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Policies on marginalized migrant communities during Covid-19: migration management prioritized over population health

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ABSTRACT

Migration management policies in many states have marginalized significant numbers of individuals on the basis of their precarious residency status, negatively impacting their health. This article looks at how three European states with high levels of contagion – France, Sweden, and the United Kingdom – adapted their migration management policies to the changed circumstances during the Covid 19 pandemic in which there was new pressure for prioritizing population health over other concerns. The analysis compares globally-recognized 'best practices' for migrant health during the pandemic with policies adopted by France, Sweden, and the UK – selected as prominent migrant-hosting states and that experienced high rates of Covid-19. The article draws on supplementary evidence through interviews with civil society organizations working directly with migrants living on the margins of society – what are termed here 'marginalized migrants' (MMs). As the article concludes, the national policies often fell below international 'best practices' such that migration management was often prioritized over population health despite the crisis. The perspective developed in this paper is important for understanding where migration control policies have been prioritized over public health.

KEYWORDS

Marginalized migrants; migration management; covid 19; France; Sweden; United Kingdom; population health

Introduction

Migrants often suffer ill health due to a mix of poor housing, vulnerable work, and restricted access to healthcare related to their precarious residency status and the impact of migration management policies. One of the common observations made early on in the Covid-19 pandemic was that the virus disproportionately hit those already living on the margins of society, such that inequality and social deprivation were clear factors undermining pandemic control. This article looks at how three European states with high levels of contagion – France, Sweden, and the United Kingdom – adapted their migration management policies to the changed circumstances in which there was suddenly urgent pressure for a reprioritisation of population health over other concerns. The analysis

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compares globally-recognized 'best practices' for migrant health during the pandemic with the policies adopted by the selected states, each with relatively high numbers of marginalized migrants, and with supplementary evidence through interviews with civil society organizations working directly with migrants living on the margins of society – what are termed here 'marginalized migrants' (MMs). As the article concludes, the national policies often fell below international 'best practices' such that migration management was often prioritized over population health despite the crisis. The perspective developed in this paper is important for understanding where migration control policies have been prioritized over public health.

Migration management and population health

This paper essentially takes a human rights-based approach to questions of global health and migration. The human right-based approach contends that all migration policies should support and follow the nine human rights treaties of international human rights law. According to these laws, all migrants irrespective of their status are entitled to the respect, protection and full enjoyment of human rights. More specifically, article 2 (2) of the 1966 International Covenant on Economic, Social and Cultural rights (ICESCR) confers a right to health to non-citizens or migrants. The right to health and social care for migrants is also provided for in a number of legal provisions and notably refugee law, international human rights, domestic laws and constitutions (Willman 2013). Moreover, most countries have signed the WHO Constitution which guarantees such rights: 'Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures' (Preamble to the Constitution of the WHO, 1948). Such rights should be upheld because migrants will be best able to integrate in the destination country if they are protected through provision of health and social care and empowered in both economic and social terms from arrival. Evidence also suggests that the benefits of international migration for both migrants and host societies depend on the protection of migrants' rights. However, many nation-states have added migration management as a justification for refusing healthcare to those in need, with migration policies often foregoing a rights-based approach (Hujo and Piper 2015; Delgado Wise 2018).

There is thus a well-noted tension between migration management policies and achieving optimal population health, something which has been exacerbated in the context of the Covid-19 pandemic. The problem arises from the fact that loopholes in international law and national legislature means that the rights based approach is not necessarily upheld. Article 2(1) of the ICESCR, for example, requires states 'to take steps, individually and through international assistance and cooperation … to the maximum of [their] available resources'. So the lack of available resources may well undermine states' abilities to fulfil migrants' entitlements. The needs of the migrant population in terms of health and social care may be greater than the host population: the need to provide shelter, etc. The European Social Charter and the Revised ESC also undermine the rights based approach and provide specifically that undocumented migrants cannot benefit from the same health rights as citizens or those who are lawfully resident. Aliens are specifically excluded from the scope of health provision.

While most states do provide for rights to health in their domestic law constitutions,[1] civil society and migrants' advocacy groups contend that international migration governance is based on a 'migration management' approach rather than a 'rights based' approach. According to Delgado Wise (2018), this is a neutral or depoliticized way to tackle migration policies along the neoliberal market ideology, but in practice it fails to respect human rights treaties. However, beyond the dichotomy of the rights based approach as opposed to migrant management or indeed other development approaches, this paper also seeks to underline the importance of understanding the complexities of developing integrated policies, which enable coherence across the various policy areas and decision-making levels during the current Covid-19 pandemic.

