for forced migrants, by promoting inclusion and by helping shape a narrative which integrates and values the experiences of this population.

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*The practice of granting asylum to people fleeing persecution in foreign lands is one of the earliest hallmarks of civilisation.*

Ruud Lubbers (2002)

Ex-UN High Commissioner for Refugees

## Introduction

Understanding the stories and experiences underpinning forced migration is crucial in responding to the health needs of refugees, asylum seekers and irregular migrants. In this paper we explore how the relatively few forced migrants who resettle in developed countries are received. Following a brief discussion which sets the context for population

movements, we consider how forced migrants are constructed as the ‘other’. We examine the role of public discourse and of political, legal and media responses in creating and reinforcing the position of forced migrants as different, as not belonging. The effects of this process and the marginalisation that results are discussed in relation to the health of migrants and that of host populations. We conclude by suggesting some of the ways in which public health may reframe thinking about forced migrants and respond to this othering at health service delivery and policy level.

Forced population movements “have extraordinarily diverse historical and political causes and involve people who, while all displaced, find themselves in qualitatively different situations and predicaments” (Malkki, 1995). What forced migrants have in common is the limited choice available to them and the pressured decisions they

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are compelled to make as they leave their homes in an effort to ensure their own, and their family's, survival.

Conditions of conflict, political unrest and economic difficulties are likely to occur simultaneously and interact to contribute to the difficult decision to flee (Castles & Loughna, 2003). It should be noted that the vast majority of involuntary migration involves the displacement of people within, rather than across, borders—UNHCR recorded 7.6 million 'persons of concern', internally displaced (IDPs) and stateless persons, at the end of 2004, but recognised this as likely to significantly underestimate the problem (UNHCR, 2005a). Furthermore, of those that do manage to flee their country, around 90% will remain within the same region and it is a very small minority who eventually settle in developed countries. How this small minority of forced migrants are received in rich, western nations is the focus of this paper.

### **Forced migration: motivations for movement and responses of resistance**

#### *Refugees and asylum seekers*

The journeys of refugees from home to final destination may include multiple border crossings, arduous land journeys, and protracted stays in formal or informal camps. They are typically marked by ongoing fear of violence and persecution: from militants, from authorities in the host country, from those who control the camps and from other refugees. Those charged with protecting such refugees may abuse their role: United Nations peacekeepers, NGO workers, and local camp staff may exploit vulnerabilities, demanding sex, for example, in exchange for access to basic supplies.

The process of applying for refugee status can be long and drawn-out. The onus to demonstrate circumstances of individual persecution and the fact that only a very few applicants will be accepted for resettlement, increases anxiety and uncertainty. Some will wait for many years in 'temporary' refugee camps hoping for a visa, a few others with the resources and connections to do so attempt to make their own way to the 'safety' of a developed country.

The Refugee Convention 1951 (<http://www.unhcr.ch/1951convention/>) defines refugees as "*persons outside their country of origin who are unable or unwilling to return because of a well founded fear of*

*persecution for reasons of race, religion, nationality, membership of a particular social, or political opinion*". It has been argued that this definition is narrow and outdated, excluding many people who fear harm and are in need of protection. There are continued calls for asylum processes to be broadened to reflect the diversity of forced migration experiences. Lubbers (2002) notes that several countries see the Refugee Convention as unresponsive to both national interests and refugee protection needs and have threatened to withdraw from it. African Nations, who together host up to 30% of the global refugee population, have sought to address some of these shortcomings in their own 1969 Convention on the Specific Aspects of Refugee Problems in Africa, which expanded the definition of refugee to include persons who are forced to flee their home as a result of external aggression, occupation, foreign domination or other events that have seriously disturbed the public order. It is noted that developing countries who bear, by far, the greatest responsibility for processing and accommodating refugees and asylum seekers, have on the whole applied broader definitions in assessing and responding to refugees<sup>1</sup> (Lubbers, 2002). Developed nations, on the other hand, have led the way in adopting ever-narrower interpretations of the Convention and implementing policies such as temporary protection which restrict rights and offer limited security for refugees.