In terms of global governance for migrant health, the WHO World Health Assembly (WHA) resolution on health of migrants, endorsed in May 2008 set forth several migrant-sensitive health policies. The European Union has a number of project which specifically focus on managing migrant health. As Zimmerman *et al.*, (2011) argue, while most governments recognize health as an essential human right, migrant policy faces different and often competing goals which undermine the ability of nation states to ensure the rights-based approach to health. Ensuring implementation of specific Covid-19 global health recommendations on national legislatures may prove difficult if there are not already provisions in place to accommodate these recommendations. As Weir and Skocpol (1985) underline, policymaking in the framework of existing institutions is constrained by preexisting laws and policy legacies. Policies will be shaped by the institutional context and path dependency of policy outcomes. Thus, in analyzing the coherence of global recommendations for Covid 19 in migrant populations, it is important to underline that there will be constraints and the lock-in effects of past policies which will influence the policies at national levels. There will inevitably be a bias toward policy continuity and this will account for the differences we note across the three European countries. While most governments do have policies in place to ensure migrants' entitlements to health and social care, migrant health policy is often uncoordinated, vague, inconsistent and contradictory for historical reasons. Moreover, recent migration policies in some European countries have concentrated on the threats or fears of migrants bringing diseases and threatening the host population which results in stigmatization.

The effect of policies that limit migrants' access to health, whether as an explicit or implicit goal, is exacerbated by structural barriers which undermine migrants' right to health. Migrant populations' access to healthcare is obstructed by factors including poor communication, a lack of continuity of care, and low trust (Brandenberger et al. 2019). For many migrants, there are important organizational, and interpersonal barriers to be considered (Norredam, Mygind, and Krasnik 2006). Other studies have found that the need to pay for care, health-care professionals' knowledge of the rights to health-care access for migrants, and their ability to communicate effectively with migrant patients all play a role in determining whether primary care represents a barrier or facilitator to migrants' access to primary care (Norredam, Mygind, and Krasnik 2006). Barriers identified in relation to primary care in the European Union include varying entitlements and financial barriers, which can also obstruct access to accident and emergency care and mental health services (Agudelo-Suárez et al. 2012; Joshi et al. 2013; Norredam, Mygind, and Krasnik 2006).

For asylum seekers in particular, the situation across European countries in terms of entitlements and access to services varies greatly (Norredam, Mygind, and Krasnik 2006). A qualitative study, for example, in the UK exploring access to maternity information among recently arrived Somali women found that punitive attitudes and prejudiced views among health professionals led to reduced access to necessary services (Davies and Bath, 2001). Also, in the UK general practitioners (GPs) have in some cases been found to be reluctant to register asylum seekers and refugees and other new migrants because they may be highly mobile and are more difficult to follow up for routine screening and vaccination (Hargreaves et al., 2008). Exclusion can therefore result from this complicated and multi-layered organizational structure of health-care systems (Davies and Bath, 2001; Papadopoulos et al., 2004; Priebe et al., 2011).

Beyond the aforementioned barriers, the conditions that undermine migrants' health are often a direct and explicit goal of policies designed for the purposes of migration management. That does not mean these policies necessarily limit the arrival of migrants, but certainly they impact the life quality of migrants within host countries. In effect, the risk of poor health serves increasingly as a tool of migration management. However, to what extent did this change in the context of the Covid-19 pandemic? Asking this question, the article is focused on how three selected governments treated migrants during the first phase of the Covid pandemic when the consequences of undermining population health were suddenly altered.

Evaluating policies toward migrants during the first phase of a pandemic

The paper focuses on the first phase of the pandemic (March – November 2020) for the reason that, as a period of crisis when new policies were being created in haste, it gives an insight into a unique moment in which the long-prioritized policy focus on migration management seen in many states was under pressure from a new prioritization toward population health.

Given the unprecedented nature of the Covid-19 pandemic's political context, there is no prior existing criteria for assessing how states treat migrants living at the margins of society – what we term here as 'marginalized migrants' (MMs) – during such a crisis. However, in March 2020 the Interagency Standing Committee (IASC) published its recommendations in a report titled 'Scaling-up Covid-19 Outbreak Readiness and Response Operations in Humanitarian Situations' (UNHCR 2020). The report concerns a broad range of migrants with varying legal status, but excluding those with permanent residency. It specifically gives guidance to host countries on how such individuals should be supported in the context of Covid-19 with a focus on public health. After a review of key documents produced by key international organizations, the IASC report was chosen as the single document to provide a multistakeholder collaboration between both international organizations and civil society, with the report representing the collective guidance given by the World Health Organization (WHO), International Organization for Migration (IOM), the United Nations Refugee Agency (UNHCR), and the International Federation of Red Cross and Red Crescent Organizations (IFRC). The guidance document mirrors other documents individually produced by the signatory organizations (UNHCR 2020), and as such stands as a credible indication of recognized 'best practices' at the global level.

To utilize the IASC report as an authoritative indication of 'best practices' regarding the treatment of MMs during the pandemic, the research divided its recommendations into five core categories that could be used as focus areas when looking at national approaches. This led to the following list:

(1) *Health information*: Information on the novel coronavirus and prevention should be effectively communicated to refugees and migrants – which means 'timely and accurate information in accessible forms and appropriate languages';
(2) *Access to health services*: migrant populations should have easy access to essential health services equipped to monitor and treat C19;
(3) *Living conditions* – Adequate support should be given to migrant populations to ensure living conditions are conducive to preventive measures against C19;
(4) *Nondiscrimination* – Specific measures should be taken to ensure that these populations are not scapegoated, stigmatized or otherwise targeted with specific, discriminatory measures;
(5) *Community engagement* – target groups should be included within the design of readiness and response plans, polices and strategies and incentivized to comply to Covid preventative measures in place, including, for example, through the declaration of temporary amnesties, to encourage full participation.

Three European states were selected for comparison: France, Sweden, and the UK. In addition to Europe becoming an epicenter of the global pandemic, the three states have had some of the highest per capita infection rates in Europe, whilst also being significant host countries for migrants in the region. The three states are most-similar cases with respect to their development level, but with distinct welfare traditions and migration policies. The countries are selected also on the basis of the authors' expertise.

The analysis began with a desktop identification of the official state-level policies on healthcare for migrants lacking permanent residency as adapted in response to the Covid-19 pandemic, drawing on the government websites. The time period covered runs from early March 2020 when the pandemic was first recognized within Europe, to November 2020 when the second wave began. During that period, there were significant policy developments in all three countries concerning the general population, with some changes specific to the types of migrants to which the IASC guidelines apply.

To assess the impact of the national policies, the research draws on interviews with prominent civil society organizations in all three countries (3 France, 4 Sweden, 2 UK) that work with migrant health and welfare. All interviews were semi-structured by the criteria identified in the IASC guidelines, and conducted during October–November 2020, lasting between 30 to 60 minutes. The civil society interviews provided a problematization of the national policy statements, enabling us to better understand how policies operated in practice, as well as their impact. We did not have access to representative MM population in all three countries and so are unable to report directly on their experiences. The civil society interviewees were presented, as a point of departure, with our analysis of the national policies in relation to the 'good governance' criteria. The government websites and civil society interviews were utilized for the descriptive information provided. The analysis was then conducted via comparing how

the situation in each country identified in these data compared with the IASC guidelines as a point of departure for 'good governance' structured via the five categories identified above.

Evaluating migrant policies during Covid-19 in France, Sweden, and the UK

In the national studies, we noted that many of the barriers for migrant which have been raised in the literature were evident in our interviews with civil society groups but new barriers to health were also described. However, there was also significant variation caused by differing structures with respect to how much the state, civil society, or the private sector is responsible for service provision to MMs.

France

France has experienced a significant increase in migratory movements in recent years. In 2018, France registered a record 123,000 asylum applications, an increase of 22% compared to the previous year when asylum applications were already high. Despite falls in 2019 and 2020, the overall significant increase in asylum applications in France has consequences for the cost of the allowance received by applicants and the financing of accommodation structures, leading each year, as the Court of Auditors noted last spring, to an overstretched system (Assemblée nationale 2020). This has created an increasingly precarious environment for migrants, especially newly arrived immigrants, who are often homeless and are continually dispersed by the police when they set up illegal camps. The situation is extremely critical in Calais and the northern region of Grande- Synthe. Given migratory pressures and the specific historical features of the country, France was in a particularly ill-placed position to follow through the recommendations at the global level in order to provide adequate health and social care to marginalized migrants during the Covid-19 outbreak.

Health information

The interior ministry translated information on Covid-19 into nine common languages. A social worker at Aurore, which is an association providing day care and assistance to single male newly arrived migrants, underlined how the government's website was useful because it provided information which they could then communicate to migrants. They used the information to make printouts in all the languages to explain what preventative measures the migrants should take. However, many of these marginalized migrants live on the street, so they did not have access to the information. The social worker explained how providing the information and being able to abide by the rules during lockdown was very difficult for many of them:

> How can you be in lockdown when you are sleeping rough, that was the most difficult thing for them and many of them were fined by the police. This was one of the biggest problems, already there is the language problem for them, the police speak French, not necessarily English, the police did not understand and did not have time to understand the situation.

A volunteer at Médecins du monde working in the Nord Pas de Calais and North regions underlined the limits of the governmental documents:

> We work with people who are in transit and therefore on the coastline in the North and Pas de Calais regions in camps which are extremely difficult and where people do not necessarily have access to water, soap, access to masks and this means that we had to rework the documents so that they could be really adapted to people's living conditions.

Health services

In terms of access to health services, no specific policies were put in place to increase migrants' access to health services during Covid 19. In France, foreigners in an irregular situation, asylum seekers, refugees or holders of a residence permit are entitled to medical assistance on the same basis as French nationals. Migrants, regardless of their status, can benefit from universal cover either through the *Aide médicale d'État (AME)* or the *Couverture maladie universelle complémentaire (CMU-C)*. Both systems allow all migrants irrespective of their status to claim state medical aid. However, both require migrants to prove that they have been in France for at least 3 months. Minors and persons being escorted to the border in an administrative detention center (CRA) benefit from the AME irrespective of length of stay. For newly arrived migrants, the only possible way of receiving health cover is through health-care access centers (*Permanences d'accès aux soins de santé* (PASS)). These are health centers located in public hospitals and intended for people without any health cover.

In Calais, a volunteer at one of the biggest migrant associations Auberge des migrants reported that access to health services is fairly good and this has not changed since the pandemic. There are several options for migrants: the PASS, but also the Red Cross and Doctors of the World care services in Calais. The association UTOPIA also provides transport to the hospital for this population on a daily basis. However, problems often arise on arrival at the hospital as the volunteer explained:

> On arrival at hospital, there are several problems, there is the language problem, the hospital does not have enough interpreters in all languages. While in French, English, Arabic, you can perhaps make yourself understood or understand what is being said to you, but for other languages like Farci, Tashto, etc, it is much more difficult, so that is a real problem.