Agier and Bouchet-Saulnier (2004) argue that the increasingly restrictive refugee processes, border closures and forced repatriations which marked the last decade, have deprived endangered communities of the option of survival through flight. They suggest this places them at the mercy of people-smugglers, and compels them to become the objects of commercial transactions. The journeys undertaken by these refugees typically involve enormous risk. It is apparent that the most vulnerable are also those most likely to sacrifice their safety: boarding unsafe vessels, paying people smugglers and 'agreeing' to arrangements that lead to debt bondage and exploitation (Zwi & Alvarez-Castillo, 2003). Those that survive these journeys, have the right to seek asylum in developed countries, regardless of whether or not they arrived by authorised means. The decision to grant asylum, however, is at the

<sup>1</sup>However, see Crisp (2003a) for discussion of developing countries' declining commitment to asylum, the 'increasingly hostile reception accorded to refugees in developing regions' and possible explanations for this.

discretion of the host states who are increasingly resistant to such claims for protection. This is evident in narrow and legalistic interpretations of state obligations under refugee law, punitive measures such as indefinite and mandatory detention, and the granting of restrictive visas that reduce access to services and other support systems.

Where protection is granted it may be temporary and thus associated with ongoing uncertainty, insecurity and the potential of forced return. Dependence may be high; in countries such as the UK and Australia newly arrived refugees and asylum seekers are often reliant on a combination of social services and charitable or faith-based non-governmental organisations (NGOs) to assist in the process of building a new life. Even after formal resettlement, high levels of anxiety persist and typically focus on concern for family and friends who were left behind and fear for future safety and security in their new country. The experience of forced migration is often one of dislocation and isolation—especially in countries where resettlement policy deliberately disperses refugee communities, effectively disrupting support networks.

In the remainder of this paper we use the term refugees to refer to persons who have been formally recognised as having refugee status by the host nation—this will include those who were processed offshore and resettled through UNHCR programs, for instance, as well as persons who applied and received refugee status onshore (after they had entered the host country). Asylum seeker is used in relation to all those whose claims are still in process and include persons in detention as well as those living in the community.

### *Irregular migrants*

Among irregular arrivals who are fleeing refugee-like circumstances some seek protection and asylum once inside the borders of another country while others attempt to remain undetected in a place where they lack authorisation.<sup>2</sup> Fear of repatriation, distrust of asylum procedures, and an unwillingness to be detained contribute to the decision to live an irregular or illegal existence (Gibney, 2000). While

<sup>2</sup>Clearly among those that enter a country illegally or who remain within borders as unauthorised migrants, there are both economic and forced migrants (either of whom may seek asylum), hence the ‘asylum-migration nexus’. We discuss here issues related to those forced to migrate for survival.

some effort has been made to understand the difficulties and challenges that irregular migrants encounter in their journey to host countries, comparatively little is known of their circumstances once they ‘settle’ and seek to establish themselves in a state where they have no legal status. Forced migrants who reside without documentation or authorisation may be among the most vulnerable of all groups (Prem Kumer & Grundy-Warr, 2004) lacking legal standing they are prey to exploitation and deception by employers, traffickers, irregular migration networks and members of their own communities (Gibney, 2000). Seeking to enter and reside undetected in a host country, they are necessarily marginalised. As the unauthorised migrant moves outside the law and seeks to conceal her presence and identity, she faces prolonged exclusion from health, welfare and social services, and becomes increasingly dependent on a variety of individuals and networks, many of whom are operating informally or clandestinely. This dependency raises the potential for exploitation and human rights violations. Undocumented migrants frequently find themselves confined to sweatshops, sex work, or begging, as they attempt to pay debts to smugglers, ‘migration agents’ or family members who assisted. Their lives, livelihoods and dignity may depend on the whims of state, police, officials and employers (Prem Kumer & Grundy-Warr, 2004).

It is against the backdrop of these different forced migrant experiences that we now examine how developed countries perceive and respond to forced migrants who make it to their shores.

### **Othering**

We adopt a framework of ‘othering’ to explore how refugees as a group are ‘constructed’ in their place of destination; and how they are set apart from mainstream communities. ‘Othering’ is a process that “serves to mark and name those thought to be different from oneself” (Weis, 1995). ‘Othering’ defines and secures one’s own identity by distancing and stigmatising an(other). Its purpose is to reinforce notions of our own ‘normality’, and to set up the difference of others as a point of deviance. The person or group being ‘othered’ experiences this as a process of marginalisation, disempowerment and social exclusion. This effectively creates a separation between ‘us’ and ‘them’.