In addition to the general issue of lack of information on available services, civil society interviewees reported that French health services were often unwilling to adapt to the needs of MM populations. and the inadaptability of services to meet the needs of this population:

Living conditions

In terms of the recommendations by IASC to provide decent and secure dwellings during Covid-19, policy measures initiated at national level and implemented at the local level proved to be inadequate to meet the needs of the populations concerned, especially in the Paris region or in complex situations like those in Calais where migrants arrive in order to attempt to travel across to Britain. Geddes and Scholten (2016) argue that a side-effect of

the laissez-faire approach to immigration in France, in line with the more liberal politics of the 1970s and 1980s and the refusal to accept the status of migrant populations, led to widespread discrimination and poor housing. The housing problem for migrants is therefore not a new issue in France, especially in densely populated cities such as Paris and an ever increasing number of MMs are among the homeless. Yet, according to French, European and international law, the French State is required to pay for the accommodation of asylum seekers, to pay an allowance to meet their primary needs and to provide administrative and social support during the processing of their asylum application.

The French state did increase funding to house the homeless during lockdown. A total of 178,800 extra shelter spots in France for homeless people (including asylum seekers) were provided from March to May 2020. According to official reports, 3,600 places in centers were opened from March 2020 across France to provide shelter for the homeless suffering from Covid-19 but who do not require hospitalization (French Gouvernement Website, 2020).

Yet, according to the social worker at the association Aurore, in Paris, the situation has worsened in terms of providing accommodation for marginalized migrants who come to their day center for assistance and for the possibility of being transferred to suitable accommodation, called CAES since lockdown. The association noted that while the government created more places, this was not at all evident at the grassroots level:

> The vast majority of them don't have any accommodation. What they are looking for really when they come here is to leave for a transfer to a centre where they are provided accommodation[2] and the problem is that since the beginning of lockdown, the places have been drastically reduced.

There seemed to be a significant problem across the Paris region for migrants according to the social worker:

> It's quite contradictory because we did ask the people who came to us every day to see if they had been approached by the 115,[3] if they had been offered accommodation or anything else and they told us that they hadn't.

In Calais, the volunteer at Auberge des migrants was also critical of the interventions to attempt to house the migrants during lockdown:

> A certain number of people did leave for new accommodation provided but they came back quickly because the material conditions, among other things, were considered not to be good. And besides, it's quite paradoxical because the migrants were put in these rooms, notably in an old Formula 1 hotel in Boulogne sur Mer and they were three or four to a room and therefore they found themselves in a context which was perhaps more likely to spread the virus than in their camps.

The volunteer at Médecins du Monde underlined that conditions had deteriorated for the migrants since the outbreak of Covid-19. First, she mentioned that the extra housing and initiatives were only in place during the 3 months of the first lockdown and since then all these extra initiatives to take care of vulnerable persons such as migrants have been disbanded. The other issue she raised was that the number of volunteers providing assistance to these communities had been reduced:

> Living conditions are extremely difficult in the camps and it's true that during lockdown everything was that bit worse. It is important to note that at the level of food distribution, it is mainly associations that carry out the food distributions, it is mainly the associations with

> volunteers over 60 years of age and therefore it was a real problem because many associations withdrew from the field in order to protect their teams and therefore access to food during this period was extremely complicated. The other thing is access to water, so also water, toilets and showers. (. . .) in the Grande Synthe area, there is one water point, 6 toilets for 400 people and no access to showers.

Anti-stigmatization

Despite encouragement to do so at the global institutional level, French authorities have not led specific anti-stigma campaigns as regards Covid 19.

In Calais, the volunteer at Auberge des migrants underlined that there were two issues: some extreme rights groups claimed that the migrants were being housed ahead of other homeless persons, which was incorrect and that there was criticism that the migrants were not respecting social distancing, hygiene, etc. Given the conditions in the makeshift camps and the refusal of the Calais authorities to provide adequate hygiene facilities since 2017, respect of basic handwashing, etc. proves very difficult for this population.

The volunteer from Médecins du monde was aware of discrimination in Calais:

> The bus drivers refused to allow exiles to get on the buses during this period because they feared that the disease would spread because supposedly the exiles did not respect social distancing, etc. The associations took several steps. First, they called the bus company to question them on this issue. Nothing came of it. The associations then contacted the sub-prefecture. For a while it was better. The exiles were able to get on the buses again, but afterwards stigma continued in other ways (. . .) the exiles were authorised to get on the buses and a few stations later on, the police got on the buses, carried out identity checks and told the exiles to get off.

Such discrimination thus prevented migrants reaching hospital services, among other things.

Community engagement and policy making

In France, it is difficult to identify clear and specific community engagement and coordination from the national level to the field level any more than the basic emergency care that was provided through associations. As Mrs Gary from Aurore underlined, there was little consultation on site to provide coordinated policies from national to local levels:

> I have not seen any such consultations. I'll come back again to the question of accommodation, there was no consultation or message to tell us that because we welcome migrants who are in difficult situations, we would get easier access to accommodation for them.