Othering has been described in both legal and social terms. Where people are outside of their ‘proper’ place of belonging and within our boundaries they are increasingly represented as a threat to notions of community and sovereignty, forcing questions of ‘who is in’ and ‘who is out’. Disenfranchisement is core to the notion of becoming a refugee, yet processes of asylum and resettlement do not guarantee new membership nor a sense of belonging elsewhere (Aleinikoff, 1995). Furthermore, social understandings of belonging can reinforce the position of ‘outsider’. Peck (1995) notes that foreigners and refugees in Germany are “constantly reminded in everyday life that they are not Germans and that they do not belong.” He concludes that the decision (of belonging) resides with the nationals and not with the refugees who may do whatever they can to assimilate but ultimately “can do nothing to become German.”

The nature of dominant discourse has important implications for refugee identity: “as genuine and deserving; as fraudulent and abusive; as needy and helpless; as autonomous and independent” (Hardy & Phillips, 1999). Discourse shapes and forms our understanding and seeks to legitimise our responses.

In the following section we describe how othering of forced migrants manifests, how it influences the way refugees and asylum seekers are perceived, how they perceive themselves and ultimately how this affects public health at individual and community level.

### The language of threat

The adoption of metaphors of threat, of natural disaster, of invasion, of war, and of contagion, have helped construct people on the move in an impersonal, destructive and destabilising light.

Turton (2003) draws attention to the use of metaphors of water (*drip*, *stream* and *flood*) in describing *flows* of forced migrants. Indeed metaphors of natural disaster are commonly employed in reporting refugee movements. Populations *pour* across borders, their condition and number often described with biblical references, they arrive in *swarms*, *tides* and *waves*, threatening to *swamp* and *overrun* host communities. They compel receiving nations to take urgent action to *stem the tide*.

Asylum seekers may also be presented as a threat to national security, with the language of war and battle used to describe the impact on host states. This reflects a process of securitisation and is

achieved through a focus on the nature of arrival (irregular and unpredictable) which is then used to paint asylum seekers as invaders warranting extreme measures of containment (Pugh, 2004). The ‘illegal’ nature of entry is used effectively to emphasise the difference between *us* and *them*: *we* are law-abiding, *they* are law-breaking.

It is argued that positioning the asylum seeker as ‘illegal’ contributes to public acceptance of ‘detention’ and shifts the focus from protection *of* the refugee, to protection *from* the refugee (Sathanapally, 2004). The term ‘detention’ powerfully criminalises forced migrants in the eyes of the community, while the detention environment (with its razor wire fencing) makes it difficult to discern the difference between this and imprisonment. That asylum seekers ‘need’ to be detained with such high security measures, speaks to the ‘fact’ that they are unreliable and untrustworthy.

As the perception of multiple threats mount, a heightened level of border protection is invoked, and increasingly complex measures are used to exclude refugees. Gibney (2005) describes the measures of exclusion employed—from restrictive visa regimes, to carrier sanctions forcing the private sector to take responsibility for transporting illegal migrants. In Australia, what was previously viewed as the everyday regulation of borders, vulnerable by their very nature to a certain level of breaching, has more recently become an issue of ‘frontier protection’. The contraction of the official boundaries of the state through excision of islands and the use of naval ships to intercept boats carrying potential asylum seekers has reinforced a ‘war on illegal migration’ and created a sense that the nation is ‘under siege’.

In these ways othering encourages us to interact with refugees and asylum seekers from a point of defense: erecting barriers, screening and deterring, defending borders, and effectively guarding against contact and confrontation. By focusing not on individual lives and circumstances, but rather on mass movement, often distorted and inflated in relative terms, we are left unable to personalise the refugee. They are set apart from us and those we know, and we remain reluctant to assist.

### Queue jumping and the uninvited guest

One of the most powerful ways in which asylum seekers and forced migrants are portrayed is as ‘uninvited’, imposing and making demands on

'us'. Typically, the focus is on ostensible deception, trickery and fraud that may be required to enter or remain in a country without a valid visa. The responsibility of the state to uphold moral principles, and fulfil a range of legal duties and obligations under international law, is rarely acknowledged or explicitly stated.

Notions of the 'uninvited guest' have been employed by politicians to justify sensational attempts at deterring 'boat people': the Australian government has defiantly declared: "*we will choose who comes to these shores and the circumstances under which they come*" (see [www.australianpolitics.com/](http://www.australianpolitics.com/)). The 'queue jumping' debate, in which governments argue that refugees should get in the queue for proper acceptance and not seek to go around it, is perpetuated by mistaken beliefs that somewhere there exists an orderly line of refugees patiently being processed by UNHCR and host government personnel. This message has been underpinned by asylum processes that link humanitarian visas granted offshore to protection visas granted to (onshore) asylum seekers, and which apparently state that one less visa is available offshore each time an onshore visa is granted (Stevens, 2002). Such policies effectively construct two types of refugees: 'good' (offshore) and 'bad' (onshore), and plays the protection needs of one group against the other (Crock & Saul, 2002).

Sathanapally (2004) has suggested that a refugee 'heap' is more accurate than a 'queue' and that these queue-jumping debates deliberately distort the experiences of those fleeing persecution, by failing to acknowledge that for many there is no queue to join; that refugee camps which are intended to provide safety are often themselves the site of violent conflict and abuse<sup>3</sup>; and that waiting out time in camps may never produce the desired outcome of resettlement in a country of safety (Dauvergne, 2003). Movements of refugees and asylum seekers have, and always will be, to some extent, chaotic and unpredictable (Crisp, 2003b). By constructing refugees as the other, reasons for this chaotic movement become peripheral and the sovereignty of the state and its right to choose its

migrants and new-comers are elevated as the central concern of refugee policy.

### Charity and choice

Refugees and asylum seekers are rarely portrayed as individuals with agency, skill or resilience, with capacity to contribute and be an asset to their new communities. Rather, as the language of 'burden-sharing' suggests, they are perceived as needy, helpless and a drain on resources. This representation starts with the reporting of humanitarian crises and is reinforced upon arrival. Dauvergne (2003) reflects that refugees and illegal migrants occupy a place in the collective imagination as desperate, brown-skinned, 'have nots hoping to gain from our beneficence' and she concludes, 'they are not us'. This is in stark contrast to the migrants which developed countries seek to attract to their shores, those who will busy themselves with hard work, simultaneously building a future for themselves and their new country. Many wealthy nations, including the US, Canada, the UK and Australia are actively recruiting 'skilled migrants' to offset labour shortages, with these migrants perceived as assets and as contributors.

Even where refugees have been welcomed, the process of othering ensures that developing a sense of belonging is difficult and that their position *within* is tenuous. Jenkins (2004) notes that definitions of community may expand and contract, redefining the boundaries between 'us' and 'them' and, for those who settle outside their 'proper place of belonging', acceptance may remain conditional on favorable local and global circumstances. This is especially true where communities have come to see the granting of asylum and safe haven as an act of charity rather than an obligation under international law (Pickering, 2001). In such circumstances, the 'other' may forever remain outside, and their responses must always convey gratitude for the generosity of the receiving community.

Refugees are, in a sense, seen as "survivors of oppression, plunged into poverty, purified by their suffering, and boundlessly grateful for safe haven" (Beiser, 1999, p. 170). They are, by definition, victims of adversity. "The fact that they are not inevitably poor, nor as pure or grateful as their hosts might wish, can be a source of difficulty" (Beiser, 1999, p. 170). In Canada, as elsewhere, there are rituals of integration, "a set of expectations initiates must fulfill, and actions they must perform,

<sup>3</sup>The precarious existence of refugees even after they have escaped the initial violent conflict is increasingly recognised; the establishment of categories such as Women at Risk acknowledge the high rates of abuse, rape and exploitation that women, and particularly unaccompanied women refugees, suffer.

as ‘they’ become ‘us’”. As they pass through this liminal period they are “supposed to be poor and to be content with their poverty; but to work hard in pursuit of full integration into the dominant society. Initiates are expected to respect authority” (Beiser, 1999).

This limits their ability to assert their rights, to question and contest their treatment, to articulate different rules of engagement. Furthermore, an expectation is established that any ‘genuine’ refugee will willingly comply with the state’s application procedures, regardless of how unfair or inefficient, and that public criticism, acts of dissent or protest all indicate a less than genuine claim.

Here, the othering that occurs through a dialogue of charity and hospitality traps the refugee by demanding their gracious acceptance of the determination and resettlement processes or risk being discredited. Forced migrants are effectively silenced. Where they break the silence, the state responds with anger and repression, as described later in relation to asylum seeker protests.

### Overload

One of the difficulties facing refugees is a public perception in developed countries of ‘overload’ in relation to immigration numbers in general and refugees in particular (Tazreiter, 2003). Policy decisions to tie offshore and onshore refugee programs together create a fictional threshold, implying that a country is at its absolute limit in terms of absorbing refugees. The reality is that demand for refugee status is often overstated and the circumstances and motivations of refugees deliberately concealed.