The volunteer from Médecins du monde noted that the extent to which consultations were carried out depended on the area, but in general the state provider was absent:

> In the Pas de Calais locality, (. . .) we had many meetings and then regular meetings to monitor the system that had been put in place. However, (. . .). I think I saw a member of the Regional Health Agency once, at a meeting at the very beginning, and afterwards it was completely absent from the discussions, and (. . .) in the North department, we did not manage to have any consultations at all.

Sweden

Sweden has historically had a welcoming approach to migrants, but due to both the EU's political crisis that followed its failure to manage the arrival of Syrian refugees in Autumn 2015, as well as the domestic rise of right-wing parties opposed to immigration, the formally pro-migrant Social Democratic-led government has engaged in a radical reversal of that history so that life for marginalized migrants in Sweden has become rapidly more precarious in the last 4 years.

Asylum seekers in Sweden are encouraged to support themselves, but if this is not possible, the government will provide support with both daily allowances and support for housing fees. After asylum is granted, asylum seekers gain refugee status and will either receive permanent or temporary residence permits (Migrationsinfo.se). Asylum seekers have the right to emergency health care or dental care and the right to emergency care (Migrationsinfo.se 2018). Those with permission to stay have full coverage for health care in Sweden.

Health information

Information for migrants regarding Covid 19 and prevention, symptoms, social distancing and prevention was conveyed through text and films in different languages and information on the website of the Public health agency. The civic and health communicators in the county of Scania, Sweden, which hosts the most marginalized migrants, produced several information films about Covid 19 in different languages. The civic and health communicators translated information from the public health agency and any questions on Covid 19 on their web page in several languages. Apart from the aforementioned work on distributing health information in Sweden, the transcultural center in Stockholm has also played a key role in informing migrant populations of Covid 19 preventative measures. On a daily basis, they have staffed a helpline where migrants have been able to speak in their mother tongue.

The Rosengrenska health clinic in Gothenburg works on a voluntary basis with undocumented migrants in Sweden. A nurse in charge of the work there expressed her views on health information for the undocumented as follows:

> From the beginning of Covid 19 we could see that information regarding this group was an issue, so we translated the health information that was up to date at the beginning of the pandemic, but realised that the information was mostly for those that had been skiing in the Alps and was not relevant for the undocumented.

In some cases, healthcarers reported that migrants, such as in the suburbs of Gothenburg, were taking much more care with face masks and hygiene as they were forced to rely on information from abroad that advocated for a much more restrictive approach to the pandemic than the exceptionally relaxed approach then recommended by the Swedish public health agency. However, overall, migrants lacked reliable information specific to Sweden. Information disparity created more serious problems where, according to the Red Cross in Stockholm, migrants without rights to subsidized health care lacked information about rights to health care for symptoms related to Covid 19. It was not clear from the information given what kind of health care people without subsidized health care could expect.

Health services

The law in Sweden says that asylum seekers have the right to emergency health care. They also mention that all migrants should have access to testing for the virus. Testing was at first very rare and only after a doctor's decision, and only later became more frequently carried out without requiring medical authorization.

When it comes to health care for the undocumented at Rosengrenska, staff have worked as usual and referred their patients to their own health-care centers and this work has been ongoing for several years. This is carried out with due regard to the general law in Sweden which states that all migrants regardless of legal status have the right to emergency health care. But some of their patients fail to receive the necessary care:

> *Since they are afraid that the police might catch them, they avoid coming and this problem has persisted during the pandemic.*

A coordinator from Doctors of the World Sweden stated there was a lack of clarity on whether EU migrants were covered by the health-care system and it differed through the different regions in the country. EU migrants, which often mean Romani people, fall outside of the health-care system, since they have often been in Sweden more than 3 months as undocumented.

A coordinator from the Red Cross explained that migrants without personal numbers or electronic ID have reported that access to health care has worsened during Covid 19.

> The digitalization of health care excludes groups in society. Not being able to enter a health care clinic, but being forced to make a call instead, makes access to care worse for this group. The automatic information in the health care phone lines is mainly appropriate for Swedish and English people with personal numbers.

Living conditions

In the context of Sweden's exceptional approach where pandemic restrictions were largely voluntary, policy has not recognized the impact of the pandemic on marginalized groups. According to a nurse at Rosengrenska, the undocumented during Covid 19 have faced challenges regarding their social situation. She expressed it like this:

> They have faced economic problems and they have suffered from unemployment and many undocumented who work on the black market, can no longer work. This group have found it difficult to self-isolate and have found it more difficult to work from home. And as they are often unable to run a car, they have to use public transport and therefore have not been able to protect their own health.

In Gothenburg, for example, the areas which typically house the socially deprived have reported higher levels of infection. Usually marginalized migrants end up in areas where they have a network of contacts and this explains why they tend to live in bigger cities where these networks are based. These are also the areas where Covid 19 infections are significantly high in Sweden. In this way, marginalized migrants are to a greater extent suffering from Covid 19.

A coordinator from Doctors of the World expressed the situation like this:

> If the migrants within our reach, are able to self-isolate they have to do that within overcrowded environments, without protection such as face masks or other sanitary equipment.

Furthermore, in Stockholm, there are only seven places for EU migrants where they could self-isolate. Those without private access to accommodation have been largely dependent on voluntary organizations.