Refugee numbers world-wide appear to have stabilised and the pressure to search for third countries willing to resettle large numbers of refugees has been moderated: in 2004, the numbers of refugees seeking asylum in industrialised countries declined for the third consecutive year and reached its lowest level in 16 years (UNHCR, 2005b). Granting temporary or conditional protection reinforces perceptions that *we* can only offer *them* the bare minimum in terms of assistance, that developed countries have capacity to assist only over the short-term and that the full resettlement of refugees (and their families) is too great a burden to bear. This defies the spirit of the Refugee Convention, conflicts with the stated aim of UNHCR to find durable solutions for those who have fled

persecution, and paradoxically may result in greater dependency and demand on social services and welfare systems. Asylum seekers and those offered limited or temporary visas, for example, may be denied the right to work causing them to rely on local charities to meet basic needs, and stretching resources available.

Antagonism to refugees and asylum seekers is exacerbated in the US when refugee populations are assisted by local, voluntary and religious agencies. Lynn suggests forced migrants may be seen as receiving ‘undeserved benefits’—benefits that are not available to American citizens—and their presence regarded as additional strain to be absorbed by local services (Lynn, 2002).

In constructing refugees as the other, the crisis of competition for local resources is more easily developed; *they want what we have*. The tabloid press in the UK has been accused of weaving together the myriad fears of the British public with issues of asylum seeking including “Illegal immigration. Radical Islam. Terrorism. Crime. Disease. An overstretched health service. And to make it all worse: falling property prices” (Crisp, 2003c).

### Maintaining the other

Maintaining the ‘otherness’ of refugees and asylum seekers, requires that *they* and *their stories* remain distant and strange, that we rarely hear from them or come to know them. So even though we may feel for the ‘victim’, we know and learn little of their personal circumstances, the emergencies that precipitated their flight, or their complex causes. Ignatieff (1998, p. 295) describes this as ‘empathy without understanding’: a condition that enables us to remain unconnected, makes it easy for us to shift our focus and commitment when “we learn something that apparently contradicts the image of simple innocence...”.

One of the ways in which this distance is maintained in Australia is through detention processes which produce very real, physical barriers to ‘knowing’ the asylum seeker. Indeed, governments may go to considerable lengths to keep detainees from public view, thus preventing asylum seekers from being seen and accepted as persons who may come to belong as members of the community. Where detainees have attempted to bring attention to their plight, both in terms of their demands to be recognised as refugees and their treatment in detention, the media has at times

presented such acts of protest in a way that further distances this ‘other’.

Protests involving self-harm, in particular, have been used to construct asylum seekers as ‘irresponsible and irrational’ (Cox & Minahan, 2004). When a large scale hunger strike in the Woomera Detention Centre in South Australia escalated with approximately 60 detainees sewing their lips together in a desperate protest over inhumane treatment, it was widely reported as a gruesome and bizarre act, and was portrayed without any context or rationale (Mares, 2002). This offered further proof that *those* people were not *like us*, and not what *we like* (Sathanapally, 2004). The former Immigration Minister Phillip Ruddock spelt it out explicitly: lip sewing “is a practice that is unknown in our culture...that offends the sensitivities of Australians.” Others have argued that lip sewing can be understood as symbolic of the impotence and invisibility felt by these detainees (Mares, Newman, Dudley, & Gale, 2002), and of their dependence on others to tell their story. Reporting of this incident included claims which were never substantiated, that parents had sewn their children’s lips together. These reports and comments such as Ruddock’s carried overtones of an earlier incident in which the Australian government had claimed that ‘boat people’ had thrown their children overboard in an attempt to blackmail the Australian Navy into rescuing them. It later became clear that these reports were inaccurate, but not before the Prime Minister could express his outrage: “The behaviour of a number of these people, particularly those involved in throwing their children overboard—I mean I can’t imagine how a genuine refugee would ever do that... I certainly don’t want people of *that* type in Australia. I really don’t” (see [www.afr.com/election2001/transcripts/2001/12/06](http://www.afr.com/election2001/transcripts/2001/12/06)). Rather than elicit empathy or understanding, protests and acts of desperation, whether real or fabricated, have been used to establish difference and distance and trap the asylum seeker in a cycle of ‘malignant alienation’ (Dudley, 2003, p. S106).

Refugees “transgress many boundaries: physical, geographic, language, legal, national, social and political” (Pickering, 2001), thus disrupting our routine and sense of normality. Deviance is conferred—*they* do what *we* don’t, *they* are what *we* are not, thus forcing choice between us or them, legal or illegal, genuine or bogus. Othering not only creates distance between ‘us *and* them’, but also

creates a sense of opposition and conflict, that leads inevitably to ‘us *against* them’.

### Public health and othering

...the social construction of boundaries of ‘self’ and ‘other’ and their relationship to boundaries of ‘safety’ and ‘danger’ are particularly relevant to understanding notions of health and disease (Flowers, 2001, p. 51).

Many forced migrants have fled poor, developing countries, where access to health care was limited, and services disrupted by conflict (Zwi, Fustukian, & Sethi, 2002). Exposure to disease and ill-health will have been substantial. The journeys of smuggled and trafficked persons are often fraught with danger: posing risks of drowning in unseaworthy vessels, attacks from pirates, suffocation in containers and vehicles, and prolonged exposure to heat, cold or injury.

In many different ways refugee populations *are* at risk and have been recognised as having unique and complex health needs which require attention both upon arrival and throughout the process of resettlement (Harris & Telfer, 2001; Steel & Silove, 2001). Rather than respond to these health needs, many receiving countries have become concerned with positioning the health problem as their ‘diseased state’ and highlighting the risk refugees pose to others in the community as well as their potential to overload services.

In addition to co-opting the language of natural disasters and war, referred to earlier, refugees are often also portrayed as a threat to a robust and healthy society, a threat of disease itself. *They* must be screened and quarantined to avoid the spread of disease. This inverts health concerns such that the receiving population is seen to be under threat rather than attending to the health needs of the displaced. Koutroulis (2003) discusses how the language of epidemics conjures images of threats of contagion and reinforces the need for quarantine and separateness, reinforcing the role of mandatory detention.

Moreover, arguments concerning the protection of public health itself are often employed in an effort to keep forced migrants out (Zwi & Alvarez-Castillo, 2003). Boat people have been portrayed as ‘carriers of disease’ (Refugee Council of Australia, 2000) and sensational headlines such as “Diseased, suicidal and angry: Iraqis suffer in PNG detention camp,” have confused health conditions in

detention centres with the health status of individuals who seek asylum.<sup>4</sup>

The pre-arrival selection of migrants typically screens for desired characteristics (e.g. education, skills, language, ability to integrate, wealth) while screening out the undesired factors such as security risk, criminality and, importantly, ill health or disease, or the risk of excessive demand on health services (MacPherson & Gushulak, 2004). In this way health becomes an instrument of social control. Refugee health in the UK for example, has at some stages been the responsibility of communicable disease departments, thus reinforcing the impression that “refugees are vectors of infection” (Burnett & Peel, 2001).

Othering based on disability, gender, health status and ethnicity has been shown to have consequences for access to, and delivery of, health services (see for example Johnson et al., 2004; Kang, Rapkin, Springer, & Haejin Kim, 2003; Kitchin, 1998; Phillips & Drevdahl, 2003). Flowers (2001) described how the emergence of HIV/AIDS led to the collective othering of gay men in an attempt to locate this health concern far from the general public and at the same time distribute blame and responsibility for managing risk within this group of ‘others’. He notes that as AIDS became associated with being gay, gay men were simultaneously positioned as ‘at risk’ and curiously as *posing* a risk to the community. This transfer of ‘at risk’ to ‘of risk’ has parallels with the health concerns associated with refugees and asylum seekers.

We have shown that forced migrants have been presented as a source of overload on social systems, and that the characterisation of asylum as charity has reduced willingness to provide basic services, including those for health needs. The desire of wealthy countries to present themselves as an unattractive option to ‘would-be refugees’ has also contributed to a reduction in available supports and services.