Anti-stigmatization

The civic and health communicators mention that the issue around anti-stigmatization has been mentioned within their work but that they have not been a part of the group that worked directly on this issue. However, some of the films they produced and translated to provide health information raised this issue. They underline, for example, when you get sick you have to stay home and should not feel stigmatized because of this.

A nurse from the health-care clinic Rosengrenska expressed the dilemma around stigmatization like this:

> Undocumented migrants are already stigmatized and it is therefore difficult to sink even further down than where they are already. This is because they live here in Sweden illegally and unwanted because of their legal status.

Community engagement and policy making

Within the county government of Scania, with a large MM population, the society and health communicators have produced posters and put them in shopping malls and mosques around the country. Their experience with civil society was important as a way of connecting to different migrant communities. However, overall, public agencies have shown little interest in working with migrant communities or civil society organizations supporting them.

According to the health-care clinic Rosengrenska, the work around the undocumented and support for this group is usually a task for volunteers. Migrants are often inexperienced and wary of seeking help from state authorities given that they survive and manage through informal work contracts, and receive food donations from civil society. At the same time, it has been harder for civil society to support migrants, one health-care clinic stated:

> This support has been challenged during Covid 19 since many of our volunteers are older people and during the pandemic, they have had to self-isolate and pull back on their efforts. As an organisation, that is built on volunteers, we now have a hard time to manage our work without these volunteers and have had to reduce our services because of this.

In addition, some of the volunteers have even quit their assignments during Covid 19 and have not come back. Many undocumented suffer from the lack of food distributions now for example. This is not possible due to restrictions around gatherings due to Covid 19.

A coordinator from Doctors of the World described the involvement of civil society:

> Without the care that we as an organization supply, these people would be without health care due to economic, legal barriers as well as because of lack of knowledge about their own rights in society.

That civil society is finding it harder to assist marginalized migrants during the pandemic was also reiterated by the Swedish Red Cross.

United Kingdom

The UK's Home Office, which has central responsibility for asylum applications, operates a highly complex migration management system openly designed to undermine the living conditions and rights of asylum seekers, within a network that shares private data on such individuals across all spheres (i.e. policing, health, social services, education) where they might interact with the state, whilst outsourcing many of its responsibilities to private contractors (e.g. transportation, and detention facilities) and public workers legally obliged to help police migration laws (e.g. doctors, university staff) as well as private landlords required to restrict housing access.

Complex institutional hostility runs parallel with a practice of infamously slow processing rates for asylum applications, meaning individuals are left in limbo for extended periods, often at the mercy of predatory solicitors doing little to support their applications, whilst the UK government also bans asylum seekers from legal access to the labor market. The effect is that asylum seekers can often stay in the UK for much longer periods than compared to other European states, due to the slow processing of their cases, but in so doing are heavily marginalized. Lacking formal access to national social security benefits, families and individuals awaiting processing are often subject to 'No Recourse to Public Funds' (NRPF) conditions, such that their access to housing and living costs is dependent upon the varying and often unreliable provision of services at the local municipal level (Institute for Public Research 2020).

Health information

The UK government's provision of Covid-19 information to migrant communities was initially very limited, with little translation. It was only on 31 July 2020 that the government body *Public Health England* published a guide for health practitioners on service entitlements for migrants related to Covid-19, updated September 8th. The document includes brief information translated into multiple languages, but has been poorly communicated with key developments announced often only online within web pages migrants are unlikely to regularly use. In addition, where many marginalized migrants are living in poverty, they are also unlikely to have reliable access to the Internet.

According to an interview with the Institute for Race Relations (IRR), the failure of the UK government to properly inform migrant communities on Covid-19 was evident where civil society – principally, Doctors of the World – have stepped in, translating NHS guidance. In contrast to the increasingly centralized system in the UK, the London Mayor's office took a lead in translating guidance for its citizens, which was then widely disseminated across the UK. The UK's national provision of Covid-19 health information

for migrants has then relied heavily on a patchwork of civil society and municipal action, with little national direction despite the increasingly centralized character of the UK's public budgetary and political structure.

According to Doctors of the World UK (DofWUK), the UK government's efforts to translate Covid-19 information was inadequate, given the diversity of the UK's population. The information translated did not keep up with new policy developments, and in the case of the shift over to prioritizing testing and tracing, 'there was no government translated guidance on that for months' (Interview with DofWUK).

According to both IRR and DoWUK, to fill the information gap created by the inaction of central government, local health authorities provided translation information to nearby migrant groups, though all had difficulties in updating information on a regular basis without more support from the national level. An important initiative in the UK on information provision emerged at the local level among doctors from minority backgrounds, such as in Leicester, where they would walk within their areas to communicate knowledge on Covid-19 and appropriate actions in minority languages.

The failure of national government was noted in the interviews (DofWUK) as being particularly surprising where the UK has a large number of persons within asylum accommodation, meaning they had detailed knowledge on the languages used by the individuals being detained or housed, and yet did not prioritize keeping them informed of how to avoid the spread of Covid-19.