A growing body of research evidence points to the inadequate responses of developed countries to the health needs of refugees and other forced migrants. Despite increased needs, the UK has recently introduced legislation which will force service providers to charge ‘failed asylum seekers’—those

who have applied for, but failed to obtain political asylum—for health care (Hargreaves, Holmes, & Friedland, 2005). Ekblad’s research in Sweden concludes that, mainstream services remain insensitive to the cultural differences among ‘outsiders’, and removing administrative obstacles to care and promoting more culturally sensitive interventions is required (Ekblad, 2004). Smith (2001) describes how restricting access to health services and procedures in processing protection visas in Australia has resulted in refugees spending months and sometimes years in the community without undergoing any basic health screening, presenting obvious concerns in relation to the spread of communicable diseases. A study of East Timorese women asylum seekers in Australia highlighted their additional needs (including physical and mental health needs), attributing these, in part to the increased vulnerability associated with living with insecurity of tenure and significant material deprivation (Rees, 2003). Mares (2002) identifies the pressures and restrictions on health workers seeking to address the needs of asylum seekers and refugees, highlighting current concerns with costs and containment, rather than addressing need and ensuring good public health practice.

Lynn and Lea (2003) in examining othering language in the UK press highlighted portrayals of asylum seekers as free agents; “*If they don’t like our rules, then they need not come to Britain*”. They noted that these constructions overlook the desperate realities that face people who flee their homes and rather presume a rational and considered approach to both leaving and to choosing their country of asylum. We recognise the same erroneous assumptions underlying the politics of restricting access to basic services in an attempt to dissuade asylum seekers from coming. Forced migrants are rarely in the position to weigh up the potential health facilities and services available in destination states.

There is no health benefit in denying health care to this group, and if it results in refugees and asylum seekers not receiving appropriate and timely health care, then this may indeed place the wider community at risk over time—the ‘burden’ on the health system that this policy was attempting to avoid. Restricting access to health services, or establishing conditions which result in reduced uptake of services does not protect the broader community. Recent efforts by some governments have focused on restricting access to care for select groups of

<sup>4</sup>This headline appeared on the front page of Sydney Morning Herald (5.2.02) attached to an article that reported detainees had contracted malaria during detention on Manus Island as a result of poor health services.

migrants. Hargreaves et al. (2005) question the implications of legislation in the UK which will charge failed asylum seekers for their health care. They worry that needed health care will become inaccessible, and that arbitrary determination of right to access may impinge on the ability of asylum seekers, refugees and other settled minority groups to access health care even when entitled to do so. Rather what is good for the individual (access to and utilisation of health services) is good for the public's health. This is most obvious in relation to infectious disease but is equally true for early detection and intervention of chronic conditions. The othering process that sets *them* and *us* in conflict over scarce health resources, reduces access to care and requires a response from health professionals. Forced migrants concerned at how they are, or will be, treated by officialdom, may predispose to late presentation or indeed fail to use services at all resulting in lack of screening or treatment. In other situations, care may be inadequately sensitive to the prior experiences of the migrant, and may pose the risk of re-traumatising a potentially fragile individual. Either way, failure to provide welcoming, accepting and fine-tuned services may do the opposite of what is required—an engagement with people through health services and support—and will instead distance people, contribute to their alienation, and undermine their health.

### **Responding to othering—towards an inclusive public health**

Public health seeks to address health needs through the organised efforts of society. Most recently Beaglehole, Bonita, Horton, Adams, and McKee (2004) have defined it as “collective action for sustained population-wide health improvement”. This recognises the importance of developing population-wide interventions and addressing structural impediments to promoting health gain. Good public health engages with these issues, with other sectors, and with the political process, to promote better outcomes and solutions.

There are compelling ethical and public health reasons to challenge the othering of forced migrants. Governments avoid their international responsibilities to protect those who are persecuted and displaced; this is made possible by a public that sees refugees and asylum seekers as a dehumanised threat, outside the boundaries of belonging and without legitimate claims to entitlements. These

processes of othering carry a “real risk of the creation of vulnerable, marginalised under classes” (Allotey & Zwi, *in press*) with very real consequences for population health. While it has been argued that “rights belong to those who can claim them”, othering renders refugees voiceless and risks their basic human rights. Health practitioners must give emphasis to one of the core lessons learned in working with vulnerable groups: that respect for human rights is critical to effective public health action.

Public health needs to respond to the current discourse of ‘othering’ or risk being co-opted into a system of heightened social control and marginalisation. The emphasis on ‘security’ has used public health issues to raise fear of infection and disease spreading from countries in conflict to the industrialised world. The othering occurring in receiving states has impacts ranging from the individual level in the clinical encounter of patient and physician through to a structural level in the organisation and delivery of health services. Responses must consider action at different levels.

Health services must address issues of access, acceptability, responsiveness and availability of services to refugees, asylum seekers and irregular residents. Barriers to treatment may relate to costs, language, and the characteristics of the provider. Training in transcultural issues, making health services more responsive, integrating health and community services, and resourcing transcultural research have been suggested as important interventions (Ekblad, 2004).

Many refugees have horrific experiences of being subjected to, or witnessing, torture, trauma or human rights abuses. They may have seen family and friends killed, been subjected to gender based violence including rape, or participated in, or been themselves forced to carry out abuses. Such circumstances clearly represent risk factors for a range of serious and debilitating mental health stresses. Rather than respond to these needs, policies of indefinite and mandatory detention for example, may exacerbate these earlier exposures and be associated with deteriorating mental health status (Steel & Silove, 2001).

One counter to this may be to enable forced migrants to ‘reconnect’ with their homeland. At present, there is an assumption that “in becoming ‘torn loose’ from their cultures, ‘uprooted’ from their homes, refugees suffer the loss of all contact to the lifeworlds they fled. It is as if the place they left

behind were no longer peopled” (Malkki, 1995). Facilitating connections with a lost home, from a new home, may help sustain links, a sense of identity, reciprocity and health.

For health-workers, training in cultural competence and cultural sensitivity, and in human rights, is desirable. Support for frontline workers is a priority as is the establishment of a working environment in which a supportive and responsive service is made possible. Health services can play a major role in promoting a sense of inclusiveness, by drawing forced migrants in and demonstrating responsiveness to community needs. Coker (2004) highlights practical measures to overcome otherness and poor access to services, among which are providing client-held records, developing gender and culture-sensitive programs and interventions, and encouraging general practitioners to play a greater role in providing long-term health care to refugees and asylum seekers.

“Perhaps the clearest indicator of a commitment to foster belonging for all in our health care settings is the allocation of resources...” (Kirkham, 2003). To better meet the needs of forced migrants, health services will require the resourcing of interpreting and translating services, outreach workers, and more specifically targeted prevention and health promotion programs to complement secondary and tertiary care services.

Public health practitioners should advocate for humane responses to forced migration, alerting policy-makers to the consequences of failing to provide adequate care. Indefinite detention of asylum seekers has provoked criticism from health professionals individually and collectively. The continued efforts of researchers to document the health consequences of detention, of temporary protection visas and of other practices designed to limit the rights of refugees, are critical. Further work is required to quantify the costs of current policies in health and dollar terms and to build the evidence that supports alternative solutions for forced migrants.

Educating medical and public health professionals to grapple with complex, global issues such as population displacement, is important. Students must be encouraged to see their responsibilities as extending beyond their own local communities; be supported to take up advocacy roles and be provided with role models who are committed and connected to the health of ‘others’ (Davidson et al., 2004).

## Conclusion

This paper has highlighted the ways in which forced migrants are ‘othered’, excluded and marginalised, and has raised concerns regarding the knock-on effects for the health of these migrants and the general public. It has argued the potentially negative effects of othering, and highlighted how this process not infrequently draws upon the legitimacy of public health and its metaphors to exclude those already seriously marginalised. Much work remains to be done in this area. Empirical research is required to understand more clearly how othering manifests, what processes take place at the individual and the collective level and how these may interact, and to document systematically the impacts on access and use of health services.

Most importantly, investigation to uncover positive responses to othering is needed. Have some communities been able to resist this othering? What are the critical elements that support such resistance? Where and how do health workers fit in? What can they do to reinforce the agency and resilience of communities which have already been through so much?

The paper calls on public health practitioners to respond by putting forward a narrative and discourse of inclusion and caring, of recognition of the complexities of the contexts out of which forced migrants come, and of the challenges they have faced every step of the way. It argues for public health to return to its social activism origins in an effort to promote social justice, critique the inadequacies of current policies and systems, and seek more inclusive means of promoting rights, responsibilities and community.

Sacks (2002) argues strongly for processes which encourage inclusiveness “We are particular *and* universal, the same *and* different, human beings as such, *but also* members of this family, that community, that history, that heritage. Our particularity is our window on to universality, just as our language is the only way we have of understanding the world we share with speakers of other languages” (italics in original).

Gibney (2005) concludes that “when exaggerated, alarmist and, frankly, racist portrayals of asylum seekers in the electronic and print media are reinforced (or even left unchallenged) by political elites, it is not surprising that governments find themselves dealing with intolerable publics”. Public health practitioners have a central role to play in

transforming the dominant discourse and narrative which surrounds forced migration and supporting asylum processes that produce better health outcomes for all.

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