Health services

In general, asylum seekers in the UK, including those refused permission to stay, should always receive medical treatment that is classed as 'urgent' regardless of their ability to pay, but this means that they may still be billed at a later date, and cannot get treatment for conditions classed as 'non-urgent' but nevertheless remain life-threatening (e.g. for cancer, or heart conditions) unless they can pay the prohibitively high costs. Evaluation of what constitutes an 'urgent' condition rests on health practitioners, who by being required to ask after a patient's residency status, and to report irregular migrants to the Home Office, are brought directly into the migration policing system at the expense of their role as health providers. In all four nations of the UK, refugees and asylum seekers with an active application or appeal are entitled to free NHS care at the point of use.

Overseas visitors were allowed access to testing for coronavirus, as well as treatment. And, of most importance particularly for irregular migrants, no immigration checks are required for patients receiving only testing or treatment for coronavirus. However, according to DoW and IRR, the effectiveness of this exception driven by the Covid-19 is greatly undermined in two ways. First, the UK government was slow to communicate the exception to health practitioners, and information to migrants remains poor and often overly technical given language difficulties. Second, it is not always clear when the exceptions apply given that individuals may have multiple health conditions requiring treatment, and that could both lead to them being charged a fee, as well as having their information passed onto the UK's Home Office and the police, exposing them to deportation.

In an interview, an activist at IRR described the main issue as being a lack of trust due to past incidences of official initiatives presented as helping migrants being used as a cover to catch and detain those individuals for deportation:

> The government didn't do … an information campaign in all languages saying, 'You can get this for free'. So again it was down to the community groups to tell people but they themselves said 'Well, we are not sure if we should because we don't know … whether people are then going to get picked up'. So, this distrust is so profound and quite rightly.

Due to many doctors' surgeries closing down during the lockdown, and providing restricted services afterward, there has been an over-reliance on online services that often exclude vulnerable groups. According to a policy advocate at DoWUK, the situation meant 'highly technologically literate people who just didn't have the technology and the resources to . . . make phone calls and to get online'. Often marginalized migrants lack their own phone, making it very difficult for them to book health-care appointments, but also be contacted by GPs. In addition, whereas at the start of the pandemic the UK government decided to release some migrants from immigration detention for public health reasons, those individuals lost access to their usual source of healthcare and, at the same time, had difficulty contacting the GP surgeries within the communities where they were moved (Interview DoWUK).

The lack of sufficient information clarifying what access asylum seekers and irregular migrants had to Covid-19 testing, mentioned above, put those individuals in an impossible situation where the positive news of not having the virus might risk them being charged for a lesser condition not exempted from fees, or being reported to the Home Office. As the Policy advocate at DoWUK stated:

> It's impossible for a patient to make a decision about whether to go forward to services or what the risks for them are so it just means that they postpone it . . . until they become really desperate. Which is obviously a disaster for public health.

Living conditions

Asylum seekers awaiting a decision from the UK's Home Office are granted an allowance of only £5.39 a day per person, provided usually in the form of vouchers or on a pre-paid card to be used at designated vendors. With no legal right to work whilst their cases are being processed, this automatically places asylum seekers in a state of abject poverty unless they have access to other means of income, which few do. During that period, the Home Office provides accommodation, but often only within extremely over-crowded facilities. Once an asylum claim has been approved, the Home Office no longer provides accommodation or financial support. Where then classed as a 'refugee', the housing of those individuals falls under the responsibility of the local authority. The bureaucratic transition between being an 'asylum seeker' to a 'refugee' is rarely seamless, with delays exposing refugees to a high risk of being made homeless.

Living in a precarious situation means marginalized migrants were already particularly vulnerable, and where that precarity is strongest in the UK, the situation with Covid-19 has created a vicious circle. The policy advocate at DoWUK stated:

> People, as their lives are becoming more difficult . . . as their financial resources are drying up, as they can't buy soap and face masks and phone credit and can't speak to people and access to food is becoming harder and people . . .. accessing health care services is becoming further and further away from reality.

One success of the UK response, noted in the interviews, was that at the start of the pandemic the national government demanded that local authorities put all homeless persons, including migrants, into hotels. In addition, there was also a temporary pause on all evictions from asylum accommodation, so that those with refused asylum claims could avoid being homeless during the lockdown in the Spring. At the same time, though, living conditions within the asylum accommodation system remained over-crowded, particularly for single men often forced to share a bed, and non-relatives having to share rooms, often without access to essential sanitation, like soap and face masks.

Furthermore, the policy to accommodate all homeless persons quickly led to more over-crowding. The national government also decided, at the height of the lockdown in Spring 2020, through its private contractors, so as to minimize the amount of journeys its staff would need to make to visit asylum seeker accommodation sites, to move approximately 300 individuals in Glasgow out of flats into mass accommodation units where individuals were suddenly forced to share transport and then rooms with complete strangers despite being urged to social distance, creating significant fear (Interview IRR).

The poor conditions in which many asylum seekers are forced to live, which worsened for some during the pandemic, were criticized by a civil society representative from IRR as follows:

> What is the point in offering them a test when you have created conditions for them to get Covid? And contained them in these circumstances.

The UK government continued to restrict asylum seekers' accommodation, preventing them from legally renting rooms, as well as maintaining the criminalization of their seeking paid employment. Where either would have helped give them a better chance to self-protect from Covid-19, the failure to improve living conditions stands out as an omission to control the spread of the virus.

Anti-stigmatization

Whilst the UK government claims to be able to directly challenge false narratives that threaten society's well-being, having established a Counter Disinformation Cell led by the Department for Digital, Culture, Media and Sport, this largely focuses on whatever the government decides is a 'false' on social media. In practice, although the 'hostile society' mantra is no longer an official policy, the logic remains pervasive such that prominent Members of Parliament (MPs), including those in government positions, have frequently been accused of stigmatizing migrants.

In the context of Covid-19, the issue of anti-stigmatization of migrants in the UK has been absorbed within the much more prominent issue of anti-stigmatization of minority and vulnerable groups in general due to the actions of several MPs in blaming black and ethnic minorities for the gross disparities

between Covid-19 infection rates among their communities compared to the wider population, whilst refusing to acknowledge evidence of structural racism as the key factor explaining such disparities.

According to DoW, in contrast to the stigmatization often pushed by the UK government, it has been civil society which has been leading anti-stigmatization efforts in the UK, to do 'campaigning and media work on what the asylum system is, why we offer asylum, why accommodation is important and also why inappropriate accommodation is not okay'. That also includes civil society campaigns to portray more positive stories on asylum seekers. That refers to a general anti-stigmatization campaign regarding migrants, rather than specific to Covid-19.

Community engagement and policy making

There have been no evident efforts from the national level in the UK to encourage engagement with marginalized migrant communities, whether to help distribute information, encourage use of health-care facilities, or seek input for policy making. Rather, the UK government and NHS have been seen to free-ride on the activities of charities and civil society, as well as the voluntary efforts of individual health practitioners, to engage with marginalized migrants. For example, the London division of the international charity 'Doctors of the World' early on worked to translate Covid-19 health information from the NHS into the vast majority of the languages used by migrants in the UK.

In an interview, a civil society representative described the UK government's approach as 'very top-down' (Interview DoWUK), but also framed heavily within an institutional history in which the NHS shares confidential patient information with the Home Office whenever it concerns asylum seekers. In that context, it is hard for functioning relations to develop between minority groups like marginalized migrants and state health institutions.

The lack of engagement from the UK government with communities was seen as highly problematic, one civil society representative from IRR stating:

> If the government had been in good faith in establishing these measures, they would have gone to the organizations that have the trust of marginalized migrants and they would have, you know, they would have found trusted partners, or partners that have the trust of the community to actually follow through the policy. That would be a good public health model. I see no evidence that the government did anything to recognize the impacts of their past policies on public health.

Discussions and conclusions

The above analysis identifies the extent to which a legacy of past, but also ongoing, migration management policies often obstructed pandemic control policies by sometimes working directly against the protection of vulnerable groups and upholding a rights-based approach. In addition, the article notes an overriding reliance on the third sector, but little effort made at state levels to acknowledge the special circumstances faced by marginalized migrants that needed to be considered in the interests of public health. Here, France and the UK grossly under-performed, with Sweden coming out

strongest, though still far below the IASC guidelines. When community groups and NGOs came together, it was often at the initiative of third-sector organizations, rather than national government, with the occasional exception of local government initiatives. However, this remained sporadic and uncoordinated.

Historic difficulties for migrants to have ready access to health services persisted during the first phase of the Covid 19 pandemic, thus confirming much of the literature on organizational, and interpersonal barriers that migrants encounter. Added to this was the reluctance for migrants to seek healthcare because of fear of deportation, especially for the undocumented. In the UK, the hostile environment further compounded this reluctance to seek help. In Sweden and the UK, digital exclusion was a clear obstacle to health access for migrants during the Covid crisis, with health services moving online. Moreover, adequate social care was also lacking in the three case studies. Living conditions for these populations have worsened since the beginning of the Covid 19 outbreak. Poor housing conditions means that it is impossible for marginalized migrants to adequately protect themselves from Covid 19.

While there is significant variation across the three European countries in health and social care provided for MMs during Covid-19, in all three cases the policies fall far below the international guidance. The gap between what is recommended and what has been implemented can be seen to not only undermine the welfare of some of the most vulnerable communities in Europe, but obstruct larger public health goals to contain the pandemic.

Notes

1. Kinney and Clark (2004), 285.
2. These centers provide accommodation for migrants occupying the illegal camps in north-east Paris who have been directed via the regular round ups or referred to by one of the two day centers run by the regional prefecture. During their stay, which lasts on average 10 days, migrants can benefit from health, social and administrative support before registering their asylum application with the *Guichet Unique pour Demande d'Asile (GUDA*), located close to the CAES. Depending on their administrative situation, migrants are then redirected to structures adapted to their situation in Ile-de-France (Paris region), while their asylum application is being processed.
3. The 115 is an emergency service for homeless people.

Key messages

The article seeks to determine the extent to which there is multi-level coherence with respect to acknowledging the situation of migrants living on the margins of host societies during the Covid-19 pandemic, focusing on France, Sweden and the UK, in comparison to international guidelines. An overriding reliance on the third sector was noted, but little effort was made at state levels to acknowledge the special circumstances faced by marginalized migrants.

Difficulties for migrants to have ready access to health services persisted during the current Covid 19 pandemic and confirms the structural, organizational, and interpersonal barriers that migrants encounter and that, overall, undermine public health and management of the virus.

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